The Entrance of the Emergency Department

To the Editor:

The article recently published by Sanchis et al[1] has, we believe, a rather unfortunate title in Spanish. The Dictionary of the Spanish Language edited by the Royal Spanish Academy[2] has, as the first meaning of the word puerta: "vano de forma regular abierto en pared…, para poder entrar o salir" (door: "regular shaped opening in a wall…, for entering or leaving") and as its third meaning: "cualquier agujero o abertura que sirve para entrar y salir por él…" ("any hole or opening used for entering or leaving through…"). The emergency room door does not, therefore, appear to be the ideal place to undertake risk stratification studies in patients with chest pain, to make clinical decisions, or even to give immediate medical care. This mistake is repeated later on in the text.

The emergency room door of almost all hospitals in Spain has a hospital porter or a member of the security staff, but we have yet to see a doctor at one, least of all a cardiologist.[3] The American College of Emergency Physicians, in its manual *Emergency Department Design: A Practical Guide to Planning for the Future*,[4] situates the area for triage or patient classification, not care, beside the main door, which is usually staffed by trained nurses using specific protocols.

In 2001 the category of hospital emergency physician was created in the area covered by the now defunct National Institute of Health-INSALUD.[5] This was later extended to most of the other areas of Spain, which had their own autonomous regions and their own health care organization and responsabilities.[6,7] The text of the decree, besides defining the functions of an emergency physician, implicitly recognizes the existence of emergency services with a hierarchical design. We believe the use of terms which, if not biased, are at least outdated in articles in prestigious journals, which we emergency physicians usually read, is the equivalent of talking about bone doctors, shrinks or tooth-pullers.[8]

Until such time as the specialty of emergency care physician is created,[9] this medical work is just as interesting, worthy and gratifying as any other, more so when it is carried out with the optimal infrastructure and staff.

We have previously expressed our opinion in this Journal concerning the relationship between the emergency and cardiology services regarding chest pain units.[10] It just remains to congratulate the authors on their work in this respect, although we trust they will in future use more appropriate terms when referring to emergency areas, units or services.

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Response

To the Editor:

Further to the letter of Burillo-Putze et al concerning the article written by our group and recently published in the REVISTA ESPAÑOLA DE CARDIOLOGÍA,[1] we should first of all like to thank them for their congratulations. Use of the term emergency room door is common, both in hospital slang and in the Spanish scientific literature. The emergency service in our hospital, for instance, has 3 definite

areas for health care: the emergency room door, the observation ward and the short-stay medical unit. Likewise, other terms are also common, such as the “door to needle” or “door to balloon” interval (time between arrival of the patient at the emergency room and start of reperfusion therapy in acute myocardial infarction). We agree that the words emergency area, unit or service might be more appropriate, but it was never our intention to use the term emergency room door disparagingly. As the authors of the letter state, we too believe that medical work in the emergency services is as interesting, dignified and pleasing as any other. Rather than being a cause of friction, we firmly hope that our article will stimulate collaboration among physicians working in the emergency and cardiological services, which is vital for the development of chest pain units.

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