gram to advocate for more funding in residency training. With the high career attrition rates prevalent in EM,[4] our goals should be to unify our training programs and ensure that there are enough trained EM specialists to provide appropriate care for our increasingly complex patients.

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EM dual training impacts the advancement of the specialty

To the editor: I read with great interest the editorials by Drs. Abu-Laban and Rutledge in the March edition of *CJEM*.[1,2] I too have the similar "queasy" feeling that Dr. Abu-Laban described when I am asked about the pros and cons of the 2 approaches to certification in emergency medicine (EM). I agree fully that our specialty needs to address this fundamental issue before we can really move forward.

Like previous research on practising Canadian emergency physicians has demonstrated, I have noted that residents in both the FRCPC and the CCFP(EM) programs perform on a similar level in the intensive care unit (ICU) environment. Although there are initially some knowledge and experience gaps when CCFP(EM) residents are in the first 2–4 months of their EM year, over a very short period of time this disappears. Most residents do very well; others do not, but there seems to be little association with which program they are in. In fact, my colleagues in critical care seem unable to determine an "EM resident's" background, if asked.

One particular point that really strikes home to me is that "the divided voice that results from our 2 routes to certification has become an increasing impediment to both our development as a specialty and our political strength."[2] Perhaps our lack of success with major issues in EM, such as emergency department (ED) overcrowding can be traced to confusion by our colleagues about whom and what EM really is. Although we are recognized as a specialty by the Royal College of Physicians and Surgeons of Canada, this may not translate into our daily lives. I personally have multiple examples of this, from being asked during an interview for a prospective attending position in critical care, "Do you think emergency physicians know enough medicine to attend in an ICU?" to having investigations questioned as an "emergency room physician" that would not have happened had they come from "the intensivist." Others with similar backgrounds have noted similar experiences, as working in other patient care areas affords insight into how we emergency physicians are perceived.

Is this because of our dual training system? In part, I am sure it is. What do we expect? How can we really be seen as specialists when one can work in an ED and have no EM training (rotating internship or CCFP certification), incomplete training (resident moonlighters), CCFP(EM) or FRCPC, or something else? Should we be surprised that overcrowding and having consult services "screen" their admissions in the ED has not been adequately addressed despite CAEP's best efforts? We need to start at the ground level and build our specialty into one that is accepted by all. It makes sense on many levels to have a single training program, and I for one am in full agreement that this has to happen.

I urge CAEP to revisit this matter, and I also urge my colleagues in EM to engage in this discussion with open minds and to keep the interest of our specialty at heart.

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[The authors respond]

We thank all the correspondents for their comments on the editorials we wrote on emergency medicine (EM) training and certification. Our mutual hope is that our editorials will stimulate and rekindle thoughtful discussion on this topic well beyond the pages of *CJEM*.

When *CJEM* invited us to write our editorials, it was recognized that both the CCFP(EM) and FRCP perspectives would need to be represented for a

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