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Society for Emergency Medicine. We presented in our Editorial[2] a model of a longitudinal and collaborative approach to CRitical Emergency Medicine (CREM), a winning approach for the best care of all critically ill or injured patients. This model of patient-centred collaboration is well established in many European countries.

As pointed out by Dr Buscher, only a very few patients in an emergency department are critically ill, and require a multidisciplinary team approach. Coordination of such a team requires specialists with the expertise to deal with impaired and rapidly changing vital functions. This is not about a specialty but about the right skills and understanding the acute care pathway. In most European countries, this function is fulfilled by anaesthesiologists/intensivists (https://www.uems.eu/__data/assets/pdf_file/0007/19438/UEMS-2012.14-SECTIONS-AND-BOARDS-Chapter-6-Anaesthesiology.pdf, http://www.eba-uems.eu/resources/PDFS/Training/Anaesthesiology-Training-Requirements-March-2013.pdf).[3,4] Ideally, critical patients are identified in the prehospital period and then 'railroaded' into the appropriate care pathway. We agree with Dr Buscher that resuscitation of critically unwell patients needs to be done in close cooperation with intensive care experts, anaesthesiologists in most cases. As pointed out in our response to Hautz *et al.*,[5,6] we doubt whether emergency medicine as an independent specialty can support the required skills or the necessary pathway continuity.

The high degree of specialisation in medicine has created segmented pathways riddled with barriers, which do not serve our critical patients well; introduction of emergency medicine must not become another hurdle in timely access to CREM specialist care. Multidisciplinary input from various specialties is essential to achieve high-quality care for critical emergency patients; close cooperation between the specialties is needed to clarify their respective tasks and to achieve a meaningful differentiation of functions amongst them.

The proponents of emergency medicine as an independent specialty in continental Europe have not made any convincing case for handing over responsibility for the sickest of our patients to one single specialty. In the interests of our patients, we urgently need to establish the roles and responsibilities of the different specialties in the emergency department to protect well functioning pathways and to maintain future development of vital function care in emergency medicine.

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Professionalisation rather than monopolisation is the future of emergency medicine in Europe

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Editor,

In their recent Editorial, De Robertis *et al.*[1] argue that some skills anaesthesiologists possess are highly relevant to a fraction of patients presenting to an emergency room (ER). From this observation, the authors conclude that emergency medicine should not be(come) a full specialty but rather be established as a supraspeciality, into which physicians can opt after their primary specialisation. However, a number of issues raised in this editorial are in fact best addressed by a full specialty of emergency medicine rather than a supraspecialisation.

For example, the authors rightfully advocate multidisciplinary reception teams for the most severely injured or ill,[1] and the importance of teamwork in the diagnosis[2] and treatment of the critically ill[3] is indeed well established. However, it remains unclear as to how these reception teams are composed, by whom and for which patients. Whom to mobilise in advance or how much blood products to pre-order are difficult but crucial decisions that should be taken by a qualified physician familiar with all

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common critical conditions and their immediate care. The advanced preparation of the ER for the critical ill and leadership in large multidisciplinary teams require considerable experience, which is easier to acquire during full specialty training than during the occasional call to the ER from the operating room. Furthermore, all specialists involved in multidisciplinary reception teams should know what to expect and have a collegial point of contact in the ER. A dedicated specialty with competencies clearly defined, taught and assessed fulfils these requirements much better than a supraspeciality degree added to a diversity of primary degrees. In addition, it is contradictory to call for a more precise definition of emergency medicine on the one hand[1] and, on the other, to advocate a supraspeciality degree adjunctive to a variety of primary degrees as different as 'anaesthesiology, surgery, internal medicine and others'[1] at the same time. De Robertis *et al.* further advocate clearly assigned responsibilities for the pathway of emergency patients, and we could not agree more. We would, however, argue that most patients have more than one active condition[4] and only a few skills that most specialty trainings convey are relevant to only a small fraction of these conditions.[1] Why not bundle the skills most commonly required by most emergency patients into a full specialty training and assign the responsibility for all emergency patient pathways accordingly? Such a responsibility obviously requires consultation with colleagues from other specialties for selected conditions.

Another issue raised by De Robertis is the lack of research on how a specialty of emergency medicine affects patient outcome. We have recently evaluated the introduction of a sedation protocol and training (which we implemented together with our colleagues from anaesthesiology) to our ER. In comparison to the pre-implementation phase, when for example patients with displaced joints were attended to by anaesthesiologists and surgeons, time to procedure and time to reposition were significantly shortened, as emergency physicians sedate and reposition independently.[5] At the same time, no complications requiring anaesthesiological intervention occured[5] and our colleagues from anaesthesiology are freed up for more specialised tasks. We would argue that the establishment of a specialty degree requires and fosters such quality improvement research,[6] much more than a supraspeciality qualification does. Setting up a research agenda (or, in fact, any other long-term project) is also simpler in and much more required of self-contained units.

Contrary to De Robertis' assumption that only few anaesthesiological skills are relevant to only a few emergency patients,[1] most patients present to the ER because of pain.[7] Arguably, anaesthesiologists are highly experienced with different forms of pain. Still, nobody calls for every patient in pain to be seen by an anaesthesiologist. We assume that this follows from the fact that people can learn. AKE and WEH are actually board certified anaesthesiologists. We were however not born as such, but acquired our expertise during training. Why should young physicians opting for a speciality degree in emergency medicine not be able to acquire relevant skills, for example during a mandatory rotation in anaesthesiology? Additionally, it is rarely an advanced airway skill that saves a life, but ventilating and oxygenating the patient – skills commonly required by many outcome frameworks, even in undergraduate education. Especially considering the history of anaesthesiology, we do not understand why some European anaesthesiologists still ignore that many countries have meanwhile introduced emergency medicine as a speciality and run successful trainings.

In sum, we found the editorial by De Robertis *et al.* was rather one-sided and appeared to be driven by an underlying fear of becoming irrelevant as anaesthesiologists in emergency care. We heartily invite the authors and other interested anaesthesiologists to visit our ER and see for themselves what benefits a clearly defined department and specialty of emergency medicine have to offer to patients and to most specialties alike. However, after all, emergency medicine is much more about all our patients, not just a small fraction of them, than it is about providing 'excellent additional perspectives for anaesthesiologists and others'.[1]

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