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Emergency medicine: welcome address

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It is with great pleasure that this issue marks the commencement of the first issue of *Internal and Emergency Medicine*.

It is especially appropriate that this issue also marks the February passage of the Italian federal law enabling the training of residents in the specialty of emergency medicine.

The specialty of emergency medicine has emerged in many different countries in the world, and it is clear that with the recognition for the time constrained management of acute traumatic and non-traumatic emergencies, there has become an ever increasing need to respond with medical personnel who possess special training and experience in the appropriate management of these problems.

There is a biology of emergency medicine[1]. That this is increasingly recognized is signified by the literature of emergency medicine, and the need for a journal such as this.

It is not enough to simply care for the clinical problems of emergency medicine. We must collect the evidence upon which to base an intelligent and safe practice, and we must attempt to answer the questions that are stimulated in the course of such practice.

There are innumerable issues that start with the correct management of the life and limb threatening emergencies, but continue on to involve the locus of care, the appropriate use of diagnostic and technologic procedures; the safest and best therapeutics, and the optimal utilization of the inpatient facilities.

There are many problems that represent acute emergencies that will fall outside the domain of emergency medicine, such as a cardiac arrest that occurs in a surgical theater, but even if there is overlap with caring for a similar emergency in the prehospital care unit as well as the emergency department, it would be impractical as well as logistically impossible for the emergency physician to attempt to respond to any emergency that would occur in such a location.

We have a mission to satisfy with this journal: that is to attempt to provide a resource for the practicing emergency physician, whether this is someone providing care in an emergency department, or prior to that in the field.

That does not mean there is no space for original clinical or basic research, which as the specialty of emergency medicine evolves will also become the means by which we answer the questions of clinical medicine. Nevertheless, in addition to such basic science research, we need and hope to supply a forum for clinical discussions that interest the clinician, as well as assist in the performance of a safer and more scientific practice.

It is simply not enough to practice in a busy emergency department with many complex emergency problems. That practice must be examined, questioned, varied and improved as we develop new answers to complex questions, and as we garner the evidence upon which to make our decisions.

There is a special logic that must be applied in emergency medicine, and only the practicing clinician familiar with this logic can pose and answer the correct questions. These do change over time, and that is why we need a journal to stay educated, and current. For example, 20 years ago the correct question in response to chest pain was: "Is this patient having a heart attack?" It is now clear that this question while important is rarely the correct question. That question is: "Is this patient having an acute ischemic coronary syndrome?" It is readily seen that the complexity of this question requires a much different strategy, plan of attack, and therapeutic management.

We must always remember that we see the unclassified patient, and that we see the patient at many varied stages of the course of a disease, and that "classic" presentations rarely are seen or identifiable during the early course of a disease. For example, if asked "what is a mandatory indication for endotracheal intubation?", most physicians would start with respiratory arrest. While this is a correct indication, how is it recognized? If you come upon a patient in the street, or in an emergency department who is not breathing, how do you know that patient is apneic? You cannot watch the absence of breathing for a sufficiently long period to be convinced the patient is in

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respiratory arrest without allowing brain death. It is more likely that we recognize this entity by the presence of unconsciousness and the absence of a heart beat. That however means that the indications for undertaking endotracheal intubation are completely different.

With this journal, we will try to present the things that can be recognized by an emergency physician, as well as to recommend the correct strategy for appraisal, and the appropriate management.

Our goal is to provide a forum for the recognition of the biology of emergency medicine, and to provide the means for our specialty of emergency medicine to grow and to flourish. We must pose our own questions, and obtain our own answers because only we, the practitioners of the specialty of emergency medicine, will be able to identify what we need, and not what some other specialty, with completely different experience and agendas thinks we need.

We invite you to join us in our quest for the descriptions of the practice of emergency medicine, and that you will increase, refresh and solidify your learning of our important and fascinating specialty.

Reference

1. Rosen P. The biology of emergency medicine. *JACEP* 1979; 8: 280-3.