Reducing Liability in Urgent Care  
A Defense Lawyer’s View

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Overview of Medical Malpractice in America

It is estimated that up to 65 percent of physicians will be named in a malpractice case during their career. While it is far less likely that nurses and other allied healthcare providers will be named individually in a case, many, if not most, will be a witness at some point in medical malpractice litigation.

While there were approximately 250,000 malpractice cases reported in the past 20 years, most end through an out-of-court settlement. Of the cases that do go to a trial, approximately 75 percent result in a verdict in favor of the healthcare provider.

It is estimated that 100,000 people a year die in hospitals due to malpractice. No such information is available for urgent care centers, but it is estimated that only a fraction of this number is the case; urgent care centers, like most
office-based practices, do not provide such high-risk procedures as surgery and other invasive procedures that can result in injury and death.

Urgent care medicine is an emerging method of delivering care, and as such, is potentially vulnerable for several reasons. First, there is a lack of uniform standards, guidelines, or protocols that may make it easy for plaintiff’s lawyers to take advantage of. The hope is that administrators and practitioners, with input from risk managers and defense counsel, can begin to formulate such standards to minimize liability exposure.

Urgent care centers are neither hospitals nor physician offices; as a healthcare facility that lies somewhere in between, the UCC is particularly vulnerable to some of the most common allegations of medical negligence, which include failure to diagnose, failure to treat, failure to report, and failure to follow up. Only time will tell what issues really do become the common risks that make urgent care centers vulnerable to lawsuits. The purpose of this article is not necessarily to provide answers, but rather to raise questions about what urgent care center owners and providers should be looking for out on the litigation landscape.

Educating Patients and Families

At first glance, there appears to be an inherent conflict in running a successful urgent care facility and sending patients somewhere else for care. However, in order for the urgent care center model to survive and thrive, the public will need to learn and understand that “urgent” care is different from “emergent” care; urgent care medicine has the opportunity and responsibility to educate the public about the differences, which will allow patients and their families to make an informed decision to seek care at an urgent care facility. “Urgent” care is “convenient” care; it is only a matter of time until the public comes to understand this.

The conflict that is inherent is that the business side wants the HCPs to treat as many comers as possible, but it is the medical and nursing side that will have to make the decision to send a patient “up” to an emergency department, “down” to the primary care physician, or “out” to a specialist, such as orthopedics, infectious disease, ophthalmology, gastroenterology, cardiology, otolaryngology, etc.

The challenge that we are currently faced with in educating the public about these distinctions is there is no industry-wide process or procedure for doing so. Whether such an education campaign is nationally created, state created, or by each company that owns or manages UCCs, there should be a dialogue on this issue.

Recognizing that the public may not clearly understand where urgent care medicine fits within the hierarchy of the provision of care, the industry should decide how best to distinguish the care provided. Certainly, facilities that have “emergency” or “ER” in their name only add to the confusion and potentially create exposure to liability base on this confusion. The ultimate question is where our responsibility begins and ends.

In reinforcing the notion that “urgent” care is “convenient” care, we need to be conscious that “emergent” care is best left to those providers working within an actual emergency department at a hospital. “When in doubt, send ‘em out” is a prudent policy to follow when there is any question about the acuity of a patient’s presentation. By the same token, “convenient” care medicine generally does not encompass treating chronic illness or disease, and a similar policy to send a patient out can and should be employed.

As patients and families follow the path from triage to discharge at an urgent care center, there should be information provided along the way, both verbally and in writing, that educates, informs, and assists patients in understanding the care to be provided is not emergency medicine, and furthermore, that they have the right and responsibility to seek emergent care elsewhere. All HCPs who encounter patients along the path, whether they be physicians, physician assistants, nurse practitioners, nurses, radiology technicians, and others, need to be cognizant of any changes in a patient’s condition that warrants emergency care. Acting on such changes will go a long way to defend against a future allegation that a patient should have been sent out for emergency care.

In addition, we need to be mindful that anything in writing, whether it be a center’s web site, print advertisements, or internal/external signage should not give the impression that emergency medical services are provided there. Consideration should be given to succinct but clear disclaimers or statements to that effect to be incorporated in any written or electronic communications.

As a legal consultant and advisor to several urgent care centers, I have been confronted with questions about when, if ever, they should provide services that do not have a sense of urgency, such as sports physicals for children or presurgical medical clearance. Such issues should be addressed on a case-by-case basis, however it would be useful to have continuing discussion and debate regarding what is best for the patient and the industry. Balancing business interests with medical decision-making is a component of what services an urgent care center should provide; as the menu of services grows, so does the number of legal issues facing a facility.

Another common inquiry is what responsibility, if any, the urgent care center has in educating the public about what the limitations of care are before or after regular business hours. While there is not enough room here to cite specific examples, suffice it to say there are plausible scenarios where a patient arrives at the urgent care center before or after regular hours and decompensates because of the ability to receive medical care.

Unless a center is open 24 hours a day, 7 days a week, there a real possibility this can and will happen. The issue is whether an urgent care center has any responsibility to inform patients of alternatives, such as providing written information about nearby emergency care or even a phone that serves as a 911 hotline. These are many of the types of questions, for which we do not yet have answers, that should be asked as we strive to reduce or eliminate the risk of liability exposure.
The better we are able to distinguish urgent care medicine from emergency care, primary physician care, or specialty care, the better we can defend ourselves later, if necessary. Certainly, there is going to be overlap of some of the services provided in these other settings, but we need to reinforce the message through verbal and written communication that urgent care medicine is not meant to be a substitute for care given by emergency departments, primary care, and specialists.

Levels of Exposure

Medical negligence or medical malpractice are the primary theories of liability used against HCPs, and urgent care staff may be confronted with these allegations. In addition, HCPs who are also owners and/or operators may also face allegations not related to direct patient care, such as the concepts of actual/apparent agency or non-delegable duty. This may occur regardless of whether a HCP accused of negligence or malpractice is an employee or independent contractor.

What is somewhat unique is that HCPs at urgent care centers may be accused of negligence or malpractice even if no care or treatment is rendered. This may be due to alleged failure to inform of the limitations of the facility, delay in arranging for transport for more advanced care, or failure to follow up with a patient after care was delivered. Developing guidelines for HCPs and administrative staff addressing such issues can go a long way to minimize the chance that they will become reality.

Theories of liability and scope of exposure will vary state to state. It is important that any specific questions be addressed to local counsel.

The “Decision Tree”

From Triage to Discharge

As patients and families travel the path from the waiting area to the discharge desk, staff members who encounter them at each step of the way have the opportunity, and likely the responsibility, of observing and reporting any changes in condition that may warrant emergent care. Patients may present with non-emergent complaints that can turn out to be warning signs for emergent conditions; if and when concern arises regarding such a condition, that patient is no longer an appropriate urgent care patient. An action plan should already be in place to address rapid transport or transfer, along with stabilization protocols.

It is recommended that urgent care centers have in place simplified protocols for sending patients and families on to emergency care, or for summoning care to the center. Regardless of how we strive to educate the public that UCCs are not emergency rooms, there are those who will continue to confuse the difference. When that happens, we need to have a system in place to get them where they need to be. A patient or patient’s family that is in distress or panicked may pull into a parking lot of an urgent care center, believing it to be an emergency room. Rapid assessment, stabilization, and transfer policies and protocols should take this scenario into account.

Given the limitations that an urgent care center has with regard to assessment and stabilization, it makes it that much more important to have a transfer policy in place. Both HCPs and non-HCPs working at the center need to be educated on what their respective roles are in such situations.

Educating patients and families about the distinction between emergent care and urgent care should not stop after examining and treating the patient has begun. Even at the discharge stage, urgent care centers should make it clear whether the patient is to follow up, and with whom. Centers are encouraged to remind patients and families, as part of the discharge process, of the limitations of care or treatment they received, and the importance of seeing other health-care providers, as appropriate.

The goal is for them to leave with the mindset that the care delivered was to address immediate issues and that the urgent care center is not to be the place where an illness, injury, or disease will be addressed if it becomes worse.

Communication With Primary Care Physicians

There is a hierarchy of medical care that includes urgent medicine, emergent medicine, primary care, and specialty care. However, where each falls in that hierarchy is still yet to be determined. It is fairly clear, however, that UCCs are not immune from two of the more common issues health care providers confront in medical malpractice: failure to communicate with other HCPs and failure to follow up with patients.

As in any other healthcare setting, subjective and objective information is gathered and evaluated for purposes of diagnosis and treatment. Objective data, such as laboratory and radiology studies, need to be shared with the patient’s primary care physician, if one is identified. If not, there needs to be documentation that the patient is given the data himself/herself, or is informed that the information will be maintained at the center and will be made available to other health care providers, if requested. In other words, urgent care centers should consider themselves as part of the healthcare “team” for patients, and that affirmative effort should be made to disseminate the subjective and objective information developed during each patient encounter.

The easy question to answer is whether or not to communicate information to a patient’s PCP; the harder question is whether or not the urgent
care center has an affirmative duty to communicate findings to medical specialists, if the urgent care provider feels that additional workup is indicated. Keeping this in mind will go a long way to defend against allegations that the urgent care center failed to communicate positive findings and that this failure to do so caused a delay in diagnosis or treatment of a medical condition.

A related allegation often seen in medical malpractice lawsuits is the failure to follow up with a patient regarding his/her progress after receiving care and treatment. There may be a temptation in the urgent care setting to discharge a patient and to assume he/she will seek care elsewhere if a medical issue later changes or worsens. However, such assumptions are fraught with risk. Once care or treatment is rendered at the UCC, arguably a duty exists to communicate with patients within a reasonable time after discharge. While the specifics of how and when to do so will vary, it should be done in order to fend off allegations that failing to do so contributed to delay in diagnosis or treatment.

The Primary Care Physician

As urgent care centers become more prevalent, the lines will continue to blur between urgent and non-urgent care that is provided. Some urgent care physicians have discussed with me the dilemma of evolving from an urgent care doctor to becoming a patient’s primary care doctor. As patients access care at a particular facility, rapport may develop with a specific doctor, and that patient may return again and again for routine care.

This situation creates opportunities for increasing business but carries with it risks of additional liability exposure. There needs to be ongoing dialogue within urgent care medicine about when a patient has exceeded the limits of care a center is providing. While it is clear that urgent care centers seek to address acute illnesses or conditions, it is far less clear whether they can, or even should, manage chronic conditions, such as diabetes, hypertension, COPD, etc.

Eventually, centers and/or companies that own or manage centers will develop policies addressing this issue. In the meantime, urgent care physicians need to consider what the potential legal consequences are for developing a physician-patient relationship with people who frequent the urgent care center. Regardless of the policy that emerges, it needs to be followed consistently from provider to provider and patient to patient at each facility.

Policies and Protocols

Like emergency departments, HCPs at urgent care centers see a broad spectrum of patients, from infants to the elderly. If diagnosis, care, and treatment are to be undertaken for pediatrics through geriatrics, the HCPs providing care must have adequate training and experience to do so. It is anticipated that lawsuits can arise because of undertrained or inexperienced HCPs rendering care.

Each patient encounter should be tailored to the category of patient in addition to the individual complaint. In addition, discharge planning should vary somewhat based on whether a patient is an infant, child, adolescent, adult, or geriatric. Even to the age of the patient, the nature of the illness or condition should tailor the discharge process and recommendations for follow up, depending on whether it is orthopedic, gastrointestinal, cardiac, infection, etc.

Does EMTALA Apply to Urgent Care

The Emergency Medical Treatment and Labor Act (EMTALA) mandates that Medicare-participating hospitals treat and stabilize patients with emergency medical conditions prior to transfer, regardless of a patient’s ability to pay for care. It is commonly referred to as “The Anti-Dumping Statute.” It is unclear whether the law requires urgent care centers to comply.

Generally, the stabilization occurs in a “dedicated” emergency department of a hospital. There are some hospital systems, however, that own or operate freestanding UCCs, and it is conceivable that the government could argue that these are “satellite” facilities of the hospital system, thus requiring compliance.

Whether EMTALA applies to independent urgent care centers is also unclear. Certainly, these facilities are generally not equipped, nor are they staffed, for purposes of stabilizing and treating patients with truly emergent conditions. It would therefore be unrealistic that EMTALA contemplates participation by these centers. At a minimum, urgent care providers and owners/operators of urgent care centers should seek a legal opinion so as to avoid a potential violation.

Conclusion

Urgent care centers provide an important role in the delivery of healthcare in the modern era. Nestled somewhere between primary care and emergency medicine, these facilities give patients another choice when convenience and time are factors. However, because it is a relatively new method of providing care, there are liability risks that are not yet known, due to the unique issues that will arise as urgent care centers are named in medical malpractice litigation.

Healthcare providers working in the urgent care setting, as well as those who own or operate these facilities, should begin a dialogue within the centers and throughout the industry to anticipate, and hopefully avoid, the dangers that lie ahead.

Whether statewide, regional, or national recommendations or standards emerge from these discussions, the industry as a whole should strive to adopt measures to balance quality medical care with an educational campaign to inform patients, their families, and even other healthcare providers about what urgent care centers are, and are not, willing and able to do in the delivery of medical care and treatment.

Ben Newman is a shareholder with GrayRobinson, P.A. in Orlando. His law practice is focused on representing healthcare providers in medical malpractice and administrative matters. Ben has developed a special interest in emerging areas of healthcare delivery, including urgent care centers, ambulatory surgery centers, and home health nursing. Ben provides legal representation throughout Florida, as well as litigation support and risk analysis for healthcare providers and insurers nationally.