

Birth of a new Journal section on Emergency Medicine

Gianfranco Cervellin¹, Tiziana Meschi²

¹Emergency Department, University Hospital of Parma, Parma Italy; ²Postgraduate Emergency Medicine School, University of Parma, Parma, Italy

In medical vocabularies the term “specialty” usually indicates a clinical discipline characterized by some essential features, such as specific field of action and defined body of knowledge, merged with a research agenda and a training plan for students. In this field, like in many others, the History has moved forward with a rather a-synchronous trend.

Although the British Association for Accident and Emergency Medicine (BAEM) has been founded in 1967, followed by the foundation of the American College of Emergency Physicians (ACEP) in 1968, and then followed in a handful of years by Canada, Japan, and many other countries all around the world (1), in Italy the University Minister has licensed and established the Specialty School of Emergency Medicine only in 2006. Due to some contrasts with the Anesthesiologists’ Society, the School was actually started in 2009, so that the first Italian Emergency Medicine Specialists could only graduate in 2014. Despite this controversial course, nearly 20 million patients are annually seen in the Italian Emergency Departments (EDs).

Emergency Physicians (EPs) act in a different environment, often in different daytimes, and with different patients compared to the vast majority of other medical specialists. EPs always see undifferentiated patients, who present with symptoms rather than with definite diagnoses. Therefore, we would never know in which direction the situation may be going when we face with challenges of new patients. Our expectation, which embraces both our and patient’s wishes, is facing subjects who will present a plain, obvious complaint characterized by a high signal-to-noise ratio, such as a dislocated joint, or a chest pain with an obvious STEMI pattern on electrocardiogram, as admirably

described by Joe Lex (2). In all these circumstances, we will be able to identify and quickly manage problems with little reflection. Unfortunately, however, in the vast majority of cases patients complain for symptoms with a huge “background noise”, thus driving us on the wrong way and often triggering a wrong diagnostic or therapeutic inference. A strong training in emergency thinking, specifically focused on error prevention, is hence compelling (3).

The ED is placed and interplays at the interface between the inpatient and outpatient delivery arms of the healthcare system. For each new patient, EPs must assess to what extent she/he would benefit from hospital care or, contrarily, whether outpatient care setting may be safer and more clinically effective. In an ideal condition, these decisions should be accurately taken, and patients should be addressed to hospital care or else should be discharged according to a set of widely accepted criteria. In the real world, however, these decisions are more multifaceted and often variable, both on individual and on institutional or regional basis. In recent years, increasingly characterized by cost containment policies, enhanced emphasis has been placed on discharging as many patients as possible from the EDs. Unfortunately, many acute medical conditions are not so straightforward to permit an easy decision as to whether the patient should be admitted or discharged, and the fear of early adverse events is somewhat paralyzing the EPs’ decision making (4). Many dispositions fall into a gray zone, whereby we (as clinicians) are not so confident about prolonged admission, but we may not either feel safe to immediately discharge the patient from the ED. To address this issue, Observation Medicine has emerged as a new area of medicine,

aimed to address these challenging dispositions. This new standard of care may also be associated with lower health care costs and enhanced patient satisfaction.

Partially due to the aforementioned issues, but largely attributable to population aging, overcrowding has become the “mother of all the problems” for EPs, since overcrowding is itself a leading source of errors and adverse events (5). In this operating environment, the physical and emotional rigors of the ED may favor stress, burnout and fatigue, which represent additional causes of errors and ultimately jeopardize both patient safety and quality of care.

We thereby welcome the new section “Emergency Medicine”, which will start from this issue of *Acta Bio Medica*. We sincerely hope that the contributions will help EPs, and maybe all Doctors, in more efficiently facing the kaleidoscope of problems observed in each new, acutely ill, patient.

References

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