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Urgent Matters

Emergency medicine—both the clinical discipline and this journal that bears its name—has now been in existence for four decades. In those 40 years, emergency physicians have had to deal with a continuous array of changes and challenges in fulfilling our mission to provide the highest-quality care to all who cross our thresholds. There has been a steadily rising demand for emergency services engendered by more patients, an aging population, and fewer in-patient beds. Legislation such as EMTALA, mandating care for all, has also contributed to the demand. Emergency medicine has responded with high-quality residency training, subspecialty fellowships, and better and less-invasive means of diagnosing and treating illnesses.

Many innovations in care have come and gone. Some were solutions for temporary problems, others temporary solutions until better ones could be devised and implemented. (An entire generation of young emergency physicians has probably never heard of MAST trousers.) Some new ways of providing care, however, have proved to be of lasting value. One such idea is the urgent care center, sometimes referred to as the "fast track."

The concept of a hospital-based urgent care center is a simple one: create an area close to, but separate from, the main emergency department so that patients with acute but not serious or life-threatening problems can receive appropriate and timely care, without competing with more seriously ill or injured patients. Designated urgent care centers facilitate the concentration of providers and resources best able to satisfy the needs of these patients. In particular, urgent care appears to be the branch of emergency medicine most suitable for utilizing the skills and talents of the growing number of well-trained physician assistants and nurse practitioners, now commonly referred to as "mid-level providers."

Urgent care resources vary by location and specific needs, but typically include comfortable, well-equipped rooms, in some cases designed with doorways too narrow to accommodate stretchers, thus preventing use of the centers as extensions of overcrowded EDs. Many emergency physicians who rotate through urgent care centers welcome the change of pace, and some eventually choose to practice there predominantly or exclusively, if they can.

Patients who can appropriately be triaged to urgent care generally prefer that setting to the main ED, experiencing less anxiety there and shorter lengths of stay and afterward expressing greater satisfaction with their visits. However, for some "inexperienced" patients, urgent care is an acquired taste. I recall one patient being upset because she didn't think we considered her problem serious enough to be treated in the "main room," only to demand to be taken to the urgent care center when she returned six months later with an acute myocardial infarction in progress.

You have no doubt noticed that EMERGENCY MEDICINE now has a monthly special section devoted to urgent care that includes at least one feature-length article, along with regular departments on dermatology, radiology, and other subjects. Long-term readers have responded enthusiastically to this addition to the journal.

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Beginning with this issue, we also offer a redesign of the journal, with a crisp new look and a "fast track" of key points that will help you navigate more easily through each issue. We hope that these changes and future innovations, in addition to those features of the journal that have proved to be of lasting value, will serve you well as our specialty and this publication continue their journey together through the next four decades. □