# My Visit to Urgent Care

*Richard Guthmann, MD*

I am standing at the counter behind the nurse's station quickly filling out encounter sheets, and I hear crying in the waiting room. It sounds like a child, a small child. The patient walks around the corner, and I see that he is a grown man. His boots drag on the hard floor. His cry quiets to a whimper as the nurse escorts him into the examination room. His crying might be that of pain, sadness, or grief, but I cannot tell. He does not appear mentally retarded, but he might have some psychological problems. What is clear is that he needs help.

I wonder whether I can help him. I would like to help, to learn, but here in the fast track of urgent care, I have no time. It was not always like this. Before I came to work at urgent care, I worked in a private office. I practiced in a 3-physician group, in a small town 1 hour outside Chicago, where the patients knew the physicians, the nurses, and the office staff. It was the sort of environment that made me want to go to medical school. Everyone in the office knew the patients, and we all prized these relationships. Patients talked about us and we talked about them. The staff traded medical stories and gossiped social histories. We knew who drank, who smoked, and who was pregnant. We exchanged daily updates about the active patients. That was in private practice; here, in urgent care, we scarcely have an opportunity to meet the patients.

When my wife landed a 1-year journalism fellowship in another state, I needed a job. Fortunately, a local urgent care center was able to fit me in. I suppose that I came to the urgent care center for the same reason that the patients do—out of need and convenience. They need walk-in clinics with convenient hours where they can be seen in the evening or on the weekend. I needed a job.

Submitted, revised, 13 August 2001.

From the Illinois Masonic Family Practice Residency, Chicago. Address reprint requests to Richard Guthmann, MD, 836 W. Wellington Ave, Chicago, IL 60657.

I was enthusiastic about working at an urgent care center. Things would be simple and focused. The patients would come in with specific concerns, and I would respond in kind. Additionally, I had heard from friends that the hours would be good and that no pager would be fantastic.

I knock and without hesitating enter the patient's room. He is still making a weak muttered cry, lying on his right side, facing me. Tears pool between his upper eye and nose. His mouth and neck hide beneath his shaggy beard. His blue jeans are as dirty as his untied work boots. He looks at me when I enter the room, but he does not make eye contact.

"Hello, I'm Dr. Guthmann."

I sit down and ask him, "What's wrong? How can I help?" He says nothing, but looks even more directly at me. I slowly ask him, "Why are you crying?"

He says, "My back hurts. I fell 20 feet off a barn on my back, 10 years ago."

I ask, "Did something happen more recently?"

He's crying when he says, "I had x-rays and they say nothing's wrong. Something is wrong."

"Do you have a regular doctor?"

"I have a lot of doctors. I was in the hospital."

"When?"

"Eight years ago, on the psyche floor."

"Do you drink? Or do other drugs?"

He pauses and says, "I only used marijuana and crack. I never did prescription drugs."

"Do you work?"

"Yeah."

"Do you smoke?"

"No."

"Do you live alone?"

"Yeah."

Again, he says with sincerity, "My back hurts." He is still sobbing. He wants help.

I excuse myself from the room saying, "I'll be right back." I go ask the clerk to pull any old records and page his previous physician. I also want to allow the patient time to calm down.

Patients usually do not know the difference between the emergency department and fast-track medical care. They enter through the same door, get billed at the same rates, and see most of the same people. When I ask them why they have come to Readycare, they frequently correct me and say, "the emergency department." It looks like a hospital—the neutral colors and decorations, the square floor tiles, the basic waiting room with chairs and a television set, the woman seated at the front desk, and the standard uniforms of medical personnel.

This urgent care service is really a fast track for the emergency department. Like the emergency department, we do not require appointments or insurance. We are therefore available for overbooked physicians, for uninsured Americans, and for patient's convenience in the evenings and on the weekends. Unlike the emergency department, however, we do not have long waits and excess high-level personnel and equipment. We take care of sprains, strains, fractures, and lacerations, but for many patients this care is primary care. We are located in the hospital, and we practice primary care, as the emergency department does.

In urgent care we usually do not know the patients. We do not schedule extra time for new patients, because all the patients are new. I work irregular shifts, evenings, and weekends, so even after 9 months, every patient is new to me. I gather data from the triage sheet and collect the rest of the historical information from the patient interview. We do not routinely search medical records for old charts, because that would take time and the charts are not generally needed. We rely on what the patients tell us during the visit. We are a frequent target for drug-seeking patients, so we must be pretty easy to fool.

Everyone wants something, and each person has his or her own way of asking. Most people ask politely, grant us respect, and accept our recommendations. Here, in urgent care, with our less-developed relationships, some people are more direct about their expectations. They say exactly what they want, and if I refuse, then they can become angry. We call security frequently. Triage usually alerts security early, but sometimes we have to notify them after the trouble starts.

While I wait for the clerk to help me get more information, I go to see the next patient. A mother, in her middle thirties, sits on the bed with her arm around her child. The mother is well dressed in office attire, an attractive necklace bringing together her sweater and business jacket. The chart reads "febrile, congested 6-year-old." She tells me, "I called my doctor, but they were booked and said to come in here." She wants antibiotics. She says, "My child is sick."

I ask, "When did it start?"

"Last night."

"Is she eating normally?"

"Yes."

"Is anyone else at home sick?"

"No."

I examine the 6-year-old. She is awake and alert, her temperature is 99.7°F without antipyretics; her tympanic membranes are pink, but translucent; she has clear rhinorrhea, erythema of the soft palate and pharynx with mild tonsil hypertrophy, small tender anterior cervical lymphadenopathy, no facial discomfort with pressure, clear lungs, regular heart rate and rhythm, a benign abdomen, and no rash. It looks like a cold. I suggest that we do a rapid strep test. As I leave the room, I mention to the mother that the child is likely to have a virus.

In the hallway by the nurse's station, the clerk hands me our back-pain patient's records. They show nine urgent care or emergency department visits in the last 10 years. Three were for complaints of back pain. Twice he had received a prescription for Vicodin—once last year and once 9 years ago. The clerk says, "His doc hasn't called back."

The nurse says, "I don't know, but we're starting to get backed up."

Urgent care aims to treat patients quickly by referring, recommending, and preparing them for further evaluation. Focus on the complaint. Do something now. Do not delve into underlying issues. Tell everyone to follow up, just not with us. The motto is to "treat 'em and street 'em." The maxim is expediency. If you are fast, the nurses and clerks will tell you that you are doing a good job. No one wants backups, no one wants patient complaints, and certainly no one wants to stay late.

I need to make a decision. I can hear through the door that the man has stopped crying, so I enter the room. It is quiet now. I ask him, "Please stand up." He moves slowly making small grunts until he reaches the ground. Then he looks to me for some direction because he is not sure which way to face. I instruct him with a pointed finger to turn away, and I say, "I want to see your back." He shows me

the area of pain in his mid back. The spine and musculature appear normal, no muscle spasm, and minimal tenderness with palpation. He has good range of motion after some encouragement and patience, and there are negative findings on straight leg raises. His reflexes are normal, as are his strength and sensation. I tell him, "The examination is fairly normal. We should start conservative treatment with anti-inflammatories, stretching, and strengthening exercises and good follow-up." As I start saying, "Ibuprofen 800. . . "

He whines, "It don't work. I tried that." He puts his hand on his stomach.

I glance at his eyes and offer, "Well, we can use acetaminophen and muscle relaxants."

He starts more whimpering and says, "I'm in a lot of pain. My back hurts. I need something stronger."

I excuse myself saying, "I'm going to try to reach your regular doctor."

The back-pain patient's doctor has not returned the page, but the strep test is back. I knock and enter the little girl's room. I tell them, "The strep test is negative."

Mom states, "I want the pink stuff. I don't come to the doctor that much. If I came in every time one of my kids had a cold, I would be in here every day. But I know that something is wrong." She seems reasonable and sensible, and, at least, she is straightforward.

I explain, "We should only use antibiotics when it's necessary."

"I understand," she interjects, "but my child needs something."

There's a pause. I say, "This is what we can do. We should give her Tylenol or Advil, push fluids, get as much rest as possible, and try some decongestants like PediaCare or Dimetapp."

This suggestion makes her fidget, and then she calmly and evenly offers, "My child's best friend was just diagnosed with strep and is taking antibiotics. I just want the pink stuff."

A knock on the door interrupts. I say, "Come in."

The nurse speaks through a crack in the door, "A doctor on the phone returning your page."

I say, "Excuse me," and quickly exit to the nurse's station. I pick up the telephone and say, "Hello, this is Rick Guthmann at the urgent care center."

"Hi. This is Dr. Rob Fine. I'm answering the page for Dr. Jones."

I continue, "I have a guy in here, named Joe Smith. I'm not sure if you know this guy. Twenty-nine years old, looks a lot older, long brown beard. He comes in here with a long history of back pain and seems to want drugs."

He responds, "Well, sounds familiar, but sorry. No, I don't know him."

"Well, thanks for calling back." I say, "I was just trying to get some information about him."

"Sorry, I can't help. Our office is closed."

"Thanks anyway," and I hang up.

I return to the back-pain patient's room, sit down, make eye contact again and say, "I'm concerned about drug abuse. And I think that you have some other issues and problems that need to be addressed." He seems to respond to these comments, becoming quiet and more attentive. I continue, "I'm concerned that the other stuff might be playing a role in your back pain."

He interrupts, "I'm in pain, man."

I interrupt, "I know. I know. But you need a regular doctor. Someone that you can follow up with, for your back and for other stuff. It should be the same person, someone who knows you."

He nods and says, "I don't have insurance." Then pauses and says, "Okay."

I tell him, " I want you to get help." I write a prescription for six Vicodin. I put the prescription and a list of local doctors on the countertop. I nod to him. I say, "You're all set." I leave the examination room.

I return to the mother and child. I look at them, take out my prescription pad, and say, "I'm writing a prescription for amoxicillin. She should take 1 teaspoon three times a day for a week." I hand her the prescription and say, "You're all set to go."

I quickly slip out of the room and into the hallway. The guy with back pain is dragging his boots around the corner, through the waiting room, and out the door.

Next year I return to Chicago to start my career as a teacher of family medicine. My visit to urgent care fulfilled my needs. It reinforced my beliefs in continuity of care, family practice, and the importance of building relationships with my patients. My experience will always encourage me to see the next patient who calls in need of urgent care.