Letter to the Editor

Emergency medicine and intensive care medicine: the missing link

George Karlis[1], Theodoros Xanthos[2], Anastasia Kotanidou[1]

[1]Department of Intensive Care Medicine, National and Kapodistrian University of Athens, Athens, Greece; [2]School of Medicine, European University of Cyprus, Nicosia, Cyprus

Correspondence to: George Karlis. Department of Intensive Care Medicine, National and Kapodistrian University of Athens, Greece.
Email: georgekarlis@yahoo.com.

Received: 09 June 2019; Accepted: 10 July 2019; published: 30 July 2019.
doi: 10.21037/jeccm.2019.07.02
View this article at: http://dx.doi.org/10.21037/jeccm.2019.07.02

Despite the fact that the principles of treating emergencies and acute diseases have been well described as far back as ancient times (1), emergency medicine (EM) as a recognized medical specialty has a life of less than 20 years. Indeed, according to the European Society of Emergency Medicine (EUSEM) website, in 2001 the United Kingdom and Ireland first recognized in Europe the specialty under the heading "Accident and Emergency Medicine". Despite the remarkable progress in EM during the last decade, there are still huge diversities regarding the curriculum, the training, and the setting of the emergency departments (ED) around Europe. Some European countries have developed EM as a stand-alone specialty, others as a supra-specialty while a few have EDs that function with physicians from several specialties, such as internal medicine, cardiology, general surgery, anesthesiology, pediatrics etc.

Intensive care medicine has a history of more than 60 years and intensivists are universally trained to deal with the whole spectrum of critical illness (2). Nevertheless, the involvement of intensive care physicians in the ED in the majority of settings is limited. Intensivists are mainly involved in the decision-making regarding admissions from the ED to the intensive care unit (ICU) but they seem reluctant to participate more actively in the treatment of ED patients with less critical conditions. A part of the intensive care community considers the ED as a sideline business and finds it unchallenging to deal with non-emergent medical problems and minor injuries. Therefore, intensive care outreach teams usually care only for patients during the immediate ICU discharge period or patients just before their admission to the ICU. A valid argument against this practice is that the early involvement of intensivists in ED patients at risk might prevent further deterioration and the need for ICU admission. The concept of "ICU without walls" is not new (3), but yet it has not been widely adopted.

We as well acknowledge that there are no clear definitions of "emergency", "urgency" and "acute" in medicine (4), but on the other hand any patient presenting to the ED has the right to be regarded as a potential emergency (5). The wording is not that important. Looking at the content and the required skills as outlined by the two major emergency medicine (EUSEM) and intensive care medicine (ESICM) societies in Europe, one can see that they are astonishingly similar. So the question is not about who takes the lead in the ED but on how the physicians who deal with emergency care can collaborate and complement each other. The concept of the ED-ICU and the ED-intensivist has already emerged in a few North American teaching hospitals. This model is led by emergency physicians who pursued fellowship training in intensive care medicine (6). Although brilliant and inspiring, this model has certain limitations such as the need for the formation of an additional hybrid subspecialty and the financial considerations for re-organization of EDs.

To overcome poor collaboration and communication between physicians from different departments dealing with acute patients we would like to introduce the "open ICU to ED" concept. The idea is to view ED and ICU as adjacent and adjoining departments, with emergency physician-led EDs supported as needed by intensive care physicians. This link will also enable clinical rotation and common educational activities for two similar but distinct specialties, preserve the integrity and structure of the EDs and hopefully optimize patient outcomes. Finally, it is imperative to underline that the success of any ED model or concept relies upon the efficiency of community-based

primary healthcare and the appropriateness of triage.

Acknowledgments

None.

Footnote

Conflicts of Interest: The authors have no conflicts of interest to declare.

Ethical Statement: The authors are accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

References

1. Askitopoulou H, Stefanakis G, Astyrakaki EE, et al. Emergencies and acute diseases in the collected works of Hippocrates: observation, examination, prognosis, therapy. Eur J Emerg Med 2016;23:399-405.
2. Kelly FE, Fong K, Hirsch N, et al. Intensive care medicine is 60 years old: the history and future of the intensive care unit. Clin Med (Lond) 2014;14:376-9.
3. Hillman K. Critical care without walls. Curr Opin Crit Care 2002;8:594-9.
4. De Robertis E, Böttiger BW, Søreide E, et al. The monopolisation of emergency medicine in Europe: the flipside of the medal. Eur J Anaesthesiol 2017;34:251-3.
5. Chalkias A, Xanthos T, Pavlopoulos F. Collaboration is the future of emergency medicine in Europe. Eur J Anaesthesiol 2019;36:379-80.
6. Weingart SD, Sherwin RL, Emlet LL, et al. ED intensivists and ED intensive care units. Am J Emerg Med 2013;31:617-20.

doi: 10.21037/jeccm.2019.07.02
Cite this article as: Karlis G, Xanthos T, Kotanidou A. Emergency medicine and intensive care medicine: the missing link. J Emerg Crit Care Med 2019;3:30.