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

https://doi.org/10.1017/S1481803500010289 Published online by Cambridge University Press

balanced presentation. It was clear to *CJEM*, as it was to us, that the experiences and allegiances we each had would undoubtedly colour and influence our opinions. However, what we found most striking about our 2 editorials was that our views were fundamentally more similar than different.[1,2] Because of the extent of our common ground and the general nature of most of the correspondents' comments, we have chosen to write a joint response to the above letters.

Drs. Ovens and Letovsky challenge the EM community to "discuss how we can improve our training programs and collaborate further to meet the needs of our trainees, our patients and our communities." We agree wholeheartedly, and it was in that spirit that we approached our editorials and independently reached the same conclusion; that *neither* of our training streams is ideal, and that our specialty and patients would be better served by a dissolution of *both* programs in their current form and the emergence of a new program that would incorporate the best features of each to train both clinical and academic emergency physicians in a coordinated manner. We share the view that 5 years is not required to train clinically competent emergency physicians, and thus we believe that by pooling the resources of our existing programs we would likely produce more emergency physicians than we currently do. A new unified EM program should be inclusive and flexible and thus should allow entry from family medicine with credit for relevant training as well as an optional program extension for those interested in developing a subspecialty or academic focus. We believe that a program designed in such a manner would efficiently meet the needs of a diverse group of trainees and strengthen our discipline.

Despite the assertion by Drs. Ovens and Letovsky that "no real evidence in support" of our common conclusions was provided, both our editorials, as well as the previous publications we cited on this topic from *CJEM* and the *CAEP Communique,* highlight numerous problems with our current system. Moreover, the letters by Drs. Green and Langhan, which we believe reflect the experiences and perceptions of countless emergency physicians across Canada, further illustrate these problems. Dr. Drummond suggests that the identity crisis we described is "artificial and fabricated." We disagree, and the reality of what we described is richly illustrated by the fact that Dr. Langhan, an EM trainee who has yet to complete his residency, is already attuned to the issues and able to write eloquently about them. Dr. Drummond also suggests that this is simply a longstanding "family feud about turf." We believe it is far more than this, and we took great efforts to rise above turf considerations in what we wrote.

Both the letter by Drs. Ovens and Letovsky and the letter by Dr. Drummond used the word "experiment" to describe the history of Canadian EM training. This is a generous term for what most would view as a political mistake. The system we inherited did not in any way arise from the careful planning of a rigorous experiment. While we agree with our colleagues that we should all take great pride in the accomplishments of Canadian EM over the past 25 years, these achievements have occurred in spite of our system, not because of it. We believe Canada's EM institutions and leaders have an ongoing responsibility to ensure our education and certification processes are optimal. We are not advocating for the adoption of "a US model" as Dr. Drummond suggests. Rather, our editorials point out that Canada currently has an internationally aberrant approach to EM training and certification, and they suggest that a better system could be designed.

We would remind Dr. Drummond of his musings in a *CJEM* editorial on nurse practitioners just 1 year ago. In that editorial, Dr. Drummond stated we should be looking at more important issues:

> In a journal like *CJEM*, I wonder why there has been such a paucity of literature on the very real human resource problems that beset our EDs? Where are the papers on the national requirements for well trained emergency physicians or nurses? What has happened to the debate on the distinctions between our 2 routes of emergency physician certification and the merits of a unified training system for Canadian emergency physicians?[3]

We point this out not in any way to discredit Dr. Drummond's assertions, as we both have enormous respect for him and all he has done for our specialty. Rather, we would suggest that the ambivalence illustrated by Dr. Drummond's own writings on the topic of emergency medicine training mirrors an ambivalence we all periodically feel regarding this issue. We suspect the great majority of Canadian emergency physicians believe our current system could be improved, but we are collectively, and to some extent understandably, trepidatious about trying to address this issue. Maintaining the status quo is undoubtedly the path of least resistance, but the question we must carefully consider is whether it is the best path for the future of our discipline.

We acknowledge that there are significant challenges currently facing EM, including overcrowding, human resources, working conditions and career sustainability. However we believe that Canadian EM would be better poised to deal with our present and future challenges as a more unified discipline. Dr. Green's letter confirms that other emergency physicians share our view. While Dr. Drummond's concerns about timing are well stated, we would counter that there will never be an easy time to address this problem. We agree

https://doi.org/10.1017/S1481803500010289 Published online by Cambridge University Press

with Dr. Green that the "fundamental issue" of our dual certification streams must be addressed to facilitate the continued advancement of Canadian EM, and we certainly do not view a discussion of this as wasting time on "negativity," as suggested by Drs. Ovens and Letovsky. Dr. Drummond raised the most important overarching question: "Where is the patient in all of this?" We believe that a wisely designed, unified system for training Canadian emergency physicians would have an enormously positive impact on the future of our discipline, the broader health care system and, ultimately, our patients.

Given the obvious sensitivities and complexities involved, it is clear that any discussion of reforming, possibly even transforming, our EM training system must be highly inclusive. All the issues would need to be considered with open minds if we are to thoroughly evaluate the merits of a unified training system for Canadian emergency physicians. We maintain that a constructive and principle-based discussion on this matter, led by CAEP and involving all stakeholder groups, would be an extremely positive venture, regardless of the conclusions that are reached. We hope our specialty is up to the challenge.

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Letters will be considered for publication if they relate to topics of interest to emergency physicians in urban, rural, community or academic settings. Letters responding to a previously published *CJEM* article should reach *CJEM* head office in Vancouver (see masthead for details) within 6 weeks of the article's publication. Letters should be limited to 400 words and 5 references. For reasons of space, letters may be edited for brevity and clarity.

Les lettres seront considérées pour publication si elles sont pertinentes à la médecine d'urgence en milieu urbain, rural, communautaire ou universitaire. Les lettres en réponse à des articles du *JCMU* publiés antérieurement devraient parvenir au siège social du *JCMU* à Vancouver (voir titre pour plus de détails) moins de six semaines après la parution de l'article en question. Les lettres ne devraient pas avoir plus de 400 mots et cinq références. Pour des raisons d'espace et par souci de concision et de clarté, certaines lettres pourraient être modifiées.

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