Specialists, guidelines and turf battles

To the editor:

I enjoyed reading the July 99 issue of *CJEM*. Thank you for a thought-provoking and diverse spread of articles. I found the discussions[1–9] about guidelines and "turf battles" fascinating and, in many ways, familiar. The Australasian College for Emergency Medicine (ACEM) has faced similar issues and processes.

ACEM produced a policy for the ED sedation procedures in November 1997. Although there was wide consultation during the formulation of the guidelines, including from our anesthetic colleagues, we did not seek endorsement from any other body. Recently, ACEM adopted a position statement regarding the use of focused ultrasound in the ED. Again, we did not seek the endorsement of any other specialty group.

I see a clear link between the way we define our "specialism" and the confidence with which we can make statements about standards. Unless we claim confident ownership of our legitimate turf, we will always be seen as "Jack of all trades and master of none." Why would another specialist body want to endorse our position papers if we are not confident that we own the territory? If we ask for endorsement, aren't we really saying that we want their permission to make our own statement about an area that is really theirs?

So, is there legitimate specialist territory that belongs to us alone? I believe that the definition of our specialty lies in a system of practice rather than a body of knowledge. Sure we know a lot about toxicology and environmental injuries, but so do others. Where we are uniquely specialized is in the reception, triage, assessment and initial management of multiple undifferentiated patients presenting simultaneously, throughout the spectrum of diagnoses and age groups, and with a minimum of background information. This territory is unique to us, and only we understand it well enough to make statements about how practice should occur within it.

Of course we must use knowledge or expertise developed by other specialists. However, we must then translate those principles into rational and realistic guidelines that are appropriate for our setting. When we sedate patients for procedures in the ED we are practising emergency medicine, not anesthesia. In the same way, an anesthetist reading a preoperative ECG is practising anesthetics, not cardiology. When we use focused ultrasound to evaluate the abdomen of a trauma patient we are practising emergency medicine, not radiology (just as we are when we interpret plain x-rays).

In relation to focused ED ultrasound, the answer to the question "why aren't we allowed to use it?" must surely be "you can do anything you like, as long as you are answerable for the consequences." The standards of training and practice must be appropriate for the setting, and the procedure and consequences must be subjected to the same quality control processes that we would apply to the interpretation of plain radiographs or the decision to use thrombolysis in ED.

We need to behave, speak and think with enough confidence in our own specialty that other specialists will understand that we have no need to invade theirs. At the same time, we must approach them with the respect and recognition that we would wish expressed towards ourselves.

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A Canadian approach?

To the editor:

Congratulations on the launch of *CJEM*. This journal represents a landmark achievement in Canadian emergency medicine and is long overdue. It's important for us to realize that the US approach is not the only standard of care, and perhaps not the best one. Finally Canadian emergency physicians will have an alternative to the legally-driven, overly investigation-oriented USA style of practice. *CJEM* will enable us to publish our own standards of care, guided by logic, evi-

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