suggestions that may be more meaningful. How about an increased and renewed emphasis on adequately preparing the family physician for emergency service? How about we rededicate ourselves to developing a system of care? How about aggressively seeking adequate compensation for those who staff the nation's EDs so that we avoid the ebb and flow of doctors in and out of the ED depending on the discrepancy between family and emergency medicine fee schedules? How about finally getting serious about emergency physician wellness and career sustainability, and in so doing prevent our best and brightest from leaving the specialty to work in travel clinics or on ocean liners? How about a uniform national insistence on providing us all with adequately supported EDs in which to better serve our patients?

Or perhaps we could just talk, yet again, about a unified training program.

Canadians deserve our full attention on the most pressing issues that affect our ability to deliver premium emergency care. While we should, perhaps in time, consider a modification of our approach to training and certification, this is not the right time or the right place in our history to consider adopting a US model. Let's celebrate our uniquely Canadian way.

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Emergency medicine certification in Canada

To the editor: I read with great interest the editorials in the March 2008 issue. I am a graduating FRCPC emergency medicine resident from the University of Calgary with additional training in medical education. I am emboldened by the courageous positions described by Drs. Abu-Laban[1] and Rutledge.[2] I agree with the authors that the divisive nature of the 2 streams has led to acrimonious feelings on both sides. Ultimately, the rift undermines the professionalism of our specialty. A sole training program mirrored after the specialty programs in internal medicine and pediatrics is an attractive alternative. Following 3 years of general emergency medicine (EM) training, residents would elect to pursue general certification (1 additional year) or specialization (2 or more additional years). EM has many unique niches within the field of medicine, and formal subspecialty fellowships in toxicology, critical care and emergency medicine services (among others) could be developed. These training programs would provide the critical mass of learners in the academic centres that cultivate an environment ripe for the promotion of the specialty and EM specific research.

Dr. James Ducharme at one time argued that EM in Canada is best served by 3 training programs, noting that the FRCPC, CCFP(EM) and the family practitioners (FPs) who practise EM serve a complementary role to one another.[3] While I would concede that the preponderance of emergency department (ED) care is delivered by FPs not formally certified in EM, I would argue that the specialty of EM suffers from an identity crisis in part because of these multiple care providers. Physicians who provide care in an ED should not, by default, be referred to as EM specialists. As we move forward, the designation of EM Specialist should be reserved for physicians who have undergone a rigorous training program and demonstrated success on a standardized exam. The designation process should be inclusive, and not discriminate against current emergency physicians (EPs) based on prior training. Practising EPs should be offered the opportunity to grandfather the residency and receive the designation on the basis of clinical experience. The vast majority of CCFP(EM) graduates practise primarily EM and no longer operate as FPs.[3,4] Unlike other FP subspecialties such as low-risk obstetrics and GP–anesthesia whose providers remain FPs first and obstetricians or anesthetists second, most CCFP(EM) physicians are emergency physicians first. While none would debate their clinical competence, the specialist designation is confusing and may be misleading. A unified training program would eliminate this confusion.

Calling oneself a specialist in a given field connotes many things, including taking part in a common training program, membership in a professional society and a standardized examination for those who hold the designation. Ultimately, the role of a specialist involves more than providing quality patient care.[4,5] Health policy advocacy, medical education and research are important aspects of a recognized specialty. The Royal College of Physicians and Surgeons of Canada has long been the national governing body that certifies physicians as specialists.[5] We should aspire to develop a 4-year program that falls under their jurisdiction and meets the needs of all learners.

We are not debating the clinical competence of graduates from any particular stream but are discussing the requirements necessary to be designated an EM specialist. Rather than knee-jerk defensive posturing and protectionist policies, graduates from and administrators for each training program should reflect on what is best for the specialty. We need to band together, focus on the similarities rather than the differences and use the political clout of a unified certification pro-

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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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