Why Specialty Recognition Matters More Than Ever for Urgent Care

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Commuting in Jakarta can be a nightmare. The average citizen in Indonesia's capital city spends weeks stuck in urban transit each year. Compare this with Singapore, which is consistently rated one of the best cities in the world for commuters. The difference between the day-to-day experience of residents of each city is stark. The root cause of why these two metropolises of southeast Asia have such disparate commuter experiences lies in the contrast of how they were planned.

Jakarta's growth unfolded haphazardly in the 20th century, driven by whatever flukes and coincidences occurred within local economics and politics. There was little centralized guidance to the process.[1] Modern Singapore, conversely, developed rapidly after independence from Malaysia in the 1960s. A shared vision for Singapore as a "global city" and leader of technology and finance provided a unified goal for those directing its development. Significant planning went into how the city should be laid out, with a ring perimeter structure being the winning design.[2]

Comparing the two cities today, the effects of the different approaches to growth—planning and oversight versus growth through happenstance—has yielded drastically different "final products." While each city certainly can claim various cultural attractions and charm, visitors and residents alike would undoubtedly agree that Singapore hustles in a more functional manner that resembles what its architects had envisioned.

Cautions of Haphazard Growth

As urgent care (UC) continues to grow, it similarly faces the risk of perpetual and irreversible dysfunction if growth is allowed to proceed in a decentralized and haphazard fashion as was the case with Jakarta.

A recent article by Duffy et al. reviewed the state of emergency department (ED) utilization and overcrowding in the United States (US), Canada, and New Zealand (NZ). The authors' conclusions were heartening for the urgent care community both in New Zealand and worldwide, as UC was rightly touted as part of a solution to the international problem of ED overcrowding.[3] While the UC community has long held this to be true (and even self-evident), prior publications focused on this sort of dysfunction among EDs have failed to even make mention of the existence of UC.[4,5]

In NZ, however, urgent care has existed as a formally recognized specialty since 2000 and prior to that as the Accidental Medical Practitioner Association since the 1980s.[6] This has been instrumental to the development of a reliable network of UC centers throughout the country. Unfortunately, UC has failed to gain similar recognition as a specialty (or even sub-specialty) in other countries, despite rapid growth in the number of UC centers, especially in the United States.[7] The acknowledgement by Duffy and colleagues that UC centers can, should, and often do provide vital expanded access to unscheduled acute care for patients with minor illnesses and injuries is a much needed step in the right direction.[3] This comes in the midst of a long standing and ongoing struggle for recognition of urgent care by the American Board of Medical Specialties (ABMS) in the US; similar unrealized attempts at specialty recognition continue to unfold in the United Kingdom (UK), Ireland, and Australia.[8]

It's undeniable to those who work in UC centers and those residing in the communities they serve that UC does provide vital access to care. The specialty recognition in

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New Zealand, along with the oversight by the Royal New Zealand College of Urgent Care (RNZCUC), which oversees the practice of UC, has been a boon for UC clinicians and patients alike. The College ensures that all approved UC facilities meet specific standards and are staffed by appropriately trained clinicians—generally physicians. This has been instrumental for the reliable provision of high-quality care and has offered a reliable alternative to EDs for patients with low-acuity acute needs.

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And while the Urgent Care Association (UCA) has made great strides in the US—through its UC center certification efforts most notably—American UC centers still very much have the prerogative to forego being evaluated or certified by the UCA. Other than state licensing requirements, they have no firm barriers to keeping their doors open for patients. This results in a frustratingly persistent state of heterogeneity among UC centers, as there remains no legal or credentialing board requirement to use the label "urgent care."

To those of us in the industry, recognizing the various tiers of facilities—ranging from retail swab stations to detached EDs—may be easy, but for patients, understanding these differences is often less obvious. The consequences of this ambiguity can be significant for the scope, quality, and cost of services they ultimately receive. Contrast this with the experience of New Zealand, where patients can rest assured they'll receive reliable care regardless of the center they select.

Plight of Primary Care

In much of the world, and certainly in the US and Canada, primary care struggles to meet the demands of aging populations and increasing demands for unscheduled care, while EDs face staffing shortages and perpetual overcrowding. In their study recently published in *Academic Emergency Medicine*, Duffy and colleagues conclude that "the New Zealand system is appealing in its efficiency but required decades of investment and iterative improvement [to achieve what it has]," which seems very pertinent given the current plight of primary care and emergency medicine (EM).[3] The latest figures available from the Association of American Medical Colleges (AAMC) indicate that there were 118,198 active primary care physicians in 2020 in the US, compared to 101,764 in 2014, a marginal increase relative to rising demands.[9,10]

Simultaneously and somewhat ironically, EM is facing a possible clinician surfeit alongside the highest rates of depression and burnout among any specialty.[11,12] With the current state of upheaval and uncertain futures for the two most UC-adjacent specialties (ie, family and emergency medicine), it is no wonder patients are seeking care in UC centers with increasing frequency.

The UC sector of America already has a considerable infrastructure in place which has grown out of necessity, but in a regionally variable and uncoordinated way, to fill the unmet needs between primary and emergency care. As the famous Chinese proverb states: "The best time to plant a tree was 20 years ago. The second-best time is now." So, while much largely uncoordinated growth of UC has unfolded already, we can still meaningfully affect the prospects of UC fulfilling its mission in the U.S. and other countries if we proceed wisely from here.

What remains most critical and, as yet, unachieved is any guarantee for our patients that the UC centers they entrust with their care will be staffed with clinicians with appropriate training and equipment to deliver on urgent care's promise. Thankfully, this very problem was solved decades ago in NZ when UC received rightful recognition as a specialty. This was the lead domino that allowed for the creation of the RNZCUC, standardized clinician training and certification processes, and ultimately to a high-functioning nationwide network of UC centers.

Unstructured Urgent Care

It gets stressful quickly spending time in a dysfunctional city. Humans don't deal well with overwhelm, hassle, and unpredictability, especially when it's an unrelenting reality rather than the exception. I've often seen stress arise for these reasons among UC providers and patients alike because, outside of NZ, urgent care remains so unstructured. This is why it's so important that the next version of UC is designed with intention. Every UC leadership meeting I've ever sat through has discussed provider retention and increasing patient volumes. But, if

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The US, Canada, the UK, and other nations would do well to heed the UC blueprint that has been laid out in NZ. Thankfully we don't need to conceptualize a city design from scratch. However, without such specialty designation (and the centralized oversight and specialized training which goes along with it), we run the real risk of happenstance, rather than strategy, driving the future function, or dysfunction, within the "cityscape" of urgent care's future. ■

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