Urgent care centres: proceed with caution

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The emergence of urgent care centres in the United States signifies an innovative response to the demands—public, private and governmental—to control the rising costs of health care. What is immediately obvious to the practitioner, however, may or may not be quite so obvious to the consumer. Simply expressed, trade-offs must be made. In the accompanying article ‘Urgent Care Centres’, Drs Janiak and Gray astutely described what has been gained by trading, but omitted what has been lost in the exchange. Although there is probably some truth in describing physicians as often the last to accept what is already obvious, the vast majority of physicians react with concern to anything that threatens a system already providing satisfactory patient care. Urgent care centres represent just such an innovative threat.

The hesitation among physicians to accept the freestanding facility has been fuelled by what the authors themselves describe as ‘business techniques such as advertising and marketing to attract patients’. If this had been done to improve the alleviation of pain and suffering, there would be no outcry. What resulted, however, was a ‘bandwagon effect’ where patients sought a professional, convenient and inexpensive alternative to the busy, bustling environs of the hospital-based emergency unit where delays were frequent, care inconsistent, and costs high. In many instances they were rewarded, in others, turned away because the rendering of ‘emergency care’ was based solely on the patients ability to pay. The end result was a movement by paying patients to the urgent care centres and an increase in the non-pay burden on the hospitals and hospital-based emergency facilities.

Perhaps central to the issue is the authors’ own definition of the private practice of emergency medicine. Is it valid? Can one, in fact, establish a private practice of emergency medicine? There are certain very obvious concerns with this concept. What happens to the ‘emergency patient’ who has no money, no insurance coverage, no endorsement? Is he to be excluded or transferred somehow (and at whose risk?) to the hospital-based emergency facility? Who is responsible for an adverse outcome under such circumstances? Can we expect patients to determine for themselves what is truly a ‘relatively minor’ affliction, and suitable for ambulatory care, from the life- or limb-threatening problem requiring immediate sophisticated care and monitoring? How

many patients with 'indigestion' end up in the coronary care unit, or arrest before we can get them there?

I have real problems accepting the term 'emergency centre' in the freestanding mode, regardless of whether the facility is open 24 hours a day or not. The move away from such terminology and toward identification as ambulatory care units will enhance operational safety while reducing opposition from traditional practitioners of emergency medicine. Yet, the establishment of standards is long overdue. When initially established, any physician (training and experience were irrelevant) could establish an 'emergency centre' with (or without) any equipment he deemed necessary. The potential for making a killing—literally and financially—was apparent to the hospital-based emergency physician and general practitioner who were the first to feel the sting of such low-overhead operations.

In short, the acceptance of the freestanding health care facility has been far greater among opportunists and third-party payers than among the majority of practising physicians. Nevertheless, this acceptance has also been high among patients. Thus, a trend toward decentralization of hospital-based resources has followed. The inevitable 'buy-ups' of non hospital-based medical care facilities by hospital chains and the rise of satellite clinics, surgicentres, and peripheral health-related support facilities, all suggest that the medical profession must respond to the challenge of providing cost-effective health care.

If the freestanding facility is dedicated to quality patient care, it should welcome close scrutiny by the appropriate licensing or regulatory agencies already in existence. To do otherwise leads one but to wonder whether the economics of medicine has superseded the caring for patients.

In the UK, opportunity now exists for adopting a new and innovative approach to the delivery of non-emergent ambulatory care. Proceed with caution.

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Dr Maull was invited by the editor to respond to the views expressed by Drs Gray and Janiak in this issue.