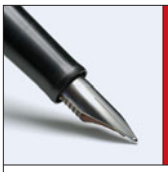

LETTER FROM THE EDITOR-IN-CHIEF

A Small Step for *JUCM*, a Giant Leap for Urgent Care

JUCM's latest initiative in publishing original research and leading an academic transformation as urgent care "comes of age"

Long before the first flowers of the new year bloom, an even earlier indicator of winter's end manifests itself: teenagers plotting and perseverating over Spring Break plans. Partially a rite of passage and in other ways an early indicator of a youth's future fate, much can be predicted about an adolescent's trajectory by their choice of destination and activity during this vernal vacation.

Sure, it's not a perfect science. However, it's safe to say that the kids who choose a booze cruise to Daytona Beach are generally less likely to achieve success by conventional standards than those who chose a mission trip to Latin America. This is because our pubescent years are a pivotal and formative stage in our development. Consequently, the choices we make during this phase of life result in a disproportionately greater impact on where we end up than decisions we make later.

I share this observation because we in the urgent care community are also squarely enmeshed within our adolescence and, therefore, the choices we make now will have a powerful impact our ultimate destiny.

A brief reflection on our history can prove informative. Urgent care was born in the 1970s in response to a rapidly changing American healthcare landscape. Millions of patients with acute medical needs were unable to get timely medical care as the GPs who made house calls closed their practices and overcrowding plagued urban U.S. emergency departments.

It was in this this same era and with this historical backdrop that emergency medicine (EM), in many ways one of UC's older siblings, came of age as a specialty. And we can glean a number of instructive lessons in UC from this chapter in the story of EM.

EM was not yet formally recognized as a specialty in this era and EDs were staffed by a hodgepodge of moonlighting physicians from various specialties. Some gravitated to the ED because they enjoyed the high-paced, high-acuity environment. However, a second, larger group had no special affinity for the practice and simply needed the job. In these days, a patient having a heart attack could walk into an urban ED and very likely be seen by a dermatologist behind on his alimony or an oncologist who'd lost her privileges everywhere else in town.

Beginning in the 1960s, a determined group of physicians who believed strongly that patients were receiving inappropriate care in American EDs began organizing and petitioning for recognition of EM as a unique specialty.

Among these pioneers committed to this cause was Dr. Peter Rosen. In 1979, Dr. Rosen wrote an essay called The Biology of Emergency Medicine. In this article, he outlined his case for the "specialness of emergency medicine" based on the unique practice demands within the ED, as well as the skill set required for appropriate management of potentially life threatening conditions.

In expressing his vision, Dr. Rosen also included, in no uncertain terms, a call to action for to his fellow emergency physicians (EP). In order that EM might be rightfully respected as a specialty in the House of Medicine, he compelled EPs to pursue EM-specific research endeavors and develop in situ EM training programs. His editorial was prescient. As it happens, EM did receive specialty recognition by the American Board of Medical Specialties (ABMS) shortly after his essay's publication.

We obviously live in a very different world than the one Dr. Rosen spoke of in 1979. However, humans haven't evolved into a new species and the rise of urgent care in the U.S. and other countries offers proof that within the specific biology of acute pathology the late Dr. Rosen spoke of, there indeed lies a large proportion of acute illness and injury which do not require advanced diagnostics nor rapid aggressive intervention. This is the realm of urgent care.

I didn't appreciate this truth until I began moonlighting in UC in the final year of my residency training in EM. After having handled most varieties of severe acute illness during my training in the ED, I presumed that working in urgent care would be a refreshingly low stress change of pace. I couldn't have been more sorely mistaken. Within a few hours of my first shift, I realized how inadequate my training had been to pre-

pare me for managing patients in the spartan setting of UC. Not only were my patients presenting with low-acuity, subacute, or chronic complaints which I had little to no experience managing (eg, ingrown toenails, trigger fingers, and ganglion cysts), but also with lower-risk versions of common acute complaints I'd routinely manage in the ED (eg, chest pain and abdominal pain), but for which I had not developed an appropriate approach without advanced diagnostic testing. Even the cases which I was quite comfortable with from my EM training (for example, shoulder dislocations and intractable vomiting) required a different mindset because of the limited human and medical resources available in UC.

I frequently worked alongside doctors trained in family medicine (FM) and I thought perhaps their training afforded a greater sense of preparedness for practicing in UC. But when I questioned several of them, I found that they too felt uncomfortable with UC practice, albeit in the management of a different set of patients and scenarios.

This realization, I believe, is the most revealing of the "specialness" of UC. For urgent care medicine is not family medicine nor emergency medicine, but something distinct. UC practice is resource-constrained, unlike EM, and continuity constrained, unlike FM. And, therefore, patients require a unique approach in UC—one which differs from that commonly used in FM clinics and EDs.

Some responsibility for the delay in the recognition of the "specialness" of UC medicine lies in semantics. The words *urgency* and *emergency* are often used interchangeably and considered to be synonymous by most laypeople. Indeed, we can see evidence of this confusion manifest on every shift when a patient mistakenly shows up on our UC doorstep with a bone protruding from their skin or severe respiratory distress. The myriad of self-referential terminology used by UC centers further contributes to such confusion. It is still commonplace, for instance, to see terms such as "Immediate Care" and "Express Care," among many others, used to label UCs throughout the U.S.

However, when one considers the actual definitions of *urgent* and *emergent*, the distinction becomes more apparent. *Webster's Dictionary* defines *emergent* as "arising unexpectedly" and "calling for immediate *action*." Whereas *urgent* is defined as "calling for immediate *attention*." This difference is actually reflected in the staffing and equipment available in EDs, which are prepared to *act* in response to a plethora of acute life threats. Similarly, UCs are designed to offer a cost-effective alternative for those seeking immediate medical *attention,* but who generally do not need much in the way of rapid *action* taken to prevent a decline in their condition.

It turns out that this represents the bulk of patients in UC (and actually the bulk of patients with acute issues in general): patients with minor illnesses or injuries who merely need a simple procedure, a prescription for an oral medication, or, as is most often the case, nothing more than simple reassurance and education. Before the rise of UC, these patients would often be seen in an ED if they could not be squeezed in for an urgent visit at their PCP's office. However, with changes in the U.S. medical insurance and primary care landscape over recent decades, these options have become increasingly unappealing for patients seeking convenient, cost-effective acute care. This is the niche that UC fills so well.

It is certain that the creation of an infrastructure of UC centers has required considerable heavy lifting over the past 30+ years. Consequently, much of the efforts of the leaders in UC have been devoted to the construction and staffing of facilities which can adequately serve as UC centers.

While this process is certainly ongoing, a largely unmet need within UC continues to loom: an assurance that the growing number of patients presenting to UC centers will receive high-quality, evidenced-based care. Much of this deficiency stems from the lack of dedicated and standardized training programs which prepare clinicians for UC practice and the lack of UC-specific academic research.

However, our patients demand and expect such quality when trusting providers with their healthcare. Certainly, we have made strides in providing access to UC for patients. In fact, in 2012 for the first time, more patients were seen in UCs in the U.S. than in EDs. Yet, similar to as was the case in EDs in the 1960s, there remains little guarantee for patients that, when they walk into an urgent care center, the clinician they see will have the training and proficiency required to deliver the high-quality care they deserve.

Next Steps for Urgent Care

So, how can this situation be corrected? The coming-of-age story of EM offers valuable insights. In 1989, exactly 10 years after Dr. Rosen published his editorial, EM was recognized as a primary specialty by the ABMS. The dedicated group of early EPs, led by Dr. Rosen and several others, had held strongly and steadfastly to the belief in the "specialness" of EM. Even when they were alone in the belief, they always operated under the premise that EM was a proper specialty. And so, consequently, they fought tirelessly for, and won, this recognition for EM within the House of Medicine. This achievement was largely attributable to their dedication to education and research within their specialty. And as a result, the quality of emergency care in the U.S. has since improved exponentially.

We have reached a similar inflection point in the domain of urgent care medicine. For reliable and universal improvement in the quality of care delivered by UC clinicians, specialty recognition is necessary. And in turn, the most assured path towards this recognition is through a self-directed academic transformation within our specialty.

Next Steps for JUCM

As the only peer-reviewed journal in UC, *JUCM* can serve as the primary platform to promote this process.

Until recently, *JUCM* has published predominantly content reviewing the core content and competencies relevant for UC practice. And while this material has undoubtedly been relevant, it has not served to develop an evidence base to drive innovation and define high-quality care in our field. In order for such an academic transformation to unfold, publication of original research within urgent care will be critical. To that end, beginning this month and continuing in perpetuity, *JUCM* will be regularly publishing UC-relevant original research. And in following in Dr. Rosen's (large) footsteps, I invite each of you to participate in this next phase, a quantum leap actually, in the story of UC by pursuing UC research and scholarly work within your practice and sharing your findings with the *JUCM* audience.

In the movie *Field of Dreams*, Kevin Costner's character wisely heeds the advice, "If you build it, they will come." Well, we have built *it*—a massive urgent care network, numbering nearly 10,000 centers in the U.S. And patients certainly have come. However, there remains much work to be done to ensure that the care delivered in these centers is reliably high quality and cost-effective.

I believe the academic transformation for our specialty must begin here. We at the *Journal* are poised to support this crucial next step in this process. However, we cannot achieve this alone. Nor can the leaders of the CUCM and UCA carry this torch without your help. Collectively, however, in true grassroots fashion, we can propel our specialty forward. The question then becomes: what role will *you* play in this exciting and pivotal chapter of our story? ■

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Resources

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