

Is this really the right time for an identity crisis?

To the editor: I was struck by the contrast of my recent attendance at the International Federation for Emergency Medicine (IFEM) meeting and the arrival of the latest issue of *CJEM* in the mail.

At IFEM, I listened with great interest to the immense struggles of many Western nations to establish the specialty of emergency medicine in their respective countries. As a Canadian, I felt a strange sense of pride in reflecting on our own experience. The traditional Canadian values of inclusiveness and acceptance of diversity have been reflected in the way we approach the training and credentialing of emergency physicians and the manner in which we staff our departments. Yes, we are an international anomaly, with our 2 routes to certification and our generous acceptance of family physicians working collaboratively with specialists in the same department, but for the most part it works. We work collaboratively, we deliver excellent care and our citizens in a wide variety of ED settings are well served. Sitting in the audience at IFEM, I felt we could be a model for the rest of the world. Then I returned home and opened my copy of *CJEM* and my prideful vision of the Canadian approach to emergency service delivery was directly assailed.

In *CJEM*, there were 2 editorials^{1,2} calling for a common training program and a common certification process, and the justification for change represented, in my view, a repudiation of what many would consider to have been a successful experiment.

I have no real problem with the concept of a unified training program. I have been a quiet supporter in 2 of the 3 previous debates. The idea largely makes sense, with a family medicine component strengthening the elements of communication, comprehensiveness

and continuity of care required for effective practice in this increasingly complex health care environment, and the specialty component providing a strong academic and research basis for the growth of the specialty.

The concept of a single unified training program was not so much the issue; it was the justification for same, the exquisitely poor timing for the proposal and the potential diversion it represented to more pressing issues of the day.

Both authors advocate the need for a unified specialty and a unified voice if the specialty of emergency medicine is to develop to its full potential, inferring we are being held back by our current approach.

The experience at IFEM suggested to me that Canadians have developed a mature specialty, with both academic and research excellence, and a typically pragmatic Canadian way of covering the emergency health care needs of our geographically diverse population. We should take a back seat to no one internationally.

Having been involved with the politics of emergency health care for at least 2 decades, in regional, provincial and national spheres, I simply do not recognize or accept the "divided voice" and the "discipline divided" suggested by the 2 editorialists. We who love and practise emergency medicine, whatever our training and whatever our practice milieu, are not divided. We have a common purpose and goal in pursuing exciting and fulfilling careers, achieving excellence in patient care and participating in the well-being of our individual communities and our nation.

Furthermore, with respect to patient-centred emergency health care, emergency physicians do speak with one voice and that voice belongs to CAEP, not the College of Family Physicians and not the Royal College. There are no 2 separate and divisive masters; there are no 2 solitudes.

The call for a debate about program unification also represents exquisitely poor timing, politically speaking.

It is extremely worrisome that at the exact moment that all provincial governments are attempting to introduce/force nurse practitioners, physician assistants and paramedics to replace emergency physicians as low-acuity providers, we should now declare an identity crisis of our own. We are not sure if a family physician working in a community ED with 20 000 patient visits should call him or herself an emergency physician? An incredible and sad suggestion to be sure, given that about one-half of the emergency care in Canada is delivered by family physicians, but equally, it is politically naive and ill-timed. If we declare, as suggested, that we are no longer sure who has the right credentials to work in an emergency department, you can be sure that government will help us all find the answer, with all manner of alternative health care providers thrust on our department while we struggle with this artificial and fabricated identity crisis.

Lastly, if the issue behind the call for a unified training and certification program is providing and guaranteeing a unified standard of excellence in emergency health care for all Canadians, then why this particular focus at this particular point in time? It represents an unnecessary distraction when there are so many more pressing issues, and so few emergency physicians with enough stamina left to contribute extra time to their resolution. There is, after all, only so much energy available to tackle the myriad of issues that are affecting the availability and quality of emergency health care in Canada. Is this really the time to reignite a long dormant, and for the most part forgotten, family feud about turf?

And where is the patient in all of this?

If we want to have a direct and immediate impact on the availability of quality care offered to our citizens, here are a few

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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References

1. Rutledge T. Emergency medicine training in Canada: learning from the past to prepare for the future. *CJEM* 2008;10:108-10.
2. Abu-Laban RB. Emergency medicine certification in Canada: the years march on but the questions remain the same. *CJEM* 2008;10:101-3.

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-Laban¹ 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 anesthesiologists 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-