LETTER FROM THE EDITOR-IN-CHIEF

The Quality of Urgent Care Depends on our Commitment to HOLA Expertise

At least once a month, a friend or family member will text me—often for the first time in years—to share the summary of a recent visit to their local urgent care (UC). While these texts are universally unsolicited, I genuinely love receiving them. The unfiltered perspective cannot be matched by even the most sophisticated electronic medical record analytics or patient experience reports. This is because the stories they share with me, while anecdotal, provide a qualitative and holistic picture of how UC is actually practiced. Through all these exchanges, I have been most fascinated by how frequently my loved ones' assessments of how they were treated, and the actual medical appropriateness of their care are at odds.

"There's a reason why television medical dramas choose ED settings over UC centers."

As an example, a good friend recently shared with me the story of a "sinus infection" that began just before a long flight. The change in cabin pressure caused him intense facial pain while he was at altitude, so after he collected his luggage at his destination, he headed directly to the closest UC center. He was thrilled that he got in and out in 20 minutes and received the antibiotic prescription he sought, and all for a reasonable out-of-pocket cost. Obviously, after hearing this, I needed to know more. I asked him how long the sinus symptoms had been going on and what antibiotic they prescribed. "I just got sick the night before," he told me, "and, so they gave me a Z-pack." He seemed almost annoyed that I was probing at all, like someone might if you brought up the environmental impacts of tuna fishing just before they ordered some sashimi.

Many of you may have cringed and rolled your eyes like I did after reading his response. Not only did he lack criteria to suggest that the sinus pressure was bacterial in etiology, but he also received an antibiotic—azithromycin no less—which is specifically *not* recommended in the current guidelines for acute bacterial rhinosinusitis.[1] Despite myriad efforts around antibiotic stewardship from various organizations, anyone practicing in UC recognizes that this is still an unfortunately common occurrence. Sinus pain perpetually ranks among the most common reasons for patients to seek care (and receive unnecessary antibiotics) when visiting UC.

Despite the collective groans that stories like these elicit from those clinicians who sincerely care about evidence-based medicine, this sense of disappointment seldom lasts very long, even for the most conscientious of clinicians. Indeed, desensitization is partially at play here—we all bear witness to cases such as this on a daily basis. However, there is something more insidious that allows these practices to persist; that *something* lies in the attitudes of both those who perpetuate these non-evidence-based practices and those who simply bear witness to them. Fundamentally, we all share an implicit belief that the stakes are so low for these common, self-limited conditions that it's really just not that important to be precise in their diagnosis and treatment. This unconscious and collective mindset is, in a way, understandable. If the patient seems to have a minor problem and we prescribe a treatment that carries a low risk of serious adverse effects, it's easy to imagine why busy practitioners pick the path of least resistance. As human beings, we evolved to conserve our precious cognitive energy, thus it is in our nature to avoid overspending mental resources. Psychologists have termed this tendency the "cognitive miser" phenomenon.[2] And while this aspect of humanity may have served our ancestors well evolutionarily speaking, our cognitive miserliness now serves as the greatest impediment to practicing high-quality UC medicine.

The Allure of HALO Focus

Beginning around 2020, the acronym "HALO" began appearing in the emergency medicine (EM) literature.

HALO—or high-acuity, low-occurrence—refers to rare but severe situations in which a patient's survival depends on an appropriate and immediate response from the emergency clinician.[3] Examples of these situations include the need for emergency thoracotomy after traumatic cardiac arrest or jet-ventilation in the midst of a failed pediatric airway. These are scenarios that emergency physicians (EP) are expected to be prepared for at all times, even though most EPs will go their entire careers and never face the majority of possible HALO situations. As such, simulation based medical education (SBME) has gained increasing acceptance in recent decades as a method to ensure emergency clinicians have opportunities to rehearse the cognitive and motor tasks required to navigate such catastrophes.[4] Participating in these simulation exercises was indeed a major portion of my EM residency training, and they worked. Even though I have thankfully never faced many of the HALO events that I rehearsed in the simulation lab, I found that practicing simulated versions of these situations was instrumental for boosting my confidence. Building confidence, it turns out, is perhaps the main benefit of simulation training for HALO events because it so effectively alleviates anxiety. Since performance anxiety, unsurprisingly, has been shown to adversely affect cognition,[5] the anxiolytic effects of simulated practice explain many of its benefits for performance when the stakes are highest.

As a resident, I didn't need convincing to rehearse for HALO occurrences; the fear of being ill-prepared and faltering when someone's life was in my hands was more than sufficiently motivating. I recall imagining worst-case scenario outcomes and feeling the negative emotions—shame, anger, grief—that would certainly arise if I failed in my attempts to resuscitate a patient who depended on me. This fear is not a unique, neurotic quirk of mine either; countless EM colleagues have confided that similar fears compel them to regularly practice (either mentally or in a simulated environment) for HALO scenarios as well.

The hallmark trait of an EP is preparedness for "anything at any time." For this reason, using simulation to prepare for HALO scenarios is now a widely accepted part of post-graduate and continuing EM education, and rightfully so. However, functionally speaking, HALO practice serves relatively few patients. For all the times I have experienced simulations of massive tracheostomy hemorrhage or perimortem cardiac arrest, I have yet to use these skills on anything but hypothetical patients. Thankfully, the same is true for most of my colleagues in EM. Yet, the fear of failure in these emergencies serves as a powerful motivator for many EPs, including myself, to invest in perpetual preparedness for the rare times when every second counts. The problem with this approach arises when focusing on HALO events distracts us (whether in the emergency department [ED] and even more so in the UC) from striving to improve how we manage the much more common and mundane presentations we encounter in real patients every day.

The Perniciousness of HALO Obsession in Urgent Care

While low-acuity complaints do certainly present to EDs, it is the UC setting that is much more defined by the ability to service this group of patients. Given UC's ambulatory nature, patients very seldomly arrive in extremis, and the UC clinician's responsibility in managing a resuscitation extends only through the brief moments from recognition of the emergency through the arrival of paramedics. Whereas the EP's core identity is necessarily preparedness for worst-case scenarios, the UC clinician's core identity should be fluency in managing the common acute-but-low-risk issues for which patients commonly seek care. Our patients rely on us—although they rarely explicitly say so—to quickly ensure they are not in immediate danger and then provide a reasonable provisional diagnosis and plan for treatment without exposing them to excessive cost or iatrogenesis. This is the job we signed up for. And unlike EP's, our capabilities in managing these low-acuity conditions are put to use many times per shift.

The issue with this imperative for UC clinicians is that it lacks the allure and outward heroism of EM. There's a reason why television medical dramas choose ED settings over UC centers. The higher the stakes, the greater the excitement. If we are being honest, there is not much that is intrinsically captivating about ear pain, sore throats, and twisted ankles. Repetition, not novelty, is the rule in UC, so some degree of ennui is understandable. This paucity of thrilling cases is arguably the greatest risk factor UC clinicians face for disregarding our primary responsibility to patients. However, simply because a case isn't exhilarating enough to be featured on an episode of "The Pitt," doesn't mean that the care we provide will not impact patient outcomes. In other words, if we aren't careful, it's easy to subconsciously find ourselves behaving as though our clinical decisions don't matter much.

Embracing HOLA in Urgent Care

For UC clinicians, managing acute bronchitis is like an EP managing septic shock: in each scenario, the patient is receiving care from the most appropriate specialist for their respective condition. Therefore, just as mastery of

HALO situations is the duty of the ED practitioner, those of us working in UC are equally responsible for mastering less serious, more common illnesses and injuries. Although the disease narratives of UC patients may be less intrinsically captivating, they comprise a much larger proportion of human symptomatology.

Given the incompleteness of data available, estimating the number of aggregate emergencies versus urgencies that occur in a population is nearly impossible.[6] We, however, can be fairly confident that the number of UC visits has exceeded ED visits in the U.S. since about 2019.[7] Furthermore, it has been estimated that up to 40% of ED visits are non-emergent in nature[8] bringing the tally of "urgent care appropriate" visits to well over 200 million annually in the U.S. alone. These figures also disregard the countless telehealth and retail clinic visits for minor medical issues for which there are no publicly available data. And as treating septic shock is the bailiwick of an emergency clinician, managing these high-occurrence, low-acuity (HOLA) presentations is what justifies and supports UC's very existence. Just as EM has embraced excellence in HALO management to justify its value in the healthcare ecosystem, urgent care's value (both actual and perceived) is predicated on our willingness to accept the mandate to excel in the safe and efficient delivery of HOLA care.

The Fundamental Challenge of HOLA Care

Why do nearly half of Americans face credit card debt and over 40% struggle with obesity?[9] And why do these phenomena continue in an era when everyone has free, constant, and effortless access to informative resources on managing their personal finances and weight? Undoubtedly each of these issues are multifactorial, but they both have a shared root cause: People have a hard time appreciating both the positive and negative consequences of their actions when they cannot perceive an immediate or obvious impact. This universal phenomenon is called the "immediacy bias."[10] Put simply, we tend to ignore the implications of behaviors unless the effects are readily apparent.

Consider the story of my friend. He presented with one day of sinus pain and walked out with an antibiotic prescription. He was content. There was very little friction. The clinician who saw him was in-and-out quickly and most likely will never think about the interaction again. This is the immediacy bias at play. It's easy to understand falling into practice patterns like these as they involve the least effort and usually have no obvious consequence. However, according to a *JUCM* analysis of Experity data from over 10 million annual UC visits, sinus complaints represent roughly 10% of all UC presentations. This amounts to over 20 million patient encounters annually in the U.S. alone. So, while the individual impact of taking the path of least resistance for any given visit generally does not produce any apparent long-term, untoward outcome, the impact of how this group of patients is managed collectively is not subperceptual. These small decisions in aggregate certainly result in measurable harms while perpetuating a suboptimal status quo, even if any individual clinician's contribution is negligible.

Urgent Care's Path Forward

While the immediacy bias may be our default setting, thankfully, there are many historic examples of humans overcoming this cognitive trap to solve large-scale problems. The "Keep America Beautiful" and Civil Rights campaigns of the second half of the 20th century, for instance, were critical for respectively reducing pollution and discrimination in America. The success of these movements depended on the cumulative effects of small, but conscious, choices made by millions of Americans over many years. No individual's behavior alone could have brought about the desired changes. Furthermore, it was rare for anyone's actions on a given day to result in perceptible progress. A single highway passenger who chose not to litter, for instance, did little to reduce the appearance of roadside debris. However, collectively and over time, those who believed in these causes and acknowledged the importance of their role–even when their individual contributions were undetectable–produced dramatic changes in our society.

Ultimately, if we are concerned for urgent care's ability to appropriately diagnose and manage minor issues, we need to appreciate that, while it may be unexciting, devoting ourselves to improving the efficient delivery of evidence-based care is our imperative. Even if mastering the management of HOLA conditions is not what we enjoy about UC practice, it is what the rest of the medical community and our patients demand of us. In his 1785 publication *Groundwork of the Metaphysics of Morals*, the German philosopher Immanuel Kant outlined the "categorical imperative," stating that our ethical duty is to behave in such a way that, if everyone were to behave similarly, it would result in the desired outcome.[11] This is indeed the UC imperative as well. Even though we may rightly feel that most of our individual clinical decisions have relatively few tangible impacts, the success (or failure) of the UC "movement" will be determined by our collective willingness to strive to deliver masterful HOLA care on every shift. With appropriate focus, I believe we

can achieve this goal in the not-so-distant future. Our success will depend on each of us taking up this charge, and will be best measured, perhaps, by the stories our friends and families text us while walking out of their local urgent care center. ■

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