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A decalogue for saving Italian emergency departments

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Abstract

The COVID-19 pandemic severely impacted Italian Emergency Departments (EDs), leading to drastic staff reductions, chronic overcrowding, widespread burnout, and an exodus of healthcare providers. Consequently, the ED system faces collapse due to relentless overloading. The authors propose a radical decalogue of provocations to drive structural reform and spark scientific debate on the future of emergency care. The core objective is to restore the ED's mission by strictly limiting access to acute, time-dependent conditions. This requires diverting non-urgent visits to a genuinely operational territorial network, creating distinct, non-ED managed flows for non-acute or destabilized chronic patients. To reach this aim, a single, national, scientifically validated triage system is essential to reliably distinguish between ED-acute patients and those who belong in alternative settings. To address staff retention, the Decalogue demands increased pay, reduced weekly working hours, optimized night work, and structured work diversification between pre-hospital and intermediate care units to make the profession sustainable. Furthermore, the ED must be restored as the hospital's strategic core, with the emergency physician as team leader. Simultaneously, boarding must end by mandating the transfer of stabilized patients out of the ED. System-wide, the network should be rationalized by concentrating resources in equipped referral centers. Finally, the Decalogue calls for legal protection for emergency professionals (with liability resting on healthcare institutions), the establishment of academic chairs in emergency medicine assigned to emergency physicians, and mandatory research for residents. The authors contend that only bold, radical choices can safeguard the ED system and the entire healthcare infrastructure.

Key words: emergency department crisis; healthcare reform; crowding; healthcare provider burnout; emergency department work-life balance.

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Introduction

The COVID-19 pandemic determined a high-profile victim: the Emergency Department (ED). The results are worrying: drastic staff reductions, chronic overcrowding, an exodus of healthcare provider, disillusionment among young physicians who before considered Emergency Medicine (EM) as a career, widespread burnout, increasingly frequent episodes of violence. Legislators appear to have accepted ED sacrifice as the only way to keep alive their increasingly fragile healthcare systems. What is striking is that the situation is becoming tragic, albeit to varying degrees.[1-4] Given the ED's centrality to the health system, it serves as the hospital's gatekeeper, identifying patients who require admission while shielding those who do not; it supports community services and provides rapid, responsive assessment for people with urgent needs. In summary, the ED is the beating heart that helps keep public healthcare standing. Yet the relentless overloading of this pivotal node threatens to break EDs themselves, with potentially disastrous repercussions for the entire hospital infrastructure and, ultimately, for community-based care. On the other hand, the EDs themselves failed to produce strong scientific responses to address the crisis. Too often limited to slogans and rhetorical appeals to the importance of care, without ever accompanying them with concrete and sustainable projects. In other cases, other Scientific Societies attempted to intervene in the EM, lacking specific knowledge and experience. The crisis remains, even when financial investments where applied, proving the problem lies not (only) in economic resources, but in the absence of ideas and operational strategies. This paper proposes deliberately radical provocations to spark a scientific debate on the future of a fundamental healthcare function, which is now at risk of disappearing, without significant and radical action.

1. Restoring the emergency department's original mission: prioritizing urgent and emergent cases over non-urgent visits

Emergency department is not a general outpatient clinic

Over the past twenty years, EDs experienced a steady increase in patient visits, reaching a true "epidemic of ED visits" affecting all Western healthcare systems, despite that, urgent or time-sensitive conditions has remained essentially stable. In some areas, such as major trauma, case numbers have even decreased thanks to technological progress and prevention.[5-7] By contrast, the exponential

rise in low-acuity cases has progressively transformed ED into large general practice clinics, where the management of acute illness risks being blurred with the treatment of exacerbated chronic conditions. International literature confirms that more than 50% of ED visits involve non–time-sensitive conditions,[8-12] often patients with chronic diseases seeking improvement of their baseline worsened status, but not to the point of posing an immediate risk to life.[13,14] In Italy, among more than 20 million ED visits annually, minor cases account for 30–50%,[14] often related to chronic diseases, minor problems or even social and care needs. Unfortunately, these unmet needs do not find an appropriate response in the current available resources of health system (e.g. out-of-hospital or in-hospital specialists, primary care, community services general practitioner). Thus, EDs mission founded on the management of acute, time-dependent conditions, in which timely intervention is crucial, has been distorted. Citizens address to the ED for virtually any problem, transforming it into an "universal gateway" to healthcare, permanently open (24 hours per day, 356 day per year). As a result, ED staff is forced to absorb inappropriate requests without adequate tools or resources, with predictable consequences represented by chronic overcrowding, unsustainable waiting times, staff burnout, and declining attractiveness of the specialty. Moreover, the training of ED professionals is not suited to solving the growing number of non-acute medical issues, increasing the risk of errors and driving up healthcare costs.

Distinct flows for separating acute from chronic disease

The survival of EDs depends on recovering their true essence: being the place dedicated to the management of clinical emergencies and other time-sensitive conditions. Crowding and boarding reduce efficiency, prolong waiting times, and ultimately undermine the very role of EM. A major driver of this erosion is the progressive blurring between acute, time-dependent presentations and non-urgent/deferrable needs (including chronic-disease related requests that require continuity rather than emergency care). When these fundamentally different demands enter the same pipeline, low-complexity care absorbs time, staff attention, and ED resources, inevitably delaying true emergencies.[15-18] Therefore, any credible reform must re-establish, from the very front door, a clear distinction between emergency care and non-emergency care needs.[15-18]

Proposal

It is necessary to restore the ED to its original mission, limiting access strictly to acute, time-dependent conditions. At the triage/front-door stage, patients should be streamed into clearly differentiated pathways: acute time-sensitive emergencies managed within the ED; and non-acute presentations (including non-severe destabilized chronic patients and deferrable needs) managed in dedicated "beyond-the-ED" settings. International experiences indicate that such front-door streaming is feasible when supported by appropriate services and governance.[15-18] Inappropriate visits must be intercepted and managed elsewhere through a genuinely operational territorial network (Community Health Centres, District Services, Pre-hospital Triage Units, telemedicine pathways, and public health education campaigns). If needed, even a review of patient co-payments could help discourage misuse. These cases should directly and promptly access to territorial emergency-urgency services, since redirecting minor cases to other care settings outside the ED does not worsen outcomes for either adults or children.[19,29] By the adoption of a simple principle, EDs should not receive patients with conditions which are not suitable for acute and urgent assessment/treatment, thus not automatically guaranteeing that a patient who refers ED just to be visited by a doctor or nurse. Patients can no longer think (or be encouraged to) that whatever happens, the ED is always there, just as community services can no longer rely on the assumption that "the ED will handle it anyway". This issue should be strongly supported by policymakers. The management of chronic diseases, non–time-sensitive exacerbations, conditions not causing acute organ failure, and low-complexity problems cannot continue to be "dumped" on emergency care: the responsibility must shift, and community healthcare services must be given both the means and the obligation to handle these cases. Alongside the emergency-urgent care pathway, a parallel and distinct system must be operationally available for non-acute or non-severe destabilized chronic patients, staffed by professionals outside the emergency field and equipped with tools designed for chronicity and continuity of care. These patients must be identified during triage and redirected to dedicated areas capable of providing appropriate solutions without burdening the ED. This second pathway is a necessary condition for recovering EM specificity. Implementing this model requires explicit legislation and institutional governance to protect triage personnel who, using standardized criteria, redirect non-urgent patients to appropriate 'beyond-the-ED' services.

2. A single, national, scientific evidence-based triage to rebuild the ED system

The selection of patients who truly need to be managed in the ED is a crucial step for the system's sustainability. Several internationally validated triage models (*e.g.*, Manchester Triage System, Emergency Severity Index, Canadian Triage and Acuity Scale) were developed to standardize early risk recognition; however, they were designed in a context that privileged sensitivity over specificity, leading to systematic over-triage in comparative studies.[30,31] In Italy, the problem is amplified by the proliferation of regional and even local triage systems, often introduced without rigorous scientific validation and with heterogeneous criteria.[30] The practical consequence is not theoretical: a recent multicentre simulation study showed marked variability in code assignment across Italian EDs, with the same clinical vignettes receiving different triage codes depending on the local system and operator.[32] This fragmentation undermines the modern mission of triage: not only to recognize severity early, but also to safely and reliably identify patients who do not require ED evaluation and can be managed in alternative settings.

Proposal

A national, coordinated, and scientifically guided effort is needed to develop and implement a single triage system that is validated and genuinely suited to today's needs. The tool must not only recognize clinical severity, but above all distinguish safely between the ED patient and the patient who can and should be managed in alternative settings (community-based, outpatient, or telemedicine). Unique system would leverage technological advances, go beyond expert opinion and anecdotal practice and instead rest on rigorous analyses of events and processes. It must be designed with strict methodological and scientific rigor and include, among the primary outcomes, the ability to reliably identify non-urgent patients without risk of deterioration.

3. Restoring emergency department centrality: returning to the emergency physician leadership of the patient's emergency department pathway and ending boarding

The ED should be the hospital's clinical command centre for acute care. Without governing the front door and the initial management, it is impossible to optimize downstream pathways and improve outcomes: the first hours often determine the trajectory of the entire hospitalization. Yet the ED is still perceived as a mere sorting area rather than the essential first step of the care pathway.

This cultural and organizational bias has practical consequences: emergency physicians often struggle to have their clinical decisions implemented across the hospital, spending time negotiating diagnostic–therapeutic choices rather than treating patients. At the same time, the progressive increase in boarding has become a dangerous and costly practice. Once the diagnostic–therapeutic process is completed and admission is indicated, the patient should not remain in the ED because inpatient beds are unavailable. Since boarding reflects an output-capacity failure, ED-focused efficiency measures are insufficient unless matched by increased acute-care bed capacity and reinforced downstream pathways, so that stabilized patients can be transferred without delay. Evidence shows that prolonged ED stays while awaiting admission are associated with worse outcomes (including higher mortality, reduced access to care, lower quality of hospitalization, longer length of stay, delirium, and provider burnout).[33-35]

Italy, already characterized by one of the lowest ratios of hospital and intensive care beds per capita among OECD countries, has paid heavily for this structural fragility during COVID-19 and continues to experience its downstream consequences on care quality.[36] Therefore, the solution cannot be framed as an ED "efficiency" issue: it requires hospital-wide accountability for output, including increased bed capacity and mandatory surge/flow strategies that relocate admitted patients to appropriate hospital areas outside the ED. Published models demonstrate that such approaches are feasible and can be implemented without shifting the burden onto ED teams.[37,38]

A change of course is essential: EDs must be recognized as the hospital's strategic centre, and the emergency physician must lead the patient's ED pathway so that disposition, treatment, and diagnostic workups can be executed without avoidable delays. Once stabilization is complete, the patient must leave the ED and be placed in an appropriate hospital area, with no possibility of remaining stalled there.

Proposal

It must be clearly established, by law, if necessary, that the emergency physician is responsible for and leads the patient's ED pathway, including disposition and hospital admission decisions, and has full authority within the acute-care team regarding treatments and diagnostic investigations. This leadership refers to coordination of early assessment and time-critical management within a multi-specialty team and does not replace specialist consultation or definitive specialty care when indicated. Because boarding is largely driven by hospital output constraints, hospitals must adopt 7-day flow standards aligned with the ED's continuous inflow. This includes structured weekend discharge processes, consistent availability of key diagnostics and specialty consultations, and empowered bed-management escalation protocols to prevent predictable weekend bottlenecks and Monday backlogs. Moreover, boarding must be operationally eliminated: once patients are stabilized and the acute diagnostic–therapeutic process is complete, hospitals must be mandated to transfer them to inpatient areas outside the ED through predefined patient-flow/surge protocols, relieving ED physicians and nurses from this inappropriate burden.

4. Rationalizing emergency departments

Urban planners have a well-known rule: "the more roads you build, the more traffic you will have." The same applies to the EDs. Multiplying access points does not reduce demand, but it amplifies it, dispersing resources and increasing inefficiency. The Danish experience is emblematic: starting in 2007, Denmark undertook a reorganization that by 2016 had closed over half of its EDs, concentrating emergency care in a smaller number of large hub centres with greater resources and expertise. Evaluation studies showed that mortality did not increase, while quality of care, safety, and appropriateness improved.[39-41] The lesson is clear since it is not in discussion denying care to the population, but about providing the right care in the right context.

Proposal

Rationalize the ED network by reconfiguring low-volume sites that cannot consistently meet minimum 24/7 staffing and capability/safety standards, and by concentrating complex emergency care resources in properly equipped referral centres within a hub-and-spoke model. Keeping dozens of small, understaffed EDs open guarantees neither equity nor safety, but instead creates a fragmented and fragile system. Wealthier and better-organized countries have long reduced and centralized emergency networks, recognizing that not every health need can, or should, be addressed inside an ED. The population must be guaranteed time-sensitive care through a strengthened territorial emergency system, but we can no longer sustain a dispersive model that creates the illusion that every need can be met by an ED around the corner. Sustainability lies in concentration, not multiplication.

5. Making emergency department work attractive: higher salary, fewer hours and night work, earlier retirement

ED work is currently the least attractive of the entire healthcare system. In Italy, paradoxically, emergency professionals are among the lowest paid, despite working in a highly risky, exhausting, and complex environment. In more competitive systems, emergency physicians and nurses are frequently better compensated precisely because recruitment is difficult and the professional toll is high. However, attractiveness and retention are not only financial issues: work–life balance is a major determinant of career choice and long-term sustainability in shift-based specialties, and poor work–life integration is consistently linked to burnout and intention to leave.[42-44]

ED activity is also not comparable to inpatient or outpatient work. No physician can be expected to complete 12-hour shifts while assessing 50 patients, nor can a nurse be expected to perform 150 triage assessments in a single shift. One hour in the ED is not equivalent to one hour elsewhere, because emotional, decisional, and clinical intensity is substantially higher. Therefore, rebuilding stable ED teams requires a package of measures addressing com-

pensation, workload, scheduling, and career longevity – and it cannot rely on the "goodwill" of individuals.

Night shifts are among the most exhausting components of ED work. Numerous studies show that chronic night work is associated with increased health risks and a marked rise in burnout and professional attrition.[45-47] Working at night is not simply "tiring": it is biologically misaligned and clinically harmful. In Italy, a recent multicenter study showed that most nighttime ED visits are minor codes and are steadily increasing.[48] This reflects a distortion: the ED is perceived as an "always on" service, without acknowledging the human and social costs of maintaining 24/7 full functionality as if every hour were equivalent. In reality, true time-sensitive emergencies during night hours account for a small minority of total visits.[47]

Proposal

Make ED work attractive and sustainable through five immediate measures: i) significantly increase pay for emergency physicians and nurses through dedicated allowances linked to risk, complexity, and unsocial hours; ii) reduce weekly working hours (e.g., ~30 hours/week) and redesign rosters to reduce cumulative burden of night work (caps on night shifts and protected recovery time); iii) recognize additional annual vacation to compensate high-burden shift work; iv) adopt workload standards (e.g., maximum of ~1 patient/30 minutes per physician) to align staffing with safe throughput; v) enable earlier retirement (or structured redeployment to lower-burden settings after 20–25 years of ED service), consistent with other strenuous/high-burden professions.

These measures are not intended to imply that other high-burden services do not warrant comparable protections; rather, they reflect the objective ED recruitment/retention emergency and the need to align compensation and rostering with demonstrable exposure to unsocial hours, workload intensity and burnout risk. Accordingly, staff numbers should be probably increased but certainly better assigned aiming to organizational reform will be able to retain or attract professionals. One of the possibilities is the limitation of night-time access for reducing ED staffing during night hours, enough to manage true time-sensitive emergencies.

6. From assembly line to modern emergency medicine: intermediate medical care units as the prerogative of the emergency physician

Alongside EDs, dedicated units for EM must be created with the clear mission to stabilize critically ill, non-intensive patients. The goal is not to replace intensive care, but to manage patients requiring organ support, including advanced support, while awaiting stabilization and subsequent admission to a specialist ward. Managing the full complexity of the acute condition means stabilizing not only the symptom but the entire pathological process in the early hours. Recent literature highlights how Intermediate Care Units (IMCUs) or Stabilization Units can improve ED efficiency, reduce boarding times, and increase the clinical safety of high-intensity patients who are not ICU candidates.[49]

Proposal

Create, within ED, true Stabilization Units/IMCUs, with a clear mission: manage the acute phase, stabilize critical patients, and guarantee an orderly pathway to inpatient wards. In addition to improving flow and safety, these units would allow specialist resources to be redirected to outpatient activity, reduce time to treatment for high-intensity patients, and restore emergency physicians to their core mission: managing acute destabilization rather than functioning as "assembly line" outpatient doctors. From these units can emerge the EM of the future, capable of making the entire system more efficient and safer. This is a fundamental step for a full development of the modern EM, which has already been proven in many countries to improve entire healthcare systems.[49]

7. Not only the emergency department: a 360° career in emergency medicine

Work in emergency care offers multiple avenues, ranging from pre-hospital emergency services to EDs and IMCU. For years, professionals have been calling for the opportunity to diversify their work across these settings. Even within the ED, specific domains could be created where professionals – if properly structured and organized – could find greater fulfilment and professional growth, just as occurs with subspecialties in internal medicine.

A service-based organization can be hypothesized, with EM specialists rotating across different areas from pre-hospital emergency services to EDs and IMCU. This approach would yield at least two immediate benefits: on the one hand, a significant increase and sharing of skills; on the other, the chance to vary workloads and clinical domains, helping to prevent burnout and loss of motivation in EM, both of which are increasingly common.

Proposal

Create structured, professionalized sectors within the emergency care network, ensuring that professionals always have the possibility to alternate their roles within EDs, in line with their skills, personal inclinations, and life rhythms. EDs should, by law, include the different components of EM work, offering all providers – both physicians and nurses – the ability to vary and alternate throughout their careers, according to their sensitivities, skills, life stages, and aptitudes.

Ensuring job flexibility would encourage alternation between high-intensity periods and phases of decompression, allowing professionals to remain in EM longer and preserving the skills and experience acquired, to the benefit of the entire system. International experiences already exist in this field, with promising results.[50-51]

8. Not guilty by duty: a special law to protect emergency workers

Italy is one of the very few countries in the world – alongside Mexico and Poland – where doctors still bear direct criminal liability for professional acts. This anomaly weighs especially heavily on EM professionals, who work every day under clinical uncertainty, with time constraints and inevitably higher margins of error. It is unreasonable to perform a job where the stakes are the patient's life while simultaneously facing the constant risk of criminal prosecution simply for doing one's duty.

The reality is that over 98% of legal actions against emergency physicians end in acquittal. It means years of trials, legal expenses, media exposure, and personal suffering. It is unacceptable that an entire professional category should live "under siege," hostage to a judicial threat that breeds fear and demotivation. This threat is all

the more serious considering, as already noted, the immense workload compared to other healthcare settings. All of this fuels defensive medicine, which in Italy has reached paroxysmal levels, generating enormous costs for the healthcare system and negatively impacting the quality of care. In countries with strongly privatized healthcare systems, the clinician is an employee of the institution and liability runs through the organization: the structure itself absorbs any legal action brought by patients, without directly involving the individual professional. In Italy, by contrast, ED workers must constantly justify and personally answer for any issue, however minor and often raised without serious reasons. Even a simple patient complaint or communication can create anxiety, heaviness, and demoralization in the professional, reinforcing the sense of always being "the guilty one." It is essential that professionals be fully protected from this condition, which must not become the normal state of working in the ED.

Proposal

Introduce a special law granting full legal immunity to emergency professionals, ensuring that direct liability rests with healthcare institutions, as already occurs elsewhere. Professionals must be guaranteed full coverage of legal expenses and protection from criminal prosecution for unintentional errors. Furthermore, in cases where lawsuits end in acquittal, institutions should initiate defamation proceedings against claimants, thereby safeguarding the integrity and dignity of their staff. Only by restoring legal peace of mind can EM be truly patient-centred, free from fear. Policymakers must develop cultural and legislative tools to forge a broad alliance between healthcare providers, the legal-insurance world, and the media. The goal is to ensure mutual protection and trust, allowing everyone to work for the citizen's benefit, without exploiting unpredictable or chance events lacking proper scientific evaluation. It is time to end, once and for all, this "war among the poor."

9. Research and scientific production

To keep emergency care consistently aligned with the needs of the population and healthcare providers, continuous research and scientific updating are essential. In Italy, however, EM has rarely acted as a true scientific driving force, often delegating this role to universities and policymakers. Meanwhile, emergency services hold a vast and increasingly standardized repository of clinical and operational data, an underutilized potential that could directly inform patient-flow strategies, triage, time-sensitive pathways, and

Table 1. A decalogue for saving Italian emergency departments.

1	Restoring the Emergency Department's original mission: prioritizing urgent and emergent cases over non-urgent visits	Restore the ED's original mission by limiting access strictly to acute, time-dependent conditions. Redirect inappropriate visits through a genuinely operational territorial network (e.g., Community Health Centres, telemedicine)
2	A single, national, scientific evidence-based triage to rebuild the ED system	Develop and implement a single, national, scientifically validated triage system to distinguish between the ED-acute patients and the patients who can be managed in alternative settings
3	Restoring Emergency Department centrality: returning to the emergency physician leadership of the patient's ED pathway and ending boarding	The ED should represent the core of the entire hospital dynamic during the acute phase and the Emergency Physician must be the team leader during the management of the acute conditions. Stabilized, boarded patients has to be moved in hospital areas outside the ED
4	Rationalizing Emergency Departments	Rationalize the ED network by reconfiguring low-volume sites that cannot consistently meet minimum 24/7 staffing and capability/safety standards, and by concentrating complex emergency care resources in properly equipped referral centres within a hub-and-spoke model.
5	Making ED work attractive: higher salary, fewer hours and night work, earlier retirement	Make the ED work attractive with a significantly increased pay, reduction of weekly working hours, optimize and reduce night work and facilitate an earlier access to retirement as for every strenuous work
6	From assembly line to modern EM: Intermediate Medical Care Units as the prerogative of the Emergency Physician	Create true Stabilization Units/Intermediate Medical Care Units (IMCUs) within the ED. These units must have the clear mission of managing the acute phase, stabilizing critical patients, and guaranteeing an orderly pathway to inpatient wards
7	Not only the ED: A 360° career in EM	Create structured, professionalized sectors within the emergency care network from prehospital to IMCUs. This must ensure that all providers have the possibility to vary and alternate their roles throughout their careers
8	Not guilty by duty: a special law to protect emergency workers	Introduce a special law granting full legal immunity to emergency professionals, ensuring that direct liability rests with healthcare institutions
9	Research and scientific production	Through a solid scientific production, Emergency Physicians should guide the improvement of EM. They must sit on national and international guideline boards, including those for highly specialized, time-critical diseases, and co-author the ED components of such guidelines. Research should be mandatory during residency.
10	EM to the Emergency Physicians	Establish university academic chairs in EM assigned to Emergency Physicians. Open academic careers to those who practice and advance the discipline in the field

ED, Emergency Department; EM, Emergency Medicine.

system redesign. A further critical issue is that international recommendations on ED processes are frequently developed by specialty societies outside EM. Pathways proposed by professionals who do not routinely work in ED settings may be poorly aligned with the operational realities of emergency care. As a result, EM too often follows agendas set by other disciplines rather than shaping its own evidence base and ED-specific guidance.

Proposal

Research should become a defining pillar of EM training and practice ("we cannot change what we cannot measure"). During residency, participation in clinical trials and research projects should be mandatory, with trainees evaluated accordingly. All emergency services should contribute standardized data flows to national databases accessible for scientific production; these results should guide, optimize, and update political and economic decisions regarding emergency care. Governance must also evolve: emergency physicians should sit on national and international guideline boards, including those for highly specialized, time-critical diseases, and co-author explicit ED sections within broader disease guidelines. Building on this foundation, international EM consortia should run pragmatic multicentre studies and health-services/implementation research. EM scientific societies should lead a coherent research agenda, coordinate networked studies, and design scientific meetings for emergency clinicians – prioritizing speakers who actively work in the ED while fostering targeted cross-disciplinary collaboration. Finally, incentives should recognize data contribution, multicentre collaboration, and measurable improvements in ED outcomes as valued academic outputs.

10. Emergency medicine to the emergency physicians

Fifteen years after the opening of Residency Schools in EM, Italy still lacks a proper academic chair in the field. For too long, the university training of emergency physicians has been entrusted to other disciplines – primarily internal medicine – ignoring the work of hundreds of colleagues who have, over the years, built expertise, clinical practice, and research in emergency care. This must end: the teaching of EM must be entrusted to emergency physicians, not granted as a waiver or "courtesy" to other specialties.

Academic careers must be open to those who practice and advance the discipline in the field, not stifled by lobbies or corporatist barriers that have so far prevented emergency physicians and nurses from occupying the positions they deserve. As explained in the previous statement, the authority of a discipline is built on innovation, not merely on teaching or reproducing simulations and courses. A "good emergency physician" cannot be only someone who teaches or organizes training: they must also be a scientist capable of turning the doubts and difficulties of daily clinical practice into research questions and, from there, into new knowledge. Only in this way can EM stop passively receiving directives from others and finally take the lead in defining what to do and when for the acutely ill patient.

Proposal

Establish university academic chairs in EM assigned to emergency physicians, end the transitional arrangement of entrusting training to internal medicine, open academic careers to those working in the field, and mandate the development of dedicated research programs within residency schools and EDs. Only in this way can the discipline consolidate, gain the recognition it deserves, and lead the medicine of the acutely ill into the future.

Conclusions

The emergency care system and EDs are experiencing the most dramatic moment in their history. The countdown has already begun, and, without bold interventions and radical choices, the risk is not only the collapse of the ED system, but of the entire healthcare system, which for far too long has – almost unconsciously – relied on the ability of the EDs to absorb everything.

Limiting access, increasing specificity, humanizing the workplace, introducing positive elements, improving scientific and legal conditions, ensuring the peace of mind of professionals, and restoring the critical nature of the EDs: these must be the objectives (Table 1).

It is clear that none of this can be achieved "at zero cost," and that a true cultural shock will be necessary to guarantee the survival of EDs. We are, however, convinced that citizens have already understood the gravity of the situation and that – as has often happened in the past – they are more ready than we might imagine, sometimes even more ready than legislators themselves, to accept sacrifices in order to safeguard a fundamental common good: the EDs.

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