emergency departments.[12,13] Tools helping us make decisions for daily clinical practice should also be designed.[14]

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Workload of on-call emergency room neurologists in a Spanish tertiary care centre. A one-year prospective study. Response to a reply☆

Labor asistencial del equipo de guardia de neurología en un hospital terciario de Madrid: análisis prospectivo durante un año. Contestación a réplica

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Dear Editor:

After a careful reading of the comments made by Vázquez Lima et al. on our article addressing the workload of on-call emergency room neurologists at Hospital Gregorio Marañón, in Madrid,[1] we wish to thank the authors for their interest.

We feel that the idea that local and medium-size hospitals have lower mortality rates in emergency departments and shorter acute care delay times than tertiary centres, which is based on the SUHCAT study,[2] is biased if we do not consider the complexity and severity of the patients treated in major hospitals. How could patient care possibly be worse in that setting? Care provided at different levels cannot be the same, and the more specialised the team, the better the care it provides to patients with complex or severe neurological cases.[3]

The purpose of our study[1] was not to promote a particular specialty, but rather to highlight the relevance of neurologists in the emergency department of a high-level hospital and underscore the need for emergency neurological care in other tertiary referral hospitals. The

workload figures provided in our study correspond to emergencies.

Unfortunately, the example of acute coronary syndrome is not comparable to stroke since stroke requires neuroimaging studies to provide treatment during the acute phase. Furthermore, types of stroke care other than stroke units, such as stroke teams, have not shown any benefits.[4]

The purpose of a clinician, whether specialised or not, is to provide effective and efficient care to patients. Care must be sustainable, but also equitable; we therefore agree that a 'nodal structure' or other organisational strategies similar to code stroke should be implemented to ensure that neurological patients are transferred to hospitals offering emergency neurological care.[5]

Lastly, the conclusions drawn in our study refer to high-level hospitals such as our own, since we understand that they may not apply to all types of hospitals.

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Neuro-emergencies☆

Neurourgencias

Dear Editor:

We have read with great interest the article 'Workload of on-call emergency room neurologists in a Spanish tertiary care centre. A one-year prospective study' by Rodríguez Cruz et al.[1] There can be no doubt that a preeminent referral centre such as Hospital General Universitario Gregorio Marañón would require a stroke unit and an on-call neurologist. That said, we would like to analyse some of the data provided in the article and qualify some of the statements made by its authors.

It is true that the 3234 neurological emergencies represent 3.48% of the total of 92 762, but it is no less true that this figure amounts to 1.3% of the total emergency evaluations if we include paediatrics, traumatology, surgical, and obstetrical/gynaecological emergencies.[1]

We should highlight that in most Spanish hospitals (91%), emergency care is unified.[2] Several authors have stated that up to 43% of hospitals attend 100 or fewer emergencies per day (small and local hospitals) and some 32% of hospitals attend between 100 and 200 emergencies per day. Only 20% of hospitals attend more than 200 emergencies per day, and barely 5% attend more than 500.[2,3] The first 2 groups (local and medium-sized hospitals) provide healthcare to approximately 50% of the population. It should also be noted that mortality rates and waiting times are lower in the emergency departments in these hospitals.[2]

Hospitals should be classified as primary, secondary, and tertiary care centres for obvious reasons. However, this distinction should not exist in emergency departments. Care provided to a patient at a local hospital's emergency department should be identical to that administered by the emergency department at Hospital Gregorio Marañón. This is the idea behind the principle of equity of access to healthcare.[4] One thing is a patient's final destination once stabilised; the quality of care initially provided by the emergency department is a completely different matter. Medical attention provided in the emergency department to a patient with chest pain (whether due to neuropathy, STE-ACS, pneumonia, diffuse oesophageal spasm, or pneumothorax) is the responsibility of the emergency department doctors.[5] Care received by a patient with any time-dependent disease, referring to initial assessment and stabilisation, diagnostic suspicion, and initial treatment measures,[6] must be provided by these clinicians based on solid training in emergency medicine.[7] This specialty is now clearly defined in many countries,[8,9] and it has contributed significant improvements in the quality of emergency medical care. Subsequent collaborative efforts with other specialties to optimise the care process will depend on the social and demographic characteristics of each area, the available resources, the viability of transportation, and healthcare policies. Information and

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