'As Little as Necessary...' – A Mantra for Urgent Care

"Do as little as necessary, not as much as possible."

This is the mantra I recite throughout every urgent care shift without fail—that's how mantras work after all. Hearing the word "mantra" might conjure images of a placid-faced yogi seated in the lotus position for some, but a mantra needn't serve only spiritual practice. A well-conceived mantra can also prove useful when deployed in any context where we might benefit from being reminded frequently to act differently than if left to the mercy of our habits or human nature. Clinical urgent care practice, in many ways, is certainly this sort of context.

Not only do I recite this mantra repeatedly on every shift, but I've also made a stylized version of the text my desktop background. This mantra is specifically important in urgent care (UC) because doing more can prove to be a constant temptation because *there's often little resistance to doing more*.

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Patients want more testing because they believe that more data equates to better care. We can have shorter conversations with our patients if we just "run some tests" rather than explaining our clinical reasoning as to the pros and cons of getting a flu swab or a mono test. More testing is also usually more revenue, so it's rare for administrators to bring up any concerns about overtesting. Similarly, offering a prescription for every symptom and an antibiotic when we are on the fence takes less time and effort than counseling patients about nonpharmacologic management and unfavorable side effect profiles.

Indeed, this is the moment when we find ourselves at the metaphorical decision intersection, where "Do More Avenue" crosses "Do Less Lane." And if we look in the "Do Less" direction it's usually red lights all the way down the road. This is why the mantra serves as such a dutiful reminder: "Do as little as necessary, not as much as possible." Doing more may be alluring for UC clinicians, but it's usually a trap.

When It's Best Not to Test

Let's turn our attention first to test ordering and diagnostic uncertainty. Diagnostic uncertainty exists to varying degrees throughout all of medicine but is nearly ubiquitous in UC. This is why it's much better for us (and especially for our patients) to practice embracing this reality rather than ordering haphazard or non-specific laboratory testing. While it is tempting to believe that collecting more data must necessarily reduce uncertainty, this premise proves misguided in practice. At times, ordering every lab test for which there's a box to click may be simply futile, more commonly (and ironically) however, doing so results in a post-test situation in which more uncertainty exists than if we had obtained no lab data whatsoever.

Imagine a 28-year-old, otherwise healthy, woman comes into your UC because she's had 4 months of intermittent, non-menses related, diffuse abdominal cramping with some fatigue. She's eating well and hasn't had vomiting, urinary, or bowel habit changes. Her weight has been stable. Even more reassuring, her vital signs are normal, and her abdomen is completely non-tender. You even check a urine pregnancy test, which is negative. What are the chances that there is a dangerous condition causing this patient's symptoms? Probably somewhere between quite low and extremely low. But how can we be certain?

You might find yourself thinking, "some screening labs would be helpful here to make sure this isn't anything more serious than it seems." Because there are other patients waiting (as there always are), you make those 2 effortless clicks to obtain a complete blood count (CBC) and metabolic panel (CMP): "CBC, check; CMP, check." Perhaps you even throw in a urinalysis and a lipase for good measure—click, click—after all, it's tempting to believe that if you cast a wider net, you're more likely to catch a fish.

The Subtly Pivotal Decision Point

When we find ourselves at the point where we must decide which of the boxes (if any) to click, we have reached the imaginary intersection of the 2 roads: more or less? The problem is that this is an insidiously and unsuspectingly important moment. Many UC clinicians, myself included, have mistakenly thought it prudent, even conscientious, to order such "screening" laboratory work-ups for patients such as the one described above. We have done so often subconsciously considering that the results would yield 1 of 2 possible outcomes: A.) Tests will return normal, and we can both breathe a sigh of relief; or B.) Tests will be abnormal, and we will have an answer to the cause of the patient's symptoms (or at least a clear path forward for continued work-up). If this were true, casting a wide net would be of tremendous utility. However, for anyone who has practiced even a few months in UC, you will realize that what I've described does not correspond with how this scenario typically unfolds.

What more commonly occurs is a third possible scenario: 1 or more lab values will return just slightly outside the reference range. Now we are forced to act on this information. The ostensibly innocuous set of clicks we rushed through after first seeing the patient now have gathered momentum; they are beginning to show that they can produce some less-than-subtle implications on the subsequent conversations and the additional testing that we are compelled towards in response to the results. Encountering incidental findings in such a way is an experience we can all relate to. And I'd be surprised if many of you felt that following up on incidental lab abnormalities is a valuable or enjoyable part of the job.

Avoid Adding Ambiguity to Uncertainty

Now it's the next day. The young woman's labs are back, and the unexpected yet predictable has occurred: exclamation points and red flags sporadically dot the laboratory values. Now we find both ourselves and our patient in differently unfortunate yet similarly unenviable positions. Let's imagine the patient's white blood cell (WBC) count is slightly elevated at 11,000, or her AST is 85 IU/L, or her urine microscopy shows 10-50 WBC. Are we any closer to determining a clear cause of her abdominal pain? Have we ruled anything out beyond what we could've reasonably excluded with our history and exam alone? In truth, we ordered the lab tests not because we were concerned for an imminently dangerous condition but rather because we couldn't explain the cause of her symptoms. And the abundant data we collected hasn't altered that reality.

It's not surprising that the anxiety of diagnostic uncertainty compels us into less than rational workups. Feeling unsettled in cases of doubt is human nature of course. However, in UC, such diagnostic uncertainty is far more common than the converse: instances where we can arrive upon a definitive explanation for a patient's presentation. Getting a positive result on an influenza or gonorrhea test are a few of the rare exceptions. This means that our success as UC clinicians is largely determined by our ability to comfort ourselves and accept this uncertainty. Equally, however, our success also depends on our ability to communicate effectively about the inevitability of uncertainty with our patients, especially when they present with seemingly benign and vague presentations like the young woman mentioned above. When UC clinicians fail to embrace this reality in such instances, reflexive patterns of test ordering often result.

Furthermore, it turns out that non-specific presentations are rarely clarified by non-specific labs. In fact, more often we realize that we've actually made the situation worse. And it's at this point that we are forced to address the ambiguous, likely irrelevant, incidental lab abnormalities, which have been heaped onto the initial uncertainty, leaving us with greater complexity and confusion than when we began our assessment.

This is why it is critical for UC clinicians to develop a level of comfort in ourselves to cope with the common diagnostic uncertainties that arise on every shift and subsequently communicate this reality to our patients in a reassuring manner. Overcoming our reflexive discomfort resulting from not having an answer takes significant conscientiousness. This is where the mantra comes in handy: "Do as little as necessary, not as much as possible."

It's a calming reminder that ordering fewer tests does not equate to practicing reckless urgent care medicine. We must develop this awareness about the knee-jerk ordering of tests in the face of uncertainty first to allow for own apprehensions to be sufficiently quieted. Conversely, if we remain anxious about uncertainty, it is unlikely we will be able communicate with enough confidence to reassure our patients.

Ultimately, an approach that does not involve test ordering must feel comfortable to both the patient and us. If we can accept this uncertainty, we can more effectively assure our patients and their families that leaving UC without a clear diagnosis is normal, common, and preferable to the alternative: ordering a laundry list of non-specific labs, which more commonly will produce the opposite effect of what they're seeking. We will be serving our patients much better (as well as whichever of our poor colleagues would be forced to follow-up on the results)

to instead take this moment to provide education about the insidious dangers of the pervasive, yet flawed, premise that more data equals more certainty.

Changing the Target from Diagnosis to Disposition

I frequently observe clinicians who have recently transitioned to UC from primary care or specialty practices struggle with diagnostic uncertainty most. In primary or specialty care, the goal is almost universally arriving upon a diagnosis to explain the patient's symptoms. For that reason, the transition from school or postgraduate medical training into these practices is less jarring because in training, we are taught that diagnosis is the objective. Get the diagnosis right, get the treatment right, and the patient gets better. The problem is that this is a fairy tale version of medicine and reality is seldom this tidy, so we'll feel more comfortable in our practice if we are prepared for the more likely eventuality where not everyone lives happily ever after.

It took me nearly my entire residency in emergency medicine to develop comfort with the loss of this Panglossian vision of how medicine was "supposed to work." This ultimately occurred when I realized that my frequent frustrations were arising because I was unwittingly aiming for the wrong target. I didn't realize that what mattered most was *not* getting the diagnosis right (which was almost always impractical during an emergency department [ED] visit) but rather making the right decision about what should happen next for the patient. It was much more important, for example, that I made the right call to admit patients who were seriously ill to the intensive care unit than it was for me figure out exactly why they were so sick. Things worked out much better for everyone involved if the provisional diagnosis was wrong, but the disposition was right compared to the converse.

Urgent care, when it's practiced most effectively, must operate the same way: our priority should be determining the safest disposition for our patients. However, we have less time and fewer tools in our clinics than I had in the ED. Therefore, it's even less likely that we would be able to make a definitive and accurate diagnosis in UC. However, based on the patient's presentation and our ability to conceive of an appropriate list of differential diagnoses, we can certainly make safe and rational decisions about where the patient should go after they leave our UC. In other words, getting the disposition right is imminently possible so long as we make this our primary objective.

While changing our focus from diagnosis to disposition may feel like a major shift in mindset—and it is—it also allows us to practice with more peace of mind. As you've undoubtedly experienced, arriving at an accurate diagnosis with certainty in UC is uncommon. By shifting our mark to a much more achievable target, our practice will feel more rewarding. After all, it's not surprising that we would feel demoralized if we are expecting to reach a goal that borders on impossible in most cases. Disposition focused care, instead, is a much more sustainable headspace to practice from.

Also consider that for many patients with non-specific symptoms, a clear diagnosis will never be reached. For example, up to 80% of patients with dizziness never receive a specific diagnosis.[1] This is why we should be glad we work in UC and not in a specialty clinic where idiopathically dizzy patients are referred.

It also turns out that shifting our attention towards an appropriate disposition is the more effective way to practice in terms of ensuring patient safety. If we get seriously ill patients immediately to the ED, possibly ill patients provisionally to the ED if their condition deteriorates, and non-seriously ill patients to appropriate outpatient follow-up, we've done our job well. And if we do all this without ordering non-indicated tests—which often do not help the disposition decision but do beget unnecessary downstream testing and iatrogenesis—so much the better. In fact, by embracing the inevitability of diagnostic uncertainty and transitioning our focus to disposition, we'll naturally feel more comfortable ordering less testing in the lower-risk situations, such as a young woman with long-standing belly pain or a middle-aged man with chronic fatigue.

"Do as little as necessary, not as much as possible." The mantra pops into your head again after seeing the 28-year-old with abdominal cramps. You can feel a weight lifted and breathe a sigh of relief as you uncheck all the lab order boxes in the EMR. You realize that this patient can go home and follow-up with her primary care provider (PCP) or perhaps a gastroenterologist. So, instead of firing off the CBC and CMP, you ask the patient to keep a journal of her diet and symptoms and bring it to her next PCP appointment in a few weeks. For good measure, you review with her the unlikely red flags that might arise. Counterintuitively, by doing less, you've done more for the patient. The mantra has saved you and the patient from the ambiguous data that you might formerly have referred to as "screening labs." Remember this in the moments when you're ever accused of not doing enough. You're not doing nothing, just as little as necessary, and that's the foundation of how urgent care is best practiced. ■

Reference

1. Bosner S, Schwarm S, Grevenrath P, Schmidt L, Horner K, Beidatsch D, et al. Prevalence, aetiologies and prognosis of the symptom dizziness in primary care - a systematic review. *BMC Fam Pract.* (2018) 19:33. doi: 10.1186/s12875-017-0695-0,