Intern Emerg Med (2011) 6:59–61
DOI 10.1007/s11739-010-0470-x

EM - EDITORIAL

Reflection on an EM newsletter and website

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Received: 26 June 2010 / Accepted: 23 September 2010 / Published online: 26 October 2010

In Italy, emergency medicine (EM) is a new medical specialty, although doctors like me have been working in this field for many years. We started long time ago, and we practiced it without any formal training in any field, and with no specific education. Our medical profession did not consider EM to be a specialty nor that doctors needed special training in emergency care. In fact, "emergency medicine" has always existed ever since patients started entering the medical delivery system; but the "emergency physician" (EP) had never been created because of the myth that anyone could take care of these patients coming to the emergency department (ED), and that there was nothing special about them.

We can look at this complex process of birth of this new specialty as composed of several overlapping steps. The first step is inevitably that someone devotes a practice to exclusively caring for emergency patients for a variety of reasons. Sometimes, it is because this is the only job available. Sometimes, it is because that is the assigned task. Worldwide, this first step take place whether or not a specialty of EM or the EP exists.

Who can do EM? Who should be the EP? For many years, in my country Italy, it was any physician who was licensed to practice. For this reason, you could find the internist, pediatrician, gynecologist, endocrinologist, surgeon, or even the pathologist and forensic scientist working in the ED. That we might need something other than to have graduated from a medical school, or completed any kind of postgraduate training, never occurred to anyone.

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Personally, I had a passion for EM ever since I was very young. It was this dream of being able to care for acute problems that induced me to enter the study of medicine. As soon as it was possible, I started to frequent the ED, first as a volunteer, and then as a student. Until the early 90s in Italy, residency was not salaried, and consisted almost wholly of theoretical lessons with little practical work, but it was compatible with having a job elsewhere at the same time. Thus, during my residency, I worked in pre-hospital medical service and other EM services to support myself while completing my 5 years of internal medicine (IM) training. To do this, I attended various courses on my own (such as Basic Life Support, Early Defibrillation, Advanced Cardiac Life Support, Pre-Hospital Trauma Life Support, Advanced Trauma Life Support). Therefore, by the time I had finished IM training, I thought that I had also managed to compete a training that was necessary to work in EM.

In 1999, my first job assignment was as an attending physician in one of the largest EDs in Rome. All too quickly, I discovered that I was not actually prepared or trained for the real practice of EM. I did not have the necessary knowledge to manage such a wide range of clinical presentations I was responsible for, and my university studies did not prepare me to work in such a chaotic, multitasking, time constrained, and stressful setting. Even if I was able to initiate critical care, due to the ambulance service experience, the job I was facing was quite another matter! There were way too many patients and there was too much responsibility, and too little time (there were only 3 attending physicians and 3–4 nurses for almost 250 visits/day).

I was really afraid that I would be involved in a medical malpractice lawsuit. Even though one of the causes of the possible bad outcome was the hospital's dreadful organization, I felt that the main problem was me. Virtually

nothing that I had learned during my residency was useful for that practice situation, and, if I looked for information and educational material to prepare myself, I could not find it easily in Italy [1, 2]. In that period, almost all the education that shaped young physicians starting to work in EM came from older physicians and their experience. Just because these older physicians had been doing it for a long time, it did not mean that they were fully confident with what they were doing, nor doing it correctly. In fact, most of them did not use an evidence-based approach to their practice.

In EM, the proverb "experience teaches us" does not really work, because to make the same error 10,000 does not give one good experience. For this reason, I decided that I must find a way to learn how to be a safe EP. In the 90s, two relevant novelties changed our way to practice Medicine dramatically: worldwide internet and evidence-based medicine. At this time, the internet was starting to be easily accessible in Italy, and through the net I discovered that EM was already a recognized specialty in the United States of America (USA). There were residencies, expert professors, a specialty literature, EM associations (such as the American College of Emergency Physicians, ACEP), and websites [3, 4]. I joined ACEP, and started to read ACEP documents and publications [5–8], to buy the books that American EPs use [9, 10], to subscribe to their journals [11, 12], to read the publications [13, 14], to visit the websites [15, 16], and to buy the software [17–23] that all my American colleagues used in an attempt to learn and be current in the practice of EM. Everything began from this.

First, I was surprised at how much change was necessary to improve my practice of EM. There were so many "basic" things that I had never read nor heard of, which were unknown to me or my colleagues. Second, it was not only a matter of knowledge as I was often impressed and excited to discover a different and novel way to learn and to study.

Soon, I felt the need to tell other people what I was discovering. Therefore, more than a decade ago, I began to send emails to my colleagues to share information that I had gathered from my personal study and readings. These emails were brief messages with important news or input or suggested readings about our practice. This newsletter started to disseminate widely and, in the past few years, I have received a lot of requests to be on my mailing list. Today, there are more than 1,400 subscribers, and more than 90% of them work in the EM setting (10% of who mare professors, or directors of EDs or Italian EM organizations). An 85% of the recipients are represented by physicians, 11% nurses, and 4% students (however, these numbers are changing with the evolution of the website). My first intent was, and still is, to convey information in a simple, readable, and useful way.

In 2005, as my activity became better known, I was contracted to write two columns in a respected Italian evidence-based publication ("Decidere in Medicina", CGMES Publisher, Torino), and shortly after I joined the scientific board of the journal. Actually, one of the two columns, called "Myths and Beliefs in Medicine" represents the natural evolution of the newsletter. My idea was, and still is, to discuss some outdated medical practices still in use in an attempt to try to convince EM doctors to change their practice.

By the end of 2008, it was impossible to continue to manage the newsletter via email. Moreover, I was also told by my colleagues that many of them saved the email content to use during their practice. For these reasons, I decided to create an independent and free website to reach more and more EPs and nurses, and to better organize the articles.

In January 2009, I created the website (MedEmIt—www.medicinadurgenza.com). At the beginning, I shared this project with a friend of mine who was an expert in website programming (Michele Alzetta, director of an ED in Venice). For the first several months, the whole content of the website originated from old newsletters or my new writings. As the website started to take off, I asked some Italian EPs already involved in EM education, to join the project. Not everyone accepted, probably because the perspective of this project was not easily understandable.

By the end of 2009, we created a group of nine "volunteer" physicians who formed the scientific board. The website is not publicized or funded, and information about it is only by word of mouth. From an initial 30 requested accesses/day, we have evolved to more than 700 day^{-1} (and we are still observing an increasing trend). As I receive the requests for newsletter registration from the website visitors, I invite most of them to collaborate with us. They can propose personal clinical cases, summarize new guidelines, review articles, translate into Italian contributions in English, or prepare any other content that the scientific board may suggest. Usually, I send them an email and I make a proposal; if they accept, the final work on the assigned task is sent back to me. During our second year, we have involved more than 100 reviewers, writers and translators. Most of them are EPs, but there are other specialists (i.e. pediatricians, anesthesiologists, cardiologist and nephrologists) and nurses who collaborate as well. Recently, I asked some of the most active and capable contributors to form an editorial board. We added a pediatric section to improve the knowledge of the care of pediatric emergencies, because often the EP must care for these patients with no available pediatric consultation. Every one works with no salary, and we frequently donate our own money as well as time to support the project. The content arises from the literature (books and reviews),

from congress proceedings, as well as from the direct experiences of the contributors. The majority of contributions is in Italian, but we have also free contributions from the USA as well (we signed an agreement with the ACEP, and we have also personal agreement with several international educational companies and internet resources involved in EM education). We are not attempting to provide a comprehensive review of the EM literature, as this is already better achieved by others.

Why was this effort so quickly successful? First, in my country, there were no internet resources such as MedEmIt. The English language is still not a source of communication for many physicians in Italy, and this may be the reason why they do not use the already existing international resources. Considerations about the feasibility of application of international standards and tailoring clinical problems to the Italian EM setting, proposed by field doctors like us, could represent additional reasons. In fact, almost all responders to a online survey we carried out declared the website to have had a significant impact on their clinical practice, recognized English as a significant barrier to their use of already existing educational opportunities, and pinpointed the "website style" as one of the principle convenience sin using the website as an updating tool.

Some conclusions about this experience are worthwhile. Our "motto" is: "*An Italian program to disseminate the best practice of Emergency Medicine*". The gap between knowledge and performance is well recognized as a major impediment to high quality health care worldwide, and a large majority of the world population receives emergency medical care from nurses and physicians with little or no specific training in EM. Knowledge translation, a "new science" in EM, investigates different aspects of this dissemination process: knowledge synthesis, exchange, and application [24]. Producing good evidence has no value if we are unable to communicate it to the physicians that are actually caring for the emergency patient.

Our experience may be an example for the development of similar programs all worldwide, especially in countries where there is no formal education or training sites for the physicians who have the clinical responsibility for the care of the emergency patients, and there is a need for advancement of EM.

Conflict of interest None.

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