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CAEP / ACMU Communiqué

Fall/Automne 1997

The FRCPC vs. the CCFP(EM)

Is there a difference 10 years after residency?

FRCPC contre CCMF(MU)

Y a-t-il une différence 10 ans après la résidence?

Dr. James Ducharme and Dr. Grant Innes

Almost 20 years ago, 2 groups perceived the importance of emergency medicine (EM) and saw the need for advanced EM training. The Royal College of Physicians and Surgeons viewed emergency medicine as a new specialty with a distinct body of expertise, while the College of Family Physicians viewed it as a critical aspect of primary care. As a result of disparate philosophies and divergent political agendas, 2 distinctly different training programs for EM arose and flourished in Canada.

The programs were created with different goals in mind: the Royal College aimed to train an academically-oriented FRCPC "consultant" and determined, over time, that 5 years of residency training was required to accomplish this goal. In contrast, the College of Family Physicians aimed to train a family physician with a "major interest" in emergency medicine. CCFP(EM) certification offered the chance to combine emergency medicine and family practice into a challenging career by adding a year of EM training to the base 2-year family practice program.

But reality — at least the Canadian version — wreaked havoc on these goals. As emergency medicine became more structured and more popular, the lack of Royal College training positions and the availability of the CCFP(EM) program led candidates interested in "career" emergency medicine to apply for 1-year CCFP(EM) positions. When provincial colleges and university hospitals began mandating that physicians who work in major centres must have some type of formal training, the paucity of Royal College graduates could not possibly cover all of the positions available. Many family practice EM proponents insisted that there was no need for a Royal College program at all, and that CCFP(EM) graduates could more than adequately fill clinical and pedagogical requirements in academic centres. At the same time, a large number

Il y a près de 20 ans, deux groupes pressentirent l'importance de la médecine d'urgence (MU) et jugèrent nécessaire d'offrir une formation de niveau supérieur en MU. Le Collège Royal des Médecins et Chirurgiens du Canada considérait la médecine d'urgence comme une nouvelle spécialité requérant des compétences distinctes alors que pour le Collège des médecins de famille du Canada, c'était un volet critique des soins primaires. À cause de cette divergence d'opinions et parce que les collèges avaient des priorités totalement opposées sur le plan de la politique, ce sont deux programmes de formation en MU complètement différents qui émergèrent et se développèrent au Canada.

Les deux organismes poursuivaient des objectifs bien distincts lorsqu'ils créèrent ces programmes : le Collège Royal souhaitait former un FRCPC dont les capacités intellectuelles seraient particulièrement développées et qui agirait à titre de «spécialiste» et décida, au bout du compte, de fixer à cinq ans le temps de résidence requis. L'autre collège avait plutôt en tête un médecin de famille qui aurait un «intérêt dominant» pour la médecine d'urgence. Le CCMF(MU) offrit aux intéressés la possibilité de combiner la médecine d'urgence et la médecine familiale et de se préparer ainsi à une carrière passionnante en suivant, après le programme d'études de deux ans en médecine familiale, une formation supplémentaire en MU s'étalant sur un an.

Mais la réalité — du moins, la façon dont les choses se présentèrent au Canada — empêchèrent ces plans d'aboutir. Au fur et à mesure que la médecine d'urgence se structurait et devenait de plus en plus populaire, la rareté des postes de stagiaire du Collège Royal et l'accessibilité du programme menant au CCMF(MU) poussa ceux qui étaient intéressés à poursuivre une «carrière» en médecine d'urgence à postuler pour les stages d'un an ouvrant droit au CCMF(MU). Lorsque les collèges provinciaux et les hôpitaux universitaires commencèrent à exiger que les médecins employés dans les principaux centres hospitaliers aient reçu, d'une façon ou d'une autre, une formation professionnelle, il s'avéra impossible de combler tous les postes disponibles en faisant appel à des diplômés du Collège Royal, étant donné leur rareté. De nombreux défenseurs

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of Royal College graduates set up clinical practices with no academic involvement — defeating the purpose of a "consultant" residency program. Thus in "the real world" it is often difficult to distinguish practice patterns between CCFP(EM) and FRCPC emergency physicians.

If it is true that there is little difference between CCFP(EM) and FRCPC emergency physicians after 10 years of practice, it is a sad commentary on the direction and content of Royal College programs to date. The question is this: If these programs gave focused training and achieved their stated objectives, how could there not be a difference?

The fact is, many Royal College programs have yet to understand their *raison d'être*. The FRCPC program was extended to 5 years for one primary reason: to address the poverty of postgraduate academic training in Canada. Royal College programs were expected to install formal teaching in research methodology and on principles of medical education. Royal College residents were to be stimulated to perform research projects and encouraged to pursue research fellowships or complete postgraduate training in epidemiology and biostatistics, medical education or other academic subspecialties. But only now are we seeing evidence of these initiatives. Many programs still lack faculty with research background, and residents continue to graduate without proper academic training. Because the demand for clinical emergency physicians remains high and immediate positions are available, most graduates see no reason for further academic training. Moreover, myopic emergency medicine groups do not insist on candidates with directed learning to fill specific needs but, rather, accept graduates with basic training to fill immediate workforce needs. Short-term lifestyle goals win out over long-term development.

At the same time that Royal College programs are falling short of academic expectations, family practice EM programs face an insurmountable task. CCFP(EM) residencies cannot possibly teach research methodology, cover the didactic requirements, and develop a strong EM clinician in 1 year; there is simply not enough time. Moreover, emergency medicine is not family medicine. The two disciplines demand different approaches and different mind-sets. Family practice training, understandably, fosters a mind-set geared to family practice, a mind-set that is often at odds with the practice of emergency medicine. Therefore, not only is it impossible to learn emergency medicine in a year; it is difficult to make the psychological transition from family physician to emergency physician in a year. Earlier and ongoing exposure to the "emergency" mind-set would help to address this problem. Ideally, "academic" thought processes could be nurtured continuously through the 3 years of combined training but, unfortunately, the third EM

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du programme combiné de médecine familiale et de médecine d'urgence arguèrent que le programme du Collège Royal était tout à fait superflu et que les détenteurs du CCMF(MU) possédaient toutes les compétences cliniques et pédagogiques requises dans les centres universitaires. Parallèlement, un grand nombre de diplômés du Collège Royal s'établirent comme cliniciens et se désintéressèrent de l'enseignement — ce qui allait à l'encontre de ce qui était recherché — la formation de «spécialistes». Ainsi, en pratique, il est souvent difficile de faire la distinction entre les détenteurs d'un CCMF(MU) et les médecins d'urgence FRCPC.

S'il est vrai qu'après dix ans de pratique, il y a peu de différence entre les détenteurs d'un CCMF(MU) et les médecins d'urgence FRCPC, cela revient malheureusement à dire que l'orientation et le contenu des programmes du Collège Royal n'ont, jusqu'ici, pas été adéquats. La question qui se pose est la suivante : si la formation assurée dans le cadre de ces programmes était bien ciblée et s'ils correspondaient à leurs objectifs déclarés, comment serait-il possible que cela ne fasse aucune différence?

En réalité, de nombreux programmes du Collège Royal n'ont pas encore trouvé leur raison d'être. S'il fut décidé d'étaler le programme de médecine d'urgence du Collège sur cinq ans, c'était, d'abord et avant tout, pour combler les lacunes qui existaient sur le plan de la formation universitaire de troisième cycle au Canada. Les programmes du Collège Royal devaient instaurer une structure d'enseignement professionnel dans les domaines de la méthodologie de la recherche et des principes de l'enseignement médical. Les résidents du Collège Royal devaient être encouragés à entreprendre des projets de recherche et à postuler pour des bourses de recherche ou à poursuivre des études de troisième cycle en épidémiologie et en biostatistique, en enseignement médical ou dans d'autres disciplines de l'enseignement supérieur. Mais ce n'est que maintenant que ces initiatives semblent prendre corps. Dans bien des programmes, on ne compte pas encore d'enseignants qui sont aussi des chercheurs, et les résidents continuent d'obtenir leur diplôme sans avoir pour autant une formation universitaire adéquate. Étant donné que la demande de cliniciens d'urgence reste forte et que des postes sont immédiatement disponibles, la plupart des diplômés ne voient aucune raison de poursuivre leur formation universitaire. En outre, certains services de médecine d'urgence à courte vue n'exigent pas, chez les candidats aux postes qu'ils cherchent à combler, des connaissances qui correspondraient à des besoins spécifiques, mais acceptent plutôt des diplômés qui ont reçu une formation de base afin de satisfaire immédiatement leur besoin de main-d'oeuvre. Les objectifs sociétaux à court terme l'emportent sur le développement à long terme.

Sur le plan académique, les programmes du Collège Royal ne répondent donc pas aux attentes et, parallèlement, les candidats au CCMF(MU) font face à une tâche insurmontable. Il est en effet impossible d'enseigner la méthodologie de la recherche, de couvrir tous les angles sur le plan didactique et de former un solide clinicien en MU en un an; cela ne laisse tout simplement pas assez de temps. En outre, médecine d'urgence et médecine familiale sont deux disciplines bien distinctes qui exigent des

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Next Deadline

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year is rarely integrally related to the first two. Given the profound temporal limitations, if CCFP(EM) residencies are to produce effective emergency physicians, they must instill in their residents the drive to continue their development once in practice.

The paucity of emergency residency positions means Canada will never have trained emergency physicians in all departments. To advance our specialty, we must recognize our needs and address them specifically at several levels. Small and rural departments will continue to be staffed by family physicians working part time. These people require outreach programs and high quality ongoing CME, developed and provided by rural medicine experts and "career" emergency physicians. Regional and major centres need dedicated full-time clinicians with emergency medicine training and expertise. In addition, such centres need 1 or more physicians with administrative training — something sadly lacking in both the CCFP(EM) and Royal College programs. Finally, academic centres need leaders, developers, researchers and teachers who have appropriate academic training and skill. Should all teachers be Royal College trained? Of course not! Clinical skills can be taught by anyone with experience and proper teaching tools, but academic leadership should come from the program that professes to be developing such people: the Royal College.

The paucity of emergency residency positions means Canada will never have trained emergency physicians in all departments. To advance our specialty, we must recognize our needs and address them specifically at several levels.

La rareté des postes de résident en médecine d'urgence signifie qu'au Canada, il n'y aura jamais de médecins d'urgence dûment formés dans tous les services. Pour faire progresser notre spécialité, nous devons reconnaître nos besoins et y répondre de façon spécifique à plusieurs niveaux.

CCFP(EM) and FRCPC programs differ in length and depth. They should differ in focus and produce different products. They are complementary, not competitive. "Turf" is a non-issue, and both programs are necessary. Is there a difference 10 years out? Perhaps. Should there be? Absolutely ! If not, then both systems have failed to produce what Canada needs.

approches et des attitudes différentes. La formation en médecine familiale, cela va de soi, favorise le développement d'une attitude axée sur la pratique de ce genre de médecine, une attitude qui, souvent, est incompatible avec la pratique de la médecine d'urgence. Par conséquent, non seulement est-il impossible d'apprendre la médecine d'urgence en un an, mais il est difficile, pour un médecin de famille, de faire la transition psychologique nécessaire pour devenir un urgentologue en un an. Le problème serait peut-être moins sérieux si le programme permettait aux participants de se familiariser plus tôt et de façon continue avec l'attitude que requiert la pratique de la médecine d'urgence. Idéalement, on pourrait développer un mode de réflexion «académique» pendant les trois années de formation combinée mais, malheureusement, la troisième année, consacrée à la médecine d'urgence, est rarement bien intégrée aux deux premières années d'étude. Étant donné que le programme menant au CCMF(MU) est si court, si l'on veut qu'il produise des médecins d'urgence efficaces, il faut parvenir à persuader les résidents de poursuivre leur formation parallèlement à leurs activités cliniques.

La rareté des postes de résident en médecine d'urgence signifie qu'au Canada, il n'y aura jamais de médecins d'urgence dûment formés dans tous les services. Pour faire progresser notre spécialité, nous devons reconnaître nos besoins et y répondre de façon spécifique à plusieurs niveaux. L'urgence des hôpitaux ruraux et des établissements de petite envergure continuera d'être desservie par des médecins de famille travaillant à mi-temps. Ils ont besoin de programmes d'action extérieure et de cours d'éducation médicale continue de grande qualité, élaborés et donnés par des experts en médecine rurale et des médecins d'urgence «de carrière». Les hôpitaux régionaux et les principaux centres hospitaliers ont besoin de cliniciens à plein temps, possédant une formation et des compétences spécialisées en médecine d'urgence. De plus, ces centres ont besoin d'un ou de plusieurs médecins possédant une formation administrative — un sujet qui n'est abordé ni dans le programme du Collège Royal ni dans celui qui mène au CCMF(MU). Enfin, les centres universitaires ont besoin de chefs de file, d'hommes et de femmes tournés vers l'avenir, de chercheurs et de professeurs qui possèdent la formation universitaire et les compétences voulues. Tous les professeurs devraient-ils être des médecins FRCPC? Bien sûr que non! Le savoir-faire clinique peut être enseigné par quiconque possède assez d'expérience ainsi que les outils d'enseignement appropriés. Mais sur le plan de la formation universitaire, le leadership devrait être assumé par l'organe offrant le programme que l'on prétend adéquat pour former de tels médecins : le Collège Royal.

Les programmes menant au CCMF(MU) et ceux qui sont offerts par le Collège Royal diffèrent par leur durée et par leur complexité. Ils devraient aussi être ciblés différemment et ne pas produire le même type de médecin. Ils sont complémentaires et non concurrentiels. Il ne devrait pas être question de défendre un «territoire» quelconque, car les deux programmes sont nécessaires. Peut-on déceler une différence de formation après dix ans de pratique? Peut-être. Devrait-il y avoir une différence? Tout à fait! Sinon, les deux systèmes ne produisent ni l'un ni l'autre ce dont le Canada a besoin.

LETTERS TO THE EDITOR

COURRIER DES LECTEURS

The FRCPC vs. the CCFP(EM)

To the CAEP Board of Directors:

Funny I should get to the latest issue of the CAEP *Communiqué* just prior to my renewal notice.

I read with dismay the lead commentary (*Communiqué*, Fall 1997). I am presently working as a full-time emergency physician at a university-affiliated teaching hospital. I have been in practice just 2 years and plan on a career in academic emergency medicine. I joined CAEP last year with the expectation that it would be a group that would represent my interests. It was not my intention to find another group to take my money and do nothing for me. I am CCFP(EM) certified. Statements like "Therefore, not only is it impossible to learn emergency medicine in a year . . ." make me question if I can do better things with my $300 than give it to a bunch of people who view me as a second class citizen. Until I hear a reasonable explanation as to why this kind of editorial should receive space (on the front page, no less) in the news bulletin of what is supposed to be my organization, I'm keeping my cash.

Bjug Borgundvaag, PhD, MD, CCFP(EM)

To the editor:

Right off the bat let me say that, as a CCFP(EM) certificant, I find Drs. Ducharme and Innes' article to be patronizing, narrow-minded, and self-righteous. There. Now that I have that out of the way I can go on and write a rational response.

The authors subtitle their paper, "Is there a difference 10 years after residency?" This is a valid question that lends itself to scientific analysis, the kind of analysis that would benefit from "formal teaching in research methodology" they pride themselves in as FRCP graduates. Unfortunately, they did not apply any of that methodology. At no point did they define, let alone validate, criteria for comparison. There was no process defined to answer the question they themselves posed. In fact, there was no real attempt to answer the question at all.

The authors, who do not define their stream of training, but who I understand to both be FRCP-trained, make sweeping generalizations about the goals of both programs and bemoan the fact that graduates do not always match those goals. If indeed neither of them is CCFP(EM)-trained, one could question their understanding of the philosophy and process behind that program. Certainly they lack an understanding of human nature if they expect physicians to be more or less involved in research/academia on the basis of their program of origin. The drive toward research is innate to the individual. Physicians will become involved in

FRCP contre CCMF(MU)

À l'attention du Conseil d'administration de l'ACMU :

Ironie du sort, j'ai reçu le dernier numéro du *Communiqué* de l'ACMU juste avant mon avis de renouvellement d'adhésion.

Je trouve votre éditorial (*Communiqué*, automne 1997) consternant. Je suis actuellement médecin d'urgence à plein temps dans un centre hospitalo-universitaire. J'exerce depuis deux ans seulement et j'envisage une carrière universitaire en médecine d'urgence. J'ai adhéré à l'ACMU l'année dernière, pensant qu'il s'agissait d'un organisme qui saurait défendre mes intérêts. Je ne pensais pas adhérer à une association qui se contente d'encaisser mes cotisations sans aucune contrepartie. Je suis certifié CCMF(MU). En lisant des déclarations du type « Par conséquent, non seulement est-il impossible d'apprendre la médecine d'urgence en un an . . . », j'en viens à me demander si je ne pourrais pas faire un meilleur usage de mes 300 $ que de les verser à un groupe qui me considère comme un citoyen de seconde zone. Aussi, tant que vous ne m'aurez pas fourni une explication valable pour justifier la présence de cet article (qui plus est en première page) dans votre bulletin, vous vous passerez de ma cotisation.

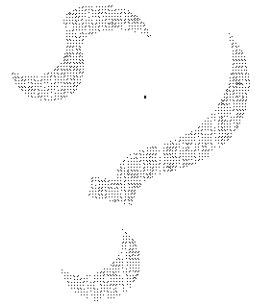
Bjug Borgundvaag, PhD, MD, CCMF(MU)

Au rédacteur :

Permettez-moi de dire d'emblée qu'en qualité de diplômé CCMF(MU), je trouve l'article des Drs Ducharme et Innes condescendant, étroit d'esprit et présomptueux. Cela dit, je peux maintenant apporter une réponse rationnelle.

Les auteurs ont intitulé l'article « Y a-t-il une différence 10 ans après la résidence? » Il s'agit d'une question pertinente qui se prête à une analyse scientifique, le type d'analyse rendue possible par un « enseignement professionnel dans les domaines de la méthodologie de la recherche . . . » qu'ils se targuent de posséder en qualité de diplômés FRCP. Malheureusement, ils n'ont pas mis en pratique cette méthodologie. Ils n'ont à aucun moment tenté de définir et encore moins de valider les critères de comparaison. Ils n'ont avancé aucune méthode pour répondre à la question qu'ils posaient. En fait, ils n'ont pas véritablement cherché à répondre à cette question.

Les auteurs, qui n'ont pas précisé leur filière de formation (je présume qu'ils sont tous deux issus des rangs des FRCP), se livrent à des généralisations à l'emporte-pièce sur les objectifs des deux programmes et déplorent le fait que les diplômés ne correspondent pas toujours aux objectifs déclarés de la formation. Par ailleurs, si aucun des deux n'est effectivement titulaire du CCMF(MU), on peut se demander ce qu'ils connaissent de la philosophie et de l'orientation du programme. Penser que les médecins sont plus ou moins impliqués dans la recherche/l'enseignement en fonction du cursus suivi, c'est méconnaître complètement la nature humaine. L'attrait pour la recherche



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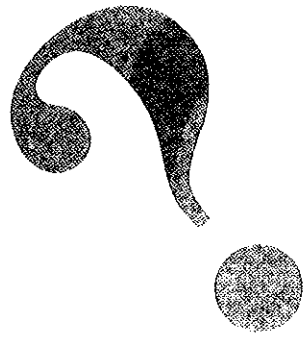


research and education if they are so inclined. They will seek out the training, look for the resources and provide the leadership our field of medicine needs. It just takes a look at the Canadian picture to see who is driving our specialty forward academically and politically. The field is far from becoming overwhelmed with FRCP graduates.

The authors state that the Royal College of Physicians and Surgeons of Canada did not provide enough positions to match Canada's clinical or academic needs. This is likely true but is certainly unsubstantiated in their paper. Their subsequent claim that trainees who could not get an FRCP training position were driven to apply for CCFP(EM) positions as a next-best option is both unproved and offensive. Perhaps those candidates realized that they could better match their needs and the needs of their communities through the latter stream? Perhaps they questioned the validity of the assumption that a 5-year residency was required to produce an academic ER physician? Or perhaps they felt a compelling need to get on with their lives, recognizing that on-line clinical experience is the most important factor in improving their skills? Any of these arguments are as valid as the one put forth by Drs. Ducharme and Innes.

...it displays, for all to see, a profound lack of understanding about what family physicians are trained to do.

Il dénote un manque de compréhension profond de la formation des médecins de famille.

In commenting on the relationship between the fields of Family Practice and Emergency Medicine the authors' argument is tautological. They state: "The two disciplines demand different approaches and different mind-sets." They substantiate this with the comment: "Family practice training, understandably, fosters a mind-set geared to family practice, . . . that is often at odds with the practice of emergency medicine." Not only does this circular reasoning prove nothing, it displays, for all to see, a profound lack of understanding about what family physicians are trained to do. The CCFP graduate sees patients who arrive undiagnosed, often with multiple and ill-defined primary complaints, and has to deal with the patient within the context of his or her environment. The family physician is often the first person to make a diagnosis and arrange for the patient's ongoing care. Sound familiar? Like it or not, there are great similarities between the mind-sets of both fields. It is precisely for this reason that many of our ERs are staffed by family physicians.

Finally, although I agree that there is a need for "outreach programs and high quality ongoing CME" for physicians working in small and rural emergency departments, I disagree that the leadership in this area should come from FRCP graduates. Quite the opposite. Until such time as the FRCP physicians work in that environment in significant numbers, they will have to take a back seat to the CCFP(EM) graduates who work the front line.

So far, in my response, I have dealt only with those arguments the authors have put forth. Now I will take my turn at unsubstantiated philosophizing about the 2 programs. Is there a difference after 10 years of residency? If so, it is untested and

est inné chez l'individu. Les médecins seront attirés par la recherche et l'enseignement si tel est leur penchant naturel. Ils rechercheront la formation, le financement et deviendront les chefs de file dont notre spécialité a besoin. Il suffit de se pencher sur la situation canadienne pour comprendre qui fait progresser notre discipline, tant au niveau de l'enseignement que de la politique. Les diplômés FRCP n'y sont pas légion.

Les auteurs affirment que le Collège royal des médecins et chirurgiens du Canada n'a pas formé assez de praticiens pour répondre aux besoins cliniques ou d'enseignement du pays. C'est probablement vrai, mais aucune preuve ne vient étayer cette allégation dans l'article. Ils prétendent ensuite que ceux qui n'ont pas pu obtenir un poste de stagiaire FRCP ont été incités à se rabattre sur des postes CCMF(MU), allégation blessante et sans fondement. Ces candidats ont peut-être réalisé que cette filière correspondait mieux à leurs besoins et à ceux de la communauté. Ils ont peut-être remis en question la nécessité d'une formation de 5 ans pour devenir un urgentologue enseignant. Peut-être ont-ils ressenti un besoin impérieux de poursuivre sur leur voie en reconnaissant que l'expérience clinique directe est le meilleur moyen d'approfondir leurs connaissances? Tous ces arguments sont aussi valables que celui des Drs Ducharme et Innes.

Dans leur analyse de la relation entre la médecine familiale et la médecine d'urgence, l'argument des auteurs est tautologique. Ils affirment : « médecine d'urgence et médecine familiale sont deux disciplines bien distinctes qui exigent des approches et des attitudes différentes ». Ils étayent leur affirmation par le commentaire suivant : « La formation en médecine familiale, cela va de soi, favorise le développement d'une attitude basée sur la pratique de ce genre de médecine, une attitude qui, souvent, est incompatible avec la pratique de la médecine d'urgence ». Non seulement ce raisonnement en vase clos ne prouve rien, mais il dénote un manque de compréhension profond de la formation des médecins de famille. Les diplômés du CCMF reçoivent des patients qui n'ont fait l'objet d'aucun diagnostic, présentant souvent des symptômes multiples et mal définis et doivent replacer le patient dans son environnement personnel. Le médecin de famille est souvent le premier à poser un diagnostic et à définir le traitement du patient. Les auteurs en ont-ils conscience? Qu'ils le veulent ou non, les attitudes des deux disciplines sont très proches. C'est justement la raison pour laquelle le personnel d'un très grand nombre de nos services d'urgence est composé de médecins de famille.

Enfin, bien que je convienne du « . . . besoin de programmes d'action extérieure et de cours d'éducation médicale continue de grande qualité » pour les médecins qui travaillent dans des petits services d'urgence ruraux, je ne pense pas que le leadership en matière de formation universitaire doive revenir aux diplômés FRCP, bien au contraire. À moins que le nombre de médecins FRCP travaillant dans ce secteur ne connaisse une progression foudroyante, ils resteront toujours au second plan par rapport aux diplômés CCMF(MU) qui travaillent en première ligne.

Dans mon courrier, je n'ai répondu qu'aux arguments

unproved. Do we in fact need 2 programs? I think not. A core content in emergency medicine can be taught within a 3-year program, perhaps under one specific college, and lead to safe emergency practitioners. For those who have an interest in academic involvement, a fellowship program can be developed to help them pursue this. Until such time, this Royal College elitism must end. It has no justification in fact and serves only to divide us.

Daniel Kollek, MD, CCFP(EM)

To the editor:

I read with interest the recent article published by Drs. Ducharme and Innes, which outlines the historical factors that led to the creation of 2 postgraduate training programs in emergency medicine. The article also, I feel, annotates clearly the reasons why 2 streams of training were created: the Royal College stream to train academically oriented "consultants" and the Family Medicine stream to guarantee that the highest quality of care would be delivered by family physicians practising in emergency departments.

However, based on research that I conducted at the Royal College of Physicians and Surgeons (RCPS) meeting in 1994, it is clear that these 2 groups are indistinguishable in terms of practice patterns. Graduates of CCFP(EM) and RCPS residency programs are equally likely to be working in large-volume emergency departments, offering bedside and didactic teaching, and participating in research.

But Drs. Ducharme and Innes have failed to address the question "Where do we go from here?" To dwell on the rhetoric of past generations, inferring that, for instance, either the Royal College or the College of Family Physicians of Canada (CFPC) have failed to live up to their mandate is fruitless. To state categorically that CCFP(EM) programs "cannot possibly teach research methodology, cover the didactic requirements, and develop a strong EM clinician in 1 year" is inflammatory and unreasonable, given the evidence cited above. Further, the authors state: "Family practice training, understandably, fosters a mind-set geared to family practice, a mind-set that is often at odds with the practice of emergency medicine." I argue, to the contrary, that Family Medicine training fosters a mind-set that is ideally suited to the practice of emergency medicine. It offers trainees a broad base, featuring issues that cross the spectrum of age and ethno–demographic background, with an emphasis on prevention, the detection and management of primary and secondary illness, and a holistic approach to the practice of medicine. Further, the Family Medicine approach is a "patient-centred" model of care — in my view, the ideal mode of practice for Emergency Medicine.

In my experience, CCFP(EM) trainees do tend to hang their Family Medicine hat at the ED door and try to practise the way they perceive an "emergency physician" should. However, in my opinion,

avancés par les auteurs. Je peux moi aussi discourir sans preuves sur les mérites des 2 programmes. Constate-t-on une différence au bout de 10 ans de pratique? Si tel est le cas, elle n'est pas démontrée ni étudiée. Avons-nous véritablement besoin de 2 programmes? Je ne le crois pas. L'essentiel de la médecine d'urgence peut être enseigné en 3 ans, peut-être dans le cadre d'un collège spécialisé qui permettra de diplômer des urgentologues compétents. Pour les candidats à l'enseignement, il est possible de créer un programme de bourses d'études pour les aider dans cette voie. Avant cela, il convient de mettre un terme à cet élitisme du Collège Royal. Il ne se justifie pas et ne fait que nous diviser.

Daniel Kollek, MD, CCMF(MU)

Au rédacteur :

J'ai lu avec intérêt l'article publié récemment par les Drs Ducharme et Innes qui retrace les facteurs historiques qui ont amené à la création de deux programmes de formation de troisième cycle à la médecine d'urgence. Cet article explique clairement les raisons qui ont conduit à la création de ces deux filières. Le cursus du Collège Royal vise à former des « consultants » axés sur l'enseignement, alors que l'objectif du Collège des médecins de famille est de former des généralistes extrêmement compétents aptes à exercer dans des services d'urgence.

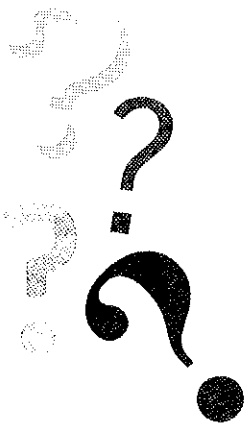
Toutefois, les recherches que j'ai réalisées lors de la Conférence du Collège royal des médecins et chirurgiens du Canada qui s'est tenue en 1994 font apparaître que ces deux groupes ne présentent aucune différence au plan de la pratique. Les diplômés du CCMF(MU) comme ceux du Collège Royal sont aussi susceptibles de travailler dans des grands services d'urgence, de dispenser un enseignement théorique ou clinique, ainsi que de participer à des recherches.

Néanmoins, les Drs Ducharme et Innes n'ont pas répondu à la question « où cela va-t-il nous mener? ». Il est stérile d'ergoter sur le passé et de conclure par exemple que l'un ou l'autre des collèges n'atteint pas le but qu'il s'était fixé. Affirmer catégoriquement que « Il est en effet impossible d'enseigner la méthodologie de la recherche, de couvrir tous les angles sur le plan didactique et de former un solide clinicien en MU en un an » est déraisonnable et ne peut que mettre le feu aux poudres, au vu des éléments susmentionnés. De surcroît, les auteurs prétendent que « la formation en médecine familiale, cela va de soi, favorise le développement d'une attitude axée sur la pratique de ce genre de médecine, une attitude qui, souvent, est incompatible avec la pratique de la médecine d'urgence ». Je soutiens pour ma part que cette formation permet d'acquérir un état d'esprit tout à fait adapté à la pratique de la médecine d'urgence. Elle offre aux stagiaires une large base de connaissances, aborde les problèmes rencontrés par toutes les classes d'âge et tous les milieux ethno-démographiques, en mettant l'accent sur la prévention, la détection, le traitement des pathologies principales et secondaires et favorise une approche holistique de la médecine. De plus, le modèle de soin « centré sur le patient » de la médecine familiale est selon moi idéal pour la pratique de la médecine d'urgence.

D'après mon expérience, les stagiaires du CCMF(MU)

Drs. Ducharme and Innes have failed to address the question "Where do we go from here?"

Les Drs Ducharme et Innes n'ont pas répondu à la question « où cela va-t-il nous mener? »



this only serves as a disservice to patients because many of the valuable adjuncts of Family Medicine training are lost to patients, who could otherwise benefit greatly from the aforementioned holistic, comprehensive, compassionate, approach to the practice of medicine.

I suggest an alternative strategy. Rather than focus on what the Royal College and the CFPC thought they could offer, perhaps the time has come to re-evaluate the educational process in Emergency Medicine. While it may be true that 5 years of training are required, the evidence for this must be re-evaluated. Further, the CFPC should re-examine the value of a combined 3-year stream of training in order to ensure that it meets the needs of physicians who become full-time emergency physicians.

Rather than focusing on the weaknesses of the training programs, perhaps we could amalgamate the positives into a new single stream of Emergency Medicine training that would meet the societal need for well-trained, motivated, emergency physicians who can serve as educators, researchers and administrators. Perhaps, by combining resources, energies and funding sources, the long-standing arguments over who should be practising where and the kind of medicine they would be practising can be set aside, and we can instead embark upon a training program that is focused on the needs of the population rather than on the needs of the individuals who are proponents for each college's mode of training.

I. Dubinsky, MD, BSc, CCFP(EM), FCFP
Chief, Department of Emergency Medicine
The Toronto Hospital
Toronto, Ont.

This would represent a monumental undertaking and might necessitate the creation of a new college.

Cela représenterait une entreprise colossale qui pourrait nécessiter la création d'un nouveau collège.

To the editors:

Thank you for the thought-provoking article regarding CCFP(EM)- and FRCP-trained emergency physicians. My impression is that it was an examination of the respective roles of the 2 residency programs. It seems that Drs. Ducharme and Innes perceive a lack of direction in the 2 programs, the result being that the "final product" may not be true to the original intent, with little to discriminate between the graduates of either of these 2 programs a few years down the road. Is this a "failure" of the FRCP program? A success of the CCFP(EM) program?

Along these lines, it is interesting that prominent emergency physicians from both colleges have been exploring the concept of a single training program with 2 streams. Although this idea has been presented to the CAEP board, neither CAEP nor any other organization has established an official position and, clearly, any such discussions are in their fetal stage. Nevertheless, this would represent a monumental undertaking and might necessitate the creation of a new college.

Some of my colleagues perceive Ducharme and Innes' article as a put down of CCFP(EM)s, which

tendent à laisser leur casquette de médecin de famille au vestiaire des urgences et s'efforcent de se glisser dans la peau d'un urgentologue. À mon avis, cette mutation se fait aux dépens du patient, car ce dernier ne bénéficie plus de tous les petits « plus » qu'offre la médecine familiale, alors que l'approche holistique, globale et empathique de la médecine lui serait pour le moins profitable.

Je suggère une autre voie. Au lieu de mettre l'accent sur les mérites supposés des deux collèges, il serait peut-être temps de repenser le cursus de formation en médecine d'urgence. Même si cinq années de formation sont peut-être nécessaires, il faut en apporter la preuve. En outre, le Collège des médecins de famille doit évaluer la pertinence de sa formation combinée sur 3 ans afin de s'assurer qu'elle répond aux besoins de ses diplômés qui deviennent des médecins d'urgence à plein temps.

Au lieu de s'appesantir sur les carences des programmes de formation, il serait peut-être plus judicieux de regrouper leurs points forts dans un nouveau cursus de médecine d'urgence apte à répondre aux besoins de la société qui veut des urgentologues bien formés et motivés qui puissent exercer des fonctions d'enseignant, de chercheur et de gestionnaire. C'est peut-être en conjuguant ressources, énergies et financements que l'on parviendra à dépasser les éternelles querelles sur la place et le rôle de chacun. Alors seulement nous pourrons mettre sur pied un programme de formation ciblé sur les besoins de la population et non plus sur ceux des partisans de l'une ou l'autre des filières de formation.

I. Dubinsky, MD, BSc, CCMF(MU), FCFP
Chef du service de médecine d'urgence
The Toronto Hospital
Toronto (Ont.)

Au rédacteur :

Merci pour votre article sur les formations des médecins d'urgence intitulé « FRCP contre CCMF(MU) » qui invite à la réflexion. Je l'ai perçu comme une étude des rôles respectifs des deux filières de formation. Il semble que les Drs Ducharme et Innes ont pointé du doigt les carences au niveau de l'orientation des deux programmes qui aboutissent à un « produit fini » non conforme à sa vocation d'origine, mais présentant des compétences comparables après quelques années de pratique. S'agit-il d'un « échec » du programme FRCP? D'une réussite du programme CCMF(MU)?

À cet égard, il est intéressant de noter que des médecins d'urgence de premier plan issus de ces deux filières ont envisagé le concept d'un tronc commun de formation comprenant deux filières. Bien que cette idée ait été soumise au Conseil de l'ACMU, ni cette dernière, ni aucun autre organisme n'a pris de position officielle sur la question et ces discussions n'en sont encore qu'à leurs balbutiements. Néanmoins, cela représenterait une entreprise colossale qui pourrait nécessiter la création d'un nouveau collège.

Certains de mes collègues perçoivent l'article des Drs Ducharme et Innes comme un dénigrement des médecins CCMF(MU), ce qui est paradoxal étant donné leur supériorité numérique au sein de la communauté des urgentologues. Bien entendu, personne n'a intérêt

is ironic given their prominence in the emergency medicine community. Clearly, opening divisive wounds is not in anyone's interest, and I doubt it was the intent of these authors. Finally, some fear that, because the article appeared on the front page of *Communiqué* and was coauthored by one of the editors, it represents official CAEP policy. I believe this is not the case, but clarification of these points would no doubt be appreciated by many.

Harold Fisher, MD

Response from Drs. Ducharme and Innes:

We are pleased that our article generated thought and controversy. We are pleased that our critics seem to share our belief that the 2 programs produce a similar product and that the current system needs to be critically appraised. We were fascinated that 2 of the writers were upset by our question ("Is there a difference?"), then proceeded to point out exactly what we concluded in our article: that there doesn't seem to be.

We are disappointed that several physicians found our article insulting, since this was not our intent. All 4 writers apparently viewed the article as a "put down" of CCFP(EM) training and CCFP(EM) physicians. Three of the writers are upset by our contention that 1 year is inadequate to learn emergency medicine and research. Dr. Borgundvaag is dismayed that an editorial like this would even be printed. Clarifications are necessary.

Our article reflects on the fact that 2 organizations established emergency medicine (EM) training programs. The College of Family Physicians of Canada (CFPC) aimed to produce family practitioners with a special expertise in emergency medicine, while the Royal College aimed to produce academic specialists. In the article, we pondered the fact that, 10 years post-residency — despite differences in program philosophy and large differences in training duration — there is little apparent difference in the clinical or academic profiles of the 2 types of emergency physician. In doing this, we made several inflammatory statements. To justify these statements, it is necessary to explain our perspective.

We believe that emergency medicine is a specialty — the most exciting and dynamic specialty of all. As members of this specialty, we have responsibilities: we must strive for clinical excellence, we must develop our own body of research, and we must teach our own. No one else can do these things for us. Emergency medicine, like other specialties, has a specific body of knowledge, but it is a huge body of knowledge. In spite of this, emergency specialists should have the same depth of knowledge in our field that cardiologists have in theirs. This implies a broad and deep knowledge base, adequate clinical experience, specific procedural skills and confidence. Just as it is impossible to learn ophthalmology or psychiatry in a year, we believe it is impossible to learn EM in a year. Moreover, we believe it is impossible to achieve all

semer la zizanie dans cette profession et je doute que les auteurs aient eu cette intention. Enfin, d'aucuns craignent, en raison de la parution de l'article en première page du *Communiqué*, qu'il ait été co-écrit par l'un des rédacteurs et traduise la position officielle de l'ACMU. Je pense que tel n'est pas le cas, mais des éclaircissements sur ce point seraient très appréciés.

Harold Fisher, MD

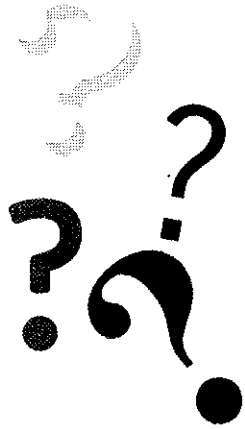
Réponse des Drs Ducharme et Innes :

Nous sommes heureux de constater que notre article a suscité débats et polémiques. Nos détracteurs semblent penser eux aussi que les deux programmes génèrent des résultats identiques et que le système actuel doit être évalué d'un œil critique. Il est frappant de noter que les deux lecteurs qui se sont dits choqués par notre question (« y a-t-il une différence? ») ont développé une argumentation qui aboutit aux mêmes conclusions que les nôtres : il semble bien qu'il n'y en ait aucune.

Nous sommes désolés que plusieurs médecins aient jugé notre article blessant, car ce n'était pas là notre intention. Quatre courriers ont estimé que cet article « dénigrait » la formation du CCMF(MU) et les médecins qui en sont issus. Trois courriers trouvent choquante notre affirmation selon laquelle une année est insuffisante pour apprendre la médecine d'urgence et la recherche. Le Dr Borgundvaag se dit même consterné par la publication d'un tel éditorial. Des explications s'imposent.

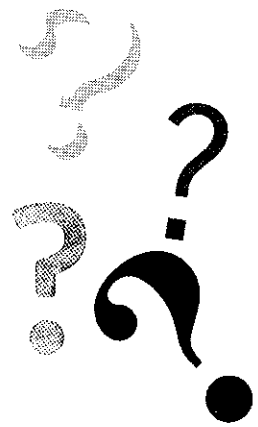
Notre article aborde le fait que deux institutions ont mis en place des programmes de formation à la médecine d'urgence (MU). Le Collège des médecins de famille du Canada (CMFC) forme des généralistes possédant des compétences spécifiques en médecine d'urgence, tandis que le Collège Royal forme des spécialistes axés sur l'enseignement. Dans notre article, nous nous interrogeons sur le fait que, dix ans après l'obtention du diplôme et en dépit des spécificités de chaque filière (orientation et durée), les différences apparentes dans le profil clinique et universitaire des deux catégories de praticiens sont faibles. Dans cette étude, nous avons fait un certain nombre de déclarations incendiaires qui méritent quelques explications.

Nous estimons que de toutes les spécialités médicales, la médecine d'urgence est la plus enthousiasmante et dynamique. En tant que spécialistes de cette discipline, nous avons des responsabilités : nous devons atteindre l'excellence clinique, développer notre corps de recherche et enseigner. Personne ne peut le faire à notre place. Comme d'autres spécialités, la médecine d'urgence nécessite des connaissances spécifiques très étendues. Les urgentologues ne doivent pas moins posséder une maîtrise de leur discipline aussi approfondie que les cardiologues, par exemple. Cette exigence implique d'acquérir des connaissances nombreuses et approfondies, une expérience clinique adéquate, des compétences spécifiques et une grande confiance en soi. À l'instar de l'ophtalmologie ou de la psychiatrie, il nous semble impossible d'apprendre la MU en un an. En outre, cette durée ne suffit pas pour atteindre tous les objectifs mentionnés ci-dessus et acquérir les aptitudes de recherche nécessaires pour devenir un urgentologue aguerri. Ce constat nous sem-



Emergency medicine is a specialty — the most exciting and dynamic specialty of all.

De toutes les spécialités médicales, la médecine d'urgence est la plus enthousiasmante et dynamique.



"My family practice training did not imbue me with the mind-set, skills, or knowledge to practise as an emergency physician."

Ma formation de généraliste ne me donnait pas l'état d'esprit, les compétences et les connaissances requises pour être urgentologue.

of the above objectives *and* learn the research skills necessary to be an academic emergency physician in 1 year. These things seem apparent to us, but are upsetting to others.

We wrote in our article: "Moreover, emergency medicine is not family medicine. The two disciplines demand different approaches and different mind-sets." This statement is evidently a source of great displeasure. Dr. Dubinsky acknowledges the difference and points out the strengths of the family practice mind-set, which are undeniable. Dr. Kollek suggests that, in making these statements, we have a profound lack of understanding about what family physicians are trained to do. The statement we made comes, I think, from one of the authors' (G.I.) personal experiences: After completing my own CCFP residency, I went directly into an EM residency. It was a culture shock. I found that my family practice training did not imbue me with the mind-set, skills, or knowledge to practise as an emergency physician. Perhaps I have incorrectly generalized my experience to the world in general, but I still believe that I would not be an optimal family physician and that most family physicians are not optimal emergency physicians.

Though we suggested there are differences between emergency physicians and family physicians, we did not state, nor did we imply, that CCFP(EM) physicians are unqualified to practise emergency medicine or that, in some way, they should be considered "second-class citizens." This would be a peculiar and untenable view for someone who completed a family practice residency and works as a teacher in a CCFP(EM) program. On the contrary, both of us believe that CCFP(EM)-trained physicians are an asset to Canadian emergency medicine.

However, given the current system, it is difficult to deny that there are 2 types of emergency physicians with different levels of experience and training. It seems likely that, at graduation, the average FRCP resident has more experience, procedural skill, confidence and academic depth than the average CCFP(EM) resident. But the fact that 2 physicians begin at different levels does not necessarily mean that this difference is maintained over time, and an ongoing commitment to clinical excellence, teaching and research is more important than one's ability level on graduation day. In writing our article, we acknowledged this and framed the question: Is there a difference between FRCPC and CCFP(EM) emergency physicians 10 years out? Our conclusion — that there doesn't seem to be — is hardly insulting to CCFP(EM) physicians. We are surprised, therefore, at the amount of flak aimed at us for addressing this issue.

To avoid invoking the rage of rural practitioners, we must correct a statement made by Dr. Kollek. We did not state, as he suggests, that rural CME must be taught by FRCP physicians. Our article

ble évident, mais d'aucuns le jugent révoltant.

Dans notre article, nous avons écrit : « En outre, médecine d'urgence et médecine familiale sont deux disciplines bien distinctes qui exigent des approches et des attitudes différentes ». Il n'est pas étonnant qu'une telle allégation ait déclenché un tollé. Le Dr Dubinsky reconnaît cette différence et souligne les atouts de l'approche du médecin de famille, qui sont indéniables. Le Dr Kollek estime que ces déclarations dénotent une incompréhension profonde de la formation des généralistes. Or, ce constat résulte de l'expérience personnelle d'un des auteurs (G.I.) : une fois mon diplôme CCMF en poche, j'ai immédiatement entamé une formation à la MU. Ce fut un choc culturel. Je me suis aperçu que ma formation de généraliste ne me donnait pas l'état d'esprit, les compétences et les connaissances requises pour être urgentologue. J'ai peut-être tort de généraliser, mais je pense que j'aurais fait un médecin de famille médiocre, de même que la plupart des généralistes ne feraient pas de bons urgentologues.

Bien que nous ayons souligné les différences entre généralistes et urgentologues, nous n'avons pas prétendu, même de manière implicite, que les médecins titulaires du CCMF(MU) ne sont pas qualifiés pour pratiquer la médecine d'urgence ou qu'ils seraient des « citoyens de seconde zone ». Un tel jugement serait absurde et paradoxal venant d'un médecin généraliste diplômé qui enseigne dans le cursus du CCMF(MU). Bien au contraire, nous pensons tous deux que les titulaires du CCMF(MU) constituent une ressource précieuse pour la médecine d'urgence canadienne.

Toutefois, compte tenu du système actuel, il est difficile de nier qu'il existe deux catégories de médecins d'urgence ayant une formation et une expérience différentes. À l'obtention du diplôme, il est probable qu'en moyenne, le médecin issu du FRCP possède davantage d'expérience, de compétences, de confiance en lui et de connaissances universitaires que le titulaire du CCMF(MU). Toutefois, le fait que deux médecins commencent leur carrière à un échelon différent ne signifie pas forcément que cette disparité perdure au fil des ans. L'engagement permanent en faveur de l'excellence clinique, de l'enseignement et de la recherche est plus important que le niveau atteint le jour du diplôme. En rédigeant notre article, nous en avons tenu compte en posant cette question « FRCPC contre CCMF(MU) : Y a-t-il une différence 10 ans après la résidence? » En concluant par l'absence de différence, nous ne pensions pas offenser les médecins du CCMF(MU). Nous sommes donc surpris par cette volée de bois vert.

Pour éviter de s'attirer les foudres des généralistes en milieu rural, nous devons corriger ce qu'écrit le Dr Kollek. Nous n'avons jamais déclaré que la formation médicale continue doit être délivrée par des médecins diplômés FRCP. Nous avons écrit : « . . . cours d'éducation médicale continue de grande qualité, élaborés et donnés par des experts en médecine rurale et des médecins d'urgence de carrière. »

S'il est vrai que la plupart des diplômés CCMF(MU) deviennent des urgentologues de carrière plutôt que des généralistes formés à la MU, ils auraient tout à gagner

reads: ". . . CME, developed and provided by rural medicine experts and 'career' emergency physicians."

If it is true that most CCFP(EM) residents end up as career emergency specialists rather than family practitioners with an expertise in EM, then surely they would benefit from greater EM integration early in their training and an extra year at the end. Conversely, if most FRCP residents have no interest in research or academics, why are they doing 5-year residency programs? If the substantial difference in training time leads to little clinical or academic difference 10 years out, then a single training path makes more sense. On the other hand, if some commit to EM as a specialty career while others view it as a sidelight to family practice, then there truly are and will always be 2 distinct types of emergency physician and a need for 2 distinct training pathways. Our article was intended to question the current way of doing things.

Does our dual system meet the specific needs of Canadian emergency medicine? Or does it just create divisiveness within the specialty? As Dr. Fisher indicates, several prominent Canadian emergency physicians feel that the 2 training programs should be combined into a "single stream" (4 years?) to which "academically inclined" EPs could add a fellowship year. This is an intriguing and promising concept, though it does not address the issue of physicians, particularly rural physicians, who will continue to focus on family practice but want to feel more comfortable in an ED.

Our aim in writing this article was not to open old wounds or split emergency physicians into warring factions. We want what is best for the specialty. Anyone who reads our article can hopefully see that our philosophy is inclusive, not exclusive. We simply wanted to point out the fact that, despite divergent objectives, philosophies and training durations, the 2 EM programs appear to produce a surprisingly similar product — often, in both cases, not the product initially intended. Maybe we should question why?

Perhaps our view of EM is reasonable; perhaps not. In either case, we can reassure Dr. Borgundvaag and the others that this editorial expresses only the opinions of its authors. It does not reflect the views of CAEP and it is not CAEP policy (this standard disclaimer is printed adjacent to the text of the article). Our article may be the product of deranged minds, but to suggest it should not have been printed is inappropriate and would amount to censorship.

Finally, we believe it would be a mistake for anyone to quit the organization because of a difference of opinion. CAEP is an organization we are proud to belong to. It represents all emergency physicians, and we wouldn't want it any other way. CAEP members work tirelessly to improve EM in Canada, and CAEP members will have a profound positive impact on Canadian EM over the years to come.

Grant Innes, MD, CCFP, FRCPC

Jim Ducharme, MD, FRCPC

d'une intégration plus précoce de la MU dans leur formation et d'une année supplémentaire en fin de cycle. À l'inverse, si la plupart des médecins FRCP ne sont pas intéressés par la recherche ou l'enseignement, pourquoi suivent-ils un cursus s'étalant sur 5 ans? Si l'allongement substantiel de la formation n'entraîne pas d'écart significatif en termes de compétences cliniques ou professionnelles après 10 ans de pratique, une formation unique serait plus appropriée. D'autre part, si certains choisissent une carrière de médecin d'urgence alors que d'autres considèrent cette discipline comme un simple à-côté de la médecine familiale, alors il existera toujours deux catégories distinctes de médecins d'urgence et il faudra conserver deux filières différentes. Notre article se proposait de remettre en question la manière actuelle de procéder.

Cette double filière répond-elle aux besoins spécifiques de la médecine d'urgence canadienne? Ou est-elle uniquement une pomme de discorde au sein de la spécialité? Comme l'explique le Dr Fisher, plusieurs urgentologues canadiens émérites estiment que ces deux programmes de formation devraient être fusionnés en un seul (sur 4 ans?), au terme duquel les urgentologues intéressés par l'enseignement pourraient étudier une année supplémentaire. Cette suggestion, bien que prometteuse, ne résout pas le problème des médecins, surtout en milieu rural, qui continuent de s'adonner principalement à la médecine familiale mais qui cherchent à améliorer leurs compétences en MU.

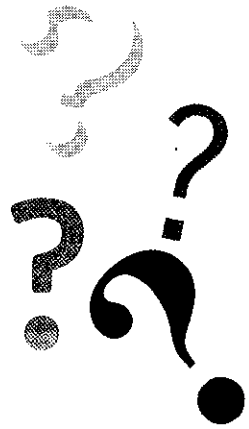
L'objectif de notre article n'était pas de rouvrir de vieilles blessures ni de semer la zizanie parmi les urgentologues. Nous recherchons la meilleure solution pour notre spécialité. Quiconque lit notre article constatera, du moins nous l'espérons, qu'il aspire à l'intégration, et non à l'exclusion. Nous souhaitions simplement souligner le fait que, en dépit des divergences dans les objectifs, la philosophie et la durée de formation, les deux programmes de MU aboutissent à des résultats étonnamment convergents, même s'ils n'ont pas grand chose à voir avec les objectifs affichés à l'origine. Peut-être peut-on se demander pourquoi?

Notre vision de la MU est peut-être juste, peut-être pas. Quoi qu'il en soit, que le Dr Borgundvaag et ses collègues se rassurent : l'éditorial ne fait qu'exprimer l'opinion de ses auteurs. Il ne reflète aucunement l'opinion de l'ACMU ni sa politique (cette précision figure d'ailleurs en marge de l'article). Notre article est peut-être le produit d'esprits dérangés, mais s'opposer à sa publication est injustifiable et s'apparente à de la censure.

Enfin, nous pensons que ce serait une erreur de quitter l'organisation pour une divergence d'opinion. L'ACMU est une organisation à laquelle nous sommes fiers d'appartenir. Elle représente tous les médecins d'urgence, et c'est très bien ainsi. Ses membres oeuvrent sans relâche pour améliorer la MU au Canada et leur action dans les années à venir continuera de promouvoir cette discipline.

Grant Innes, MD, CCMF, FRCPC

Jim Ducharme, MD, FRCPC



Does our dual system meet the specific needs of Canadian emergency medicine? Or does it just create divisiveness within the specialty?

Cette double filière répond-elle aux besoins spécifiques de la médecine d'urgence canadienne?

An immodest proposal

The future of emergency medicine training in Canada

Une proposition présomptueuse?

L'avenir de la formation à la médecine d'urgence au Canada

Dr. Jeremy Etherington

I read, with more than my usual interest, the recent *Communiqué* article entitled "The FRCPC vs. the CCFP(EM): Is there a difference 10 years after residency?" (Fall, 1997). I immediately thought of a line from that great *Ten Years After* anthem, Alvin Lee's melancholic ode to the common man and his inability to change the complexities of life: "I'd love to change the world, but I don't know what to do, so . . . I leave it up to you." Although this sounds trite by current pop standards, its simplicity reflects our apparent powerlessness to alter intricate events as they spiral beyond our grasp, much as the gyre of emergency medicine's future has done for the last 2 decades in this country.

What gives me the right to comment on the state of emergency medicine training in Canada? First, I am now off my lithium. Second, I am a member of CAEP's Task Force on Specialty Education in Emergency Medicine. Third, I am an ex-CCFP(EM) residency director, certified by the CFPC, and I sit on that body's National Committee on Emergency Medicine. Finally, I am currently the Chair of the Department of Emergency Medicine and of the Medical Advisory Committee at St. Paul's Hospital in Vancouver, a tertiary-level, university-affiliated teaching institution. By many people's reckoning, my department members are academic leaders within the hospital, the province and perhaps the country. One of my principal responsibilities is to evaluate the performance of these physicians. But surprisingly, even 5 years out, I doubt an outsider could tell who is FRCPC- or CCFP(EM)-[illegible] because we have tremendous clinici[illegible] and researchers from each progra[illegible]

The reasons why the Royal Colle[illegible] of Physicia[illegible] and Surgeons of Canada (RCPSC) [illegible] Colleg[illegible] of Family Physicians of Canada (CFPC) were unabl[illegible] to agree on a single emergency medicine training program 20 years ago remain a matter for debate among medical historians. Responsibility lies in both camps. It was not simply a matter of disparate philosophies, but also of a desire for influence. Advocates within the CFPC, with some justification, viewed emergency medicine as acute primary care, a logical extension of CCFP residen-

J'ai lu avec un intérêt tout particulier l'article récent du *[illegible]niqué* intitulé « FRCP contre CCMF(MU) : Y a-t-il une [illegible]férence 10 ans après la résidence? » (automne 1997). J'[illegible] immédiatement songé aux paroles de la célèbre compl[illegible]e mélancolique *Ten Years After* d'Alvin Lee évoquant l'homme de la rue et son incapacité à changer les choses : « J'aimerais tant changer le monde, mais je ne sais pas comment faire . . . À vous de le faire ». Bien que cette chanson semble vieillotte comparée aux tubes d'aujourd'hui, elle reflète notre impuissance à influencer des événements qui nous dépassent, à l'image des circonvolutions de la médecine d'urgence depuis deux décennies dans ce pays.

Qui suis-je pour commenter la situation de la formation à la médecine d'urgence dans ce pays? D'une part, je suis « hors circuit ». D'autre part, je suis membre du groupe de réflexion de l'ACMU sur la spécialisation en médecine d'urgence. Enfin, je suis ancien directeur de la résidence CCMF(MU), certifié par le Collège des médecins de famille du Canada et je siège au Comité national sur la médecine d'urgence de cet organisme. En outre, je suis actuellement président du Service de médecine d'urgence et du Comité médical consultatif du St.Paul's Hospital de Vancouver, un établissement de soins tertiaires et hôpital d'enseignement rattaché à l'université. Pour de nombreuses personnes, les membres de mon service sont des chefs de file de l'hôpital, de la province et peut-être même du pays. L'une de mes principales responsabilités consiste à évaluer le travail de ces médecins. Mais même après 5 ans de pratique, je doute qu'une personne étrangère au service puisse distinguer les médecins FRCPC de ceux titulaires du CCMF(MU), car ce sont tous des cliniciens, des enseignants et des chercheurs hors pair.

Les historiens continuent de débattre des raisons pour lesquelles le Collège royal des médecins et chirurgiens du Canada (CRMCC) et le Collège des médecins de famille du Canada (CMFC) ne sont pas parvenus à s'entendre sur la création d'une filière unique il y a 20 ans. Les responsabilités sont partagées. Ce n'était pas simplement une [illegible] de différence d'approche, mais également un [illegible] influence. Les partisans du CMFC considéraient à juste titre la médecine d'urgence comme relevant des soins de santé primaires, c'est-à-dire comme le prolongement logique de la formation à la résidence CCMF.

cy training. Those within the Royal College envisioned a new specialty, an exclusive program aimed at producing emergentologist academicians which, to be fair, puts them at odds with the majority of RCPSC training programs whose principal mandate is to train specialists within a given discipline. This disagreement between the 2 *Great Houses* (as Shakespeare might have called them) eventually led to alternate certification routes for emergency medicine and, in many respects, to a two-tiered system. As Dr. Anton Grunfeld correctly points out in a recent proposal to the CAEP Board of Directors: "Canada is the only country within the International Federation of Emergency Medicine to have two streams of training."

Although I agree with the majority of the article by Ducharme and Innes, I disagree with their conclusion that " 'Turf' is a non-issue, . . ." For many years, the University Chair of Emergency Medicine here in Vancouver viewed the discipline as so arcane that he denied academic appointments to non-FRCPC emergency physicians. Fortunately, this has now changed with the appointment of his successor. Granted, many CCFP(EM)s now work in major teaching hospitals and fulfill academic roles, but this may be a simple matter of supply and demand. More than 60 residency-trained and 20 to 30 practice-eligible candidates sit the CCFP(EM) certification exam annually, compared with 10 to 25 FRCPC candidates who sit the Royal College exam. The statistical truth is that, by sheer numbers, CCFP(EM) certificants have become the dominant players in Canada. Would they still be offered major academic appointments in emergency medicine were these numbers skewed in the opposite direction?

As Ducharme and Innes point out, the perception that little difference exists between CCFP(EM) and FRCPC emergency physicians after a decade in practice is, indeed, a "sad commentary." If this perception is correct, residency directors clearly need to rethink the FRCPC program and implement significant change. Why would prospective emergency physicians languish for 5 years in a Royal College program if the end product is eventually the same as if they had taken the shorter route? At the very least, I suppose they could expect to be more clinically proficient in the short term. I have no doubt that, at least off the mark, the FRCPC graduate is *clinically* superior to the CCFP(EM) graduate. In our experience, it probably takes 4 years in practice for CCFP(EM) certificants to achieve clinical equality with their Royal College counterparts, and the learning curve during those years is steep.

Despite the fact that both a Royal College program and a CFPC program exist, we are strange bedfellows in each house. To family physicians, emergency physicians are, at best, distant cousins. To other specialists we are not exactly kindred spirits, and are often viewed as pretenders to the mantle of "consultant." Even though emergency physi-

Ceux du Collège Royal envisageaient une nouvelle spécialité, un programme exclusif destiné à former des urgentologues spécialisés dans l'enseignement ce qui, à dire vrai, les démarquait de la plupart des programmes du RCPC dont le principal objectif est de former des spécialistes dans une discipline donnée. Ce désaccord entre les deux chapelles a abouti à deux cursus de formation différents à la MU et, sous bien des aspects, à un système à deux niveaux. Comme le Dr Anton Grunfeld l'a à juste titre souligné dans une proposition récente soumise au Conseil d'administration de l'ACMU : « le Canada est le seul pays de la Fédération internationale de la médecine d'urgence où deux cursus de formation coexistent ».

Bien que je sois globalement d'accord avec l'article des Drs Ducharme et Innes, je récuse leur conclusion selon laquelle « il ne devrait pas être question de défendre un territoire quelconque ». Pendant de nombreuses années, le chef du Département de médecine d'urgence de l'Université de Vancouver considérait que cette discipline était si ésotérique qu'il refusait de confier des postes à des urgentologues non diplômés FRCPC. Heureusement, les choses ont changé avec son successeur. Certes, de nombreux titulaires du CCMF(MU) travaillent maintenant dans de grands centres hospitalo-universitaires et y enseignent, mais c'est peut-être simplement la loi de l'offre et de la demande. Plus de 60 candidats ayant suivi le programme de résidence et 20 à 30 praticiens passent chaque année l'examen du CCMF(MU), contre 10 à 25 candidats au FRCPC. Les statistiques montrent que, en chiffres, les diplômés du CCMF(MU) sont majoritaires au Canada. Mais s'ils étaient minoritaires, se verraient-ils proposer des postes d'enseignement importants en médecine d'urgence?

Comme les Drs Ducharme et Innes le font remarquer, il est plutôt inquiétant de constater la quasi absence de différences entre les urgentologues des 2 collèges après dix ans de pratique. Si ce constat est exact, les responsables de la résidence doivent repenser le programme du Collège Royal et mettre en œuvre des transformations profondes. Pourquoi des futurs médecins d'urgence devraient-ils consacrer 5 années d'études au Collège Royal si, à terme, ils ne sont pas plus compétents que leurs homologues ayant suivi une formation plus courte? Ils pourraient pour le moins espérer de meilleures compétences cliniques à court terme. Je suis presque convaincu que, soit dit entre nous, le diplômé FRCPC est *techniquement* supérieur au titulaire du CCMF(MU). Notre expérience montre qu'il faut probablement 4 années de pratique à un titulaire du CCMF(MU) pour atteindre une compétence clinique égale à celle de son homologue du Collège Royal, et la courbe d'apprentissage pendant ces années est abrupte.

En dépit de l'existence d'un programme au sein des deux institutions, nous formons une drôle de famille. Pour les généralistes, les médecins d'urgence sont au mieux des cousins éloignés. Pour les autres spécialistes, nous ne sommes pas vraiment complémentaires, mais concurrents au titre de « consultant ». Même si les urgentologues diplômés contribuent beaucoup à leurs collèges respectifs, on a souvent l'impression que, d'un côté comme de

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cians have contributed significantly to their respective colleges, one is occasionally struck by the suspicion that both might rest easier if we quietly disappeared. Although we pretend otherwise, ours remains a continuous struggle for acceptance and respectability.

These issues are deeply divisive to our profession and pose 4 important questions. First, are 5 years of emergency medicine training really necessary? Second, can a physician safely practise emergency medicine after 1 intensive year of training? Third, should 2 routes to certification continue to exist? Finally, who should champion the cause of academic emergency medicine?

At the risk of alienating some of my colleagues, my answers are as follows: Training for a clinical practice in emergency medicine does not require 5 years. One year, however, is completely inadequate. Having 2 routes to certification is not only odd, but divisive. Academic emergency medicine should be championed by those who are properly trained in academics.

We should take charge of our political destiny rather than subordinate it to institutions whose thinking and goals are out of step with our own.

Nous devons prendre en main notre destinée politique plutôt que de nous en remettre à des institutions dont la démarche et les objectifs ne sont pas les nôtres.

What we need is a new mind-set and a new paradigm. First, since we are 1 profession, we should be accredited and represented as such. Next, we should lobby every university in the country to give us autonomy over all years of training that lead to the practice of emergency medicine. Finally, we should take charge of our political destiny rather than subordinate it to institutions whose thinking and goals are out of step with our own.

By my conservative estimate there are at least 180 CCFP(EM) resident-years (3 years × 60 residents) and 100 FRCPC resident-years (5 years × 20 residents) of training available in Canada for physicians who will eventually practise emergency medicine. Combined, these 280 resident-years could be distributed to provide 65 4-year training positions in the discipline of emergency medicine. This would leave enough resident-years for 20 additional 1-year fellowships in areas such as pre-hospital care, research, teaching, administration, toxicology, or whatever else we deem important for the future. In addition, training and CME for primary-care physicians who practise emergency medicine in small communities or rural areas must be addressed.

The Canadian Association of Emergency Physicians is the only body whose *raison d'être* is to represent emergency medicine in Canada. In my opinion, CAEP is still trying to define itself and find its niche. I suggest CAEP become the Canadian College of Emergency Physicians (CCEP); obtain a charter much as the other colleges have done; lobby for control of residency training; establish a certification exam for our specialty (current certificants from each college would be practice-eligible); and confer fellowships in emergency medicine based on a fair but strict standard. If this sounds outlandish, remember that within the not-too-distant past, a group of disgruntled general practitioners did exactl'autre, on pousserait un soupir de soulagement si les médecins d'urgence n'existaient plus. Même si nous nous en défendons, nous ne menons pas moins une lutte permanente pour nous faire accepter et respecter.

Ces thèmes divisent la profession, ce qui nous amène à poser 4 questions importantes : premièrement, 5 années de formation à la médecine d'urgence sont-elles véritablement indispensables? Deuxièmement, un médecin peut-il pratiquer la médecine d'urgence en toute sécurité après un an de formation intensive? Troisièmement, faut-il conserver deux filières de formation? Enfin, qui peut prétendre à enseigner la médecine d'urgence?

Au risque de m'attirer les foudres de certains de mes collègues, mes réponses sont les suivantes : la formation à la médecine clinique d'urgence ne nécessite pas 5 années d'études. Toutefois, une année est loin d'être suffisante. L'existence de deux cursus différents est non seulement étrange, mais également source de discorde. Enfin, les postes d'enseignement de la médecine d'urgence doivent être occupés par des professionnels dûment formés à l'enseignement.

Un nouvel état d'esprit s'impose. Nous représentons une seule et même profession et devons être formés et représentés comme tels. D'autre part, nous devons faire pression sur chaque université du pays pour obtenir carte blanche pour toutes les années de formation menant à la pratique de médecine d'urgence. Enfin, nous devons prendre en main notre destinée politique plutôt que de nous en remettre à des institutions dont la démarche et les objectifs ne sont pas les nôtres.

D'après mes calculs les plus prudents, il existe au moins 180 places de formation en résidence pour le CCMF(MU) (3 ans × 60 étudiants) et 100 places pour le FRCPC (5 ans × 20 étudiants) offertes au Canada à ceux qui souhaitent se tourner vers la médecine d'urgence. Au total, ces 280 places pourraient être réparties de façon à ce que 65 candidats bénéficient d'une formation de quatre ans. Cela laisserait suffisamment de possibilités pour organiser une année d'études supplémentaire ouverte à 20 médecins dans des domaines tels que les soins d'urgence préhospitaliers, la recherche, l'enseignement, la gestion, la toxicologie ou toute discipline jugée importante pour l'avenir. En outre, il convient d'offrir une éducation médicale continue à ceux qui pratiquent la médecine d'urgence dans les petites villes ou les zones rurales.

L'Association canadienne des médecins d'urgence est le seul organisme qui a pour raison d'être de représenter la médecine d'urgence au Canada. Selon moi, l'ACMU est toujours en quête d'identité et cherche encore sa place. Je propose que l'ACMU devienne le Collège canadien des médecins d'urgence (CCMU), se dote d'une charte sur le modèle des autres collèges, fasse pression pour décider librement du contenu de la formation en résidence, élabore un examen d'agrément adapté à notre spécialité (les diplômés actuels de chaque collège bénéficieraient de droits acquis — en vertu de la fameuse clause «grand-père») et octroie des bourses d'études en médecine d'urgence basées sur des critères sévères mais justes. Si ces propositions semblent farfelues, je rappelle qu'il n'y a pas si longtemps, un groupe de généralistes

ly this, which is why the College of Family Physicians of Canada exists today.

Some would argue that our credibility as specialists in emergency medicine is predicated upon continued involvement with the Royal College. I believe our credibility will eventually evolve to be based upon 4 strengths: our training programs, our credentialling process, the clinical and academic ability of our graduates, and the stewardship of our own college. In short, *if you build it, they will come.*

This goal can be achieved, but not without widespread support and commitment from our profession. As Shakespeare said: "There is a tide in the affairs of men which, taken at the flood, leads on to Fortune; omitted, all the voyage of their life is bound in shallows and in misery." For emergency medicine in Canada, I believe the tide is now full. Shall we set sail, or founder in the shallows for another 20 years? ■

Editor's note: More emergency physicians with more training would be a good thing for Canadian emergency medicine. Limiting the "fifth year" to people who are actually motivated towards fellowship training would be a more efficient use of resources. Let me be the first to cast aside my "FRCP elitism" and endorse Dr. Etherington's concept of a unified EM training program, even if this means acknowledging that I am not intrinsically superior to my CCFP(EM) colleagues. (G.I.)

mécontents ont agi ainsi, donnant naissance au Collège des médecins de famille du Canada.

Certains allégueront que notre crédibilité en tant que spécialistes de la médecine d'urgence dépend de notre coopération permanente avec le Collège Royal. Je pense qu'à terme, notre crédibilité dépendra de quatre facteurs : nos programmes de formation, nos modalités de délivrance de diplômes, les compétences cliniques et universitaires de nos diplômés et la gestion de notre propre collège. En bref, nous en sommes les artisans.

Cet objectif peut être atteint, mais pas sans le soutien et l'engagement résolus de la profession. Comme l'expliquait Shakespeare, la vie de l'homme est telle le flux et le reflux. Il faut savoir partir avec la marée haute, sous peine de s'échouer. Pour la médecine d'urgence au Canada, je pense que c'est désormais marée haute. Allons-nous prendre la mer ou rester enlisés pendant encore 20 ans? ■

Note du rédacteur : Disposer de plus de médecins d'urgence mieux formés serait un atout pour le Canada. Restreindre l'accès en « cinquième année » aux médecins véritablement intéressés par des bourses d'études garantirait une utilisation plus efficace des ressources. Je suis prêt à être le premier à mettre de côté mon « élitisme FRCP » et à appuyer la proposition du Dr Etherington d'un programme de formation MU unifié, même si cela implique de reconnaître que je ne suis pas intrinsèquement supérieur à mes collègues CCMF(MU). (G.I.)

Is it a Monster or is it . . . Communiqué

S'agit-il d'un monstre ou du . . . Communiqué?

Dr. Grant Innes

CAEP is growing, and *Communiqué* is growing with it. Our last issue sprawled to an incredible 40 pages — some of it high-quality material. But growth means more articles and more work. We need help. Moreover, it is important that *Communiqué*'s incredible power isn't concentrated in the hands of a few radical extremists and exploited for evil purposes. To insure that *Communiqué* continues to reflect the interests of its membership, we need broader editorial representation. We need an editorial board.

All Canadian emergency physicians are invited to nominate themselves. If you feel you belong to an under-represented group of emergency physicians (e.g., researchers, expatriates, toxicologists, gnomes), you are especially welcome. Editorial board membership would involve soliciting articles from colleagues in your area of interest or geographic area, reviewing and editing submitted articles, and writing an occasional editorial if you are comfortable doing so.

If you are willing to do a small amount of work and reap the unspeakable rewards, submit your name to the CAEP office or address questions to me by email (**ginnes@unixg.ubc.ca**) or c/o the CAEP office.

L'ACMU grandit, tout comme le bulletin *Communiqué*. Notre dernier numéro a atteint le chiffre record de 40 pages, dont certaines d'excellente qualité. Toutefois, cette croissance implique davantage d'articles et un surcroît de travail. Nous avons donc besoin d'aide. Par ailleurs, il est important de ne pas laisser le pouvoir démesuré du *Communiqué* aux mains d'une poignée d'extrémistes radicaux qui l'exploiteraient à des fins peu avouables. Pour s'assurer que le *Communiqué* continue à refléter les intérêts de tous ses abonnés, nous souhaitons élargir sa représentativité. Il nous faut donc un comité de rédaction.

Tous les urgentologues canadiens sont invités à faire acte de candidature. Si vous pensez appartenir à une catégorie sous-représentée (ex : chercheurs, expatriés, toxicologues, lutins), vous êtes les bienvenus. L'appartenance à ce comité implique de solliciter des articles de vos collègues dans votre zone géographique ou spécialité, de réviser et de corriger lesdits articles et de rédiger de temps à autre un éditorial si cela ne vous effraie pas.

Si vous êtes prêt à retrousser vos manches et à récolter une gratification incommensurable, transmettez vos coordonnées au bureau de l'ACMU à Ottawa ou adressez-moi vos questions par courrier électronique (**ginnes@unixg.ubc.ca**).

PRESIDENT'S LETTER

Challenges for 1998

Dr. Michael Murray

The development of emergency medicine as a specialty in Hong Kong mirrored that of Canada's in many ways.

The long winter season is here. It is a good time to reflect on past events and those to come. The holiday season is also one of reflection, and I would like to reflect on CAEP's past and on its future as a prosperous association.

I was most fortunate, as the president of CAEP, to participate in two international events this fall. The first was the October ACEP meeting in San Francisco. During this event, I convened a meeting of the presidents of the IFEM countries (USA, UK, Australia and Canada) to discuss the future of the International Federation of Emergency Medicine. It was a very productive meeting because all agreed on the organization of the IFEM, the development of operational guidelines and a mechanism to invite other countries into the federation. Our international colleagues believe that the IFEM should be "inclusive" and promote international "fellowship." At the 7th ICEM we will host an international congress and invite presidents of other national associations to discuss the future of the IFEM.

The second event was the inauguration of the Hong Kong College of Emergency Medicine into the Hong Kong Academy of Medicine. This outstanding event began with the inauguration ceremony and ended with a scientific symposium. I extended congratulations on behalf of all CAEP members. CAEP presented the college with an original watercolour of the historic homestead of Dr. Norman Bethune. I saw that the development of emergency medicine as a specialty in Hong Kong mirrored that of Canada's in many ways. However, Hong Kong emergency medicine is represented by one college, which is responsible for the training and certification of all its members. In Canada, CAEP is a national association that represents some 1,000 emergency physicians, who come from two national colleges, all provincial colleges and emergency sections of provincial associations.

1998 marks CAEP's 20th anniversary. The association's inaugural meeting was held in Toronto. Ten years later, after much discussion, it was decided that CAEP would be the national body to represent all emergency physicians in Canada. CAEP recognized then, as now, the important role played by all types of emergency physicians: FRCP, CCFP(EM), CCFP, ABEM and MD. Over the last decade, CAEP has worked toward representing the interests of our members as a unified group. We have seen

LETTRE DU PRÉSIDENT

Les défis de 1998

Le chemin parcouru par la médecine d'urgence à Hongkong pour devenir une spécialité s'apparente à bien des égards à la situation canadienne.

L'hiver est de retour. Voici venu le temps de faire le point sur les événements passés et ceux à venir. À l'approche des fêtes de fin d'année, j'aimerais me pencher sur l'histoire de l'ACMU et son avenir riche de promesses.

J'ai eu la chance, en qualité de président de l'ACMU, de participer à deux manifestations internationales cet automne. La première, la réunion de l'ACEP, s'est tenue en octobre à San Francisco. À cette occasion, j'ai convié une réunion des présidents des pays membres de l'IFEM (États-Unis, Royaume-Uni, Australie et Canada) pour discuter de l'avenir de la Fédération internationale de la médecine d'urgence. Cette rencontre fut productive à plus d'un titre, car elle a permis de parvenir à un accord sur l'organisation de l'IFEM et d'élaborer des lignes directrices et un mécanisme visant à inclure d'autres pays dans la fédération. Nos collègues estiment que l'IFEM doit être largement ouverte et promouvoir un esprit de « confrérie » internationale. Lors de la 7e édition de l'ICEM, nous accueillerons un congrès international et inviterons les présidents d'autres associations nationales pour réfléchir en commun au futur de l'IFEM.

Le deuxième événement fut l'inauguration du Collège de médecine d'urgence de l'Académie de médecine de Hongkong. Cet événement de première importance a débuté par la cérémonie d'inauguration et s'est achevé par un symposium scientifique. J'ai d'ailleurs présenté des félicitations au nom de tous les membres de l'ACMU. L'ACMU a offert au collège une aquarelle originale représentant la demeure historique du Dr Norman Bethune. J'ai constaté que le chemin parcouru par la médecine d'urgence à Hongkong pour devenir une spécialité s'apparente à bien des égards à la situation canadienne. Toutefois, à Hongkong elle est représentée par un collège qui forme et diplôme ses membres. Au Canada, l'ACMU est une association nationale qui représente près d'un millier d'urgentologues, issus de deux collèges nationaux, de tous les collèges provinciaux et des sections médecine d'urgence des associations provinciales.

1998 marque le 20e anniversaire de l'ACMU. La réunion inaugurale de l'association s'est tenue à Toronto. Dix ans plus tard, après bien des débats, il fut décidé que l'ACMU serait l'organisme national représentant tous les urgentologues du Canada. L'ACMU reconnaît le rôle important joué par les urgentologues, toutes catégories confondues : FRCP, CCMF(MU), CCMF, ABEM et MD. Ces dix dernières années, l'ACMU s'est efforcée de défendre les intérêts de ses membres en tant que groupe uni. Le nombre de nos adhérents a considérablement augmenté, conférant à l'association encore plus de poids.

tremendous membership growth and, with that, we have a stronger voice. Developing a strategy for our organization for the next decade is an important task. Difficult questions must be asked, and we need the opinions of our members to guide us.

In the last edition of *Communiqué* the opening article addressed the issue of training in emergency medicine. It questioned whether two separate colleges with separate training programs were in fact meeting the objectives for training in emergency medicine in Canada. The authors asked whether, ten years later, there was any difference between individuals from both colleges. In this *Communiqué*, you will read the opinions of others as they reflect on this issue. Perhaps the route of training is but only one factor in the complex determination of the quality of an emergency physician 10 years later. For some, emergency medicine is an incidental job that they enjoy and work in throughout their lives. For others, emergency medicine extends beyond a secondary focus to a lifelong career and commitment. Career emergency physicians in Canada are many and can be found in all of our emergency departments. These physicians, regardless of training, are the leaders in the specialty of emergency medicine in this country. They are the directors of our departments, large and small. They are our EM physicians. They are our researchers, our teachers and our educators. They are our local, provincial and national emergency medicine spokespersons and leaders. They promote emergency medicine in their communities, in their provinces and throughout Canada.

The questions that we should perhaps ask are, What is the best way to train and continue to maintain competence in emergency medicine in the future in Canada? Are we best served by the training programs of two colleges? Do they, our provincial colleges and associations, continue to educate our emergency physicians and ensure maintenance of competence? Do they provide a political platform to promote the interest of emergency medicine and emergency physicians in Canada? Is emergency medicine strong enough to support an independent college of emergency medicine responsible not only for training and certification but continuing education and maintenance of competence of all emergency physicians?

CAEP is approaching the two national colleges to ask some of these questions. The opinions of our members are important in these discussions, and I welcome your comments.

The future of CAEP is exciting. We are fortunate, in this our 20th year, to be hosting the 7th ICEM in Vancouver this coming March. The ICEM incorporates our annual conference, and we will be holding the annual general meeting at that time. I invite all members to consider attending this outstanding conference at such a superb site. Meet with your national colleagues and get acquainted with our international colleagues. I look forward to seeing you there. ■

Aujourd'hui, il est important d'élaborer une stratégie pour la prochaine décennie. Il faut se poser des questions difficiles et les suggestions de nos membres sont nécessaires pour nous guider sur cette voie.

Dans le dernier numéro du *Communiqué*, le premier article était consacré à la formation des urgentologues. Il cherchait à déterminer si l'existence de deux collèges distincts dispensant deux programmes de formation différents répondait véritablement aux objectifs de formation à la médecine d'urgence au Canada. Les auteurs se demandaient si, au bout de dix ans, les praticiens issus des deux collèges présentaient des différences. Dans ce numéro, vous prendrez connaissance de l'avis d'autres médecins sur ce thème. La formation n'est peut-être qu'un des paramètres de l'équation complexe de la compétence d'un urgentologue après 10 ans de pratique. Pour certains, la médecine d'urgence est une activité complémentaire à laquelle ils s'adonnent occasionnellement avec plaisir. Pour d'autres, c'est un pilier de leur carrière et ils s'y consacrent pleinement. Les urgentologues de carrière sont nombreux au Canada et présents dans tous nos services d'urgence. Ces praticiens, quelle que soit leur formation, sont les spécialistes de cette discipline dans le pays. Ils dirigent nos services, grands et petits. Ce sont nos médecins de l'urgence, nos chercheurs, nos enseignants et nos chefs de file. Ils sont également les porte-parole de la médecine d'urgence à l'échelon local, provincial et national. Ils assurent la promotion de cette discipline dans leur communauté, leur province et dans tout le pays.

Les questions qu'il convient peut-être de se poser sont les suivantes : quelle est la meilleure manière de former et de recycler les urgentologues? Les cursus des deux collèges offrent-ils la meilleure solution? Ces collèges, les collèges provinciaux et les associations dispensent-ils une éducation continue à nos urgentologues? Constituent-ils une plate-forme politique pour la défense des intérêts de la médecine d'urgence et de ses praticiens au Canada? La médecine d'urgence est-elle suffisamment structurée pour permettre la création d'un collège indépendant responsable non seulement de la formation et de la délivrance de diplômes, mais aussi de l'éducation continue et du recyclage de tous les urgentologues?

L'ACMU pose actuellement certaines de ces questions aux deux collèges. L'avis de nos membres joue un rôle important dans ce débat et vos suggestions sont les bienvenues.

Les perspectives qui s'ouvrent à l'ACMU sont enthousiasmantes. À l'occasion de notre 20e anniversaire, nous avons le privilège d'accueillir à Vancouver, en mars prochain, la 7e édition de l'ICEM dans le cadre de laquelle auront lieu notre conférence et notre assemblée générale annuelles. J'invite tous nos membres à participer à cette conférence exceptionnelle dans cette ville magnifique. Vous rencontrerez nos délégués nationaux et ferez la connaissance de collègues du monde entier. J'espère avoir le plaisir de vous y retrouver. ■

For some, ...emergency medicine extends beyond a secondary focus to a lifelong career and commitment.

Pour certains, la médecine d'urgence est... un pilier de leur carrière et ils s'y consacrent pleinement.

CAEP / ACMU Communiqué

Summer/Été 1998

The Task Force on Emergency Medicine Training

Le groupe de réflexion sur la formation à la médecine d'urgence

Anton F. Grunfeld, MD, FRCPC

The following is a summary of the background to the task force project.

September 1997. Proposal to the CAEP Board: Twenty years ago, the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) both instituted emergency medicine training programs. Several hundred physicians have since graduated from these programs. We believe that the existence of separate classes of emergency physicians has fragmented clinical and educational resources, and has not served the best interests of providing improved care to our patients. Canada is the only country within the International Federation of Emergency Medicine to have 2 parallel streams of training.

We propose a task force, which will review the historical circumstances that led to the current system, consider the impact of this system on physician education and patient care, and undertake an extensive survey and consultation with Canadian physicians and the 2 colleges, to investigate the desirability, willingness and feasibility of establishing a unified education program in emergency medicine.

Voici un résumé des circonstances qui ont conduit au projet de groupe de réflexion.

Septembre 1997. Proposition soumise au Conseil de l'ACMU : Il y a vingt ans, le Collège des médecins de famille du Canada (CMFC) et le Collège Royal des Médecins et Chirurgiens du Canada (CRMCC) ont tous deux décidé d'instaurer des programmes de formation en médecine d'urgence. Depuis lors, plusieurs centaines de médecins ont été diplômés de ces deux établissements. Nous pensons que l'existence de formations distinctes à la médecine d'urgence entraîne un éparpillement des ressources, à la fois cliniques et de formation, et dessert les intérêts des patients en matière de qualité de soins. Le Canada est le seul pays membre de la Fédération internationale de la médecine d'urgence dans lequel deux filières de formation coexistent.

Nous proposons de créer un groupe de réflexion pour examiner les circonstances historiques qui ont abouti au système actuel, étudier l'impact de ce système sur la formation des praticiens et les soins des patients et entreprendre une enquête et une série de consultations à grande échelle auprès des médecins et des 2 collèges canadiens afin d'évaluer l'opportunité et la volonté d'établir un seul

Fear and loathing in emergency medicine

Is the Task Force on Emergency Medicine Training the worst abomination ever perpetrated against Canadian emergency medicine? If not, how could it have triggered the explosion of hostility that it has? One reading of Dr. Grunfeld's summary and letter will convince you that to even discuss this matter is a recipe for certain disaster. Or maybe it won't. Also in *Communiqué*, you will read about the crisis in EM, expanded-role nurses, the 7th ICEM, the Vancouver Ankle Rules, and the new role for residents in CAEP. [G.I.]

L'être et le néant en médecine d'urgence

La création du groupe de réflexion sur la formation à la médecine d'urgence est-il le pire des crimes jamais perpétré contre la médecine d'urgence canadienne? Si ce n'est pas le cas, comment expliquer la levée de boucliers qu'il a provoquée? La lecture du résumé et de la lettre du Dr Grunfeld vous convaincra que le simple fait de débattre de la question a suffi à déclencher un tollé. Espérons toutefois que cela ne prendra pas d'autres proportions. Ce numéro de *Communiqué* porte sur la crise de la MU, l'apparition de «super infirmières», la 7e ICEM, et les Règles de la cheville de Vancouver, ainsi que le nouveau rôle dévolu aux résidents au sein de l'ACMU. [G.I.]

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Next Deadline
Nouveau délai

August 7 is the deadline for material for the Fall issue of *Communiqué*. Please submit a hard copy and disk in Microsoft Word of ASCII format with graphics or photos to the address provided above.

Le délai pour l'envoi d'articles pour le numéro d'automne du *Communiqué* est fixé au **7 août**. Prière d'adresser une copie papier et une disquette Microsoft Word de format ASCII avec graphismes ou photos à l'adresse indiquée ci-dessus.

continued from page 1

September 1997. The Board response: CAEP Board members felt they could not fully support unified training without further consultation and discussion, but agreed to the establishment of the task force — to include members representing Royal College physicians, CCFP(EM) physicians, rural physicians, and one member of the CAEP board. The task force must report back to the Board before any steps toward unification can be taken. Members of the task force were identified and included: Drs. Anton Grunfeld (Chair), Jeremy Etherington, Michael Murray, Douglas Sinclair and Claude Topping.

March 1998. Presentation to CAEP members at the annual general meeting: At the AGM, the tentative timetable was defined:

Mar. to Dec. 1998: Survey and consultation within the profession.
Jan. to Mar. 1999: Proposal to the CAEP Board of Directors (if consensus achieved)
Apr. 1999: Proposal to the RCPSC and CFPC (if consensus achieved)

The following "open letter" was drafted to explain the process to interested parties.

Dear Dr. _____
The Board of Directors of CAEP has sanctioned a task force whose mandate is: ***to consult with Canadian emergency physicians*** and ***to investigate the desirability and willingness of establishing a unified education program in emergency medicine.***

Over the next 6 to 12 months the task force will approach professors and teachers in emergency medicine, program directors of the Royal College and the College of Family Physicians, officials of the two colleges, licensing bodies, deans of medical schools, residents in emergency medicine programs and students interested in emergency medicine, and practising emergency physicians in Canada.

The ***members of the task force hope that a consensus will evolve*** that will allow the gradual implementation of a unified residency program in emergency medicine. ***If such a consensus can be achieved*** the task force will recommend to the Board of Directors of CAEP an implementation plan that will address the needs of providing emergency medical services in Canada in the future.

Please contact us with your ideas and suggestions.

Yours truly,

Anton F. Grunfeld, MD, FRCPC
Chair, Task Force on Specialty Education

suite de la page 1

cursus de formation en médecine d'urgence.

Septembre 1997. Réponse du Conseil : Les membres du Conseil de l'ACMU ne peuvent pas apporter leur soutien à une formation unifiée sans procéder à des consultations et à des discussions supplémentaires. C'est pourquoi il est décidé d'établir un groupe de travail, comprenant des représentants des diplômés du Collège Royal, des médecins CCMF(MU), des médecins ruraux et un membre du Conseil de l'ACMU. Le groupe de réflexion doit remettre son rapport au Conseil avant toute décision éventuelle d'unification. Les membres du groupe de réflexion sont : Dr Anton Grunfeld (Président), Jeremy Etherington, Michael Murray, Douglas Sinclair et Claude Topping.

Mars 1998. Présentation lors de l'Assemblée générale annuelle de l'ACMU : Un calendrier provisoire est défini lors de l'Assemblée générale annuelle :

Mars à déc. 1998 : Enquête et consultation auprès de la profession
Janv. à mars 1999 : Proposition soumise au Conseil d'administration de l'ACMU (si un consensus est atteint)
Avril 1999 : Proposition devant le CRMCC et le CMFC (si un consensus est atteint)

La «lettre ouverte» suivante est rédigée pour expliquer le processus aux parties concernées.

Cher Dr _____,
Le Conseil d'administration de l'ACMU a donné son aval à la création d'un groupe de réflexion ayant pour mission de ***consulter les médecins d'urgence canadiens*** et ***d'évaluer l'opportunité et la volonté d'établir un seul cursus de formation en médecine d'urgence.***

Au cours des 6 à 12 prochains mois, ce groupe prendra contact avec les professeurs et les enseignants de médecine d'urgence, les directeurs de programme du Collège Royal et du Collège des médecins de famille, les responsables des deux collèges, les organismes d'habilitation, les doyens des écoles de médecine, les résidents en médecine d'urgence et d'autres étudiants intéressés par cette discipline, ainsi que les urgentologues en exercice au Canada.

Les ***membres du groupe de réflexion espèrent qu'un consensus se dégagera***, permettant la mise en œuvre progressive d'un programme de résidence unifié en médecine d'urgence au Canada. ***Si tel est le cas***, le groupe de réflexion préconisera au Conseil d'administration de l'ACMU un plan de mise en œuvre qui répondra aux besoins futurs en médecine d'urgence au Canada.

Vos idées et vos suggestions sont les bienvenues.

Bien cordialement,

Anton F. Grunfeld, MD, FRCPC
Président, groupe de réflexion sur la formation de spécialité

LETTERS TO THE EDITORS

COURRIER DES LECTEURS

Symposium highlights

To the editors:

I was dismayed by a publication I received from CAEP entitled "New insights: Emergency Management of AMI. Highlights from CAEP/ACMU May 1997 Satellite Symposium." Although the goals of such a publication (and indeed of these symposia) are laudable, this publication in particular seemed, in parts, to be more an ad for TPA than an objective and useful review of new approaches to AMI.

Essentially, the results of the GUSTO[1] trial are presented as fact, leaving compelling results of trials such as ISIS-3 and GISSI-2 aside.[2,3] Furthermore, the entire last page is given over to a 3-man defence of GUSTO, without giving any time to numerous vocal and thoughtful critics of the GUSTO trial.

Finally, the only mention of ASA in AMI is to suggest that its effect is "weak"! The ISIS-2 trial showed a 23% relative risk reduction in mortality from AMI and, further, that ASA acts synergistically with thrombolytics.[4] This mortality reduction with ASA is larger than the putative advantage of TPA over SK shown.

I hope that in the future CAEP will be more careful, and publish documents that more objectively and accurately represent the spectrum of clinical opinion on such important topics.

Michael Schull, MD, MSc, FRCPC
Sir Mortimer B. Davis–Jewish General Hospital
Montreal, Que.

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The FRCPC vs. the CCFP(EM)

To the editors:

I found the recent exchange of ideas that began with the article "The FRCPC vs. the CCFP(EM). Is there a difference 10 years after residency?" to be interesting (*Communiqué*, Fall 1997 and Winter 1997–98). It is clear that most of the contributors are urban-based. Here in a semi-rural area, the differentiation

Réflexions sur le symposium

Aux rédacteurs :

J'ai été très surpris par la publication récente reçue de l'ACMU intitulée «New insights: Emergency Management of AMI. Highlights from CAEP/ACMU May 1997 Satellite Symposium». Bien que l'objectif d'une telle publication (et de ces symposiums) soit louable, elle s'apparentait davantage à une publicité pour l'ATP [activateur tissulaire du plasminogène] qu'à un examen objectif et utile des nouveaux traitements de l'infarctus aigu du myocarde (IAM).

Les résultats de l'essai GUSTO[1] sont présentés comme des faits et passent sous silence les résultats incontestables d'essais tels que ISIS-3 et GISSI-2.[2,3] Par ailleurs, la dernière page est consacrée exclusivement aux commentaires de trois partisans du GUSTO, sans laisser voix au chapitre aux nombreuses critiques pertinentes de l'étude GUSTO.

Enfin, on évoque seulement l'incidence de l'acide acétylsalicylique (AAS) sur l'IAM pour suggérer que son effet est «faible»! L'essai ISIS-2 a révélé une réduction relative de 23 % des risques de mortalité due à des IAM et que l'AAS agit en synergie avec les thrombolytiques.[4] Cette réduction de la mortalité grâce à l'AAS est plus importante que les avantages présumés de l'ATP sur la streptokinase.

J'espère qu'à l'avenir l'ACMU se montrera plus circonspecte et publiera des documents qui présentent de manière plus objective et précise l'ensemble des avis cliniques sur des sujets aussi importants.

Michael Schull, MD, Maîtrise de biologie, FRCPC
Sir Mortimer B. Davis–Jewish General Hospital
Montréal (Qué.)

FRCP contre CCMF(MU)

Aux rédacteurs :

J'ai trouvé assez intéressant le débat engagé par l'article «FRCPC contre CCMF(MU). Y a-t-il une différence 10 ans après la résidence?» (*Communiqué*, automne 1997 et hiver 1997–98). Il est évident que la plupart des intervenants sont des citadins. Dans la zone semi-rurale où j'exerce, le démarcation entre ces deux programmes est dérisoire et la question concernant les capacités universitaires des deux formations est purement académique. Étant donné que le tiers des Canadiens a décidé de ne pas vivre dans des jungles de béton et s'adresse à des généralistes en cas d'urgence, je me pose théoriquement la question «à qui servent véritablement ces deux programmes?»

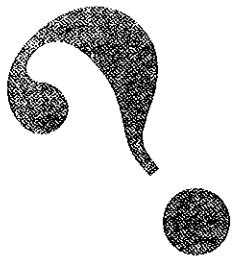
Souvent, dans les petits centres, la médecine d'urgence relève des compétences et des prérogatives des médecins. Ils y consacrent une grande partie de leurs journées. Au fur et à mesure que la médecine en général (et la médecine d'urgence en particulier) progresse et que les exigences de la communauté augmentent, ces médecins sont soumis

I hope that in the future CAEP will be more careful, and publish documents that more objectively and accurately represent the spectrum of clinical opinion on such important topics.

J'espère qu'à l'avenir l'ACMU se montrera plus circonspecte et publiera des documents qui présentent de manière plus objective et précise l'ensemble des avis cliniques sur des sujets aussi importants.

As one-third of Canadians opt not to live in concrete jungles and therefore most of their emergency medicine is provided by GPs, who needs either program (I ask rhetorically)?

Étant donné que le tiers des Canadiens a décidé de ne pas vivre dans des jungles de béton et s'adresse à des généralistes en cas d'urgence, je me pose théoriquement la question «à qui servent véritablement ces deux programmes?»



between the 2 programs is rather inconsequential and the question of academic abilities is academic. As one-third of Canadians opt not to live in concrete jungles and therefore most of their emergency medicine is provided by GPs, who needs either program (I ask rhetorically)?

Often, physicians in smaller centres are asked to provide ED coverage as part of their duties and privileges. This can amount to a significant portion of their time. As medicine in general (and emergency medicine in particular) advances and as community expectations rise, there are greater pressures placed on these docs. A case in point is the recent withdrawal of on-call emergency hospital services by several of our northern BC colleagues.

One of the roles of a CCFP(EM) physician in a smaller centre can be to provide a current set of standard ED practices in his or her department. Through direct teaching, leading by example and CME activities, the emergency medicine standard of care is elevated. It is unreasonable and impractical to expect any MD working in a rural setting to consider a 1-year CCFP(EM) program because to fulfil their role as a generalist they must also be proficient in obstetrics, pediatrics, geriatrics, etc. This role is important to millions of Canadians, a point often overlooked in "urban-based" debates.

What do we need here? The current CCFP(EM) program suits the rural situation quite well. Two years of family practice residency and 1 year of ED training provide 3 years of residency before rural practice. Dr. Etherington commented that it takes the CCFP(EM) grad 3 to 4 years to catch up in clinical proficiency to their FRCP counterpart (Winter 1997–98, pg 17). While this is probably true in the downtown high-acuity centre, in my opinion the opposite is true in the rural setting: the FRCP doc would be lost without a CT scanner and bedside ultrasound machine. If I were king for a day, I'd arrange for some ED rotations, in both training paths, to be done in nontertiary centres. It wouldn't hurt FRCP residents to learn to handle (at 0100 hours and with only a nurse as backup) the 240-lb, intoxicated, psychotic lumberjack.

I believe there is a differentiation in our field of emergency medicine, although I don't think it should pose a major hurdle. Just as there are several types of cardiologists (EP, invasive), surgeons (general, vascular) and GPs (obstetrics, geriatrics), some of us enjoy the challenge of providing good acute care in the rural setting and others like the thrill of the inner city. May I be so bold as to suggest another residency training scheme: a 2-year emergency medicine program followed by a 2-year fellowship option for those who want more training.

David Mann, MD, CCFP(EM)
Powell River, BC

One of the editors responds:

For shame you should malign us urban docs. I consider myself an astute clinician, I don't have a bed-

à des pressions croissantes. Le retrait récent de certains de nos collègues du nord de la Colombie Britannique des services hospitaliers d'urgence sur appel illustre bien cette réalité.

L'un des rôles du médecin CCMF(MU) d'un petit centre est d'assurer un ensemble de pratiques de MU standard et actualisées dans son service. Grâce à l'apprentissage direct, aux exemples concrets et aux cours de formation médicale continue, le niveau des soins de médecine d'urgence est élevé. Il n'est pas raisonnable ni réaliste de demander à un médecin exerçant en milieu rural de suivre une formation CCMF(MU) sur un an, car pour mener à bien sa mission de généraliste, il doit également maîtriser l'obstétrique, la pédiatrie, la gériatrie, etc. Cette polyvalence est importante pour des millions de Canadiens, élément souvent passé sous silence dans les débats «urbains».

Quels sont nos besoins dans ce contexte? Le programme CCMF(MU) est assez bien adapté à la réalité rurale. Les deux ans de résidence en médecine familiale et la formation d'un an à la médecine d'urgence constituent une résidence de 3 ans avant la pratique rurale. Je prends note du commentaire du Dr Etherington selon lequel il faut au CCMF(MU) trois à quatre ans pour rattraper son retard par rapport à son homologue FRCP (Hiver 1997–98, page 17). Bien que cela soit probablement vrai dans un centre urbain de soins aigus, il en va tout autrement dans un contexte rural : le médecin FRCP serait perdu sans son tomoscanner et son appareil à ultrason au chevet du malade. Si j'étais le roi d'un jour, j'instaurerais des rotations en médecine d'urgence dans les deux formations qui auraient lieu dans des centres non tertiaires. Tout bien pensé, cela ne ferait pas de mal aux résidents FRCP d'apprendre à prendre en charge (à une heure du matin et avec le seul secours d'une infirmière) un bûcheron psychotique de 120 kilos en état d'ébriété.

Je pense qu'il existe une démarcation dans le secteur de la médecine d'urgence et cela ne constitue pas, à mon avis, un obstacle rédhibitoire. Tout comme il existe plusieurs types de cardiologues, de chirurgiens (généralistes, vasculaires) et de généralistes (obstétrique, gériatrie), certains seront attirés par le défi de prodiguer des soins d'urgence aigus dans un environnement rural, alors que d'autres préféreront l'excitation de la ville. C'est la raison pour laquelle j'irai jusqu'à suggérer un autre programme de formation : 2 ans en médecine d'urgence suivis d'un cursus de perfectionnement facultatif de 2 ans pour ceux qui souhaitent une formation plus complète.

David Mann, MD, CCMF(MU)
Powell River (C.-B.)

Réponse d'un des rédacteurs :

Ne jetez pas l'anathème sur les médecins des villes. Je me considère comme un clinicien perspicace, je n'ai pas d'appareil à ultrason et j'aspire à une vie paisible à la campagne (je préférerais toutefois travailler moins dur). À propos, j'ai eu moi aussi maille à partir avec ce satané bûcheron! Il a laissé des morceaux d'écorce et des aiguilles de pin partout sur notre nouvel appareil d'imagerie à résonance magnétique. Trêve de plaisanterie, il est important de souligner que la médecine d'urgence est en grande

side ultrasound machine, and I pine for the simple country life (though I'd rather not work that hard). By the way, I saw that damn lumberjack too! He left bark and spruce needles all over our new MRI scanner. More seriously, it is important to remember that much emergency medicine is provided in non-urban areas. I concur with you that most of the best training experiences take place outside university hospitals.

Grant Innes, MD, CCFP, FRCPC

To the editors:

I'm sure you've received a huge response to the front page article by Drs. Ducharme and Innes in the Fall 1997 *Communiqué*. I would like to add a couple of humble points.

First, I keep hearing reference to the "1 year" of training received by CCFP(EM) graduates. My training in emergency medicine took place over 3 years. I trained at St. Mary's Hospital in Montreal, an "interns-only" type hospital; my teachers in family medicine were also my teachers in emergency med, obstetrics, internal medicine and often also in the intensive care unit. We, as all residents, dealt with emergency cases from day one. Experience and knowledge accumulated over time, and the 3rd year was a period of refinement and development of expertise — certainly not a beginning.

Second, with respect to the elusive "mind-set" of emergency medicine, I consider that the family medicine "mind-set" is in fact an excellent attitude with which to approach emergency medicine. Coupled with emergency medicine expertise, this style of practice is very effective. People are not diseases, diagnoses to be made, nor codes to be run. Nor are they "derelicts" or "trolls" (p 7), or "inferior subspecies" (p 23), as Dr. Innes describes some patients in the same issue of *Communiqué*.

Last, because I did my residency at McGill I am familiar with Dr. Ducharme's provocative style. Reading Ducharme and Innes' article, I realize that they wish to stimulate debate. Their main point is that the 5-year FRCP program is in need of improvement. They have succeeded in making us all think about this issue. I applaud them for that. However, even though they deny the intention, they demonstrate a bias against family-medicine-trained emerg docs. This is not a necessary nor even valid point to flog, because it is simply divisive. I wish Drs. Ducharme and Innes the best of luck in improving their FRCP programs.

Mike Taylor, CCFP(EM)
Hôpital Montfort, Ottawa, Ont.
Centre hospitalier régional de l'Outaouais
Hull, Que.

One of the editors responds:

This letter reflects one reader's interpretation but does not reflect the content or the spirit of the articles he refers to. We encourage readers to review the articles in question (*Communiqué*, Fall 1997, Winter 1997-98) and draw their own conclusions.

Grant Innes, MD, CCFP, FRCPC

partie pratiquée dans les zones non urbaines. Comme vous, j'estime que les expériences les plus formatrices se déroulent pour la plupart hors des hôpitaux universitaires.
Grant Innes, MD, CCMF(MU), FRCPC

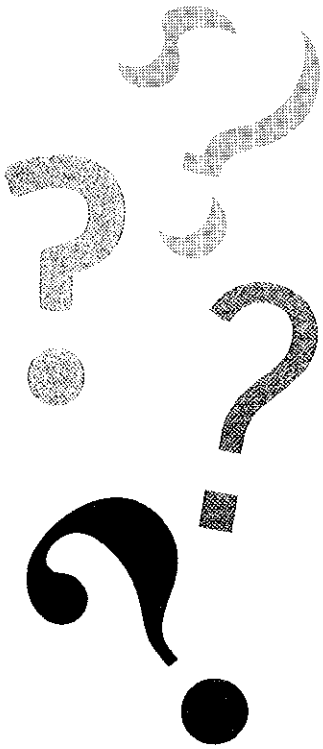
Aux rédacteurs :

Je suis certain que l'article des Drs Ducharme et Innes, en première page du numéro d'automne 97 du *Communiqué*, vous a valu beaucoup de courrier. Je voudrais moi aussi apporter mon humble contribution.

Premièrement, l'on n'arrête pas de parler de la formation «d'un an» suivie par les diplômés CCMF(MU). Or, pour moi, il est évident que ma formation en médecine d'urgence s'est déroulée sur 3 ans. J'ai été formé au St. Mary's Hospital à Montréal, un établissement «réservé aux internes». Mes professeurs en médecine familiale enseignaient également la médecine d'urgence, l'obstétrique, la médecine interne et étaient souvent présents dans l'unité de soins intensifs. Comme tous les résidents, nous avons dû prendre en charge des urgences dès le premier jour. Nous avons progressivement accumulé les expériences et les connaissances et la 3e année marquait une phase de perfectionnement et de développement des compétences et absolument pas un point de départ.

Deuxièmement, pour ce qui est de «l'attitude» qu'exige la médecine d'urgence et que l'on ne semble pas pouvoir définir, je constate que «l'attitude» exigée par la médecine familiale constitue une excellente approche de la médecine d'urgence. Allié aux compétences de la médecine d'urgence, ce style de pratique est très efficace. Les gens ne sont pas des pathologies, des diagnostics à poser, ni des codes à traiter. Ils ne sont pas non plus des «sans-abri», des «trolls» (p 7) ou «une sous-espèce peu évoluée» (p 23), comme le Dr Innes décrit certains patients dans le même numéro du *Communiqué*.

Troisièmement enfin, je connais bien le style provocateur du Dr Ducharme, car j'ai fait ma résidence à McGill. En lisant l'article des Drs Ducharme et Innes, j'ai compris qu'ils souhaitaient engager un débat et que leur principal souci est l'amélioration nécessaire du programme FRCP sur 5 ans. Je pense qu'ils ont réussi à nous faire réfléchir à cette question et je les en félicite. Néanmoins et bien qu'ils s'en défendent, ils sont tendancieux à l'égard des urgentologues issus de la médecine familiale. Ce n'est pas une question qui mérite que l'on disserte à longueur de journée, car elle ne fait que nous diviser. Je souhaite bonne chance aux Drs Ducharme et Innes pour l'amélioration de leurs programmes FRCP.



Mike Taylor, CCMF(MU)
Hôpital Montfort, Ottawa (Ont.)
Centre hospitalier régional de l'Outaouais
Hull (Qué.)

Réponse d'un des rédacteurs :

Cette missive reflète une interprétation parmi d'autres, mais son auteur laisse de côté l'esprit et la lettre des articles en question. Nous incitons nos lecteurs à jeter à nouveau un coup d'oeil à ces textes (*Communiqué*, Automne 1997 et Hiver 1997-98) et à tirer leurs propres conclusions.

Grant Innes, MD, CCFP, FRCPC

Minutes: CAEP Annual General Meeting
Governor General Room,
Pan Pacific Hotel, Vancouver
Thursday March 26, 1998, 1200-1400

1.0 President's Remarks: Michael Murray summarized the activities of CAEP over the last year, highlighting the contributions of several outstanding members.

2.0 Finances: Harold Fisher reviewed CAEP's financial status, reported our current surplus, and discussed the new philosophy of planning balanced annual budgets and running CAEP operations out of membership revenues, leaving conference income for other specific projects. He then presented the proposed budget for this year.
Dan Cass moved we accept the financial report and approve the proposed budget. Tony Taylor seconded. Passed by the membership.

3.0 Membership: Garth Dickinson reported that CAEP membership is rising steadily, and that there has been a shift to the "active" category.

4.0 Research Endowment Fund: Garth reported that the fund has grown by $7000. in the last year and now sits at $15,058. Interest earned has been reinvested in the fund.

5.0 Nominations: Garth introduced the nomination slate and entertained nominations from the floor. There were none. Eric Letovsky moved that we elect the nominated candidates. Andrew Affleck seconded the motion. The membership was unanimously in favor. This year's Board is:

President:	Michael Murray
Vice-President:	Douglas Sinclair
Treasurer:	Harold Fisher
Secretary:	Grant Innes
Director-at-large:	Cheri Nijssen-Jordan
Director-at-large:	Claude Topping
Director-at-large:	James Thompson
Director-at-large:	Timothy Allen
Director-at-large:	Brian Weitzman

6.0 Strategic Plan: Doug Sinclair discussed the development of our strategic plan and invited comment and feedback from the membership.

7.0 Task Force on Specialty Training: Anton Grunfeld described the activities of the Task Force on Specialty Training and reviewed their efforts to develop a unified track for Emergency Medicine training in Canada. The task force's intent is to consult with Canadian emergency physicians over the next 6 months, to prepare an implementation plan in the Fall of 1998, to forward this plan to the College of Family Physicians and the Royal College of Physicians and Surgeons, and to begin implementation in the spring or summer of 1999.

8.0 Closing Remarks: Michael Murray made some brief closing remarks. The meeting was adjourned.

LETTERS TO THE EDITORS

On unified EM training

To the editors:

I am deeply concerned with CAEP's involvement in an issue that appears to be predominantly a problem of the Royal College. The majority of emergency medicine practised in this country is and will continue to be community based and dependent upon part- and full-time physicians whose careers include, at some time or another, primary care. My understanding of the task force's goal is to create a single RCP-accredited program that would essentially destroy the CCFP(EM) training.

What is the problem with the present 2 streams if, as the task force has already acknowledged, 2 patterns of practice are an acknowledged end point? CCFP(EM) certificants are meeting manpower needs in a diversity of emergency departments, especially community-based hospitals that cannot attract or sustain an FRCPC. The CCFP(EM) program also addresses a very real need for emergency-trained physicians in rural Canada. A single stream would set back the development of emergency medicine skills and knowledge amongst this cohort of physicians. CCFP training permits the combination of emergency medicine with family medicine in a flexible, sustainable pattern of practice with either part-time involvement in both, or a shift from one to the other according to career and lifestyle priorities. Conversely, licensing authorities do not recognize Royal College Fellows as trained in family medicine and competent to conduct primary care.

As the task force's intent is to have the Royal College completely control EM, it is most unlikely that the 2 years required for certification in family medicine would be recognized. This attitude was recently displayed in *Communiqué*, in the authors' assumption that the 2 years of family medicine training required prior to the EM certification contributed nothing to their emergency medicine skills or knowledge base. The emergency department, as the dynamic interface between the community and the hospital, requires physicians who are both knowledgeable and well grounded in the provision of community-based care. The involvement of family physicians, home care and other care providers is just as important to the efficient operation of an emergency department as our interaction and consultation with hospital-based specialists.

This task force is extremely ill-advised for CAEP. CAEP does not need to be dragged through a contentious political battle that will be perceived as an attack on its CCFP(EM) members. It will be seen as openly antagonistic to both the rural and urban non-specialist physicians with an interest in emergency medicine who are presently attracted to CAEP and form the bulk of its membership. Ultimately it would

COURRIER DES LECTEURS

À propos d'une formation unifiée à la médecine d'urgence

Aux rédacteurs :

Je m'étonne que l'ACMU se mêle d'un problème qui semble concerner principalement le Collège Royal. La médecine d'urgence dans ce pays est et continuera d'être communautaire et tributaire de médecins à temps plein ou partiel qui ont, à un moment ou à un autre de leur carrière, prodigué des soins de santé primaires. Selon moi, l'objectif du groupe de réflexion est de créer un seul cursus reconnu par le RCP qui sonnerait le glas de la formation CCMF(MU).

En quoi l'existence de deux formations pose-t-elle problème, puisque deux programmes distincts aboutissent au même résultat, comme le groupe de réflexion l'a déjà reconnu? Les diplômés CCMF(MU) occupent des postes dans de nombreux services d'urgence, surtout dans les hôpitaux locaux incapables d'attirer ou de conserver un diplômé FRCPC. La filière CCMF(MU) répond également à un besoin bien réel de professionnels formés à la médecine d'urgence dans les régions rurales du Canada. Une formation unique nuirait à l'acquisition de compétences et de connaissances en médecine d'urgence chez ces très nombreux praticiens. La formation CCMF permet d'associer médecine d'urgence et médecine familiale et de pratiquer ces deux disciplines de manière souple et viable, soit de front en temps partiel, soit en passant de l'une à l'autre au gré de l'évolution de carrière et des aspirations de chacun. Inversement, les autorités qui délivrent l'autorisation d'exercer ne reconnaissent pas aux diplômés du Collège Royal une formation à la médecine familiale et des compétences pour prodiguer des soins de santé de base.

Comme le groupe de réflexion a pour but de placer la MU sous la coupe du Collège Royal, il est fort improbable que les deux ans nécessaires pour obtenir le certificat en médecine familiale soient reconnus. Ce point de vue a d'ailleurs été exprimé dans *Communiqué*, les auteurs ayant indiqué que les deux années de formation à la médecine familiale nécessaires avant la délivrance du certificat de MU n'ont rien apporté à leurs compétences ou connaissances en médecine d'urgence. Le service d'urgence, interface dynamique entre la collectivité et l'hôpital, nécessite des praticiens bien formés et expérimentés dans les soins de santé de base. La participation de généralistes, de personnel médical pratiquant les soins à domicile et d'autres professionnels de la santé est tout aussi importante pour le bon fonctionnement du service que l'intervention et la consultation de spécialistes hospitaliers.

Le recours à un groupe de réflexion est extrêmement mal venu pour l'ACMU. L'ACMU n'a pas besoin de s'engager dans une bataille politique controversée interprétée comme une offensive contre ses membres CCMF(MU). Cette démarche sera perçue comme une attaque de front contre les médecins ruraux et les généralistes urbains

CAEP does not need to be dragged through a contentious political battle that will be perceived as an attack on its CCFP(EM) members. [P.R.B.]

L'ACMU n'a pas besoin de s'engager dans une bataille politique controversée interprétée comme une offensive contre ses membres CCMF(MU). [P.R.B.]

be ill-advised, if not impossible, for the CFPC to turn its back on emergency medicine as family physicians will continue to provide the bulk of care in Canadian emergency departments.

I do not believe the CAEP Board has thought this through from either a strategic or tactical perspective. The membership's response to this issue in recent *Communiqué* articles is an indication of how contentious it will become. CAEP's reputation as the home for all physicians desiring to improve their skills and knowledge in emergency medicine will be destroyed.

P.R. Butt, MD
Saskatoon, Sask.

The President of CAEP responds:

The problem is that of finding the best method(s) to train emergency physicians (not necessarily family physicians working part time in the ED). This includes training for those who will ultimately practise emergency medicine in urban/community/tertiary centres as well as those practising in academic health centres. As an example, rather than have 2 systems, could the specialty be better served by a single training program that perhaps would allow for dual certification and an option for further fellowship training for those pursuing an academic interest? The task force is really charged with obtaining broad consultation on the issue and developing a plan for the future of training. There is no intent to eliminate one training program in favour of another. The intent is, rather, to look at the possibility of finding a single stream that builds on the strengths of the two.

The intent is, rather, to look at the possibility of finding a single stream that builds on the strengths of the two. [M.J.M.]

Au contraire, l'objectif est d'envisager une filière commune qui cumulerait les avantages des deux formations existantes. [M.J.M]

Michael J. Murray, MD
President, CAEP

To the editors:

Congratulations. Your recent articles on the current state of training in emergency medicine made for the liveliest reading in a CAEP journal I can remember for a long time. I was amused, however, by the references to the "philosophical purpose" of our current 2-track system as an attempt to accommodate both academic and practice-oriented careers. Funny, but what I remember is different and less noble than that.

I remember a group of physicians intent on forging their own discipline, passionate about their work and desperate for recognition of their field as a specialty. The Royal College seemed the natural body in this country to perform this function, although other avenues, including the American College, were also considered at the time. When the Royal College finally accepted emergency medicine as a specialty, the jubilation was muted by the realization that they had their own priorities. Anxious not to discredit themselves and their existing relationship with the other specialties, the Royal College

intéressés par la médecine d'urgence et qui constituent la majorité des adhérents à l'ACMU. À terme, il serait inopportun, voire impossible, que le CMFC tourne le dos à la médecine d'urgence car les médecins de famille continueront de prodiguer l'essentiel des soins dans les services d'urgence canadiens.

Je ne pense pas que le Conseil de l'ACMU y ait réfléchi, d'un point de vue stratégique ou même tactique. La réaction de ses membres dans le dernier numéro de *Communiqué* montre combien cette initiative est contestée. Après cela, l'ACMU pourrait ne plus être considérée comme une association qui s'adresse à tous les médecins qui souhaitent améliorer leurs compétences et leurs connaissances en médecine d'urgence au Canada.

P.R. Butt, MD
Saskatoon (Sask.)

Réponse du Président de l'ACMU :

Le problème est de trouver la ou les meilleures méthodes pour former les urgentologues (pas forcément des médecins de famille qui travaillent à temps partiel dans un service d'urgence). Il s'agit de former ceux qui se destinent à la médecine d'urgence en ville, au niveau communautaire ou dans des centres de soins tertiaires, ainsi que ceux qui exercent dans les centres hospitalo-universitaires. Ainsi, au lieu des deux systèmes existants, la création d'un seul cursus qui déboucherait sur un double certificat et offrirait une spécialisation pour ceux qui se destinent à l'enseignement ne serait-elle pas profitable à la spécialité? Le groupe de réflexion est justement chargé de recueillir les avis les plus divers sur la question et d'élaborer un plan pour l'avenir de la formation. Il n'a pas pour objectif de supprimer un programme et d'en favoriser un autre. Au contraire, l'objectif est d'envisager une filière commune qui cumulerait les avantages des deux formations existantes.

Michael J. Murray, MD
Président de l'ACMU

Aux rédacteurs :

Félicitations. Vos articles récents sur l'état actuel de la formation à la médecine d'urgence ont rendu passionnante la lecture du journal de l'ACMU. Les références à «l'objectif philosophique» de notre système actuel de double formation qui permettrait des carrières universitaires et axées sur la pratique m'ont fait sourire. C'est amusant, mais mes souvenirs sont bien différents et beaucoup moins nobles.

Je me souviens d'un groupe de praticiens passionnés par leur travail qui s'efforçaient de créer leur discipline et qui voulaient absolument faire reconnaître leur domaine comme spécialité. Le Collège Royal semblait l'établissement idéal pour remplir ce rôle, bien que d'autres institutions, notamment le Collège américain, aient été également envisagées. Lorsque le Collège Royal accepta finalement la médecine d'urgence comme spécialité, la prise de conscience que le Collège avait ses propres priorités ternit quelque peu l'enthousiasme. Soucieux de ne pas se discréditer et de ne pas nuire à ses relations avec

permanently excluded a large number of dedicated and competent practitioners with their rigid and often arbitrary barriers. Those who were accepted into the hallowed halls of the Royal College had limited bargaining power to deal with the situation, while those left outside who were still committed to practising emergency medicine were forced to find an alternate route to credibility.

I also remember that at that time the College of Family Physicians was itself struggling for recognition and survival. It had been formed during the late '60s by a disgruntled group of general practitioners because the Royal College hadn't shown any interest in furthering the education of GPs. In that sense the Royal College has always seen the newer College as a competitor, both for credibility, and more importantly, for training dollars. But the newly formed College of Family Physicians was, by that time, in trouble. Its 2-year residency program was being ignored by the majority of new graduates because no one had been able to convince any of the provincial licensing bodies (except Alberta) to make it mandatory. Without this requirement, an extra year over the standard rotating internship was seen by many as not worth the loss of income and career progression. Faced with their own credibility problems, the College of Family Physicians was not likely to turn their backs on a new group of disgruntled physicians looking for a group to join. Finding something in common between emergency and primary care was not difficult, and, since funding for Royal College programs fell far short of demand, the Family Practice College knew it stood eventually to gain an easy windfall in credibility based on numbers alone.

So here we are 15 years later with 2 training streams that divide the profession on the basis of political accident rather than direct intent. A cynic might be excused for suspecting that the separate "objectives" we now accept for the 2 were developed as an afterthought and are more of an excuse for the situation rather than a real intent. The fact is, no one in his or her right mind would have designed 2 separate streams that don't communicate with the other and don't build on what each has to offer. No wonder any "benefits" of the 2 systems have failed to materialize. Who really believes that simply adding more years to a training program is more important than either the quality of the people within the program, or the simple accumulation of experience? The end result is that we have been left with parallel systems that fail to take advantage of any synergism and have tremendous potential to divide our profession with elitism and suspicion.

Some people suggest forgetting about the past and going ahead to forge a new relationship between the 2 streams that allows people to choose the type of practice they want to do, and build on their previous training and experience. What? Something to benefit the practitioners and the public who receive their care, rather than the institutions involved? What

les autres spécialités, le Collège Royal exclut un grand nombre de praticiens dévoués et compétents en instaurant des barrières rigides et souvent arbitraires. Les heureux élus dans le saint des saints durent marcher droit, alors que les candidats malheureux qui souhaitaient toujours exercer la médecine d'urgence furent contraints de se rabattre sur une autre formation reconnue.

Je me souviens également qu'à cette époque, le Collège des médecins de famille se battait pour survivre et être reconnu. Il fut fondé à la fin des années 1960 par un groupe de généralistes mécontents que le Collège Royal n'ait pas voulu promouvoir la formation des généralistes. En ce sens, le Collège Royal a toujours considéré le nouvel établissement comme un concurrent, tant au plan de la crédibilité qu'à celui plus important des subventions. Mais à cette époque, le tout nouveau Collège des médecins de famille connaissait bien des déboires. La majorité des diplômés se détournaient de son programme de résidence sur 2 ans, car personne n'avait su convaincre les autorités provinciales qui délivrent l'autorisation d'exercer (sauf celles d'Alberta) de le rendre obligatoire. Sans cette condition, beaucoup considéraient une année supplémentaire après l'internat par rotation comme une perte d'argent et un report inutile du début de carrière. Aux prises avec ses problèmes de crédibilité, le Collège des médecins de famille n'allait certainement pas bouder un nouveau groupe de médecins mécontents. Il ne lui fut pas difficile de trouver un terrain d'entente entre la médecine d'urgence et les soins de santé primaires. Comme les financements pour les programmes du Collège Royal étaient loin de couvrir la demande, le Collège de médecine familiale a pressenti qu'il pourrait asseoir sa crédibilité sur le seul nombre de ses étudiants.

Voilà la situation actuelle, 15 ans après, avec deux cursus de formation qui divisent la profession sur des motifs politiques plutôt que sur des raisons de fond. On pardonnera à un esprit cynique de suspecter que les «objectifs» distincts attribués aux deux formations ont été définis après coup et sont davantage un prétexte pour justifier la situation actuelle qu'une volonté délibérée. En réalité, une personne sensée n'aurait jamais créé deux formations séparées et cloisonnées qui ne cherchent pas à profiter de leurs atouts mutuels. Il n'est pas étonnant que les «bénéfices» des deux systèmes ne se soient pas concrétisés. Qui pense vraiment qu'il est plus important de rallonger un programme de formation que de miser sur la qualité des étudiants ou l'acquisition de l'expérience? Nous nous retrouvons ainsi avec deux systèmes parallèles qui ne cherchent pas à générer des synergies et qui ont tout pour diviser notre profession sur des questions d'élitisme et de méfiance.

Certains proposent de tirer un trait sur le passé et d'aller de l'avant pour bâtir une nouvelle relation entre les deux établissements, afin de permettre aux candidats de choisir le type de médecine qu'ils souhaitent pratiquer, en tirant parti de leur formation et de leur expérience acquises. Comment? Une formule qui satisferait les praticiens et leurs patients plutôt que les institutions concernées? Quelle idée radicale! Le Collège des médecins de famille a beau jeu d'encourager cette approche, car il ne peut que profiter de ce rapprochement. Tout ce qu'il nous reste à faire,

No one in his or her right mind would have designed 2 separate streams that don't communicate with each other and don't build on what each has to offer. [L.V.]

Une personne sensée n'aurait jamais créé deux formations séparées et cloisonnées qui ne cherchent pas à profiter de leurs atouts mutuels. [L.V.]

a radical idea! The College of Family Physicians should be an easy sell, since they only stand to gain by a combined approach. Now all we have to do is find something in it for the Royal College. Something more than merely what's good for physicians and their patients, I mean.

Does anyone have any ideas?

Les Vertesi, MD
Vancouver, BC

To the editors:

I read Drs. Ducharme and Innes' front-page article in the Fall 1997 *CAEP Communiqué* concerning emergency medicine training with great interest. I also concur with Dr. Etherington's "An immodest proposal" (Winter 1997–98 issue), which suggested an integration of the FRCPC and CCFP(EM) streams.

As a recent CCFP(EM) graduate who is interested in academic emergency medicine I have found that there are virtually no opportunities available to expand my knowledge and skills through structured fellowships. In fact, there are very few such opportunities for FRCPC graduates in Canada.

...we have been left with parallel systems that fail to take advantage of any synergism and have tremendous potential to divide our profession with elitism and suspicion. [L.V.]

Perhaps this problem could be addressed by restructuring FRCPC programs along the lines of the model provided by internal medicine and pediatrics. These programs require 4 years of training before exams can be written. The 4th year can be a general clinical year or a fellowship year such as cardiology or gastroenterology. This training system has worked well for these programs for many years.

A similar structure could be designed for emergency medicine. For example, a resident might do 3 core years in Halifax and then subsequently do 1 or 2 years of toxicology fellowship in Vancouver prior to writing her exams. A resident who preferred to be a generalist could do a 4th clinical year prior to sitting his exams. This approach would provide FRCPC residents with a much greater opportunity to bring needed expertise to the departments they will eventually join.

In addition, this structure could be adapted to allow CCFP(EM) residents the opportunity to apply for additional clinical training, if desired, which could be designed to meet a required number of core rotations to sit a common exam with their FRCPC colleagues. CCFP(EM) graduates might then be considered candidates for fellowship training.

This approach would maintain the current CCFP(EM) programs that are crucial to emergency care in community and rural hospitals while adding strength and flexibility to existing FRCPC programs. It might also allow more physicians to be trained in emergency medicine by reducing the total length of training required to achieve the FRCPC or equivalent certification. (An exam administered by a separate College of Emergency Medicine, as suggested by Dr. Etherington, would reduce the inevitable conflicts with the Royal College over these proposed changes.)

c'est de trouver une bonne raison pour que le Collège Royal fasse de même. J'entends une raison plus valable que le simple intérêt des médecins et de leurs patients.

Toutes les suggestions sont les bienvenues.

Les Vertesi, MD
Vancouver (C.-B.)

Aux rédacteurs :

J'ai lu avec beaucoup d'intérêt l'article des Dres Ducharme et Innes sur la formation en médecine d'urgence qui a paru en première page du *Communiqué* de l'automne 1997. Je suis également du même avis que le Dr Etherington qui suggérait dans son article «Une proposition présomptueuse?» (Hiver 1997-98) une intégration des deux filières de formation, soit celles du FRCPC et du CCMF(MU).

En tant que membre du CCMF(MU) récemment certifié qui s'intéresse à l'enseignement de la médecine d'urgence, j'ai constaté que les possibilités de parfaire mes connaissances et mes habiletés grâce à une bourse universitaire sont pratiquement inexistantes. En fait, elles ne sont pas meilleures pour les membres certifiés par le FRCPC au Canada.

Nous nous retrouvons ainsi avec deux systèmes parallèles qui ne cherchent pas à générer des synergies et qui ont tout pour diviser notre profession sur des questions d'élitisme et de méfiance. [L.V.]

La restructuration des programmes du FRCPC s'inspirant du modèle de la médecine interne et de la pédiatrie pourrait être la solution à ce problème. Ces programmes requièrent quatre années de formation avant d'accéder aux examens finaux. La quatrième année peut être soit une année de pratique clinique générale, soit une année de formation en cardiologie ou en gastro-entérologie, par exemple. Ce système fonctionne fort bien pour ces programmes depuis des années.

Une structure semblable pourrait être établie pour la médecine d'urgence. Par exemple, un résident pourrait compléter les trois années de formation de base à Halifax pour terminer par une ou deux années de formation additionnelle en toxicologie à Vancouver avant de passer les examens. Un résident qui préfère la médecine générale aurait la possibilité de faire une quatrième année de travail clinique avant les examens. Cette approche offrirait beaucoup plus l'occasion aux résidents du FRCPC de mettre leur savoir fort recherché au service du département où ils travailleront éventuellement.

De plus, cette structure pourrait être adaptée pour donner la chance aux résidents du CCMF(MU) de poser leur candidature pour parfaire leur formation clinique, s'ils le désirent. Cette formation serait planifiée de façon à intégrer un certain nombre de stages de base obligatoires pour que les résidents du CCMF(MU) puissent ensuite passer un examen en même temps que leurs collègues du FRCPC. On pourrait alors considérer la candidature des membres certifiés par le CCMF(MU) pour une bourse universitaire.

Cette approche maintiendrait les programmes actuels du CCMF(MU) qui sont essentiels aux soins d'urgence au sein des hôpitaux ruraux et communautaires tout en ajoutant force et flexibilité aux programmes du FRCPC existants. La réduction de la durée totale de formation requise pour obtenir la certification du FRCPC ou l'équivalent permettrait de former un plus grand nombre de médecins d'urgence. (Un examen donné par un Collège

I believe a system similar to that described above would go a long way to unifying emergency medicine in Canada, without destroying the current programs. More importantly, it might help ensure that most Canadians have access to physicians with emergency training whether they live in cities or more rural locations.

Jock A.G. Murray, MD, CCFP(EM)
North Vancouver, BC

On the crisis in emergency medicine

To the editors:

Over the last few months, the media has been replete with articles and documentaries about overcrowded emergency departments. The public is getting the message that there is insufficient ED funding, that patients are backing-up in our emergency departments, and that care is being compromised.

But we all know the real reasons. ED overloading has little to do with department funding and it does not reflect an inability to deal with increasing patient volume and acuity. It has far more to do with the central management of our hospitals and the lack of priority given to ED patients who need admission. Our ability to cope with "incoming wounded" is compromised almost entirely by patients who are stuck in our departments awaiting beds on inpatient services. While the solution to this problem is not directly within our control, it is our responsibility to ensure that our administrators and medical advisory committees establish policies to protect the patients we serve.

The first step in resolving this issue is to secure the support of our medical and surgical colleagues. The way to do this is to ask them what aspect of medical care should receive the highest priority. Should it be elective medical and surgical services, or the care of urgent and emergent patients? Surely, this is a no-brainer! I suspect that few of our colleagues would refute the wisdom of providing emergency care. Once we have their agreement on the importance of adequate emergency care, we can argue that admitted patients in the emergency department consume valuable nursing resources and compromise the care of both emergent patients and other patients awaiting beds. No one believes that the ED is the right place to care for inpatients.

The next step is to develop institutional policies that give top priority to admitted patients in the emergency department. On any given day, if there are insufficient hospital beds to accommodate the anticipated number of ED admissions, then elective surgical admissions have to be cancelled. This has been the practice at our institution for several years, and it has resulted in patients being admitted to the emergency department fewer than half a dozen times each year!

The obvious question is: Are our volumes and acuities similar to other "overloaded" departments?

de médecine d'urgence distinct, tel que suggéré par le docteur Etherington, atténuerait les conflits inévitables avec le Collège Royal quant aux changements proposés.)

Je crois qu'un système comme celui que je viens de décrire favoriserait l'unification de la médecine d'urgence au Canada, sans détruire les programmes existants. Et surtout, il assurerait peut-être à la plupart des Canadiens l'accès à des médecins formés en médecine d'urgence, que ce soit en ville ou à la campagne.

Jock A.G. Murray, MD, CCMF(MU)
North Vancouver (C.-B.)

À propos de la crise de la médecine d'urgence

Aux rédacteurs :

Ces derniers mois, les médias, à grand renfort de documentaires, se sont fait largement l'écho des problèmes d'encombrement des services d'urgence. Le public prend conscience que les ressources allouées à la MU sont insuffisantes, que les patients s'entassent dans nos services et que la qualité des soins est remise en cause.

Mais nous en connaissons tous les véritables raisons. La surcharge de l'urgence n'est pas due au manque de crédits et ne traduit pas notre incapacité à gérer un nombre croissant de patients présentant des pathologies de plus en plus graves. Le problème est lié à la gestion centrale de nos hôpitaux et à des patients dont l'admission à l'urgence n'est pas considérée comme prioritaire. La présence à l'urgence de patients qui attendent qu'un lit se libère dans les autres services compromet gravement notre capacité à traiter les cas urgents. Même si la solution n'est pas directement entre nos mains, nous devons veiller à ce que nos administrateurs et les comités consultatifs médicaux mettent en œuvre des politiques qui protègent nos patients.

La première étape consiste à avoir le soutien de nos collègues médecins et chirurgiens. Pour ce faire, nous devons leur demander quel aspect des soins médicaux doit être prioritaire. S'agit-il des services médicaux et chirurgicaux non urgents ou au contraire des cas urgents? La réponse est évidente. Qui dénierait l'importance des soins d'urgence? Une fois obtenu leur accord sur ce point, nous pourrons leur expliquer que les patients admis par le biais de l'urgence mobilisent un personnel infirmier précieux et compromettent le traitement des cas urgents et des patients en attente d'un lit. Personne ne considère que l'urgence est le lieu adéquat pour soigner les hospitalisés.

L'étape suivante consiste à élaborer des politiques institutionnelles qui donnent la priorité absolue aux patients de l'urgence. Si les lits disponibles sont insuffisants pour les accueillir, les admissions dans les services chirurgicaux non urgents doivent être suspendues. C'est ainsi que nous fonctionnons depuis plusieurs années, avec pour effet que le nombre de patients admis par le biais de l'urgence ne dépasse pas la demie douzaine chaque année!

La question évidente est la suivante : le nombre de nos patients et la gravité des cas sont-ils comparables à ceux d'autres services «surchargés»? Il est indéniable que l'urgence du Victoria Campus du London Health Sciences Centre voit passer des patients présentant des

This approach would maintain the current CCFP(EM) programs that are crucial to emergency care in community and rural hospitals while adding strength and flexibility to existing FRCPC programs. [J.A.G.M.]

Cette approche maintiendrait les programmes actuels du CCMF(MU) qui sont essentiels aux soins d'urgence au sein des hôpitaux ruraux et communautaires tout en ajoutant force et flexibilité aux programmes du FRCPC existants. [J.A.G.M.]

Indeed, the ED at Victoria Campus of the London Health Sciences Centre does see patients with significant illness and injury. We treat 45 000 patients per annum and admit 15%. But our hospital administration has always considered the ED a top priority. Internists and surgeons may scream about their lack of beds, but giving priority to emergency patients serves our community best, and this is not something that can be reasonably questioned. Furthermore, the practice has led to same-day admission and shorter hospital stays for surgical patients, as surgeons make every effort to maintain their patient "through-puts."

There is no question that the sorry state of many emergency departments is related to health care cutbacks. But perhaps, in some cases, hospital administrators are using embattled emergency physicians and rows of gurneys as a visible symbol (to the media) of lack of funding. I believe that better management of our dwindling hospital resources can resolve the problem of admitted patients in the ED. However, we need to champion this more responsible solution.

Internists and surgeons may scream about their lack of beds, but giving priority to emergency patients serves our community best... [J.D.]

Les internes et les chirurgiens ont beau se lamenter du manque de lits, c'est en donnant la priorité aux urgences que l'on sert le mieux les intérêts de la collectivité... [J.D.]

Jon Dreyer, MD
Chief of Emergency Medicine
London Health Sciences Centre
London, Ont.

Editor's note: After reading the first half of this letter, I asked myself: "Is this Dreyer guy from another planet or does he just live in a dream world?" When I read the last half of the letter and realized he was describing something that has ACTUALLY HAPPENED, I asked myself: "Do they have any jobs at the London Health Sciences Centre?" Maybe it's just me, but it's hard to envision a world where emergency medicine isn't low woman on the totem pole. [G.I.]

To the editors:

Here in Nova Scotia we've developed a great new innovation in aeromedical transport. It's a wellness helicopter staffed with counsellors. We simply fly in and "prevent" things.

John Tallon, MD
Halifax, NS

Dear Abby (Grant):

Seven years ago, when I was ED Director at McMaster, the hospital closed a number of wards, and admitted patients started to back up in the ED — typically 13 to 15 patients for 1 to 3 days at a time. The ED nursing complement was held constant, so we looked after admitted patients as well as emergency patients — that is, when we could find a stretcher or a chair or a corner to put them in. We began having trouble getting consultants to come down to the ED because, they argued, there were no ward beds to admit patients to. The ED had one bathroom,

pathologies et des blessures graves. Nous soignons 45 000 patients par an et en hospitalisons 15 %. La différence, c'est que l'administration a toujours considéré l'urgence une priorité absolue. Les internes et les chirurgiens ont beau se lamenter du manque de lits, c'est en donnant la priorité aux urgences que l'on sert le mieux les intérêts de la collectivité, et personne ne peut sérieusement remettre en cause ce principe. De plus, cette pratique a favorisé les hospitalisations de jour et réduit la durée des séjours des patients opérés, puisque les chirurgiens font tout leur possible pour accélérer la rotation de leurs patients.

Il est indéniable que l'état lamentable de nombreux services d'urgence est dû à des coupes budgétaires dans les soins de santé. Mais dans certains cas, les administrateurs hospitaliers se servent d'urgentologues en colère et de rangées de civières roulantes comme symbole visible (pour les médias) du manque de ressources. Je pense qu'une meilleure gestion de nos maigres ressources hospitalières peut résoudre le problème des patients admis à l'urgence. Nous devons toutefois nous faire les chantres de cette solution plus adaptée.

Jon Dreyer, MD
Chef du service de médecine d'urgence
London Health Sciences Centre
London (Ont.)

Note du rédacteur : Après avoir lu la première partie d ce courrier, je me suis demandé : «Ce Dreyer vient-i d'une autre planète ou vit-il dans un monde idyllique? En lisant la seconde partie, je me suis rendu compte qu' décrivait une situation BIEN RÉELLE, et la question qu m'est venue à l'esprit fut la suivante : «Est-ce qu'ils recru tent au London Health Sciences Centre?» Je suis peu être une exception, mais j'ai du mal à m'imaginer u monde dans lequel la médecine d'urgence n'est pas l parent pauvre du régime. [G.I.]

Aux rédacteurs :

En Nouvelle-Écosse, nous avons beaucoup innové e matière de transport aéromédical. Nous utilisons un hél coptère avec à son bord des conseillers de santé. Les vo sont l'occasion d'organiser des séances de prévention.

John Tallon, MD
Halifax (N.-É.)

Chère Abby (Grant) :

Il y a sept ans, lorsque j'étais directeur de l'urgence McMaster, l'hôpital ferma un certain nombre de servic et les patients admis se retrouvèrent à l'urgence. En génér on comptait 13 à 15 patients qui restaient de 1 à 3 jou Comme le nombre d'infirmiers n'avait pas augmenté, no devions nous occuper des patients hospitalisés comr des cas d'urgence, à condition bien sûr de trouver u civière, une chaise ou un coin où les installer. Les médec consultants commencèrent à rechigner lorsqu'ils devai descendre à l'urgence, prétextant qu'il n'y avait pas de pour admettre les patients. Le service d'urgence était équ d'une seule salle de toilettes, il n'y avait pas de douc pas de salle pour accueillir les visiteurs ni d'équipeme

no shower, no facilities for visitors and no capacity to provide meals or scheduled medications.

Rather than line all these patients up in the halls of the ED, I suggested to administration and to the medical advisory committee that we distribute "overflow" patients to the wards. When the ED was holding more than 4 or 5 admitted patients, each ward would accept one "hall patient" and then, if necessary, a second, so that the "discomfort" of the overflow would be shared equally throughout the hospital. I argued that all patients would get better care that way and that the ED staff would be better able to fulfill their function and would be less frustrated. Also, we might avoid killing someone because of the constant chaos that overflow caused.

Funnily enough, I was the only one who thought this was a good idea. I eventually left, after being completely unable to institute any sort of real improvement in care (or attitude).

Why is chaos acceptable in the emergency department but nowhere else in the hospital? Why is it okay to "sacrifice" ED patients and staff for the good of the rest of the institution? Why do emergency physicians continue to expose themselves to the frustration of working in substandard conditions? And why am I even bothering to write this? (Especially since I now work in a wonderful semi-rural environment where my life no longer centres around emergency medicine.) Please Abby (Grant), tell me why I should still care.

Michael Shuster, MD
Banff, Alta.

Expanded-role nurses in the ED?

To the editors:

Expanded-role nurses? They're coming whether we support the concept or not! Many American EDs couldn't function without nurse practitioners and physician assistants. The key is to have medical involvement in the training of these individuals.

Dan Cass, MD
Toronto, Ont.

To the editors:

"Expanded nursing roles" are based on a nursing agenda and will not improve patient care. At our hospital we have difficulty getting nurses to perform traditional nursing duties (e.g., getting patients into a gown, preparing necessary equipment) so that patients can be treated expeditiously by the emergency physician. The idea of having a "nurse practitioner" see one patient per hour and do detailed nursing assessments is, in my opinion, counterproductive. The patients may enjoy an hour of TLC, but it would be a horrendous waste of health care dollars. (Consider the ludicrous increased cost of deliveries by midwives.) And, after all, I don't know too

pour servir les repas ou administrer les médicaments.

Au lieu d'aligner tous ces patients dans les couloirs de l'urgence, j'ai proposé à la direction et au comité consultatif médical de répartir les patients «en surnombre» dans les différents services. Lorsque le nombre de patients admis à l'urgence dépassait 4 ou 5, chaque service accueillerait un patient en attente, et si nécessaire un second, afin de répartir équitablement dans tout l'hôpital le surplus de patients et les problèmes que cela occasionne. Pour moi, cette solution profitait à tous les patients et le personnel de l'urgence pouvait mieux remplir son rôle en étant moins frustré. Nous pouvions également éliminer les risques de tuer quelqu'un du fait du désordre que provoque le trop grand nombre de patients.

Ironie du sort, j'étais le seul à trouver cette idée valable. Au bout du compte, j'ai quitté mes fonctions sans avoir réussi à imposer une véritable amélioration des soins (ou des comportements).

Pourquoi le chaos est-il acceptable à l'urgence et pas ailleurs dans l'hôpital? Pourquoi tolérer le «sacrifice» des patients et du personnel de l'urgence pour le bien des autres services? Pourquoi les urgentologues continuent-ils de supporter de travailler dans des conditions déplorables? Et à quoi bon prendre la peine d'écrire ce courrier (d'autant plus que je travaille aujourd'hui dans un milieu semi-rural très agréable où mon existence ne gravite plus autour de la médecine d'urgence). Abby (Grant), donnez-moi une bonne raison de m'intéresser encore à la question.

Michael Shuster, MD
Banff (Alb.)

Des super infirmières à l'urgence?

Aux rédacteurs :

Des super infirmières? C'est déjà le cas, qu'on le veuille ou non! De nombreux services d'urgence américains ne pourraient pas fonctionner sans le personnel infirmier et les auxiliaires médicaux. L'essentiel est que des médecins participent à leur formation.

Dan Cass, MD
Toronto (Ont.)

Aux rédacteurs :

Le concept de «super infirmières» est mis de l'avant par la profession elle-même et n'améliorera pas les soins aux patients. Dans notre hôpital, les infirmières rechignent déjà à exécuter leurs tâches classiques (ex. faire revêtir au patient une chemise d'hôpital, préparer les équipements nécessaires) pour permettre à l'urgentologue de traiter rapidement les patients. À mon avis, l'idée d'un «praticien infirmier» qui consacrerait une heure à chaque patient et évaluerait précisément les besoins en soins infirmiers est anti productive. Les patients apprécieraient sûrement une heure de soins dévoués, mais ce serait un terrible gaspillage financier (songez par exemple au surcoût énorme des accouchements pratiqués par les sages-femmes). De plus, je ne connais pas beaucoup de gens qui préféreraient être soignés par une infirmière que par un médecin. Et je

Why is chaos acceptable in the emergency department but nowhere else in the hospital? [M.S.]

Pourquoi le chaos est-il acceptable à l'urgence et pas ailleurs dans l'hôpital? [M.S.]

Expanded-role nurses? They're coming whether we support the concept or not! [D.C.]

Des super infirmières? C'est déjà le cas, qu'on le veuille ou non! [D.C]

many people who would rather be treated by a nurse than a doctor, given the choice. This is not to mention the adverse effect on medical student and resident education.

If we stick to our designated roles and work together as a team, patient care will be optimized. But if we condone the nurses' agenda to take over as much of our job as possible, while they remain unwilling to perform less glamorous tasks (traditionally nursing duties that no one wants to do now), we will be left with a less efficient health care system and fewer health care dollars available for patient care by physicians. We need to take a strong stand against this trend. It's the thin edge of the wedge, and there are more of them than us!

Name withheld by request

To the editors:

Nurse practitioners are coming, whether we like it or not. We can be proactive, or we can have it handed to us. I say we design the program and certification process, otherwise it will be done for us in a way we don't like.

Bruce Campana, MD
Riyad, Saudi Arabia

"Expanded nursing roles" are based on a nursing agenda and will not improve patient care.

Le concept de «super infirmières» est mis de l'avant par la profession elle-même et n'améliorera pas les soins aux patients.

ne mentionne pas les conséquences négatives sur la formation des futurs médecins et des résidents.

Si nous nous en tenons aux rôles établis et coopérons dans un esprit d'équipe, les soins aux patients s'amélioreront. Mais si nous nous déchargeons sur les infirmières du plus de travail possible, alors qu'elles rechignent à accomplir les tâches moins valorisantes (le travail traditionnel des infirmières que plus personne ne veut faire aujourd'hui), nous nous retrouverons avec un système de soins de santé inefficace et avec des ressources réduites à consacrer au traitement des patients par les médecins. Nous devons nous opposer fermement à cette tendance. Sinon ce serait s'engager sur une pente savonneuse qui nous mènerait à l'impasse.

Nom de l'auteur non communiqué sur sa demande

Aux rédacteurs :

Bon gré mal gré, nous entrons dans l'ère des praticiens infirmiers. Nous pouvons anticiper le changement ou tolérer qu'on nous l'impose. Soit nous organisons le programme et le processus de certification, soit on prendra à notre place des décisions qui ne nous plairont pas.

Bruce Campana, MD
Riyad, Arabie Saoudite

Hot new CAEP Web site is in the works

Jim Thompson, Chair, CAEP Web site Editorial Board

In February, CAEP President, Dr. Michael Murray, signed a contract with Conceptis Technologies of Montreal to begin building a hot new CAEP Web site. The site will have both public and member-only sections.

CAEP members will find many "value-added" services at the site, including access to information for diagnosing and treating patients, clinical practice guidelines, CAEP policies, slides for downloading into presentations, participation in live forums, enhanced function for committee members who find it hard to work across Canada's wide geographic boundaries, and links to all kinds of emergency medicine web sites.

Do you have material in electronic form for the Web site? Your submissions will be subject to approval by the CAEP Web site Editorial Board. Anything and everything will be considered. Send to:

jthompso@telusplanet.net

The site will be sponsored by tasteful commercials that will conform to CAEP's ethics policy for interactions with industry. Interested sponsors should contact Mr. Greg Ogrodnick:

greg@conceptis.com

LETTERS TO THE EDITORS

COURRIER DES LECTEURS

Emergency residency training

To the editors:

The Task Force on Emergency Medicine Training has received such harsh criticism from all quarters that one wonders whether the task force will be allowed to fulfil its mandate. Investigating the need for 2 separate streams of emergency residency training strikes me as an excellent idea. Particularly when I need to choose which stream to apply to this September.

As a medical student who will begin residency in 1999 (hopefully in emergency medicine), it is difficult to wade through the similarities and contrasts between the CCFP(EM) and FRCPC programs. How do the educational and practical experiences differ? How will I perform as an emergency physician 10 years from now? Although studies indicate that either route will be sufficient, how will my future career options be affected by my imminent choice? Will a CCFP(EM) residency meet job criteria for urban trauma centres or academic research positions 10 years from now?

I realize that the task force recommendations will come too late to influence my decision. Indeed, I have already decided. However, clarifying the myriad discrepancies between the 2 programs can only lead to a better understanding of their strengths and weaknesses. I can't be the only one who is confused. "Strong team player" is one of those qualities that all the programs seem to want in their future residents. Let's start demonstrating some of those qualities by working together to resolve the issues.

Sara Gray
UWO Meds '99

The crisis in EM

To the editors:

ED overcrowding is a system-wide problem that is largely due to underfunding and poor planning by governments, economists and misinformed health planners. Factors include a poor understanding of funding reallocation implications; co-optation of health planning by finance departments; inadequate long-term planning with respect to elderly care; inattention to population demographics; ignorance of health system needs for nurses, physicians and acute care beds; unfamiliarity with the role of new technology; and a basic lack of understanding of the health care industry.

The best approach is an evidence-based one (a

La formation en résidence à la médecine d'urgence

Aux rédacteurs :

Le groupe de réflexion sur la formation à la médecine d'urgence a été si violemment critiqué de toute part qu'on peut se demander s'il pourra mener à bien sa mission. S'interroger sur la nécessité de deux cursus de formation en résidence à la médecine d'urgence me semble une excellente idée, d'autant plus que je dois choisir mon orientation en septembre.

En tant qu'étudiante en médecine qui commencera sa résidence en 1999 (je l'espère en médecine d'urgence), j'ai du mal à m'y retrouver dans les similitudes et les différences entre les programmes CCMF(MU) et FRCPC. En quoi la formation et la pratique diffèrent-elles entre ces deux cursus? Quelles seront mes compétences en tant que médecin d'urgence dans dix ans? Bien que les études montrent que les deux formations sont de qualité, en quoi ma décision aujourd'hui influencera-t-elle mes options de carrière futures? Une résidence CCMF(MU) remplit-elle les critères professionnels pour travailler dans les centres de traumatologie urbains ou postuler à un poste d'enseignement universitaire dans 10 ans?

Lorsque les recommandations du groupe de réflexion seront connues, j'aurai déjà pris ma décision. En fait, j'ai déjà fait mon choix. Cependant, clarifier les innombrables différences entre les deux cursus ne peut qu'améliorer la compréhension de leurs atouts et de leurs faiblesses respectives. Je ne suis certainement pas la seule à m'interroger. «Savoir travailler en équipe» est l'une des qualités que tous les programmes semblent vouloir inculquer à leurs futurs résidents. Faisons déjà preuve de ces qualités en coopérant pour résoudre les problèmes.

Sara Gray
UWO Meds '99

À propos de la crise de la médecine d'urgence

Aux rédacteurs :

Le surpeuplement de l'urgence est un problème structurel largement imputable au manque de financement et à une mauvaise planification des pouvoirs publics, des économistes et de responsables de la santé mal informés. Les raisons sont notamment les suivantes : mauvaise compréhension des conséquences de la redistribution des ressources; cooptation des services de planification de la santé par les services financiers; planification à long terme, inadaptée pour les soins aux personnes âgées; non prise en compte de l'évolution démographique; ignorance des besoins du système de santé en infirmiers, médecins et lits de soins intensifs; méconnaissance du rôle des nouvelles technologies; impossibilité de percevoir les soins de santé comme un secteur économique à part entière.

Let's start demonstrating some of those qualities by working together to resolve the issues. [S.G.]

Faisons déjà preuve de ces qualités en coopérant pour résoudre les problèmes. [S.G.]

Emergency medicine training in Canada

Kieran Moore, MD; Cindy-Ann Lucky, MD

SUMMARY: Canada is the only country with two colleges governing emergency medicine (EM) certification. Does this serve us well or does it divide us and our resources? If most CCFP(EM) graduates practise strictly EM, with no family or rural practice, then reform in the certification process may be necessary. At the same time, FRCPC residencies seem excessively long and lack the numbers to develop "critical mass." Shortening the length of training would allow more residency positions to be created, thus advancing the goal of optimum emergency care for the Canadian public. Canadians deserve one standardized, certified, accredited EM training program that produces the highest quality emergency physicians.

RÉSUMÉ : Le Canada est le seul pays où deux collèges régissent la certification en médecine d'urgence. Cette situation est-elle à notre avantage ou crée-t-elle une division de nos médecins et de nos ressources? Si la plupart des diplômés CCMF(MU) pratiquent strictement la médecine d'urgence, sans pratique familiale ou rurale, il faudrait peut-être alors songer à revoir le processus de certification. En même temps, les résidences du (FRCPC) semblent excessivemnt longues et les résidents sont en nombre insuffisant pour créer une «masse critique». Le fait de raccourcir la durée de la formation permettrait de créer un plus grand nombre de postes de résidence, et de faire progresser par le fait même l'objectif qui est d'offrir des soins d'urgence optimaux à la population canadienne. Les Canadiens méritent les soins de médecins d'urgence du plus haut calibre issus d'un seul programme de formation en médecine d'urgence normalisé, certifié et accrédité.

Introduction

Canada is the only country with two colleges governing certification in emergency medicine (EM). Does this serve the specialty of emergency medicine appropriately or does it divide the specialty and its resources?

To address this question we reviewed the emergency medicine accreditation guidelines of the College of Family Physicians of Canada (CFPC)[1] and the Royal College of Physicians and Surgeons of Canada (RCPSC).[2] In addition, we interviewed key representatives from both colleges, compared Canadian accreditation guidelines to those of the American Board of Emergency Medicine and reviewed the literature on EM accreditation, certification and training.

The two colleges

It is admirable that, in 1982, the CFPC introduced a certification of Special Competence in Emergency Medicine — the CCFP(EM). The CFPC's *Accreditation and Certification Guidebook*[1] expressed the desire to optimize Canadian emergency care delivery and noted that much emergency care was [and still is] provided by family physicians, especially in nonurban environments.

In its accreditation guidelines, the CFPC recommends that during the extra year of training: 1) family physicians provide a significant portion of the clinical care and take direct responsibility for residents' education and teaching; 2) experience in a rural setting be available; and 3) residents be trained to assume leadership roles in improving services and monitoring the quality of community-based emergency medical care.

The stated goals of the CCFP(EM) program are: to improve the standards and availability of emergency care from practising family physicians; to establish guidelines for the development and administration of emer-

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gency medicine training programs; and to ensure the availability of preceptors in emergency medicine.

According to 1997–98 CFPC figures, there are 734 physicians registered as CCFP(EM), of whom 486 were practice eligible and 445 residency trained. The Canadian Medical Protective Association (CMPA) states that between 1500 to 2000 Canadian physicians are registered as full-time emergency physicians. The RCPSC states that, between 1987 and 1996, 138 physicians graduated from Royal College emergency medicine residency programs. Of 374 graduates of the Royal College certification process, 360 are fellows and 307 are practising in Canada.

The CFPC should review their special competency guidelines and consider the product that they are creating and certifying. If the result is physicians who practise only EM with little or no rural experience and few family physician preceptors, then the stipulated objectives are not being met. Reform in the certification of Special Competence in Emergency Medicine may be necessary. It would appear that Canadian emergency medicine practice is becoming a specialty that is in need of re-evaluation of its residency programs and certification processes.

At present, the specialty of family medicine "hyphenates" itself with other specialties such as emergency medicine, anesthesia and surgical obstetrics, thereby creating a parallel to RCPSC programs. The ongoing discussions regarding EM training reflect directly on the overall goals of the CFPC. Will there be continuing expansion of the current CFPC accreditation process or will this stop with the realization that family medicine is a specialty with a need for more than two years of training? Special Competence training could be coordinated and certified with the RCPSC disciplines. This would diminish bureaucracy and administrative expense. More importantly, it would give family medicine the respect that it is due as a specialty.

A decision on this matter would also help resolve the issue of dual EM training pathways. If the CCFP(EM) process is creating, in the vast majority of cases, full-time emergency physicians, then noble intentions need to be revisited. On the other hand, the RCPSC must also evaluate its residency training program to see whether it is meeting the requirements of the American *Graduate Medical Education Directory for Emergency Medicine*.[3]

US EM programs have existed since 1972. Currently, there are 119 US emergency medicine residency programs, with 3239 residents in training.[4,5] In contrast, RCPSC emergency medicine training programs have a total of 87 residents, with 5 in their 5th post-graduate year and 24 in their 4th post-graduate year. This year, the CFPC expects 61 residents and 70 practice-eligible candidates to sit their CCFP(EM) exam.

Canada is the only country with two colleges governing certification in emergency medicine.

Each US program requires a minimum of 6 residents per year of training in order to: 1) achieve a major impact in the emergency department; 2) assure a meaningful conference schedule; 3) provide progressive responsibility and; 4) foster a sense of residency program and department identity. US residency programs are 3 years, and any program that extends beyond this must present a clear educational rationale. Why should the RCPSC training program differ? And further, do any of the current Canadian programs truly achieve the 4 US objectives listed here? With respect to faculty, a minimum of 6 physicians should be devoted to providing leadership and resident supervision. Amalgamating the teaching faculties from the current two tracks in Canada may help meet this requirement.

Training and certification

Some authors recommend re-evaluating the length of EM training in Canada,[6–8] and some suggest moving to a shorter program with the option of postresidency fellowship years in areas of special interest, such as trauma, research, disaster medicine, toxicology or administration. Shortening the length of training would allow more residency positions to be created, thus advancing the goal of providing optimum delivery of emergency care to the Canadian public. Creating a separate college for emergency medicine is an option, but the question remains whether it is cost efficient to create another bureaucracy. The RCPSC is the certifying body for specialists in Canada and should be maintained as the certifying body for EM, but change is necessary.

The certification process should be open to practice-eligible candidates. In Canada, EM can still be practised by a physician with a general licence, and, based on the figures discussed above, there may be up to 1000 physicians who are not certified by either

college delivering full-time emergency care. In spite of this, neither the provincial colleges nor many of the hospital credentialling committees, although entrusted to promote quality care for the public, have set definite or specific standards for EM providers.

Organizations such as the RCPSC, the CFPC, the Canadian Association of Emergency Physicians (CAEP) and the provincial colleges should meet to discuss the certification process. This would be a way of establishing minimum knowledge standards and ongoing CME requirements. Physicians could have portability of certification across Canada, and the public could expect to receive care from qualified emergency physicians who have achieved a specified level of competence.

The current debate regarding the future of EM residency training is very important if we are to assure the delivery of certified, appropriately trained physicians to Canadian emergency departments. We must acknowledge the fact that most physicians who provide emergency care in this country belong to neither college. Whatever process we develop, it must include these noncertified physicians and must encourage them to participate in the decision-making process. In the interest of quality care for Canadians, certified emergency physicians should be magnanimous; they should be willing to accept and certify practice-eligible physicians who are not "formally trained." Canadian citizens have a right to certified emergency care; until the number of graduating EM residents equals or surpasses the number of physicians leaving the field, this will not be the case. This raises the issue of manpower needs and begs the question: Should further EM residency positions be made available?

Models could be developed to predict the number of residents necessary to maintain a steady-state work force. The eventual standard for entry into an emergency medicine position should be residency training and EM certification. If we plan appropriately and maintain high-quality patient care as our goal, emergency medicine can rise above the current political debate and agree upon common guiding principles.

Conclusion

Emergency medicine is a specialty. One voice should represent Canadian EM at all levels. Currently, CAEP best represents this voice. There are over 1000 CAEP members, representing every province and territory. CAEP must maintain its focus on optimal patient care in the emergency departments of this country and on the emergency health care needs of the Canadian public. Our citizens deserve one standardized, certified, accredited EM training program that produces the highest quality emergency physicians. While the RCPSC and CFPC discuss reforms, we should not lose sight of this goal.

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Building a national organization of future emergency medicine physicians

Jason R. Frank, MD

Resident interest in emergency medicine (EM) is on the rise. Each year, postgraduate matches add to the ranks of Canadian EM residents, and the Canadian Association of Emergency Physicians (CAEP) Residents' Section (RS) continues to expand. The numbers are inspiring. This year, 16 residents accepted Royal College EM postgraduate year-1 (PGY-1) slots. Many more began their CCFP(EM) PGY-3 year, and this doesn't include the residents who matched separately to EM training programs in Quebec. At the same time, the Canadian Resident Matching Service (CaRMS) matched about 433 new Family Medicine residents and 63 new Pediatrics residents. A significant number of these groups will also go on to develop interests and skills in EM.

There is a large and expanding pool of EM residents. This expansion has fuelled parallel growth in the CAEP Residents' Section. As of January 1999, the Residents' Section's 161 resident members and 13 medical student members accounted for 13% of CAEP membership and included a significant proportion of all Canadian EM residents. If we can harness this talent and enthusiasm, our numbers give us an unprecedented opportunity for development of the Canadian EM residency experience. Consider that EM residents share many common interests, including an enjoyment of EM work, a desire to become the most effective clinicians possible, an interest in maximizing residency experiences, an interest in working toward an optimal practice opportunity, the need to improve our understanding of EM research, and a stake in furthering the specialty of EM in Canada.

Through the CAEP RS, we can build a national network of EM residents and help make the most of our residency education. We should expand our role in, and take full advantage of *CJEM*, the CAEP annual conference, and general CAEP activities. *CJEM* is a forum in which residents can discuss important EM issues, communicate our concerns to other emergency physicians, share our residency experiences, and proudly publish our research. The annual conference provides an opportunity to network with other residents, present research projects, and — as of this October — play hockey against EM faculty! Through CAEP's Residents' Section, we can create national projects of interest to EM residents and help guide the evolution of Canadian EM.

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A Call for Papers

The Resident Issues section of *CJEM* is a forum for discussion of topics of particular relevance to emergency medicine residents in Canada. *CJEM* extends a special invitation for submissions by individuals and groups of authors of papers on the following topics:

- Reports on curriculum developments in EM residencies
- Resident research
- Featured electives
- Opinion pieces on a resident issue

Residents, this is your section of *CJEM* and your opportunity to publish your ideas and analysis!

For submissions and further information, contact:

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Emergency medicine training in Canada: a different perspective

To the editor:

In the last issue of *CJEM*, Moore and Lucky argued for a unified emergency medicine (EM) training pathway.[1] But the matter may be more complex than it seems. Concerns revolve around manpower problems, postgraduate training issues and national certification, and we must consider both sides of the argument.

EM, like Pediatrics, is not practised exclusively by FRCP(C) specialists. Based on geographic, medical, fiscal and political realities, family physicians and CCFP(EM) certificants will continue to provide much of Canada's emergency care. Interestingly, ED directors[2] do not identify either training path as the sole desirable one.

A 1996 manpower study suggests that by 2001 Canada will face a shortage of 562 trained emergency physicians.[2] Demand for individuals with any type of EM training will be high, and the majority of graduates (from both programs) will be recruited into full-time urban EM practice. Contrary to opinions held by some, this does not reflect a failure of either College in terms of educational philosophy or certification process. It is simply a reflection of marketplace reality.

One solution is to expand Royal College training programs and make smaller increases in CCFP(EM) programs. This would address urban needs but would not provide solutions for small towns or rural areas. The ongoing review of rural family physician training, however, is a step in the right direction that will help clarify and remedy rural problems. In addition, the urban (family physician) curriculum requires re-examination: it is important for all primary care physicians to attain a level of emergency care competence. I agree with Drs. Moore and Lucky that, in comparison with other English-speaking countries, our two-year family medicine training program is too short, but this should not prevent others from respecting family physicians. It is a matter of professional courtesy and simple decency.

Moore and Lucky suggest that, in terms of educational objectives and accreditation processes, both colleges have failed to meet objectives. But the evidence these authors provide is less than convincing. Their conclusion that the Canadian College of Family Physicians (CFPC) needs to review its objectives and certification process was based on two clauses taken (out of context) from the Residency Program Accreditation and Certification book.[3] A careful reading of the reference does not support the conclusion made.

The educational model they suggest for Royal College programs is similar to the US model, both in scope and length, but this is not a realistic solution for Canada, where workloads differ, where system resources are limited, and where the supervision provided by attending physicians is unlike that in the US. Nor is it feasible to blend the two Canadian educational tracks; the funding formula for postgraduate medical education precludes this. There is an obvious need for monitoring of educational parameters such as training objectives, training duration and educational outcomes, and these expectations are included in the mandate of both colleges. The implementation of the joint accreditation survey of emergency programs is a step in the right direction. The Canadian Association of Emergency Physicians (CAEP), the national body representing all practising emergency physicians, has a limited role in this educational process. Another proposed solution is the establishment of a separate college for emergency medicine. However, this is impractical, and there is neither the need nor the political will.

Most would agree that practising emergency physicians, including those without residency training, should be eligible for national certification. Since 1995, the CCFP has implemented a formal process that addresses this problem. This avenue for national certification of family physicians will remain open for the foreseeable future, and the role of CAEP and the emergency physician community in this area is limited.

Clearly we all have a keen and sincere interest in the advancement of emergency medicine in Canada. Some of us perceive the manpower, educational and national accreditation issues differently. The coin does have two sides.

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Schedule of CAEP Meetings
for the
1999 CAEP/AMUQ Annual Scientific Assembly

Monday, October 25, 1999

Meeting	Time	Location	No. of attendees	Comments
Meeting of the Program Directors	1900 – 2100 hrs			Meeting with FRCPC Program Directors

Tuesday, October 26, 1999

Meeting	Time	Location	No. of attendees	Comments
Meeting of the Program Directors	during daytime			Meeting with FRCPC Program Directors
Opening Cocktail	1700 – 2000 hrs	Hilton Québec – Panorma Rm		
Arrhythmia Roadshow Faculty	1800 hrs	Restaurant in Québec City	9	Arranged by Wyeth

Wednesday, October 27, 1999

Meeting	Time	Location	No. of attendees	Comments
Board Meeting – luncheon	1130 – 1330 hrs	Hilton Québec – Salle Ste Foy	12	
Pediatric Section Meeting	1630 – 1800 hrs	Convention Ctr – Room 207	10	Coffee & juice provided
Standardized Program in EM Undergraduate Curriculum	1630 – 1800 hrs	Hilton Québec – Salle Ste Foy	15	Contact: Audrey Hunt for Mike O'Connor (613) 549-6666 X4515
CME Committee	1630 – 1730 hrs	Convention Ctr – Room 301 AB		
EMS Committee	1630 – 1730 hrs	Hilton Québec – Salle Portneuf		
President's reception (cocktail)	1730 – 1900 hrs	Hilton Québec – Salle Villeray	100 +	Drinks and appetizers provided
Private CAEP/AMUQ Board & Spouse	1930 -		60 +	

Specialists, guidelines and turf battles

To the editor:

I enjoyed reading the July 99 issue of *CJEM*. Thank you for a thought-provoking and diverse spread of articles. I found the discussions[1–9] about guidelines and "turf battles" fascinating and, in many ways, familiar. The Australasian College for Emergency Medicine (ACEM) has faced similar issues and processes.

ACEM produced a policy for the ED sedation procedures in November 1997. Although there was wide consultation during the formulation of the guidelines, including from our anesthetic colleagues, we did not seek endorsement from any other body. Recently, ACEM adopted a position statement regarding the use of focused ultrasound in the ED. Again, we did not seek the endorsement of any other specialty group.

I see a clear link between the way we define our "specialism" and the confidence with which we can make statements about standards. Unless we claim confident ownership of our legitimate turf, we will always be seen as "Jack of all trades and master of none." Why would another specialist body want to endorse our position papers if we are not confident that we own the territory? If we ask for endorsement, aren't we really saying that we want their permission to make our own statement about an area that is really theirs?

So, is there legitimate specialist territory that belongs to us alone? I believe that the definition of our specialty lies in a system of practice rather than a body of knowledge. Sure we know a lot about toxicology and environmental injuries, but so do others. Where we are uniquely specialized is in the reception, triage, assessment and initial management of multiple undifferentiated patients presenting simultaneously, throughout the spectrum of diagnoses and age groups, and with a minimum of background information. This territory is unique to us, and only we understand it well enough to make statements about how practice should occur within it.

Of course we must use knowledge or expertise developed by other specialists. However, we must then translate those principles into rational and realistic guidelines that are appropriate for our setting. When we sedate patients for procedures in the ED we are practising emergency medicine, not anesthesia. In the same way, an anesthetist reading a preoperative ECG is practising anesthetics, not cardiology. When we use focused ultrasound to evaluate the abdomen of a trauma patient we are practising emergency medicine, not radiology (just as we are when we interpret plain x-rays).

In relation to focused ED ultrasound, the answer to the question "why aren't we allowed to use it?" must surely be "you can do anything you like, as long as you are answerable for the consequences." The standards of training and practice must be appropriate for the setting, and the procedure and consequences must be subjected to the same quality control processes that we would apply to the interpretation of plain radiographs or the decision to use thrombolysis in ED.

We need to behave, speak and think with enough confidence in our own specialty that other specialists will understand that we have no need to invade theirs. At the same time, we must approach them with the respect and recognition that we would wish expressed towards ourselves.

Sue Ieraci, MD, FACEM
Vice-President and past Chair
of Standards Committee
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for Emergency Medicine

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A Canadian approach?

To the editor:

Congratulations on the launch of *CJEM*. This journal represents a landmark achievement in Canadian emergency medicine and is long overdue. It's important for us to realize that the US approach is not the only standard of care, and perhaps not the best one. Finally Canadian emergency physicians will have an alternative to the legally-driven, overly investigation-oriented USA style of practice. *CJEM* will enable us to publish our own standards of care, guided by logic, evi-

dence and common sense rather than by the Bar Association, the National Rifle Association, commercial interests and big industry. In addition, *CJEM* is showing us that medical journals don't have to be dry, with a stiff upper lip. An informal approach that is intellectual and, at the same time, humorous, provides the ideal format for learning. Congratulations on a job well done.

Anurag Saincher, MD
Surrey, BC

ED ultrasound

To the editor:

I wish to address comments made by Drs. Ducharme and McPhee in the July issue of *CJEM*.[1,2] Their comments on the use of ED ultrasound (ED U/S) seem to reflect common misconceptions about this important diagnostic tool. These doctors suggest that the amount of training required to perform ED U/S is prohibitive and that, to meet the requirements of the Canadian Association of Radiologists, a great deal of EM residency time would have to be reallocated. This might be true if the purpose of such exams was to delineate specific pathologies or disease processes. But ED U/S exams were never intended to be definitive evaluations, which are far too time intensive to be practical in the busy ED setting. On the contrary, ED U/S is meant to provide rapid answers to specific questions, such as: Is there free fluid in the abdomen of this trauma patient? Is there an intrauterine pregnancy in this woman with suspected ectopic? and Does this hypotensive patient have an abdominal aortic aneurysm?

To avoid confusing ED U/S with the comprehensive exams carried out in the radiology suite, I propose that we refer to the former as EMERGENT scans.[3] Emergent scans are performed by **E**mergency physicians, are **M**edically indicated, occur in the **E**mergency department, are **R**apid, **G**oal directed, **E**vidence-based, **N**ot difficult and will decrease **T**ime to diagnosis. Less training time is required to master EMERGENT scans. The Society of Academic Emergency Medicine recommends only 40 hours of didactic teaching and by 150 clinically-indicated examinations.[4] This could easily be accomplished during a 5-year EM residency and might even be possible within the CCFP(EM) curriculum.

Importantly, the recognition of the EMERGENT scan as distinct from the definitive radiology U/S should facilitate a more open dialogue with our radiology colleagues. Perhaps if radiologists realized that EMERGENT scans are not a threat to their incomes, then a more collegial interaction could occur.

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EM training

To the editor:

I am pleased that Dr. Steiner, in the July issue of *CJEM*,[1] responded to our article.[2] He made several interesting points, but I am less than convinced by his arguments. Steiner refers to two clauses in the CCFP Residency Program Accreditation and Certification book that were, in his opinion, taken out of context. This has not been the view of others (from whom Dr. Moore and I have received positive feedback), so I guess interpretation remains a judgement call. In any case, it's clear that the coin does have two sides and that, for now, we'll agree to disagree.

The important issue is to ensure the continuing positive evolution of Canadian emergency medicine. As long as this remains our primary goal, then let the debate continue.

Cindy-Ann Lucky, MD
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Esophageal detector devices and children

To the editor:

Rhine and Morrow[1] suggest that the esophageal detector device (EDD) is a useful adjunct for confirming tube placement in adults. It may be less accurate in young children.

The EDD was evaluated in 20 children under 1 year of age undergoing elective surgery.[2] All were intubated and had a second ET tube placed into their esophagus. An observer, blind to tube placement, was then asked to use a modified EDD and aspirate from one of the tubes. Esophageal tube placement was identified correctly in 7 of 10 cases and tracheal tube placement in 8 of 10 cases, giving an overall failure rate of

25%. The authors suggest that failure to recognize esophageal placement could occur if gastroesophageal reflux or hiatus hernia allow gas to be aspirated from the stomach, if the esophageal tube is passed into the stomach, or if the esophagus doesn't readily collapse and form a seal around the tube. Failure to confirm tracheal tube placement could occur if young childrens' more flexible tracheal rings fail to hold the airway rigidly open or if the tracheal mucosa collapses over the tube when negative intraluminal pressure is applied.

Relying on the EDD to confirm proper placement of an ET tube in young children may be dangerous.

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Propofol for sedation

To the editor:

In the July issue of *CJEM*, Innes stated that he was unaware of any Canadian emergency physicians who are permitted to use propofol.[1] In fact, we have used propofol for procedural sedation and as an induction agent for intubation since 1995. Among our emergency physicians it has become the agent of choice (in combination with appropriate analgesia), particularly for orthopedic procedures. Although we have not been tracking its use, we are unaware of any adverse outcomes. Due to its rapid onset, short duration, and ease of titration, we find it easier to employ when one physician performs the procedure while another manages the sedation.

We have been performing policy-driven conscious sedation since the mid-1980s. Our procedural sedation policy was written in consultation with our Anesthesia Department and has their approval. Although the policy does not refer to the use of specific agents, our anesthetists have not objected to our use of propofol. In fact, they (and our surgeons) have grown to expect it and depend on it!

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Correction

In Dr. Del Donald's Letter to the editor[1] in the July 1999 issue of *CJEM*, we mistakenly gave Sudbury, Ont., as Dr. Donald's city of practice. Dr. Donald practises in Sarnia, Ont. We apologize for this error.

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Manpower crisis in emergency medicine: Can residency programs make an impact?

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RÉSUMÉ : Une étude sur la main-d'œuvre canadienne menée en 1994 avait prédit une pénurie à l'échelle nationale de 562 médecins d'urgence qualifiés avant 2001. Plusieurs facteurs ont changé depuis la publication de ces données; cependant, aucun n'a changé l'ordre de grandeur de cette pénurie. À la lumière de ces renseignements, on a étudié la situation de la Edmonton Capital Health Region (CHR) et évalué l'impact des programmes de résidence en MU de l'Université de l'Alberta (CRMC [Collège Royal des médecins et chirurgiens du Canada] et CMFC [Collège des médecins de famille du Canada], créés en 1992) sur les besoins locaux en main-d'œuvre.

Le nombre de médecins d'urgence certifiés dans la CHR est passé de 9 du CRMC-MU et 2 du CMFC-MU en 1990 à 14 du CRMC-MU et 16 du CMFC-MU en 1999, soit une augmentation de 27 %. Le gain le plus important provenait du recrutement de 14 diplômés en médecine d'urgence de la région; cependant, malgré ce succès, et même avec un recrutement de 100 % des diplômés de l'Université de l'Alberta, on constate encore une pénurie importante de médecins d'urgence dans la CHR.

Cette situation n'est pas unique. Elle est le résultat d'un nombre insuffisant de postes de formations en médecine d'urgence au Canada. La seule solution possible à long terme serait d'augmenter considérablement le nombre de postes de résidence du CRMC tout en maintenant, et dans certaines juridictions en augmentant, le nombre de diplômés du CMFC.

Key words: manpower, emergency medicine, residency programs

Background

During recent years, US and Canadian emergency medicine (EM) workforce studies have been published.[1–3] A 1994 manpower study[3] suggested that by 2001, Canada will be short 562 qualified emergency physicians; however, for several reasons, this prediction may not be accurate. First, it is difficult to gauge how the changing health care environment will modify the demand for emergency physicians. Second, since the 1994 publication, the number of Canadian entry-level EM training positions (RCPSC and CFPC) has increased from 60 to 101 per year.[4] Third, while some Canadian emergency physicians are leaving the country, others are returning after completing US residencies, and transborder fluxes are difficult to quantify. Finally, the College of Family Physicians of Canada's (CFPC) practice-eligible certification option has offered an additional avenue to EM certification.[5] In our opinion, however, these variables have not substantially altered the manpower shortfalls predicted in 1994.

In light of this background information, and given the recent establishment of two EM residency programs in Edmonton, we performed a manpower review to determine the future needs for emergency physicians in the Capital Health Region (CHR), which includes metropolitan Edmonton and its surrounding municipalities.

From *the Department of Family Medicine and †the Division of Emergency Medicine, University of Alberta, Edmonton, Alta.
Presented on Feb. 1, 1999, to the Faculty of Medicine and Alberta Health Care — Rural Physicians Action Plan Committee.

A Northern Alberta perspective

In 1990, the University of Alberta Faculty of Medicine created the freestanding Division of Emergency Medicine. At this time, a manpower review indicated that, of 55 emergency practitioners, 9 (16%) were Royal College certified, 2 (3%) were CCFP-EM certified and 44 (80%) had CCFP or other qualifications. Subsequent efforts to recruit trained and certified emergency physicians proved unsuccessful. Between 1990 and 1992, perhaps related to the lack of local residency programs and the geographical location of Edmonton, only 3 individuals were recruited and only one of these physicians practises in Edmonton today.

Edmonton's two EM residency programs were launched in 1992. Our first residents enrolled in the 1993–94 academic year and graduated in 1994 (CFPC-EM) and 1996 (RCPSC) respectively. The Royal College of Physicians and Surgeons of Canada (RCPSC) program accepts 3 residents each year, but the situation with our CFPC-EM program is more complex. Between 1993 and 1997, all CFPC-EM positions were reserved for physicians who agreed to relocate to rural or regional Alberta centres. Since 1997 the situation has changed: we now have 3 rural track positions and 2 unrestricted positions.

In January 1999, to assess the impact of our residency programs and to estimate our current emergency physician resources and future needs, we conducted a follow-up manpower survey. The 1999 survey identified 63 practising emergency physicians who comprise the bulk of clinical and academic EM faculty. The number of certified EM physicians has increased from 11 in 1990 to 30 in 1999, and the largest growth is in the CCFP-EM category (Table 1). A substantial proportion (43%) are 45 years or older.

While we still have a long way to go, our success in recruiting local EM graduates and other certified emergency physicians has increased since 1993 (Table 2), and the general profile has shifted significantly toward certified emergency physicians. It is noteworthy that the CFPC-EM graduates who left generally did so because of their contractual commitment to practise outside large urban centres.

The CHR EM Program Council recently addressed current and 5-year manpower needs for the region and concluded that there is an immediate need for 16.65 full time equivalent (FTE) positions and that, in 5 years, there will be an additional need for 16.75 FTE positions. The 33.4 FTE positions include 23 clinical, 2 administrative, 3.65 teaching and 3.75 research. Our current annual residency output is 3 RCPSC and 2 (urban-eligible) CCFP-EM physicians. Even in a best-case scenario, if we successfully recruit all 25 local graduates into full-time practice over the next 5 years, there will be 8.4 unfilled FTE positions.

Is this shortfall an isolated phenomenon specific to the CHR? We suspect not. While US residencies graduate 1039 emergency specialists annually,[2] Canadian residencies graduate about 20 RCPSC and 80 CCFP-EM physicians respectively.[4] The number of Royal College EM residency positions is 5 times lower (per capita) than the number of US EM positions. These statistics are troubling because they suggest that our substantial manpower shortfall is likely to continue. They also clarify how and why CFPC emergency medicine programs — which were designed to enhance the EM skills of family physicians and to provide administrators and clinical faculty for CFPC-EM programs[5] — have, by default, become a major training route for full-time urban emergency physicians. Canada needs graduates from both programs, but there is currently a serious shortage in training positions for emergency medicine (RCPSC) specialists.

Solutions

The emergency physician manpower shortage is alarming. Despite recent recruiting success, our number of EM training positions is insufficient to meet local needs and we face the certainty of a serious ongoing emergency physician shortage. This situation is not unique; it reflects the Canadian EM reality and it points to the obvious local and national solution. Canada has a large shortage of EM train-

Table 1. 1999 Edmonton Capital Health Region (CHR) manpower

Type of certification	Age group (and %)			Total
	≥ 50	45–49	< 45	
RCPS-EM	5 (8)	3 (5)	6 (9)	14 (22)
CCFP-EM	1 (2)	1 (2)	14 (22)	16 (24)
CCFP and other	13 (20)	4 (6)	17 (27)	34 (54)
Total	19 (30)	8 (13)	37 (58)	64 (100)

Table 2. Recruitment and loss of CHR emergency physicians 1993-1999

Type of change	Edmonton residency graduates		Out-of-region certified physicians		
	RCPS-EM	CCFP-EM urban	RCPS-EM	CCFP-EM	Total
Recruited	4	10*	2	2	18
Departed	2	0	1	0	3
Net	2	10	1	2	15

*Denotes inclusion of 5 graduates with a rural/regional return-in-service commitment who remained in the city.

ing positions, especially in RCPSC programs. Unless this problem is resolved, the predicted shortfall of 562 qualified emergency physicians[3] will remain a reality. Immediate resolution is impossible, but urgent planning is essential. It will take a 4- to 5-fold increase in the number of Royal College entry positions to provide long-term solutions. Unfortunately, cutbacks in health care and higher education have made it difficult for university administrators to find new funds, and convincing faculties of medicine to invest in new EM residency positions will be a huge challenge.

It is safe to assume that the total number of postgraduate training positions will remain constant and that emergency medicine will be forced to compete with other disciplines experiencing manpower shortages. Even if EM directors lobby successfully and increase the number of Royal College residency positions, it is important to maintain (and in some jurisdictions increase) the level of output of CFPC emergency medicine programs. This will preserve much needed short-term relief in urban settings and will eventually enable the CFPC-EM programs to fulfill their official mandate.

Conclusions

Edmonton's EM training programs are fulfilling their educational mandate and producing qualified emergency physicians, but they cannot provide enough graduates to meet local needs. The situation is the same across Canada; however, the solutions for the local and national EM manpower shortages are clear and feasible. The task ahead is difficult but not impossible.

Competing interests: Drs. Steiner, Yoon and Holroyd are emergency physicians. Drs. Steiner and Yoon are CFPC-EM program administrators, and Dr. Holroyd is the Director of the Division of Emergency Medicine at the University of Alberta and the Chief of Service of the Department of Emergency Medicine at the University of Alberta Hospital, Edmonton, Alta.

Acknowledgement: We wish to thank all the emergency department medical directors in the Capital Health Region for their contributions to this review. A special thank you to Drs. C. Evans and A. Walker for their assistance.

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CAEP Manpower Study – Executive Summary

Introduction

In 2002, the CAEP board asked Doug Sinclair and Tim Allen to develop a proposal to address manpower issues for the speciality. We met with the CCFP[EM] and FRCPC program directors at the CAEP meeting in Hamilton in April 2002, reviewed the previous manpower survey conducted by Bob Beveridge and Steve Lloyd in 1992, and solicited advice from the CAEP research ctte. Our conclusion from this review, was that manpower issues for Emergency Medicine were very complex, largely due to the variety of physician credentials and practice settings in Canada. We felt that CAEP should begin to address this issue by measuring Emergency physician supply and engage an external consultant to lead this process. We were fortunate to contract with Ms Eva Ryten, a consultant who had done an excellent project for the Canadian Anesthesia Society. Ms Ryten has completed her report, which has been circulated to the board for discussion at the October board meeting. I have completed an executive summary and also some suggested actions arising from the report for consideration by the board.

Summary of Methods

As all are aware, the fundamental problem in addressing issues of Emergency Physician manpower is the fact that Emergency physicians have variable certification or none at all, making it very difficult to identify their exact number or distribution. Our consultant has utilized a number of sources to develop the first comprehensive picture of Emergency medicine practice in Canada. Because trend data from the CIHI and the CMA physician manpower databases are not currently accurate or comprehensive enough for the speciality of emergency medicine, she utilized records from the College of Family Physicians of Canada, and the Royal College, and the College of Physicians of Quebec to identify certificants in emergency medicine of both colleges and the CMQ by age/sex/year of certification/ and current location of practice in 2003. The records permit an identification of the numbers of these certificants who hold active membership/certification as of the spring of the year 2003 and by inference, the numbers whose membership has lapsed or is not currently active. The number do not definitively equate with actual ED practice. However, they are the best indicator we currently have for estimating the size of the clinical emergency medicine physician workforce. They are also completely up to date.

The CAPER data base was used to provide data on residency training programs.

We have been aware for many years that there is a large cohort of family physicians providing a significant amount of emergency care. The College of Family Physicians of Canada conducts periodic surveys of its members [Janus Survey]. Courtesy of the CFPC,we were able to access the 2001 survey database to provide the first information ever gathered on this group of providers.

The report is divided into a number of sections, which comment on each specific group of emergency service provider, with some overall trends identified. It is important to remember that this report comments only on physician supply, not demand, and does not

identify the practice profile of emergency physicians, only that they continue or not to remain as certificates of either College.

Royal College Certified Physicians [FRCPC]
Over a twenty year period, 468 physicians have been certified in Emergency Medicine by the Royal College, 374 of whom remain certified in Canada in 2003. Current output, excluding visa trainees, averages 20-23+ per year, with a median age at certification of 32. There is very low percentage of women [16%] among the RCPSC/EM certificants. Of the certificants located in Canada, 35% are aged 50 or more. There is an uneven distribution of certificants with low numbers in Quebec, Newfoundland and Saskatchewan. The age distribution is uneven and relatively high, with an increasing need for replacement in the coming years.

College of Family Physicians Certified Physicians [CCFP-EM]
The College of Family Physicians offers certification to both residency- trained and practice eligible physicians, and the data is analysed for both of these groups of physicians. Over a twenty-two year period, 1555 physicians have been certified by the College [742-47.7% practice eligible, 813 – 52.3% residency trained], 1198 of whom remain certified in Canada in 2003. Current output from residency training programs averages 80 per year, with a median age at certification of 30 years. The percentage of women is 27 percent, and the age distribution shows a younger cohort than the Royal College group[only 15.3% of the active certificants in Canada are 50 years of age or older]. The geographic distribution is better than the Royal College group with certificants in all provinces in Canada.

Combined FRCPC- CCFP[EM}
In this section, Ms Ryten has combined the data from both programs to describe national trends in EM physician manpower. Table 21 on pages 43-45 of chapter V is particularly useful as it outlines the ratio of active certificants/population by province.[see also table 29 on page 62] This section also illustrates very well the changing nature of the speciality with the increasing ratio of CCFP[EM] to FRCPC certified physicians. [76.7 vs 23.1] and the overall female percentage of 22.6.

Pediatric Emergency Medicine
Since 2000, the Royal College recognized pediatric emergency medicine as a subspeciality. Eight universities currently have training programs, and in 2002-2003 there were 24 trainees in these programs. All these trainees have come from a pediatric residency program, rather than an emergency medicine program. Trends will need to be observed for this group, as it potentially could increase the number of emergency physicians.

CMQ Certification
The province of Quebec has responsibility for both training and licensing physicians. Emergency Medicine has only been recognized as a speciality since 1999. Because most of the CMQ certificants in EM have already been certified in EM by either the RCPSC or the CFPC, this new CMQ certification makes avoiding " double counting" Quebec

emergency physicians a tricky statistical issue when adding CMQ data to the data from the RCPSC and the CFPC. Ms Ryten has a specific chapter explaining the situation in Quebec and its effect on manpower predictions in detail. Currently, there appears to be 48 physicians in Quebec with CMQ certification, who are not also certified by the CCFC or Royal College.

Role of Family Physicians in Emergency Care

By utilizing the Janus Survey, Ms Ryten was able to derive some very useful data concerning this important group of physicians who provide a significant amount of emergency care. This survey had 14319 respondents out of 27980 family physicians, a response rate of 51 %. There was a section in the survey concerning number of months of EM training and questions on number of hours providing ED care as physician on duty on a regular basis. By using the number of respondents with of 12 months or more of EM training as a surrogate for CCFP[EM] training, our consultant was able to separate out CCFP[EM] residency trained physicians, and compare their work patterns to other groups of family physicians.
This chapter provides the first data ever collected on this important group of physicians. A number of important trends are identified. One quarter of family physicians identified the ED as a practice setting, but the number of hours per week worked varied from 1 to over 48hrs. 1807 physicians identified the ED as their main practice setting, and 55% of these physicians had no extra training in Emergency Medicine. There is a significant cohort of physicians aged 45-55 without extra training in Emergency Medicine providing ED care, but the younger cohort aged 35-45 is more likely to have certification in Emergency Medicine. It is still difficult to identify an absolute number of family physicians without certification providing ED care due to the variation in hours provided and the lack of definition of a full-time equivalent EM practioner. The survey does show that a quarter of all generalist physicians in Canada[including those with CCFP[EM] certification] provide emergency care on a regular basis.

Residency Training in Emergency Medicine

This excellent chapter reviews the output of all CCFP[EM] and Royal College programs by province. The provincial data comparisons will be of particular interest to program directors so they can make a case for an increase in residency training positions. Note is made of the relatively large numbers of visa trainees in the Royal College programs, and the high popularity of the Royal College training program from the CARMS data related to residency matching results. With the expansion of the medical schools, a strong case is made for immediate expansion of the Royal College training program positions by 5 slots per annum until 35 new slots[excluding visa trainees] has been reached. With respect to the CCFP[EM] programs, the addition of a training program this year at Memorial brings the number of positions to approximately 100. Expansion of these programs should be done on a regional basis, probably at the new Northern medical school in Ontario, and the new campuses in BC.
A critical question identified in the report is a decision on the relative mix of CCFP[EM] and Royal College training program positions. This question cannot be answered by this

report. The other challenge identified in the report is-how do we support the ongoing educational needs for family physicians without extra training in EM to continue to provide ED care?

Summary and Recommendations

In this final chapter, the difficulties with data collection are again summarized, and the need to update these type of statistics on an annual basis emphasized. CIHI and the CMA are not currently collecting accurate information on emergency medicine human resource needs, and CAEP needs to provide leadership in this area.

Emergency physicians are currently unevenly distributed across Canada, depending on the location and longevity of residency training programs. The profession is largely male with significant attrition with age. Family physicians without additional training in EM provide significant amounts of ED care. Younger family physicians are more likely to have extra training in emergency medicine.

We have very limited information on practice profiles for practicing emergency physicians and future demand for care.

Recommendations from the study include:
-update these statistics on an annual basis
-work closely with the CCFP on the next Janus survey
-work closely with CIHI and the CMA to improve data collection and the development of an ambulatory data set
-call for an immediate increase in Royal College training positions – five per year to a target of 35 new positions
- support the CCFP in plans to increase the number of family physicians in Canada
-expand CCFP[EM] programs on a local basis

Thinking outside the box

Grant Innes, MD

Facing an emergency department staffing crisis, the Quebec government has devised a brilliant solution: legislation that forces doctors to work in emergency rooms on threat of "heavy financial penalties." Normally I'm skeptical of politicians, but this time they've hit a home run with an innovative concept that could change the face of society — or at least the health care system. Forcing unwilling (and generally unqualified) physicians to provide emergency services is a stroke of genius: It will save politicians the hassle of actually negotiating with doctors. Some call it a dangerous precedent, but I see it as a solution for all sorts of human resource problems.

Why train expensive surgeons when we can force GPs to work in the operating room? And why insist on qualified airline pilots if a zealot with 8 hours in a Cessna can fly a 757? Imagine the cost-saving possibilities when governments tackle private sector problems. Simple legislation will replace lawyers with notary publics and architects with carpenters. Baseball players will never go on strike again; not when they realize there are whole cadres of unemployed synchronized swimmers just waiting to be legislated into the dugout.

Emergency physicians and family physicians are different animals with different knowledge, experience and skills. How many GPs can open a chest and evacuate a knife-induced hemopericardium? But penetrating trauma aside, surely "replacement physicians" can perform the bulk of emergency work. Or can they? Can they use a slit lamp? Stop a posterior nosebleed? Measure compartment pressures in the leg? Do they know that verapamil is a poor choice for SVT with rapid ventricular response? Will they spot the trifascicular block in the syncope patient? Do they realize that the T = 0 troponin assay misses most cases of myocardial infarction and almost all cases of unstable angina? Can they isolate flexor digitorum superficialis function when evaluating a wrist laceration? Will they recognize the Maissoneuve injury — or treat it as a sprained ankle? Do they know how to place a chest tube? Painlessly? If the patient is in shock, can they vent the chest in 15 seconds? Are they competent to clear trauma C-spine films at 2 in the morning? When was the last time they restrained and sedated a violent, psychotic patient? Do they know enough to intubate the woman with thermal airway burns before it seems like airway management is necessary (and it's too late)? Can they perform a saphenous cutdown, a femoral line, or an internal jugular in a hypotensive patient with no veins? Will they miss the ruptured spleen in the rugby player because they believe early hemoperitoneum causes guarding and rigidity? Can they recognize blood in the basal cisterns? And do they know enough to do a lumbar puncture if there isn't any? Do they remember that methanol poisoning can present without an anion gap — or an osmolar gap? Do they remember what an osmolar gap is, and how to calculate it? Can they do a rapid sequence intubation? Can they manage a difficult airway at all? Will they know that succinylcholine is not the best choice in a patient with hyperthermia and muscular rigidity?

Maybe the government is right: You don't really need emergency physicians in emergency departments. Unless there are emergencies there.

CAEP President, Dr. François Bélanger, says that this legislation "will ***possibly*** subject the public to an increased risk of poor clinical outcomes when faced with an acute medical illness or injury." Dr. Bélanger is a nice fellow, but he is dead wrong in this. This legislation will ***definitely*** lead to many poor outcomes and deaths. It is, as he says, "a convenient façade to comfort an unsuspecting public." It will provide them with false hope and expectations when what they **need** is emergency care.

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CCFP-EM versus FRCP

To the Editor: It has been a few years since the furor[1–8] in the *CAEP Communique* regarding the debate as to whether the two tracks into Canadian emergency specialization should be merged or adjusted in some way, so it is probably time for those emotional letters to start again. Some CCFP-EM graduates, like myself, still suffer from a "second class citizen" complex and are without means to dig ourselves out of it (so that we can concentrate on our other complexes). I propose that CAEP considers awarding of "Fellowships" of the organization to emergency physicians who have made meaningful contributions to the field of emergency medicine in Canada (much like the CFPC does with the FCFP). The "FCAEP" could be a goal to which EPs from each track could aspire.

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Listen to the people on health, PM told

To the Editor: Quebec Premier Bernard Landry recently discussed the death of Claude Dufresne,[1] a 51-year-old man from Shawinigan who sustained a heart attack but could not be treated in the ED in Shawinigan, which was closed because of a staff shortage. Dufresne was transferred to Trois Rivières, but died en route.

Gaps in the emergency health system are not unique to Quebec. There are other examples in Canada of tragic deaths because of difficulties in emergency health care delivery. Kyle Martin died while waiting in the overcrowded waiting room of the Credit Valley Hospital in suburban Toronto.[2] Joshua Fleuelling, also of Toronto, died of asthma.[3] His transport to hospital was complicated by ambulance diversion.

These were people who looked to the emergency system in their hour of greatest need, and the system, through lack of planning, failed them. As Mr. Landry suggests, Mr. Chrétien should be sensitized by the tragedies his constituents endure. The Prime Minister, in searching for a health care legacy, should commit to a course of action that prevents these tragedies from recurring. Unfortunately, the Romanow and Kirby reports[4,5] barely acknowledge the national crisis in emergency care and offer little in the way of credible solutions. The crisis will not be solved by home care, pharmacare or primary care reform, no matter how important these initiatives ultimately prove to be. Mr. Chrétien should insist that emergency health care is given prominence in all future discussion on health care reform. He should vigorously support a national forum on emergency health care.

Alan Drummond, MD
Perth, Ont.

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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.

Emergency medicine training

Editor's note: Two different educational tracks can lead to emergency medicine specialization in Canada: the 5-year emergency specialist program of the Royal College of Physicians and Surgeons, and certification from the College of Family Physicians. We asked two experts in emergency medicine to comment on the relative merits of these training paths. Ivan P. Steiner's perspective follows this comment by James Ducharme.

Preparing emergency physicians for the future

James Ducharme

ß See related article page 1549

Where is emergency medicine headed? Budget constraints leading to decreased acute care bed availability have affected all of medicine, but emergency medicine most of all. Forced to cope with increasing numbers of admitted patients, emergency departments suffer from a lack of acute care beds. Bed shortages create stressful working conditions and oblige emergency physicians to increase their scope of practice. Patients who in the past would have been quickly transferred to wards receive longer-term care in the emergency department. Many patients are held overnight or under observation rather than being put through the futile exercise of requesting a (brief) admission. Patients who require intensive care are often held in the emergency department for many hours. Consequently, emergency physicians are required to improve their critical care skills. Because failure to improve such skills will result in suboptimal outcomes for these patients, residency training has to address this change in emergency department practice.

Emergency department overcrowding is an issue in rural sites as well, owing to fewer local resources, and delays in patient transfers to overburdened tertiary care centres. How can we expect rural physicians — the foundation of primary emergency care in Canada — to manage acutely ill, unstable patients for longer periods of time?

When we add the problem of an aging physician population to the problem of an increase in critical care demands and the associated increase in stress, we can predict an exodus of general practitioners from emergency medicine. Family physicians who hope to incorporate emergency care into their practice will have to consider adding more emergency and intensive care rotations to their training.

There is a power vacuum in emergency medicine. Although we supply an adequate number of specialists to many areas, we need more leaders with long-term vision and planning ability. As a group, we are stumbling forward as health care changes dramatically around us. Although there are many successful directors who are improving care at many sites, there are not nearly enough, and very few have administrative training. We need more leaders in our specialty to establish national standards, to identify and solve workforce issues and to plan emergency medicine for this century. We have yet to establish a structure that provides time to work on these issues: almost all contributions toward improving emergency medicine are provided by physicians on a voluntary basis, adding to their already lengthy lists of tasks.

Emergency specialists from the Royal College of Physicians and Surgeons of Canada (RCPSC) will remain a minority among physicians providing emergency care. Expertise is required in several nonclinical areas, such as administration, teaching, research, pre-hospital care and toxicology. A 5-year program is necessary to provide training beyond the primary clinical domain. The RCPSC program in emergency medicine must respond to that need and encourage even further training after residency. A 5-year residency is not required to produce a good emergency clinician, but it is required if we hope to prepare physicians for nonclinical roles. The primary reason the RCPSC program was lengthened by a year more than a decade ago was to allow a fellowship-type year to encourage nonclinical expertise.

In a time when we have an inadequate number of physicians, it does not make sense to restrict clinical positions to RCPSC graduates only, as is the practice in many centres. Most clinical positions in major centres can and should be filled by physicians with emergency medicine certification from the College of Family Physicians of Canada (CCFP-EM). The 2 programs complement each other very well: the clinical scope of the CCFP-EM program and the academic scope of the RCPSC program are both desperately required in emergency medicine in Canada.

Students considering emergency medicine as a career should understand why the programs are different, and that these 2 options will have different implications for their future career path. With such limited residency po-

sitions available, it makes little sense to have a resident train in an RCPSC program for 5 years only to enter a purely clinical practice. This needs to be made clear to medical students before and during residency interviews. Most CCFP-EM residents should expect to enter a practice that is focused primarily on patient care, but which may also accommodate interests such as clinical or didactic teaching.

For emergency medicine to fulfill its role in coming years, we need to prepare residents for the emergency department as it now exists and how it is expected to evolve — not how we wish it could be. We will not be working in emergency departments where admitted patients move immediately to ward beds.

Family medicine, the CCFP-EM program and the RCPSC fellowship each provide training that leads to satisfying, but different, emergency medicine careers. There will always be exceptions in emergency medicine training, but those exceptions should not be used to conclude that the programs produce similar results. All 3 training pathways are essential in providing quality emergency medical care in Canada.

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Commentary

Commentaire

Emergency medicine training

Emergency medicine practice and training in Canada

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In the late 1970s, emergency departments of urban hospitals were staffed by physicians without formal training in emergency medicine, which was not recognized as a distinct, specific discipline. Comprehensive emergency care was rare. Most university emergency departments did not provide round-the-clock coverage by an attending physician, and during the night shift unsupervised junior residents made all decisions related to patient care. Undergraduate education in emergency medicine did not exist, and a 1-year rotating internship was often sufficient in many jurisdictions to obtain a licence for general practice and to practise emergency medicine.

In June 1980, the Royal College of Physicians and Surgeons of Canada (RCPSC) recognized emergency medicine as a free-standing specialty requiring 4 years of residency training. (This was subsequently extended to 5 years.) Concurrently, the College of Family Physicians of Canada (CFPC) identified the need to upgrade emergency medicine education for family physicians (FPs) and created the administrative framework for a 1-year training program. As a result, emergency care in Canada today is provided by a heterogeneous group of clinicians. In urban centres, emergency departments are staffed by specialists who hold fellowships from the RCPSC (FRCPCs), FPs with certificates of special competence in emergency medicine from the CFPC (CCFP-EMs) and progressively fewer FPs and clinicians with a general licence.[1] The situation is different in smaller regional and rural hospitals, where the latter 2 groups provide virtually all emergency care. This diversity of emergency care providers reflects the varied educational, economic and geographic realities of our vast country, and it is further complicated by an overall shortage of Canadian emergency physicians.[2,3,4]

Moorehead and colleagues[5] have calculated that, in the United States, physicians certified or trained in emergency medicine fill 58% of full-time-equivalent positions in acute care hospitals,

and FPs and internists account for most of the rest. Adapting their formula to a Canadian setting, we can calculate that physicians certified in emergency medicine in this country fill about 45% of full-time-equivalent positions and that FPs fill the rest. In the United States, 124 emergency medicine training programs produce 1136 graduates each year.[6] In Canada, at present, there are 27 training programs: 11 for FRCPCs and 16 for CCFP-EMs, with 20 and 70 postgraduate entry positions, respectively.[7,8] Even with 2 educational tracks, the proportion of residency positions that are in emergency medicine is 21% lower in Canada than in the United States.

In Canadian urban and regional settings, career emergency physicians are coming increasingly from these 2 educational tracks and provide comprehensive, round-the-clock patient care. This workforce comprises a large cohort of full- or half-time clinicians and a smaller group of physicians in academic tracks. However, the 2 educational tracks are distinctly different. The objective of the FRCPC program is to provide residents with in-depth knowledge of emergency medicine and to prepare them for academic careers involving teaching, research and administration. The mandatory curriculum includes a year of basic clinical training, a number of months in adult and pediatric emergency departments, and a broad base of training in surgical and medical specialties, critical care and anesthesia. Training in pre-hospital care, administration and epidemiology is common, and 1 year is devoted to subspecialization, research or medical education. In fact, many residency programs exceed the minimum requirements for emergency department training.

The CCFP-EM track aims to "provide family physicians with ... enhanced skills in emergency medicine" and to prepare future CCFP-EM educators and administrators.[9] The certification year is intense, with time divided evenly among adult and pediatric emergency medicine and related subspecialties. Time constraints preclude virtually all elective work. Since it would be impossible to provide residents with the in-depth and comprehensive knowledge required for an academic career during this year, the primary objective is clinical competence.

Graduates of these 2 educational streams work mainly in urban areas. FRCPCs typically practise at university centres or in other settings that can support a number of full-time emergency physicians. Because of marketplace demands, many graduating CCFP-EMs also end up practising full-time emergency medicine in urban centres.[1] For FRCPCs and a number of CCFP-EMs, this is in keeping with their respective college-given mandate. As trainees continue to graduate, we may expect that urban patients will receive increasingly consistent and high-quality emergency care. As the quality of emergency care increases in our cities, it is important to pay particular attention to the challenge of providing emergency care in other settings.

To address this, over the last 10 years, the CFPC has implemented changes to the training of residents in the core family medicine programs and has made emergency medicine training mandatory. Currently, the challenge for those who provide education in acute care to rural FPs is to provide an adequate base of knowledge and skills for independent function. Training of family medicine residents needs to maximize educational opportunities in all settings by offering rotations in urban and regional emergency departments and in rural locations. New educational resources in emergency medicine for FP trainees should help this process, but more exposure under the supervision of qualified and experienced urban, regional or rural mentors is still needed.[10]

Future urban emergency practice should become the domain of physicians certified in this speciality, whether FRCPCs or CCFP-EMs. Emergency departments in larger centres are the entry points for patients who present with increasingly more acute or complex medical, psychological or social problems. It is appropriate that practitioners with the most intensive training should carry out patient care, clinical teaching and research in those settings. FRCPCs will be able to draw upon their preparation for academic work and didactic teaching and by virtue of their training in family medicine, CCCFP-EMs will be able to apply their humanistic skills to patient care and clinical teaching.[11] FPs will continue to be responsible for providing much of the emergency care in our rural settings. Although training in emergency skills for FPs is, overall, too short, we may expect that the further development of educational resources for emergency medicine in core family medicine programs will enhance the quality of emergency care in nonurban settings.

ß See related article page 1548

Footnotes

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Related Articles

Highlights of this issue
Can. Med. Assoc. J. 2003 168: 1521. [Full Text] [PDF]
Preparing emergency physicians for the future
James Ducharme
Can. Med. Assoc. J. 2003 168: 1548-1549. [Full Text] [PDF]

How to train emergency docs

Russell D. MacDonald

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I fully support the notion, expressed by James Ducharme,[1] that emergency physician training through the Royal College of Physicians and Surgeons of Canada (RCPSC) specialist program and certification by the College of Family Physicians of Canada (CFPC) complement each other by virtue of the differences between the 2 educational tracks. I am the end- product of a defunct "hybrid" program combining the CFPC and RCPSC programs, which was intended to balance the principles of an in-depth academic knowledge of emergency medicine with a humanistic approach to patient care. Today, it seems that trainees must choose between these 2 aspects. I recommend that the RCPSC and the CFPC join forces to develop a single emergency medicine training program with 2 tracks: academic and clinical. Fundamental humanistic values would be instilled early in the program, through a model of primary care delivered in suitable urban, rural and remote training sites. Trainees pursuing a predominantly clinical practice would undertake a 4-year program and receive significant clinical exposure to all services and subspecialties. This would alleviate the training time constraints highlighted by Ivan Steiner.[2] Trainees pursuing a predominantly academic career would undertake a 5-year program, receiving similar clinical exposure but with additional training in a specialty field of their choice (e.g., emergency medicine services, public health, education). This would formalize training in the nonclinical expertise that Ducharme mentions.[1]

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2. Steiner IP. Emergency medicine practice and training in Canada [editorial]. *CMAJ* 2003; 168 (12): 1549-50.[Free Full Text]

Alan Drummond

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I enjoyed reading the opinions of James Ducharme[1] and Ivan Steiner,[2] 2 respected leaders within emergency medicine, even though I disagreed with the basic premise of these commentaries.

Human resources are indeed an important component of emergency care, but I believe the crucial question is not how to train the physicians who will staff our nation's emergency departments (EDs) but rather how to improve the quality of care given to individual patients presenting for emergency care. No matter how well trained our emergency physicians, they will ultimately be unable to have a sustained, meaningful impact on patient care if they find themselves unsupported, working in overcrowded emergency departments EDs and stressed to the point of burnout. Unfortunately, these 3 factors constitute the "new norm."

There are currently no enforced performance standards for any ED in Canada. This means that many physicians find themselves working in departments with insufficient numbers of nurses, inadequate equipment, inaccessible diagnostic tools and limited consultant support. Overcrowding in EDs has perversely come to be accepted as routine. The problem has been reported in Canada since the mid-1980s[3,4] and, despite a clear understanding of the causes and

solutions,[4,5,6] there appears to be no political will to solve this public health hazard. Finally, a lack of attention to the wellness of emergency physicians has contributed to the dreadful loss of many talented colleagues at the peak of their clinical, academic and administrative careers. More than a debate on training, we need a comprehensive strategy to give Canadians the emergency care they deserve in their hour of greatest need. Leadership and vision we have in blessed abundance within the talented pool of our country's emergency physicians. What is required is an appropriate forum to develop such a strategy and sufficient political will to give substance to the ideas we share.

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The possibility of a 4-year common-track program, as described by Russell MacDonald, has been discussed for more than a decade. Although appealing at first glance, it faces what appear to be insurmountable barriers. The CCFP-EM 1-year program has been popular, producing the majority of emergency-trained clinicians in this country. To maintain the same number of graduates would require a large increase in 4-year residency slots, but such an increase cannot be justified under today's budgetary constraints. On the other hand, the fifth year of the Royal College program was added specifically for subspecialty or nonclinical training that was not available because of a lack of fellowships.[1] Reducing the program to 4 years would risk eliminating that aspect of training.

As is almost always the case, I agree heartily with Alan Drummond's insightful comments. With the closing of acute care beds and inadequate funding for patients needing long-term care, the health care system has been overwhelmed. EDs, rather than being a safety net for the patient, have become the safety net for a fragile system. In my own hospital we have found that to solve overcrowding problems in the ED, we must participate in finding solutions for problems in other hospital departments. Emergency medicine training programs have created expertise. Perhaps the time has come to use our vision and expertise to work with Health Canada and provincial health ministers to develop and implement the approach suggested by Drummond.

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I agree with Russell MacDonald's emphasis on integrating the academic knowledge of emergency medicine with a humanistic approach to patient care, and our research has confirmed the value of this approach.[1] However, I disagree with his proposal for achieving this goal. It is family physicians who are providing emergency care outside urban centres, and the humanistic education provided by family medicine programs must be supplemented by adequate acute care training, as through the CCFP-EM program. The concept of merging the 2 training streams has been debated in the past. However, accreditation is the purview of the 2 national colleges and to my knowledge they are not considering integration. Furthermore, a merger would also reduce the total number of emergency medicine training positions (because of the formula for provincial allocation of funds for postgraduate training positions in family medicine and specialties). Emergency medicine is already short of training slots, and such a loss of positions would be disastrous. The solution to the issues raised by MacDonald is to improve the existing educational tracks.

The Commentary format of my article[2] precluded discussion of the topics that Alan Drummond has raised. Indeed, the quality of emergency care in Canada is negatively affected by all of the factors he describes. I would welcome a comprehensive strategy that would alleviate these problems. I also maintain that the quality of emergency medicine training is a crucial issue. The credibility of the specialty is based on our ability to advocate for patients and on our capacity to develop high-quality clinicians, educators, researchers and administrators.

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A survey of one CCFP(EM) program's graduates: their background, their intended type of practice and their actual practice.

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INTRODUCTION: The purpose of this study was to examine one College of Family Physicians of Canada Certification of Special Competence in Emergency Medicine [CCFP(EM)] program's graduates to determine their background, their intended type of practice and their actual practice. **METHODS**: All 83 physicians who had completed a CCFP(EM) residency year of training at the University of Western Ontario (UWO) from 1982-2004 were surveyed. Cross tabulations tables for all combinations of two characteristics/factors from the data set were calculated. Chi-square tests of interdependence were applied. **RESULTS**: We received 72 survey replies for a response rate of 87.0%. 71% of the respondents were male. Only 8% grew up in a rural community versus 43% and 49% from regional and urban centres respectively. Overall, 50% of respondents intended to practice emergency medicine exclusively at the start of their CCFP(EM) residency training while 47% intended to undertake a blended practice of family medicine and emergency medicine with 3% undecided. Neither gender nor medical school attended influenced intended type of practice. The majority of graduates (range 72-53% over the first four positions of employment) practiced emergency medicine exclusively. The number of physicians practicing a blended emergency and family medicine practice was never greater than 20% throughout all positions. Examining all positions of employment, 11.3% were in a rural setting vs. 48.4% and 40.3% in regional and urban centres respectively. There were no relationships demonstrated between gender, size of city in youth and eventual location of practice. For all positions "type of practice" was the highest ranked factor of influence in choosing position of employment. **CONCLUSIONS**: The majority of graduates of the UWO CCFP(EM) program have worked in emergency medicine positions and had this intention from the start of residency. No demographic factors surveyed had significant correlation with intended or actual practice. **Key words**: workforce; emergency medicine; medical training

CONTROVERSIES

Subspecialization in emergency medicine: Where do we go from here?

Douglas Sinclair, MD

As emergency physicians, our principal mission is evaluating, managing, treating and preventing unexpected illness and injury.[1] In contrast to most subspecialties, which developed to serve patients with discrete, single-system problems, the specialty of emergency medicine (EM) grew out of the premise that high quality medical care should be available to the public 24 hours a day, and that the broad range of injuries and undifferentiated illnesses that can pose immediate life and limb threats require the skills of a generalist physician. Emergency medicine bridges the gap between family physicians and subspecialty services and functions at the interface of community and hospital-based care.[2] Emergency medicine also has an important role in health advocacy and health system reform.

The rise of a new specialty is driven by patient need, a distinct body of knowledge and a unique field of research. Emergency medicine developed as the result of the increasing demand for around-the-clock primary and acute care, and through advances in cardiac resuscitation and trauma care. A collaborative group of organizations in the United States recently proposed a 3-dimensional matrix model of EM practice that includes a listing of clinical conditions based on presenting complaints, physician tasks and patient acuity frames.[3] The striking finding from this analysis is the richness and variety of EM practice. The emergency physician roles vary from primary assessment of individual patients with undifferentiated disease to multi-tasking and team management in a complex emergency department (ED) environment.

During the last 20 years, EM has made dramatic advances in terms of acceptance as a specialty. A recent US analysis documented a significant increase in the number of academic EM departments and residency programs between 1991 and 2001.[4] At the same time, the International Federation of Emergency Medicine has grown from 4 founding members in 1984 to over 20 members in 2005, reflecting the international development of the specialty.

Technological advance and the exponential growth of medical knowledge have spawned numerous new disciplines. The Royal College of Physicians and Surgeons of Canada now recognizes 60 specialties and subspecialties. The Royal College defines a specialty as a specific body of knowledge and skills used by a group of physicians and applicable in community and tertiary settings. The definition of a subspecialty is less clear, and the Royal College has addressed subspecialty development on a case-by-case basis, but the basic requirement is certification in an existing core specialty.[5]

As EM has matured as a specialty, many physicians have focused on discrete areas of practice and research. Some of these are shared with other specialties, and some are unique to EM. Some of these subspecialties are now recognized with certification examinations and certification in conjunction with other specialty groups. These areas of subspecialty interest include pediatric EM, sports medicine, toxicology and emergency medical services (EMS). Today, many emergency physicians hold dual certification in family medicine, anesthesia and, more recently, critical care medicine.

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Pediatric emergency medicine

Pediatricians and emergency physicians have long recognized the special needs of children who require emergency care. In most general EDs, 20%–30% of visits involve patients under 16 years of age, and most children's hospitals have EDs that see only children.[6] Visit acuity analysis indicates that urgent and life-threatening conditions are less common in pediatric than adult populations;[7] thus there is greater need for enhanced education and continuing professional development in pediatric EM for both adult and pediatric EM practioners.

To achieve educational and research goals, pediatric EM fellowship programs, supported both by EM and pediatric colleges, have been developed in the US (1992) and Canada (1998), and they are currently under development in Australia and the United Kingdom. Although access to these fellowship programs is either through residency training in pediatrics or EM, over 90% of the fellowship candidates have their primary training in pediatrics. The vast majority of these fellows practise in pediatric EDs and have a significant role in the education of both pediatric and EM residents.

Since the number of pediatric EM specialists is limited, most pediatric emergency care will continue to be provided by general emergency physicians.[8] Reflecting this reality, there have been recent improvements in pediatric EM training for all EM residents. Subspecialists in pediatric EM have a unique role in advocacy, education and research for the pediatric population.[9]

Emergency medical services and prehospital care

Emergency medical services (EMS) has always been a core function of EM and one of the knowledge and research areas that defines the specialty. Many emergency physicians have a special interest in EMS and have made substantial contributions to the field. As "system thinkers," we have been largely responsible for the development of EMS systems worldwide, and no other specialty groups have specific interest in this area.[10] As a result, many EM-based EMS fellowships have appeared across North America, and both the American College of Emergency Physicians and CAEP have EMS sections, but EMS lacks official subspecialty recognition or certification.

Toxicology

Historically, pediatricians led in the development of poison centres and toxicology fellowships, but toxicology is also a core knowledge area for emergency physicians. The American Board of Toxicology has a 2-year fellowship with certification, accessible through EM and pediatrics. There is no Canadian equivalent, although many Canadians have achieved US certification. In the UK and Australia, extended electives in toxicology are available but there are no formal fellowship programs.

Critical care

Rotations in critical care are regarded as some of the most valuable by EM residents. Developing a close working relationship with critical care teams is important for the continuum of care and the ongoing education of EM residents and staff.[11]

Reduced intensive care unit (ICU) bed availability has resulted in prolonged lengths of stay for ICU patients in the ED. This new reality underscores the need for improved ICU expertise for ED physician and nursing staff. Emergency physicians who are dually certified in EM and critical care will help lead the development of new care protocols and research studies involving this patient population.

In Canada, EM is one of 5 specialties, along with anesthesia, surgery, medicine and pediatrics, that can recommend residents for a 2-year fellowship program in critical care. In the US, EM residents may be accepted into critical care fellowships, but there is no American Board of Emergency Medicine (ABEM) examination in critical care, so no official recognition of added qualification. In Australia, negotiations with the College of Anesthesia are nearing completion for a similar program.

Other subspecialties

Other areas of interest, including sports medicine, observation medicine, hyperbaric medicine, wilderness and remote medicine, disaster medicine, and acute cardiology have the potential to be recognized as EM subspecialties. Of these, the ABEM has examinations in sports medicine and undersea and hyperbaric medicine.

Subspecialization in emergency medicine: the wrong direction

The evolution from "area of interest" into true subspecialty depends on a critical mass of physicians with the vision to articulate a unique clinical role and the development of supporting education and research programs. In other specialties, subspecialization has been a natural development, paralleling the expansion of knowledge and techniques in a certain discrete area of practice. A clear example of sub-

specialization improving care has been in cardiac services. Research has shown that processes and outcomes improve for discrete groups of patients who receive subspecialty care[12] and there has been acceptance of the need for subspecialization, but concerns have been raised about the increasing number and narrow scope of some of these fields.

General medicine and general surgery have important lessons to teach us about subspecialization. Over 80% of medical admissions now come through the ED, many with multiple undifferentiated acute problems. The management of these patients has become problematic for subspecialty services, and specialists in teaching hospitals have become increasingly dependent on trainee physicians to cover emergency admissions; yet the role of the general internist is not seen as attractive to upcoming residents.[13] In general surgery, the situation is even more critical. The range of surgical services available in community hospitals is shrinking because new trainees are less comfortable with the broad spectrum of surgical emergencies that may present. Indeed, many general surgeons have limited their practice to subspecialty areas of interest, such as head and neck, hepato-biliary or anorectal disease.[14]

On a daily basis, emergency physicians see examples of how subspecialization has fragmented patient care. Should the myocardial infarction patient with diabetes and chronic obstructive lung disease be admitted to cardiology or respirology? And, once that issue is resolved, who will take care of the patient's diabetes? What do we do when a trauma patient arrives with a small bowel perforation and splenic injury — and a thyroid surgeon is on call? How long can the patient with penetrating chest trauma wait for a cardiac anesthetist to be called in?

Many emergency physicians feel (and at least one recent survey shows) that, after 20 years of development, there is still some stigma that EM is not a "real" specialty.[15] For some, these attitudes may drive the desire for subspecialization. However, it is important to understand EM as a complex system or matrix that crosses multiple areas of content, attitude and skill.[16] Educational theory supports the concept that cross-linking themes improves the performance of complex tasks.[17] The emergency science around medical error and patient safety also supports the need for metacognition or "thinking about thinking" as a key strategy for decision-making.[18] Experienced emergency physicians acquire skills of pattern recognition and use heuristics (shortcuts or abbreviated thinking strategies) in order to make decisions in an uncertain environment. An important component to this skill set is the ongoing exposure to a wide variety of clinical experiences to achieve further refinements in cognitive processing.

As the specialty of "the first five minutes of everything," we need to embrace, support and protect the concept of the generalist. Emergency physicians face a high volume of patients with undifferentiated illness and a significant degree of pathology on a daily basis. Our education and research agendas should address this reality. Specialized expertise is important, and effective emergency physicians will have advanced knowledge and skill in pediatric EM, toxicology, EMS and critical care, but formal EM subspecialties will play a limited role in the future of the specialty.

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I AM Emergency Medicine

I read with great interest Douglas Sinclair's Commentary[1] on subspecialization in emergency medicine (EM). I was particularly pleased to see the final section, which suggested that subspecialization in EM may be the wrong direction for the EM community.

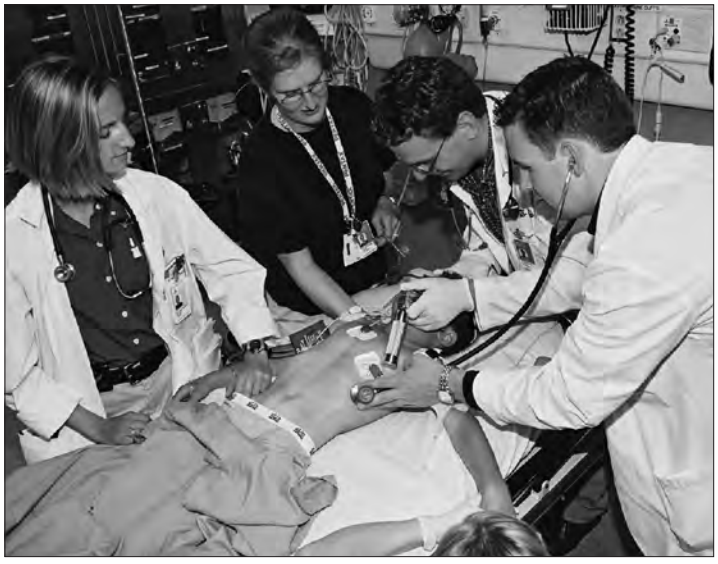
My experience and biases declared

I currently work in a split practice of tertiary EM at the Royal Columbian Hospital in New Westminster, BC, and the community EM at Eagle Ridge Hospital in Port Moody, BC. I am also lucky enough to be able to work the occasional shift at BC's Children's Hospital (BCCH) in Vancouver, BC. In each of these sites, I admit that there are differences, yet what we do at each site is very much the same. In the short time that I have been practising, I have been the emergency physician (EP) who calls to transfer a sick patient out of a less resourced community hospital (when I am at Eagle Ridge). When working at our tertiary centre (Royal Columbian), I have had to take calls from smaller centres seeking advice, or wishing to send in sick patients. I have even had the role of subspecialty consultant at BCCH when colleagues phone in about the care of children and adolescents.

Acknowledging where we've come from

I understand and respect the work that has been done over the past 31 years by my predecessors and contemporaries to carve out the "new" specialty of EM. I imagine that, in creating a specialty where it didn't exist before, turf battles must have been the norm. It is my understanding that surgery didn't let go of trauma easily (perhaps still hasn't) with respect to the golden hour (actually the golden 8–24 hours in our department). I know that cardiology was reluctant to allow other physicians to make choices about thrombolytics. Given the breadth of EM, there have probably been battles with many specialist colleagues over the years that eventually established the domain of EM practice that we know today. We still have new frontiers in EM that are not yet defined: the role of ultrasound, and the approval of certain drugs for procedural sedation, to name only two. The task of defining ourselves as a specialty is an ongoing one, and the field of EM is organic, in that it will continue to grow as new members explore broader, and narrower, areas of practice.

A great deal of work has been done to establish EM as a specialty area in the house of medicine, and despite ongoing skirmishes at the fringes, the battle has been won.


Dr. Adam Lund

Mock Code: University of Alberta Hospital, Stollery Children's Hospital, Pediatric Emergency Department, 2002.

EM specialists versus specialists in general EM

One of the key questions that I see facing our "specialty" today is one that has clinical, academic, financial and political implications. What is an EP in 2005–2006 in the current Canadian schema? Is it only the small group of EPs who practise in the tertiary centres who come from the FRCPC-EM training program? What about the CFPC-EM–trained EPs who work right beside the FRCPCs in many of the tertiary centres? What about the EPs from either program working in medium-sized and even smaller centres around the country? What about the FRCPC Pediatricians and Pediatric EM fellowship-trained physicians who work at BCCH? Are they EPs? Are they Pediatric EPs? What about the many family physicians and general practitioners from all over the country who work shifts in their local hospitals and deal with emergent medical problems at all hours in their own communities, regardless of training background? Are they not also EPs?

I believe that the answer to all of the questions above is "yes." We are all EPs. Depending on where we practice, we have different patient mixes, different levels of resources for diagnosis, treatment and referral, different complexity and acuity mixes, different workloads and different patient volumes … but we are all EPs. We all take our turn on the evenings, weekends, nights and holidays, greeting patients whose problems vary from the worried well to the critically ill. We all do our best to integrate the best evidence that we know into the complicated and broad landscape of clinical presentations that present to our various health care facilities. Some of us have nurtured areas of interest and have developed expertise in some interesting, narrow, cutting-edge (*insert your favourite adjective*) areas of EM, but ***none*** of us do only that area and still call ourselves EPs. As much as we may seek to subspecialize in one direction, we all must remain specialists in general EM.

For the future

I applaud and support my colleagues who seek to expand their knowledge and the reach of EM by pursuing areas of subspecialty interest. Where relevant, these people will be the leaders who bring back the experience and evidence-base to inform the EM community as a whole about the best care for the patients we all see. At the same time, I would view with caution any move to further break apart this community into any exclusive areas of practice. Emergency medicine is special in that, as a group, we deal with "whatever comes through the door," and any doctor who takes on that responsibility in their community is an EP to me. Putting aside politics, finances and any other divisive considerations, I look forward to a future for our profession that is as diverse in its membership as it is in practice. I look forward to conferences and EM community activities attended by general practitioners, family physicians, CFPC-EMs, FRCPCs, Pediatric EPs, and others who all take their turn in their local emergency department, specializing in whatever comes through the door, 24/7/365. I look forward to a much larger community than we have today, where this whole diverse group can stand up and say, "I AM Emergency Medicine."[2]

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Correction

In the Case Report by Dr. Hendrik P. van Zyl[1] in the November issue of *CJEM*, a reference citation was inadvertently omitted from the text. Reference 5 should have been cited in the 3rd sentence of the 1st paragraph of the Discussion, following the phrase "...has a variable origin from level T9 to L3..." (p. 421). Our apologies for this error.

Reference

1. van Zyl HP. Paralysis: a rare presentation of abdominal aortic aneurysm thrombosis. Can J Emerg Med 2005;7(6):420-2.

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.

Wednesday, June 6, 2007

0800-0850	**PLENARY** Education & Emergency Medicine ***Dr. Tim Rutledge*** *Location: Lecture Theatre*				
TRACK SESSIONS 0900–1230	**ICU IN THE ED** ***Track Chair:*** ***Dr. Alec Ritchie*** *Location: Lecture Theatre*	**MEDICAL IMAGING** ***Track Chair:*** ***Dr. Louise Rang*** *Location: Saanich Room*	**TOXICOLOGY** ***Track Chair:*** ***Dr. Chris DeWitt*** *Location: Oak Bay Room*	**RESEARCH – Oral Presentations/ Research Workshop** ***Track Chair: Dr. Ran Goldman*** *Location: Esquimalt Room*	
0900-0940	Pharmacotherapy in Cardiac Arrest ***Dr. Riyad B. Abu-Laban***	Advanced Applications of ED Targeted Ultrasound ***Dr. Michael Lambert***	Making Order Out of C.A.O.S. – Management of Acetaminophen Poisoning in 2007 ***Dr. Mark Yarema***	0900-1000	Workshop #3
0945-1025	Pharmacotherapy in Rapid Sequence Intubation ***Dr. John Tallon***	Top 10 Recent Articles in Medical Imaging ***Dr. Mark Mensour***	Toxicity of the newer antidepressants ***Dr. Roy Purssell***	1000-1015	Paper #35
				1015-1030	Paper #36
1030-1100	**COFFEE BREAK**				
1100-1140	Ventilator Science & Strategies ***Dr. Bill Henderson***	Emergency CT Coronary Angiogram ***Dr. Ben Chow***	Clandestine drug labs and potential poisonings ***Dr. Robert Palmer***	1100-1115	Paper #37
				1115-1130	Paper #38
				1130-1145	Paper #39
1145-1225	ICU in the ED ***Dr. Rob Green***	Paediatric Xray Pearls ***Speaker TBC***	Drug-Related ED Visits: An Underrecognized Epidemic ***Dr. Peter Zed***	1145-1200	Paper #40
				1200-1215	Paper #41
1230-1300	**CONFERENCE CLOSING STATEMENTS** *Location: Lecture Theatre*				

Photo credit: Tourism Victoria

EM ADVANCES

Emergency medicine training demographics of physicians working in rural and regional southwestern Ontario emergency departments

Munsif Bhimani, MSc, MD;[*] Gordon Dickie, MB ChB;[†] Shelley McLeod, MSc, BSc;[‡] Daniel Kim, MD, BSc[§]

ABSTRACT

Objectives: We sought to determine the emergency medicine training demographics of physicians working in rural and regional emergency departments (EDs) in southwestern Ontario.

Methods: A confidential 8-item survey was mailed to ED chiefs in 32 community EDs in southwestern Ontario during the month of March 2005. This study was limited to nonacademic centres.

Results: Responses were received from 25 (78.1%) of the surveyed EDs, and demographic information on 256 physicians working in those EDs was obtained. Of this total, 181 (70.1%) physicians had no formal emergency medicine (EM) training. Most were members of the College of Family Physicians of Canada (CCFPs). The minimum qualification to work in the surveyed EDs was a CCFP in 8 EDs (32.0%) and a CCFP with Advanced Cardiac and Trauma Resuscitation Courses (ACLS and ATLS) in 17 EDs (68.0%). None of the surveyed EDs required a CCFP(EM) or FRCP(EM) certification, even in population centres larger than 50 000.

Conclusion: The majority of physicians working in southwestern Ontario community EDs graduated from family medicine residencies, and most have no formal EM training or certification. This information is of relevance to both family medicine and emergency medicine residency training programs. It should be considered in the determination of curriculum content and the appropriate number of residency positions.

Keywords: emergency medicine; rural, community, emergency physician demographics; emergency physician training, residency

RÉSUMÉ

Objectifs : Nous avons tenté de recueillir des données démographiques sur la formation en médecine d'urgence des médecins travaillant dans des salles d'urgence (SU) rurales et régionales du Sud-Ouest de l'Ontario.

Méthodes : En mars 2005, un sondage en 8 points a été envoyé par la poste aux chefs des services d'urgence dans 32 salles d'urgence du Sud-Ouest de l'Ontario. Cette étude se limitait à des centres non universitaires.

Résultats : Parmi les SU sondées, 25 (78,1 %) ont retourné le sondage, et nous avons obtenu des

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This article has been peer reviewed.

Can J Emerg Med 2007;9(6):449-52

données démographiques sur 256 médecins travaillant dans ces SU. De ce nombre, 181 (70,1 %) médecins n'avaient aucune formation professionnelle en médecine d'urgence (MU). La plupart étaient membres du Collège des médecins de famille du Canada (CMFC). Huit des SU sondées (32,0 %) exigeaient, comme compétences minimales, le certificat du CMFC, et 17 SU (68,0 %) exigeaient le certificat du CMFC ainsi que le cours en soins avancés en réanimation cardiorespiratoire (ACLS) et le cours en soins avancés de réanimation des polytraumatisés (ATLS). Aucune des SU sondées n'exigeait le CMFC (MU) ni le FRCP (MU), même dans les agglomérations de plus de 50 000 habitants.

Conclusion : La majeure partie des médecins travaillant dans des SU du Sud-Ouest de l'Ontario sont des diplômés de programmes de résidence en médecine familiale et la plupart n'ont pas reçu de formation complémentaire ni d'accréditation en MU. Cette information est pertinente tant pour les programmes de formation des résidents en médecine familiale qu'en médecine d'urgence. Il faut tenir compte de cette information pour la préparation du programme d'études et la détermination du nombre adéquat de postes en résidence.

Introduction

Emergency medicine (EM) training and certification in Canada involves either 5 years of EM-specific training by the Royal College of Physicians and Surgeons of Canada (leading to an FRCPC designation), or 1 year of EM training above and beyond a 2-year family practice residency by the College of Family Physicians of Canada (leading to a CCFP[EM] designation). However, the proportion of physicians currently working in Canadian emergency departments (EDs) who actually have EM training or certification, and the certification they have, remains poorly understood.

An Ontario billing data study examined whether family physicians (FPs) with EM certification actually practised family medicine (FM) or instead practised full-time EM.[1] Physicians were classified into 4 categories according to the proportion of patient assessments that occurred in an ED over 1 year: "almost all EM" (> 90%); "mostly EM" (51%–90%); "mostly non-EM" (10%–50%); and "almost no EM" (< 10%). This study found that of the 345 FPs with EM certification, 56% were in the "almost all" or "mostly" EM categories. Physicians in these groups were younger and less likely to be in a rural practice than physicians in the other 2 categories.[1] Another study examined graduates of the CCFP(EM) program at the University of Western Ontario and found that less than 20% of graduates of this training track actually practise any FM.[2] While these 2 studies commented on practice patterns of CCFP(EM)-trained physicians, neither examined the level of training of the physicians who staff rural and regional EDs.

In contrast with the United States,[3] the demographics of EM providers in Canada has not been formally evaluated. The JANUS project, an initiative of the College of Family Physicians of Canada to collect information on the clinical activities of FPs, found that 24% of 13 088 FPs surveyed worked in the ED setting and 7% described the ED as their main practice setting.[4] A more comprehensive analysis of the Canadian community ED workforce would be useful to several stakeholders to better understand the current situation and to help guide the content of physician training and the allocation of residency positions. The purpose of our study was to determine the emergency medicine training demographics of physicians working in rural and regional EDs in southwestern Ontario.

Methods

Approval was obtained from the Health Sciences Research Ethics Board of the University of Western Ontario to carry out a physician workforce survey in EDs across southwestern Ontario. A survey instrument was developed and was piloted among physicians at the St. Joseph's Family Medical Center in London, Ontario (Appendix 1).

The Southwestern Ontario Rural and Regional Medicine Unit, an academic rural medicine research and teaching facility within the University of Western Ontario, was approached to help compile a list of EDs and their physician leaders in southwestern Ontario. The EDs of 3 London, Ontario, teaching hospitals were excluded as the study was limited to nonacademic centres. Physician leaders of the remaining 32 rural and regional EDs were contacted during January and February 2005 by telephone, email or regular mail by one of the investigators, and the survey was mailed during the month of March 2005, with a letter of invitation. Participant consent was assumed upon return of the survey as explained in the letter of invitation.

The survey consisted of 8 multiple choice and fill-in-the-blank questions. Anonymity of respondents and their prac-

tice sites was ensured by coding each questionnaire with anonymous identifiers upon receipt. Means with standard deviations were generated for continuous data, and percentage frequencies were generated for categorical data. Data analyses were performed using SPSS 13.0 (SPSS Inc., Chicago, Ill.) and Microsoft Excel 2002 (Microsoft Corp., Redmond, Wash.).

Results

Responses were received from 25 (78.1%) of the surveyed EDs, and demographic information on 256 physicians working in those EDs was obtained. Twenty-three (92.0%) surveys were fully completed, and partial data was available for the remaining 2 EDs.

Of the 256 physicians working in the surveyed EDs, only 75 (29.3%) had formal EM training (8 FRCP[EM] and 67 CCFP[EM]). The remaining 181 (70.1%) physicians had no formal training in EM (Fig. 1). Most of this group had CCFP certification.

A stratification of the qualifications of physicians working in the surveyed EDs by community population indicated that:

- 10 sites (40.0%) had a community population of less than 10 000 with an average of 7.5% (range 0.0%–25.0%) physicians with EM training;
- 6 sites (24.0%) had a community population of 10 000–19 999 with an average of 30.6% (range 0.0%–83.3%) physicians with EM training;
- 6 sites (24.0%) had a community population of 20 000–49 999 with an average of 43.1% (range 0.0%–91.7%) physicians with EM training; and
- 3 sites (12.0%) had a community population of greater than 50 000 with an average of 47.2% (range 25.0%–75.0%) physicians with EM training.

Of the physicians working in the surveyed EDs, 73.7% (range by ED 8.3%–100.0%) had no formal EM training. Smaller communities (< 10 000) were staffed predominantly by physicians with no formal EM training (92.5%), whereas CCFP(EM) and FRCP(EM) certified physicians were more prevalent in larger centres (Fig. 2).

The minimum qualification to work in the surveyed EDs was a CCFP in 8 EDs (32.0%) and a CCFP with Advanced Cardiac and Trauma Resuscitation Courses (ACLS and ATLS) in 17 EDs (68.0%). None of the surveyed EDs required a CCFP(EM) or an FRCP(EM) certification, even in population centres larger than 50 000.

Discussion

This study demonstrates that in community EDs in southwestern Ontario the minimum physician qualification is completion of FM training and a CCFP, usually with ACLS and ATLS certification, even in larger regional centres with populations greater than 50 000. Our findings show that the majority of surveyed physicians in the region who work in EDs originated from FM residencies (96.9%), and most (73.0%) have no formal EM training. Because physicians with no formal EM training are providing the bulk of ED coverage in the nonurban setting, FM residencies in the province of Ontario should consider providing greater EM teaching that could include mandatory EM rotations and appropriate EM seminars and lectures; and the government should consider whether the current size of EM residency programs is sufficient for the needs of the population.

Shepherd and Burden surveyed all physicians who had completed a CCFP(EM) at the University of Western Ontario from 1982 to 2004 and discovered that the majority of these physicians have worked in EM-only positions since gradua-

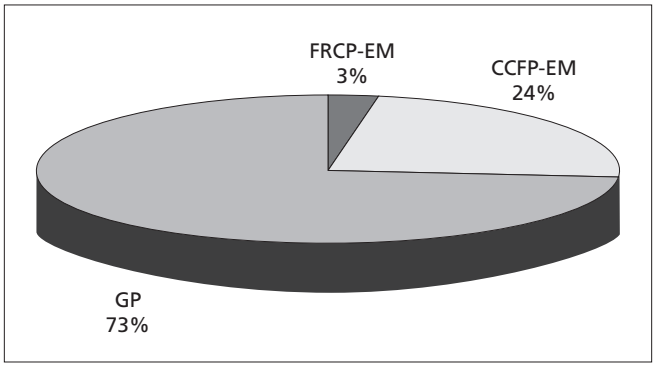

Fig. 1. Breakdown of total emergency department physicians in rural and regional southwestern Ontario by training. GP = general practitioner.

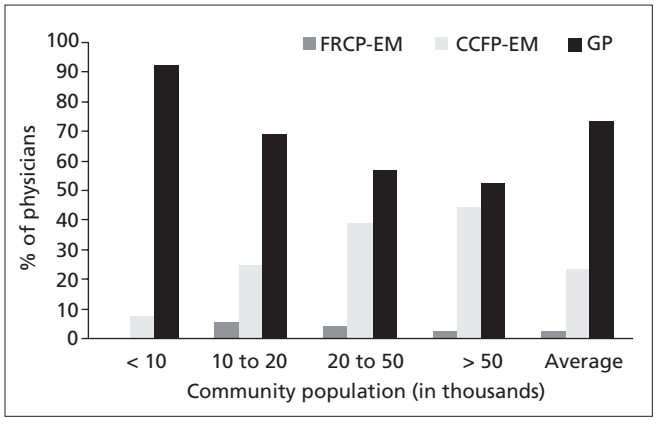

Fig. 2. Breakdown of training of emergency department physicians in rural and regional southwestern Ontario by population of practice community. GP = general practitioner.

tion. Less than 20% were engaged in a blended EM and FM practice.[2] Our study complements these findings and indicates that CCFP(EM)–trained physicians are much more prevalent in the EDs of larger communities.

Limitations

Because respondents to this study were the ED chiefs, it is conceivable that their responses were occasionally biased and not reflective of the opinion of their local colleagues. Physician characteristics were not captured in this study, so we cannot comment on age, sex or years of EM experience. This study excluded academic teaching centres and therefore excluded many FRCP(EM)-trained physicians. Future studies are needed to evaluate academic and tertiary care centres and to investigate the EM providers in these settings. We plan to carry out a larger study of all physicians working in EDs across Ontario to better understand training, demographics, work pattern and FM involvement of physicians in rural and regional EDs. Additionally, we hope to frame this more comprehensive information in the context of a "rurality index." Leduc created a General Practice Rurality Index (GPRI) for Canada based on 6 factors: 1) remoteness from the closest advanced referral centre; 2) remoteness from the closest basic referral centre; 3) drawing population; 4) number of GPs; 5) number of specialists; and 6) presence of an acute care hospital.[5] Applying such an index to the communities whose EDs are analyzed in a future study will allow correlation of the information gathered to a quantitative descriptor of each community's rurality.

Conclusion

This study shows that in southwestern Ontario the majority of rural and regional physicians working in EDs have trained through FM and have no formal EM training or certification. Despite the limited scope of our study, it appears that ED care is population-based and is practised differently depending on population size, as formal EM training is more prevalent in larger communities. This information is of relevance to both FM and EM residency training programs, and should be considered in the determination of curriculum content and the appropriate number of residency positions. We hope to continue this research to investigate further patterns and trends in the staffing of EDs in rural and urban areas.

Competing interests: None declared.

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Appendix 1. Survey

1. What is the population of your town?
   ❑ < 10 000 ❑ 10 000–20 000 ❑ 20 000–50 000 ❑ > 50 000
2. How many hospitals are there in this town?
   ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5
3. How many emergency rooms are there in the town?
   ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5
4. How many physicians staff the emergency room at your hospital? _____
5. How many of your emergency room physicians have FRCP training in EM? _____
6. How many of your emergency room physicians have CCFP-EM training? _____
7. How many of your emergency room physicians have neither CCFP-EM training nor FRCP-EM training? _____
8. What is the basic qualification required for a doctor to work in your ER?
   ❑ CCFP only ❑ CCFP with ACLS/ATLS ❑ CCFP(EM) ❑ FRCP(EM)

Emergency medicine certification in Canada: the years march on but the questions remain the same

Riyad B. Abu-Laban, MD, MHSc

SEE RELATED ARTICLE ON PAGE 108
VERSION FRANÇAISE À LA PAGE 104

In 1987, I found myself in the painful situation of struggling to answer a key question during a residency application interview. The question: what did I feel were the differences between the Royal College emergency medicine fellowship program, FRCP(EM), and the CCFP(EM) program of the College of Family Physicians of Canada. My uncertainty regarding Canadian EM certification routes was patently evident. Following that unpleasant interview, I worked full-time in EM for several years with a general license, completed a Royal College EM residency and obtained a masters degree in epidemiology. Now, 2 decades later, I am a researcher and emergency physician (EP) at Vancouver General Hospital, a tertiary trauma centre and a base hospital for a Royal College EM residency program. I teach medical students during most of my emergency department (ED) shifts, and sometimes the students interested in EM ask me the same question that I was asked in 1987. And guess what? I still struggle to answer it with any clarity, much less with any conviction. Perhaps it is time to ask why.

Canada is the only country with 2 colleges governing EM certification, yet fundamental questions regarding our system remain difficult to answer. Each college has published goals for its program, and each curriculum appears consistent with those goals. But do 2 independently managed training programs provide the optimal solution for Canada? Do they prepare physicians with different aspirations to pursue different career paths? The evidence indicates that the answer to these critical questions is a resounding "no." In my view the inconsistencies, redundancies and inefficiencies in our current system make suboptimal use of our scarce human and educational resources. Beyond this, I believe the divided voice that results from our 2 routes of certification has become an increasing impediment to both our development as a specialty and our political strength. Despite these issues, we remain paralyzed at the prospect of reforming our 2-college system, even though its evolution and perpetuation have more to do with politics and market forces than with vision or standards.

The history of our 2 certification streams is well described,[1–3] but questioning the bizarre Canadian approach to EM training is nothing new. Back in the days of the *CAEP Communiqué* (a newsletter that preceded *CJEM*), there was vigorous debate regarding fundamental questions about EM training and certification.[4–9] In 1998, the Canadian Association of Emergency Physicians (CAEP) struck a task force to examine this very issue.[10] Our inability to reach consensus in the past should not preclude us from revisiting these issues. EM is very different than it was a decade ago; we are now firmly established and accepted as a specialty. Several Canadian universities have departments of EM, and EM training is now a core rotation in most medical schools. Although a significant proportion of emergency care in Canada is and will continue to be provided by family physicians without EM certification or formal training, certification is the norm for new physicians intending to pursue a career as a full-time EP. Positions in almost all academic and large community centres now mandate some form of EM certification. This mandate has not arisen out of self-justification but because of increases in the scope and complexity of standard ED care.

Our terminology is central to discussing the problems

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with EM in Canada. We have avoided defining such things as "delivering EM care," "being an EP" and "being an EM specialist." CAEP has understandably taken an inclusive approach to date, and, despite its name, defines itself as the "national voice of emergency medicine" (rather than the national voice of emergency physicians).[11] Avoiding unnecessary distinctions makes sense when a specialty is young. However, EM certification has now existed for a quarter century in Canada, and clarity of terminology is important if we are ever to have a united voice and defined standards. Surely the time has come to acknowledge that not everyone who delivers EM care is an EP, just like not everyone who delivers a baby is an obstetrician. The fact that excellent EM care is provided every day across Canada by physicians from a range of backgrounds is indisputable.[12] However, in all established fields of medicine the name of a specialty must eventually become synonymous with certification. For example, a "cardiologist" is, by definition, certified in cardiology. Are we not at the point where providing optimal care by certified EPs in all but the smallest EDs should be our objective? Should this not, therefore, be championed by CAEP as a national goal to be met within a specified time frame?

Although many physicians (myself included, in my pre-residency years) developed EM expertise "on the job" and without training, such an approach is not ideal. Our collective silence on the issue of EM certification contrasts with the position of the American College of Emergency Physicians, and gives tacit approval for future EPs to develop their skills in this same manner. Some may argue that we don't have the resources to train enough EPs to meet Canada's future needs. However, rather than a reason to avoid endorsing an appropriate standard, this is a reason to vigorously advocate for more training slots (something an appropriate standard would facilitate). The 2002 CAEP submission to the Romanow Comission called for a "minimum basic skill set for all health professionals" in Canadian EDs.[13] Endorsing certification in EM is the appropriate way of defining such a skill set.

The question of who we call an "EM specialist" is potentially divisive, and in my view has been a significant factor in the delay of CAEP's evolution to function as the specialty society we increasingly require. In contrast to the Royal College program, CCFP(EM) training was intended to improve the ED care delivered by family physicians through "special competence" training, not to produce career EPs.[1,14] But studies have shown that the overwhelming majority of CCFP(EM) graduates practise full-time EM with little or no family medicine.[15,16] Many of Canada's leading EM clinicians, educators, researchers and administrators are CCFP(EM)s. They are EM "specialists" in every sense of the word except the technical one, as provincial colleges reserve this designation for FRCPs. Moreover, although CCFP(EM)s comprise the majority of Canada's certified EPs, they are ostensibly represented by a college with a primary focus on family medicine and no mandate to produce EM specialists. Given this situation, it is not surprising that some CCFP(EM)s have proclaimed that they feel like "second class citizens,"[17] an unfortunate situation that underscores the current division in our specialty. Similarly, I believe many Royal College trained EPs are deeply troubled at suggestions that jobs with an FRCP minimum requirement are "elitist," and the belief, by some, that after an arbitrary number of years any benefit from their additional education is negated. Proponents of such concepts often make the regressive proposal that despite the standardized curriculum and validated evaluation that a specialty establishes, job applicants should be judged individually, solely on subjective merits, rather than face a credential hurdle. It is clear that frustrations with our current system exist for graduates of both training streams.

There remain inadequate resources to train EPs in Canada.[13,18,19] To use these resources efficiently and effectively, we must strive to match the educational experience with the intended practice at the level of each individual resident. A resource misallocation occurs every time a future EP in a CCFP(EM) program spends the first 2 years of his or her education developing an expertise in office-based family medicine; this is expertise that he or she will likely never use, at the expense of a curriculum thoughtfully designed for a career in EM. Meanwhile, the extra years of the Royal College program are in part touted as a route to develop nonclinical EM expertise, as 5 years of training is not required to produce an excellent EM clinician.[2] But many FRCP residents do not take advantage of this opportunity. Thus every time a future EP in a Royal College program graduates without additional nonclinical expertise, or with expertise that they fail to apply, a resource misallocation has also occurred.

In my view, we are long overdue for changes to produce a united and strong EM specialty with well-allocated resources, thus optimizing ED care for Canadians. Achieving this requires leadership, which I believe must come from CAEP. A task force should be re-established to review the history of prior CAEP initiatives in this area, consult widely, bring the key parties together and broker an acceptable solution. Both colleges must be willing to compromise, and must set aside their vested interests in a principled effort to retool the system. During this process, I suggest we be mindful of the wisdom of Grant Innes, the

first Editor-in-Chief of *CJEM*. He wrote a provocative editorial in 2002 listing some of the countless skills EPs must possess and stated that Family Physicians and Emergency Physicians are not the same and are not interchangeable.[20] In keeping with this, and despite the fact that family medicine and emergency medicine will always have overlaps and close linkages, it makes no sense for career EPs to be trained and certified by the College of Family Physicians of Canada. Nor does it make sense to create a separate EM college or CAEP fellowship, as some have proposed.[6,17] The Royal College of Physicians and Surgeons was established in 1929 by a special act of parliament to oversee the education of specialists in Canada,[21] and the strides EM has made through our affiliation with the Royal College are innumerable. It is within the Royal College that a reformed coordination of EP education and certification should reside. My proposed solution is similar to that put forward by many people previously: a common stream curriculum of an appropriate length (3 or at most 4 years) leading to a specialization in clinical EM, followed by the option of 1 or 2 fellowship years for those who are more academically inclined.[1,22] The pros and cons of a limited window of practice eligibility access to the exams for the common stream should also be carefully considered.

Nine years ago, in the inaugural issue of *CJEM*, a paper was published entitled "Emergency Medicine Training in Canada." The authors concluded "Our citizens deserve one standardized, certified, accredited EM training program that produces the highest quality emergency physicians."[1] I couldn't agree more, and I think it's high time we got on with it.

Competing interests: Dr. Riyad B. Abu-Laban has FRCP(C) emergency medicine certification and is a Fellow of Royal College of Physicians and Surgeons of Canada. He holds an appointment as an assistant professor in the Department of Surgery at the University of British Columbia.

Keywords: emergency medicine, certification, training, residency, standards, education

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Emergency medicine training in Canada: learning from the past to prepare for the future

Tim Rutledge, MD

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Emergency medicine has been recognized as a specialty in Canada for a quarter of a century. But how distinct is our discipline, and how well prepared are we to meet the challenges facing us in the years to come? At this time, it seems appropriate to reflect on what we have learned during our first 25 years and consider some tough questions on how best to meet the future emergency medical needs of Canadians.

It is easy to understand why there is a lack of clarity regarding what defines an emergency physician (EP) in Canada. Our workforce is made up of practitioners from disparate backgrounds with a variety of credentials. There are 2 separate paths to certification in emergency medicine (EM) through different colleges. Furthermore, data from the 2004 National Physician Survey indicates that the majority of physicians who identify the emergency department (ED) as their main patient care setting have no EM certification at all.[1] This is not surprising given that our residency programs still do not produce nearly enough graduates to meet the demand. Many EPs have learned on the job and have developed considerable expertise in this manner.

Our dual training system arose more as a result of politics than wise planning. In the late 1970s and early 1980s, both Canadian colleges were lobbied to establish EM training programs and both initially resisted. The Royal College of Physicians and Surgeons of Canada encountered reluctance within its ranks to accept EM as a specialty, and the College of Family Physicians of Canada had concerns that creating a specialty program could lead to fragmentation in family medicine (concerns that continue to this day). A conjoint committee was established to decide on the most appropriate home for the new discipline and the optimal format for its training program (oral communication, Dr. Paul Rainsberry, Associate Executive Director, Academic Family Medicine, College of Family Physicians of Canada, January 2008). After failing to achieve consensus on the issues in the context of misaligned political agendas, both colleges established EM programs with different ideologies and goals.[2,3] Advocates at the College of Family Physicians viewed EM as acute primary care and a natural extension of the family medicine residency. The third-year CCFP(EM) program was designed for family medicine graduates to develop special competence in EM, and its first certification exam was held in 1982. With the goal of establishing EM as a discipline on par with other specialties, the Royal College developed a program designed to produce academic emergentologists. The first Royal College FRCP(EM) certification exam was held in 1983.

And so here we are, a quarter of a century later, a discipline divided, with 2 training streams that have ostensibly different goals. What we have learned, however, is that the graduates of the 2 streams do not fit neatly into their intended career paths. The real-world experience has been that EPs from both streams go on to pursue a wide variety of career paths that overlap considerably. It has been suggested that this may be a failure of the 2 programs to attain their objectives.[4] In my view, what it really reflects is that people's career paths evolve over time. It would be most

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unfortunate if our career options were unduly limited by a decision we made in medical school.

I believe it is time we confront a pivotal question: Is there sufficient rationale to continue to have 2 separate training streams for 1 discipline? A number of Canadian EPs have published opinions on this matter, some with considerable passion.[2–11] This topic is fraught with sensitive issues that are potentially divisive. In 1998, the Canadian Association of Emergency Physicians (CAEP) struck a task force to consult with Canadian EPs and investigate the desirability of establishing a unified education program.[12] The initiative was short-lived, as the task force quickly determined that consensus could not be achieved. I believe that the benefits of reviving this discussion outweigh the risks. A healthy debate on this topic could, and perhaps should, foster collaboration and ultimately strengthen our discipline.

Is there a problem with our current system? On the positive side, the quality of emergency care in this country is generally excellent. Canadian EM scholars have made enormous contributions to the world literature. In general, EPs from the 2 programs have worked well together and have encountered few limitations in their career paths. Scholarly, administrative and political leaders in our discipline have arisen from both training streams.

However, there are clearly downsides associated with being a divided discipline. There are EDs with exclusive recruitment policies. Residents from 1 stream have been precluded from valuable clinical experiences with faculty from the other stream. This is most unfortunate as there are outstanding EM teachers across the country from each stream. The coexistence of the 2 programs inevitably leads to competition for resources and lost opportunities for synergy. Moreover, having 2 streams is confusing for medical students who are considering a career in EM, making it difficult for them to choose the most appropriate program.[8] Because both programs have specific goals beyond producing proficient clinical EPs, both are inherently inefficient. In fact, it could be argued that we do not have a program in Canada that specifically aims to produce clinical EPs!

An ongoing dialogue about the optimal structure and function of EM training is required. The practice of EM is growing in complexity. Faced with the looming demographic changes of our population and our workforce, we need an efficient way to produce a significant number of competent clinical EPs. Unfortunately neither existing stream is well positioned to do this. The CCFP(EM) may appear to be the most efficient program. However, the amount of family medicine content provided over the 3 years is considerably more than is required for those residents planning to work as full-time EPs. Policy-makers also have concerns with the collateral effects of this stream, as it tends to divert physicians trained in family medicine away from comprehensive practice. The FRCP(EM) program is long and produces academic EPs who tend to work in tertiary care centres, often with less than a full-time clinical shift load.

What Canada needs is a single EM residency program that efficiently and effectively produces competent EPs. I believe that this could be accomplished with a 3-year program. There should be a route into this program from family medicine and relevant training should be recognized, shortening the program length for family medicine graduates. After completion of the base EM program, an additional 1 to 2 years should be available for those interested in developing a subspecialty or academic focus. The flexibility of this program would support the development of a wide array of career paths while unifying EM training.

It is unclear whether either of our national colleges would be adaptable enough to develop and accredit such a program. This could be an opportunity for the colleges to collaborate on a conjointly accredited program. It may be that our discipline doesn't fit well with the mandate of either college, as we are both specialists and generalists. Thus the possibility of a Canadian College of Emergency Physicians, as suggested previously,[2] has merit and could be considered.

Residency programs should be designed with 2 fundamental goals: 1) to meet the educational needs of the trainees; and 2) to produce graduates who will meet the needs of society. Ideally, these goals should be unfettered by the political agendas of colleges or university departments, the needs of educators or the service requirements of teaching hospitals. With these goals in mind, I have 2 other concerns with postgraduate EM training.

First, it is important that we produce EPs for all practice environments in the country and avoid the current trend of training physicians who are best prepared for practice in urban academic centres. Graduates need to be aware of the realities of diverse practice settings. All EM programs should provide core rotations in community and rural centres, where valuable insights and experiences would be gained.

Second, I believe that all EM programs should include family medicine rotations in their core curriculum. Consider how often we advise patients to follow up with their family doctor. Our graduates must have insight into the realities of family practice and what can reasonably be accomplished in a community office setting. This would also provide future EPs with a better understanding of the factors involved in family physicians' decisions to refer patients to the ED. Beyond the valuable system perspectives,

there are many important lessons to learn from family medicine educators, particularly their emphasis on a humanistic, patient-focused approach to care. I would add that there is more overlap in the roles of family physicians and EPs than is generally appreciated. I certainly feel that my family medicine training has served me well.

Whatever form our postgraduate training programs take in the future, we need to reach a point where EM in Canada is viewed by all as 1 united discipline. Our education system should foster collaborative and supportive relationships among all physicians who will practise EM. I don't have the answers to all the difficult questions we must tackle, but there is 1 central tenet that seems obvious: emergency medicine is 1 discipline and it should have a unified training program. I believe it is time for a national forum on this matter that should be led by CAEP. As our professional association, CAEP must play a central role in shepherding the formulation of a shared vision of what emergency medicine is in Canada, and what it will be. Our degree of success in addressing these important matters will impact the future welfare of our discipline and, in turn, the broader health care system.

Competing interests: Dr. Tim Rutledge has CCFP-EM emergency medicine certification and is a Fellow of College of Family Physicians of Canada. He holds an appointment as an associate professor in the Department of Family and Community Medicine at the University of Toronto.

Keywords: education, emergency medicine, certification, training, residency

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EM training in Canada: two is better than one

To the editor: We read with interest and concern the articles by Drs. Rutledge[1] and Abu-Laban[2] on EM training in Canada. Dr. Rutledge states that "the coexistence of the 2 programs inevitably leads to competition for scarce resources and lost opportunities for synergy … both are inherently inefficient." Dr. Abu-Laban asks, "but do 2 independently managed training programs provide the optimal solution for Canada. … The evidence indicates that the answer … is a resounding no." Abu-Laban goes on to say, "it makes no sense for career EPs to be trained and certified by the College of Family Physicians of Canada," while Rutledge believes that "1 central tenet seems obvious: emergency medicine is 1 discipline and it should have a unified training program." Rutledge would keep some family medicine rotations, but both are essentially calling for an end to the CFPC route toward EM certification. Abu-Laban would leave only the RCPS(C) route and Rutledge suggests (perhaps) a new college of emergency physicians. Despite these conclusions, no real evidence in support is offered, and we feel the assertions are neither inevitable nor obvious.

Strangely, both authors acknowledge the competency, contributions to the discipline and leadership provided by many graduates of the CFPC program. Both authors describe the national reality that a great deal of emergency care in Canada is and will continue for the foreseeable future to be provided by physicians with no special certification. While not doubting the good intentions of our colleagues and friends, we are disturbed that they are advocating the elimination of an admittedly highly successful program when the benefits are uncertain and the risks and downsides never explored. The whole issue of pediatric emergency training is not addressed.

Canada remains a country of a few dense urban concentrations and a large number of far flung medium and smaller communities. Our greatest challenges in EM today are overcrowding and understaffing. Crowding is almost universal; staffing is most difficult in the medium and smaller community settings, many of them not far from major centres. It is difficult to discern how eliminating our CFPC training route would help with either challenge. Abu-Laban makes a comparison between emergency care and obstetrical care. It isn't a bad comparison. Many family doctors deliver babies in communities with no obstetricians. Some family doctors have extra training and do a great deal of obstetrical care, often side by side with obstetricians. They teach and do research and contribute to policy. They have demonstrated superior outcomes to their obstetrical colleagues in some populations in C-section and episiotomy rates. No one would suggest we do without obstetricians, but family physicians with an interest in obstetrics make significant contributions and provide a different approach and perspective based on their training and clinical experience.

Twenty-five years into a grand experiment, we should be celebrating our successes. Canadian emergency medicine has made significant contributions to the discipline. CTAS is arguably the best validated and described triage scale in the world. The Ottawa Ankle Rules are taught everywhere. Emergency physicians have become key members of the hospital and university community, and many of our colleagues have gone on to key leadership positions as chiefs of staff and CEOs of hospitals, deans of medical schools, registrars, and even a minister of health and an astronaut! So where others see competition and inefficiencies, we see synergy and collaboration. Where others see confusion for prospective trainees, we see extra opportunities and extra choices. Where others see failures, we see resounding success. We could have a national forum to define the term "emergentologist" and to dream about our own college, but most of us have too much work to do. Let's have a national forum on overcrowding and working conditions. Let's have a discussion about what our goals as a discipline should be during our next 25 years. Let's discuss how we can improve our training programs and collaborate further to meet the needs of our trainees, our patients and our communities. But let's not waste any more time on negativity.

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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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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-

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

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

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.

10:30 – 12:00	CONCURRENT SESSIONS				Calgary TELUS Convention Centre
	RESEARCH ***Glen 201***	**MEDICAL EDUCATION** ***Glen 206***	**INTERNAL MEDICINE (CARDIOLOGY/ID)** ***Glen 202-204***	**DISASTER MEDICINE** ***Glen 209***	**PATIENT SAFETY** ***Glen 205***
Chairs:	*Dr. Eddy Lang* *Moderator: Dr. Jeff Perry*	*Dr. Trevor Langhan* *Dr. Ian Wishart*	*Dr. Cathy Dorrington* *Dr. Mike Kenney* *Dr. Adam Oster*	*Dr. Daniel Kollek*	*Dr. Bruce MacLeod* *Dr. Denise Watt*
10:30	Getting to the Finish Line - Publication of Research Results *Dr. Brian Rowe*	Top Educational Research Papers *Dr. Jonathan Sherbino*	Approach and Management of the Sick Cardiac Patient *Dr. Mel Herbert*	EMS Readiness for Tactical Violence *Dr. Karen Wanger*	Context is Everything or How Could I Have Been that Stupid? *Dr. Pat Croskerry*
	PATIENT SAFETY				
11:15	Prescription Errors Detected and Corrected by Pharmacy Service in the ED *Dr. Philip Stasiak*	Continuing Medical Education: The Future is Now *Dr. Mel Herbert*	STEMI – Current and Future Therapies and the Calgary PCI Experience *Dr. Dean Traboulsi*	Gap Analysis and the Hospital Emergency Readiness Overview (HERO) Study *Dr. Daniel Kollek*	Oh Oh – What Do I Do Now? - Management of Serious Adverse Events by Acronym *Dr. Bruce MacLeod*
11:30	Factors Associated with Relapse After Discharge from the Emergency Department with Acute Asthma: The Role of Non-medication Factors *Dr. Brian Rowe*				
11:45	Follow-Up Care and Adverse Outcomes in a Population-Based Cohort of 799,454 Emergency Department Patients Who Left Without Being Seen ** Dr. Michael Schull*				

12:00 – 13:00	LUNCH on Exhibit Floor & Poster Viewing	Exhibition Hall C – CTCC

13:00 – 14:30	CONCURRENT SESSIONS			Calgary TELUS Convention Centre
	RESEARCH ***Glen 201***	**MEDICAL EDUCATION** ***Glen 209***	**INTERNAL MEDICINE (CARDIOLOGY/ID)** ***Glen 206***	**CRITICAL CARE** ***Glen 202-204***
Chairs:	*Dr. Eddy Lang* *Moderator: Dr. John Tallon*	*Dr. Trevor Langhan* *Dr. Ian Wishart*	*Dr. Cathy Dorrington* *Dr. Mike Kenney* *Dr. Adam Oster*	*Dr. Jason Lord*
13:00	And the Survey Says…Survey-Based Research Methodologies *Dr. Jeff Perry*	Emergency Medicine Specialty Certification *Dr. Riyad Abu-Laban, Dr. Brian Holroyd, Dr. Howard Ovens and Dr. Tim Rutledge*	Evidence-based Management of CHF *Dr. Julian Marsden*	Emergency Management of the Severely Head Injured Patient *Dr. David Zygun*
	EMS / GERIATRICS			
13:45	Increased Chest Compression Fraction is Associated with Increased Return of Spontaneous Circulation in Non-ventricular Fibrillation Out-of-Hospital Cardiac Arrest Victims *Dr. Christian Vaillancourt*	Career Longevity versus Seniority: Maintaining Excellence as the Years Roll By *Dr. Peter Gant*	"Crash" Syndromes in the ED *Dr. Robert Rodriguez*	Sepsis Emergency Department *Dr. Robert Green*
14:00	Electronic Selection of EMS Destination to Enhance Capacity and Flow Management *Dr. Bruce MacLeod*			
14:15	Paramedics Assessing Elders at Risk of Independence Loss (PERIL): Non-Transportation Rates of Older Clients in Three EMS Systems *Dr. Jacques Lee*			

Practice patterns of graduates of 2- and 3-year family medicine programs

In Ontario, 1996 to 2004

Michael Green MD MPH CCFP Richard Birtwhistle MD MSc CCFP FCFP Ken MacDonald MSW John Kane MASc Jason Schmelzle MSc

ABSTRACT

OBJECTIVE To compare patterns of practice between graduates of core 2-year family medicine (FM) training programs and those completing an additional postgraduate year (PGY3) of training.

DESIGN Retrospective cohort study using administrative data from the Ontario Health Insurance Plan.

SETTING Ontario.

PARTICIPANTS Graduates of Ontario FM residency programs from 1996 to 2002 who provided insured services in Ontario for 1 or more fiscal years between 1996 and 2004.

MAIN OUTCOME MEASURES Proportion of physician years of service in which a minimum number of services were provided in each of the following categories: anesthesia, emergency medicine (EM), home visits, hospital visits, nursing home visits, intrapartum obstetrics, palliative care, office-only practice, and rural locations, as well as deciles for proportion of billings for emergency department work and "quasi-specialty" designations based on billing patterns. Results are stratified by type of training and years in practice.

RESULTS Graduates of PGY3 programs are significantly more likely to practise in a range of nonoffice settings than their counterparts who completed core 2-year FM training programs. Differences were the most marked in areas in which additional training had been undertaken, but also extended to other categories. There was no effect on the proportion practising in rural locations, unless the training was undertaken in a rural setting or in anesthesia. Physicians including EM in their practices were more likely to practise mostly or almost all EM if they had undertaken either EM programs or self-directed programs at non-northern training sites. Very few graduates of any type were classified as belonging to a quasi-specialty group, other than those who completed care of the elderly or palliative care (hospitalist) and anesthesia programs.

CONCLUSION Completion of a PGY3 program is strongly associated with increased participation in practice outside the office, particularly in the area of the training provided.

EDITOR'S KEY POINTS

- In recent years there has been a slow trend away from comprehensive family medicine practice, as defined by participation in care in various nonoffice settings. Providing family medicine trainees with the skills to provide such services is among the goals of enhanced skills training programs. This study aimed to explore the practice patterns of graduates of such programs.
- The authors found significant differences in the practice patterns of third-year program (PGY3) graduates and those of core program graduates. Graduates of PGY3 programs are more likely to provide care in nonoffice settings, but by far most core program graduates also participate in out-of-office care; only 13.8% initially and less than 20% after 6 years have "office-only" practices. Concerns about substantial diversion into specialized niche practices are largely unfounded, as only a very small number of recent graduates are classified as "quasi-specialists."
- Participation in PGY3 training is strongly associated with increased participation in care outside the office. Access to additional training might be one way to ensure that comprehensive family medicine continues to be a vital component of our health care system.

*Full text is available in English at www.cfp.ca.
This article has been peer reviewed.
Can Fam Physician 2009;55:906-7.e1-12

This is the second of 2 related papers* presenting the results of original research undertaken during a review of postgraduate year 3 (PGY3) residency programs in family medicine (FM) in Ontario.[1] The objective of this study was to compare the practice patterns of PGY3 FM graduates with graduates of the core FM program. These programs exist in designated areas such as emergency medicine (EM), anesthesia, care of the elderly, and palliative care, as well as a range of other areas of interest defined more loosely as *category 2 enhanced skills programs*.

There are only a limited number of publications on the practice patterns of PGY3 graduates. Chan (2002) found that PGY3 EM graduates practised primarily EM (more than 50% of all visits took place in emergency departments), but also noted that 34% of all patient visits by those holding Certification in EM from the College of Family Physicians of Canada (CCFP[EM]) were provided in office settings, and that there was a trend toward more office work the longer these physicians were in practice.[2] Sansom et al (2001) surveyed family physicians with additional training in anesthesia and found that 87% provided anesthesia services, devoting about 13 to 16 hours per week to these services.[3] Chan and Schultz (2005) looked at the practice patterns of all GPs and FPs in Ontario from academic years 1993-1994 to 2001-2002. They found that in general there has been a slow trend away from comprehensive practice, as defined by participation in care in a variety of nonoffice settings.[4,5] Providing FM trainees with the skills to provide such services is one of the goals of enhanced skills training programs. We did not identify any previous studies that undertook a comprehensive examination of the practice patterns of graduates of other PGY3 training programs.

METHODS

Ethics approval was granted by the Health Science Research Ethics Board at Queen's University in Kingston, Ont. Graduates of Ontario FM programs between 1996 and 2002 who provided insured services in Ontario for 1 or more fiscal years between 1996 and 2004 were included in the analysis. Ministry of Health and Long-Term Care (MOHLTC) data on funding of resident training were used to identify and categorize physicians. These years were selected for inclusion because substantial changes in the structure of postgraduate training came into effect for residents graduating in 1995. A number of changes in the designations of funding streams at the MOHLTC were also introduced at this time, which made it difficult to accurately categorize training type before this date.

Many funding categories had small numbers of physicians. These were rolled into a single large category representing most of the category 2 PGY3 programs in the province. Northern program graduates who were not in category 1 programs were left as a separate group. Previously validated algorithms, developed by the Institute for Clinical Evaluative Sciences and the Ontario Physician Workforce Database, were applied to billing data from the Ontario Health Insurance Plan to determine which physicians were providing services in each category.[4,5] For physicians identified as providing EM services, the degree to which they included EM as a part of their practices was determined by allocating each active physician into deciles based on the percentage of their total billings for the fiscal year coming from work in the emergency department. They were then grouped into 4 distinct categories: some EM (<20%), moderate EM (21% to 50%), mostly EM (51% to 80%), and almost all EM (>80%). "Quasi-specialty" designations are assigned to physicians whose billings for each year meet specified criteria, indicating that they are more likely to be practising as a "specialist" in a defined area rather than as a family practitioner.[5] Each fiscal year, a physician contributes to the number of physicians in that year if he or she meets the definition of *active physician* established by the Institute for Clinical Evaluative Sciences.

Given the natural evolution of physicians' practice patterns after graduation, data were summarized by time since graduation. Three time periods were selected: the first 2 years of practice, years 3 to 5 in practice (inclusive), and after 6 or more years in practice. Data availability limited the study to graduates of Ontario FM programs who remained in Ontario after completing their training. Data were compiled by the MOHLTC and provided to the research team in Microsoft Excel. R, version 2.4.1, was used to generate summary tables by training type and number of years since graduation. Stata, version 10, statistical software was used for the analyses. Two sample comparison of proportions were used for the paired comparisons in **Table 1**, χ^2 and Fisher exact tests were used for comparison of the distribution across EM categories between groups and over time, and 1-sided comparisons of proportion versus a presumed value of 1% or less were used for the results of the quasi-specialty designations.

RESULTS

The proportions of graduates in each training category who met the defined service thresholds for each area of practice are summarized in **Table 1**. Comparisons between PGY3 graduates and core 2-year program graduates as well as changes within programs over

*The companion paper on resident and program director perspectives on third-year family medicine programs can be found on **page 904.**

Table 1. Practice patterns of Ontario family medicine graduates (academic years 1995-1996 to 2002-2003) working in Ontario during fiscal years 1996 to 2004: *A) First 2 years of practice after residency; B) years 3 to 5 in practice; C) years 6 and more in practice.*

A)

TYPE OF TRAINING	TOTAL NO. OF PHYSICIAN YEARS	PROPORTION OF PHYSICIAN YEARS								
		ANESTHESIA	EM	HOME VISITS	HOSPITAL VISITS	NURSING HOME VISITS	OBSTETRICS	OFFICE ONLY	PALLIATIVE CARE	RURAL
PGY2 (all)	2051	0.7	35.7	32.4	48.8	10.1	11.1	13.8	0.8	15.7
EM	347	6.3*	98.6*	8.1*	68.3*	3.2*	1.7*	0.3*	0.0	13.8
Anesthesia	47	91.5*	72.3*	19.1	68.1†	10.6	6.4	0.0†	0.0	31.9†
Elderly or palliative care	31	0.0	25.8	61.3‡	71.0§	41.9*	3.2	6.5	6.5‡	19.4
NOFM or NOMP	53	20.8*	86.8*	17.0†	88.7*	18.9§	39.6*	1.9§	1.9	73.6*
All others	224	10.7*	48.2†	24.1§	63.8*	8.0	33.0*	12.9	0.9	12.9

B)

TYPE OF TRAINING	TOTAL NO. OF PHYSICIAN YEARS	PROPORTION OF PHYSICIAN YEARS								
		ANESTHESIA	EM	HOME VISITS	HOSPITAL VISITS	NURSING HOME VISITS	OBSTETRICS	OFFICE ONLY	PALLIATIVE CARE	RURAL
PGY2 (all)	2422	0.8	30.8	33.4	47.4	9.8	8.6	14.6	2.0	14.6
EM	346	9.0*	95.7*	10.4*	67.1*	2.9*	1.4*	0.9*	0.3§	11.9
Anesthesia	34	91.2*	55.9†	26.5	64.7§	17.6	14.7	0.0§	0.0	23.5
Elderly or palliative care	24	0.0	29.2	33.3‖	62.5	37.5*	0.0	16.7	4.2	16.7
NOFM or NOMP	48	16.7*	72.9*	20.8	79.2*	20.8§	43.8*	14.6	0.0	64.6*
All others	246	15.0*	44.7*	24.4†	62.6*	6.9	30.9*	9.4§	2.0	10.6

C)

TYPE OF TRAINING	TOTAL NO. OF PHYSICIAN YEARS	PROPORTION OF PHYSICIAN YEARS								
		ANESTHESIA	EM	HOME VISITS	HOSPITAL VISITS	NURSING HOME VISITS	OBSTETRICS	OFFICE ONLY	PALLIATIVE CARE	RURAL
PGY2 (all)	1389	1.0	23.2¶	31.7	41.2¶	10.2	6.4¶	19.3#	3.4#	11.7**
EM	159	15.7*††	91.2*¶	13.8*††	66.0*	3.8†	0.6†	0.6*	1.3††	8.2
Anesthesia	Cell numbers too small to report									
Elderly or palliative care	Cell numbers too small to report									
NOFM or NOMP	22	22.7*	86.4*	18.2	77.3†	18.2	45.5*	0.0§	9.1	50.0*‖
All others	168	14.3	44.0	22.0	51.8‖	4.2	25.0	13.7	1.8	10.7

EM—emergency medicine, NOFM—Northeastern Ontario Family Medicine Program, NOMP—Northwestern Ontario Medical Program, PGY2—postgraduate year 2.
Data from the Ontario Ministry of Health and Long-Term Care, April 2006.
*$P < .0001$ compared with PGY2 graduates.
†$P < .01$ compared with PGY2 graduates.
‡$P < .001$ compared with PGY2 graduates.
§$P < .05$ compared with PGY2 graduates.
‖Decreased ($P < .05$) compared with years 1 and 2 in same program (years 3-5 for anesthesia and elderly or palliative care, years ≥6 for all others).
¶Decreased ($P < .0001$) compared with years 1 and 2 in same program.
#Increased ($P < .0001$) compared with years 1 and 2 in same program.
**Decreased ($P < .001$) compared with years 1 and 2 in same program.
††Increased ($P < .001$) compared with years 1 and 2 in same program.
‡‡Increased ($P < .05$) compared with years 1 and 2 in same program.

time are also reported. These results are also presented graphically in more detail in **Figures 1** to **6**. **Table 2** presents data on the proportion of physicians in each category of EM practice, as well as a comparison of practice distribution among training programs and within training programs over time. **Figures 7** to **12** present these results graphically in more detail (by deciles). **Table 3** presents the proportions of physician years in each quasi-specialty area by training program. We elected to compare these to an arbitrarily set limit of 1% to determine if there was significant movement away from general practice to more specialized practice.

DISCUSSION

There are significant differences between the practice patterns of PGY3 program graduates and those of core program graduates. Graduates of PGY3 programs are more likely to be involved in the delivery of care in nonoffice settings, particularly hospitals. By far most core program graduates also participate in out-of-office care, with only 13.8% initially and less than 20% after 6 years having "office-only" practices. Concerns that have been expressed about substantial diversion into specialized niche practices are largely unfounded, with only a very small number of recent graduates being classified as "quasi-specialists." The type of training undertaken has a substantial effect on the areas of care included in future practice. Graduates of EM programs are significantly more likely than graduates of any other program to include work in the emergency department as part of their practices, with 98.6% doing so initially. This proportion remains high but drops in later years. Emergency medicine graduates are also more likely to work in hospital settings and provide anesthesia services, but are less likely to provide home visits, nursing home visits, or obstetric services than core program graduates are. About 75% of this group practises mostly EM, but less than 18% is considered to be practising "almost all" EM.

During the first 2 years of practice, we found significantly fewer EM program graduates practising "almost all" EM than did Chan (12% vs 36%).[2] Although basic differences in our definitions could account for this (we used proportion of billings rather than proportion of visits), we also used a more liberal definition (>80% of billings vs >90% of visits) than Chan, which should have had the opposite effect. Other possible explanations include the substantial changes that occurred in the postgraduate training system and the expansion of the numbers of positions offered over time. Our data also show that core program graduates and graduates of non-EM enhanced skills training programs continue to play important roles in the provision of EM services in Ontario, with more than 70% of physician years identified as coming from these categories. While most of these physicians practise "some" (0% to 20% of billings) or "moderate" (21% to 50%) amounts of EM, by 6 years after residency and beyond they also made up more than half of the "mostly" (51% to 80%) and "almost all" (81% to 100%) EM groups. This is consistent with the findings of Bhimani et al who, in their 2005 survey of emergency departments in southwestern Ontario, found that 70% of physicians practising in the emergency departments they studied were family physicians with no formal additional EM training.[6]

Graduates of other programs also demonstrated increased involvement in nonoffice care, with the strongest effects being in the areas in which they had trained. All PGY3 graduates were more likely to include hospital inpatient care in their practices initially and, except for graduates of care of the elderly or palliative care programs, to work in the emergency department. Category 2 programs include programs with additional training in obstetrics, and the high rates of participation in this important area of FM is evident—more than a third of PGY3 graduates in these categories included obstetrics in their practices in the first 2 years and more than a quarter were still doing so after 6 years of practice. As is the case with EM, it is important to recognize the essential contributions of core program graduates to this area of service, with approximately two-thirds of those practising obstetrics having no additional formal training. This finding highlights the importance of maintaining adequate educational experiences in intrapartum obstetrics in the core FM training program in addition to providing additional experience through PGY3 opportunities.

There were no statistically significant differences in rural versus urban practice location between graduates of EM, care of the elderly or palliative care, and other category 2 programs and their core program peers. Only anesthesia and category 2 programs offered by the Northeastern Ontario Family Medicine Program and the Northwestern Ontario Medical Program were associated with increased rural practice. This contradicts the findings of previous studies that showed that EM training was significantly associated with a trend toward urban (odds ratio 2.62, 95% confidence interval 1.19 to 5.75) rather than rural (odds ratio 0.30, 95% confidence interval 0.13 to 0.67) practice, and that non-EM additional training resulted in increased rural practice ($P<.001$).[2,7] There are some likely reasons for this. First, we were limited to examining the practices of residents trained in Ontario who remained in Ontario after graduation. Compared with what was reported by Hutton-Czapski and Thurber, our data show less participation in rural practice for core program graduates (15.7% vs 20.9%) and more participation in rural practice for EM graduates (13.8% vs 6.5% early in practice.).[7] Our rates (13.8% initially, 8.2% later in practice) are closer to those reported by Chan (10.1%) in his cross-sectional survey of

Figure 1. Comprehensiveness of care provided by graduates of core 2-year family medicine programs in Ontario

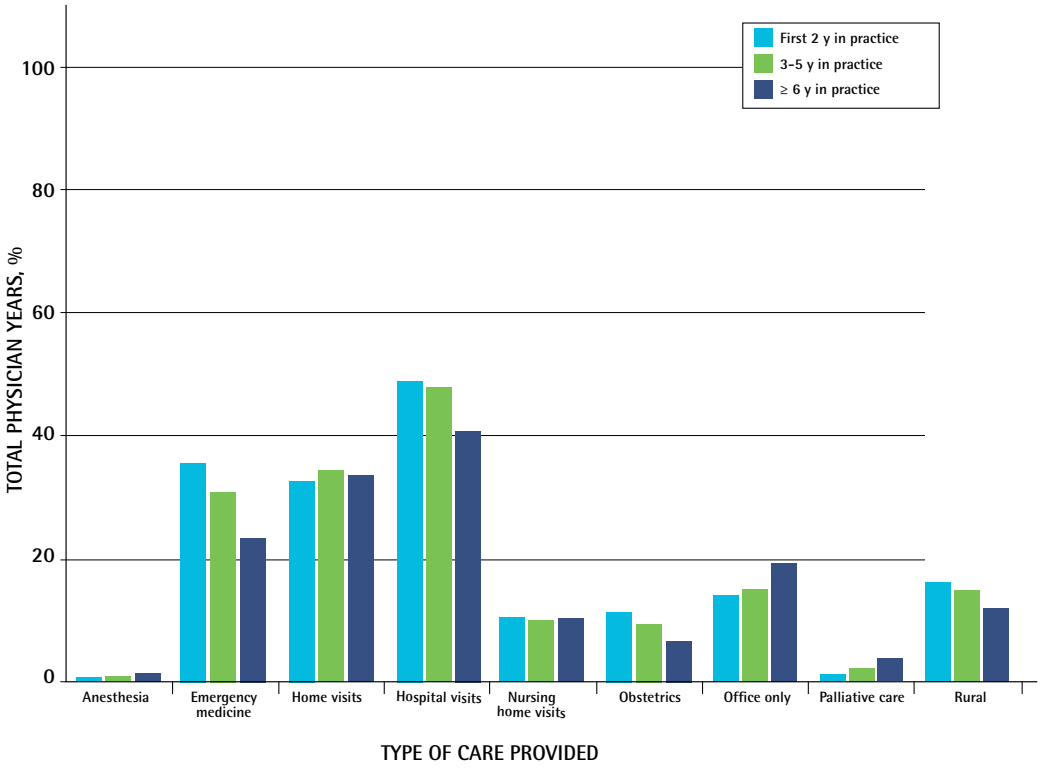


Figure 2. Comprehensiveness of care provided by graduates of third-year programs in emergency medicine in Ontario

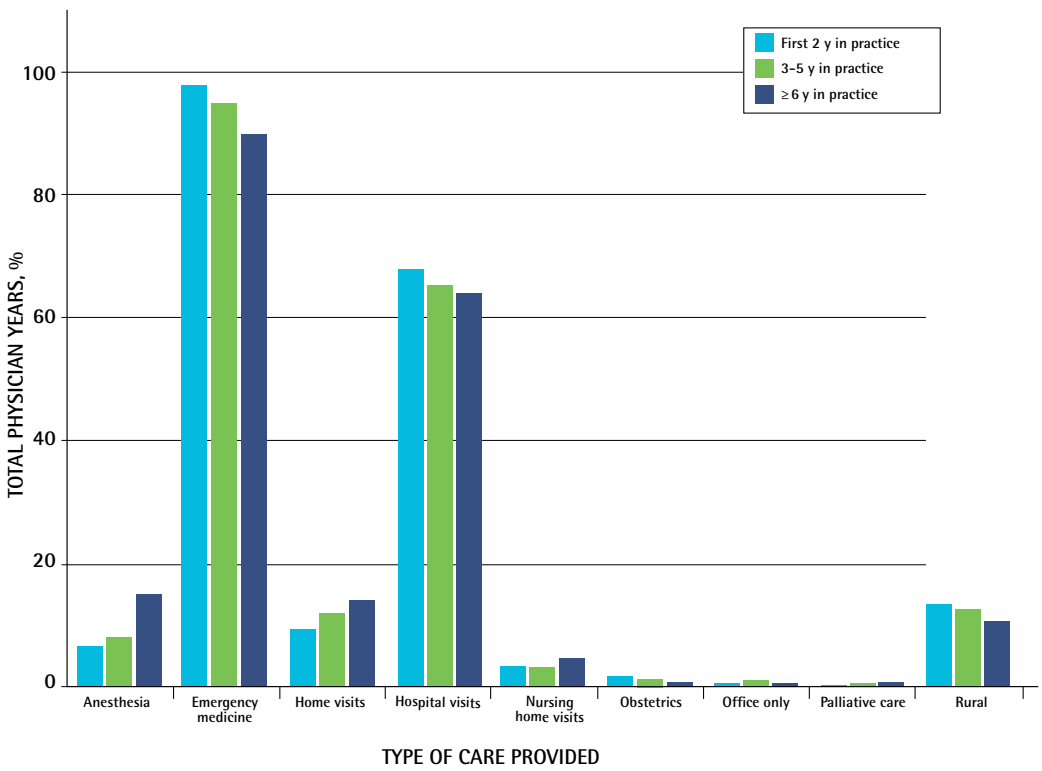


Figure 3. Comprehensiveness of care provided by graduates of third-year programs in anesthesia in Ontario

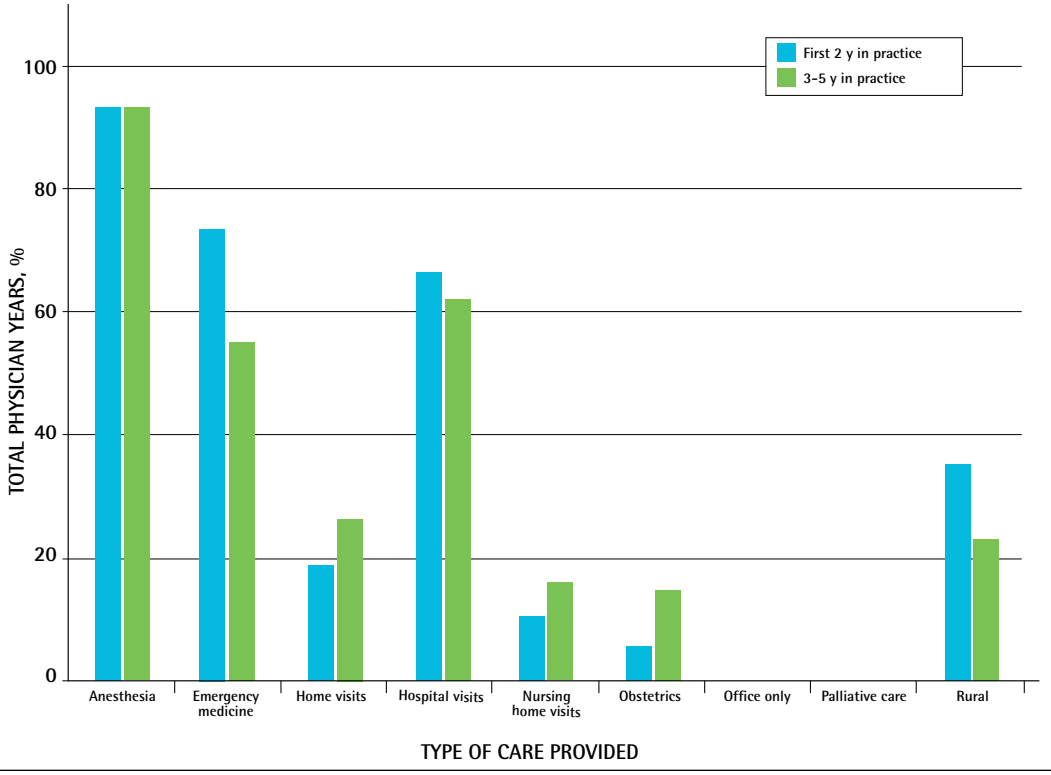


Figure 4. Comprehensiveness of care provided by graduates of third-year programs in care of the elderly and palliative care in Ontario

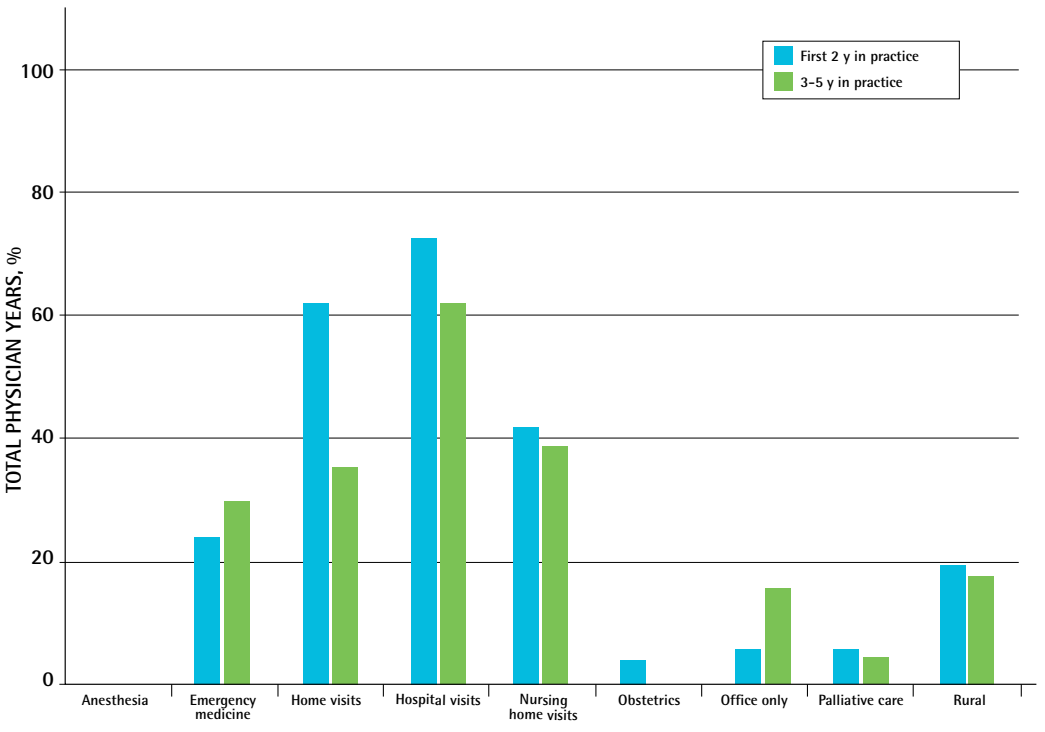


Figure 5. Comprehensiveness of care provided by graduates of third-year programs other than emergency medicine (all years) or anesthesia (2000-2001 to 2002-2003) from the Northeastern Ontario Family Medicine Program or the Northwestern Ontario Medical Program

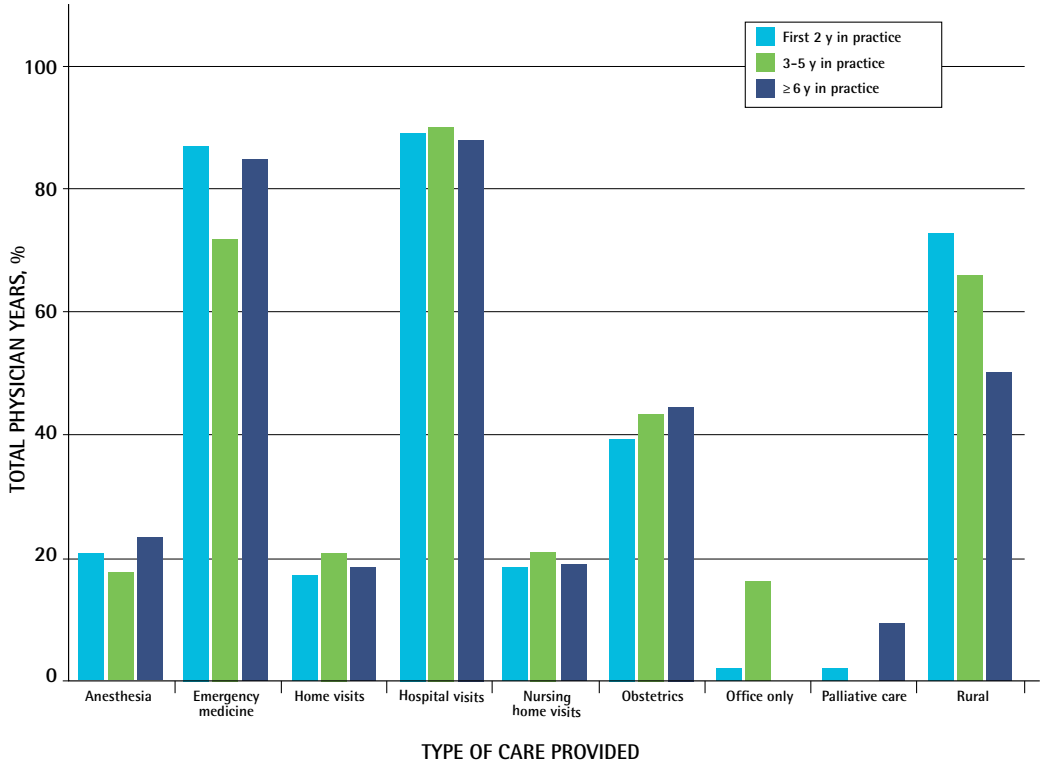


Figure 6. Comprehensiveness of care provided by graduates of all other third-year programs (excluding emergency medicine, anesthesia, care of the elderly or palliative care, and northern program graduates) in Ontario

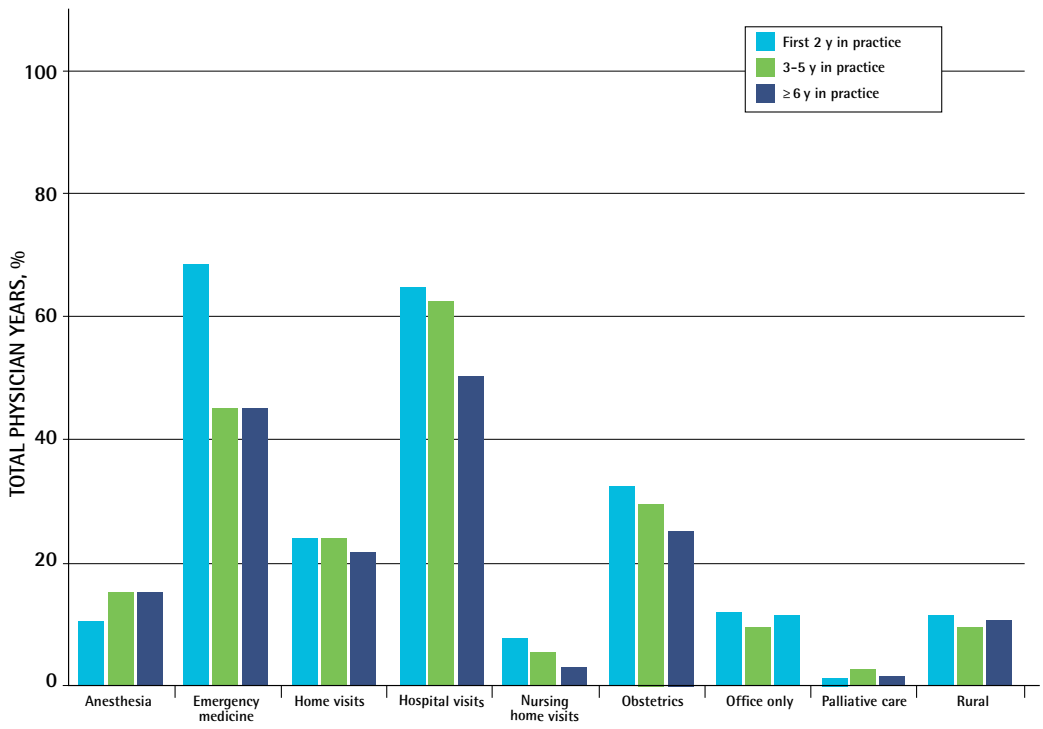


Table 2. Proportion of physician years worked by physicians providing some EM (emergency department billings accounting for 0%–20% of total billings), moderate EM (21%–50%), mostly EM (51%–80%), or almost all EM (81%–100%) care, by type of training: *A) First 2 years of practice after residency; B) years 3 to 5 in practice; C) years 6 and more in practice.*

A)

TYPE OF TRAINING*	TOTAL NO. OF PHYSICIAN YEARS	PROPORTION OF TOTAL PHYSICIAN YEARS BY TYPE OF TRAINING (PROPORTION OF PHYSICIAN YEARS BY AMOUNT OF EM CARE)			
		SOME EM N = 596 PHYSICIAN YEARS	MODERATE EM N = 285 PHYSICIAN YEARS	MOSTLY EM N = 327 PHYSICIAN YEARS	ALMOST ALL EM N = 55 PHYSICIAN YEARS
PGY2 (all)	733	63.4 (78.0)	26.1 (67.0)	8.9 (19.9)	1.6 (21.8)
EM	342	7.6 (4.4)	16.1 (19.3)	64.3 (67.3)	12.0 (74.6)
Anesthesia	34	76.5 (4.4)	23.5 (2.8)	0 (0)	0 (0)
Elderly or palliative care	Cell numbers too small to report				
NOFM or NOMP	46	76.1 (5.9)	17.4 (2.8)	6.5 (0.9)	0 (0)
All others	108	40.7 (7.3)	21.3 (8.1)	36.1 (11.9)	1.9 (3.6)

B)

TYPE OF TRAINING†† §	TOTAL NO. OF PHYSICIAN YEARS	PROPORTION OF TOTAL PHYSICIAN YEARS BY TYPE OF TRAINING (PROPORTION OF PHYSICIAN YEARS BY AMOUNT OF EM CARE)			
		SOME EM N = 508 PHYSICIAN YEARS	MODERATE EM N = 274 PHYSICIAN YEARS	MOSTLY EM N = 354 PHYSICIAN YEARS	ALMOST ALL EM N = 104 PHYSICIAN YEARS
PGY2 (all)	745	55.0 (80.7)	25.2 (68.6)	16.1 (33.9)	3.7 (26.0)
EM	331	6.3 (4.1)	15.1 (18.2)	59.9 (55.9)	18.7 (59.6)
Anesthesia	19	63.1 (2.4)	31.6 (2.2)	5.3 (0.3)	0 (0)
Elderly or palliative care	Cell numbers too small to report				
NOFM or NOMP	35	74.3 (5.1)	14.3 (1.8)	11.4 (1.1)	0 (0)
All others	110	35.4 (7.7)	22.8 (9.1)	28.2 (8.8)	13.7 (14.4)

C)

TYPE OF TRAINING†||§	TOTAL NO. OF PHYSICIAN YEARS	PROPORTION OF TOTAL PHYSICIAN YEARS BY TYPE OF TRAINING (PROPORTION OF PHYSICIAN YEARS BY AMOUNT OF EM CARE)			
		SOME EM N = 198 PHYSICIAN YEARS	MODERATE EM N = 125 PHYSICIAN YEARS	MOSTLY EM N = 176 PHYSICIAN YEARS	ALMOST ALL EM N = 61 PHYSICIAN YEARS
PGY2 (all)	322	45.6 (74.2)	25.7 (65.6)	22.1 (40.4)	6.6 (36.1)
EM	145	9.6 (7.1)	15.9 (18.4)	56.6 (46.6)	17.9 (42.6)
Anesthesia	Cell numbers too small to report				
Elderly or palliative care	Cell numbers too small to report				
NOFM or NOMP	19	68.4 (6.6)	0 (0)	26.3 (2.8)	5.3 (1.6)
All others	74	32.4 (12.1)	27.0 (16.0)	24.3 (10.2)	16.3 (19.7)

EM—emergency medicine, NOFM—Northeastern Ontario Family Medicine Program, NOMP—Northwestern Ontario Medical Program, PGY2—postgraduate year 2.

Data from the Ontario Ministry of Health and Long-Term Care, April 2006.

*First 2 years of practice: Distribution by type of training significantly different between those completing EM training and all other groups ($P<.0001$) and between "All others" and all other groups ($P<.0001$), but not between PGY2 and anesthesia or NOFM/NOMP.

†Years 3-5 in practice: Distribution by type of training significantly different between those completing EM training and all other groups ($P<.0001$) and between "All others" and all other groups ($P<.0001$ vs EM, PGY2, and NOFM/NOMP; $P=.03$ vs anesthesia), but not between PGY2 and anesthesia or NOFM/NOMP.

‡Distribution of amount of EM within a particular type of training program significantly different later in practice (years 3-5 for elderly or palliative care, years ≥ 6 for all others vs years 1 and 2) for PGY2 ($P<.001$), NOFM/NOMP ($P=.02$), and "All others" ($P=.002$), but not for EM or anesthesia.

§Over time the relative contribution of training programs other than EM to the "Mostly EM" ($P<.0001$) and "Almost all EM" ($P=.003$) categories increases significantly.

||Years ≥ 6 in practice: Distribution by type of training significantly different between those completing EM training and all other groups ($P<.0001$) and between "All others" and all other groups ($P<.0001$ vs EM, $P=.03$ vs PGY2, $P=.01$ vs NOFM/NOMP), but not between PGY2 and NOFM/NOMP.

physicians with the CCFP(EM) designation in Ontario in 1999 and 2000, so regional variation could be a factor.[2] The effects of large urban medical schools, such as the University of Toronto in Ontario, which are known to produce fewer rural physicians, might explain the lower overall rate of participation in rural practice. In addition, any PGY3 EM graduates seeking work in large urban centres outside of Ontario would have been excluded from the study. The fact that we were comparing 2 fairly homogeneous groups who have relatively greater access to PGY3 training than their counterparts in other regions (Ontario has more PGY3 positions per graduating PGY2 trainee than most other provinces) could also explain the relative lack of effect on location of practice.

Limitations

There are some limitations to our analysis. We were provided with summary information by type of training and year of graduation only and did not have access to individual physician-level data, so were not able to conduct

Table 3. Proportion of physician years worked by physicians with quasi-specialty designations, by type of training program: *A) First 2 years of practice after residency; B) years 3 to 5 in practice; C) years 6 and more in practice.*

A)

		PROPORTION OF PHYSICIAN YEARS (95% CI)				
TYPE OF TRAINING	TOTAL NO. OF PHYSICIAN YEARS	HOSPITALIST	SURGERY	SURGICAL ASSISTANT	ANESTHESIA	PSYCHOTHERAPY
PGY2 (all)	2051	1.1 (0.7-1.7)	0	0.15 (0.03-0.4)	0.1 (0.01-0.3)	0.8 (0.5-1.3)
EM	347	0	0	0.3 (0.01-1.6)	0.6 (0.1-2.1)	0
Anesthesia	47	0	0	0	42.6 (28.3-57.8)*	0
Elderly or palliative care	31	25.8 (11.9-44.6)*	0	0	0	0
NOFM or NOMP	53	1.9 (0.5-10.1)	0	0	5.7 (1.2-15.7)†	0
All others	224	1.3 0.3-3.9)	0.9 (0.1-3.2)	0	2.2 (0.7-5.1)‡	1.8 (0.5-4.5)

B)

		PROPORTION OF PHYSICIAN YEARS (95% CI)				
TYPE OF TRAINING	TOTAL NO. OF PHYSICIAN YEARS	HOSPITALIST	SURGERY	SURGICAL ASSISTANT	ANESTHESIA	PSYCHOTHERAPY
PGY2 (all)	2422	1.0 (0.1-1.5)	0.04 (0.001-0.2)	0.1 (0.01-0.3)	0.3 (0.1-0.6)	0.7 (0.4-1.1)
EM	346	0	0	0.3 (0.01-1.6)	0.9 (0.2-2.5)	0
Anesthesia	34	0	0	0	41.2 (24.6-59.3)*	0
Elderly or palliative care	24	16.7 (4.7-37.4)*	0	0	0	0
NOFM or NOMP	48	0	0	0	4.2 (0.5-14.3)‡	0
All others	246	1.2 (0.3-3.5)	1.6 (0.4-4.1)	0	6.1 (3.5-9.9)*	0.4 (0.01-2.2)

C)

		PROPORTION OF PHYSICIAN YEARS (95% CI)				
TYPE OF TRAINING	TOTAL NO. OF PHYSICIAN YEARS	HOSPITALIST	SURGERY	SURGICAL ASSISTANT	ANESTHESIA	PSYCHOTHERAPY
PGY2 (all)	1389	1.8 (1.2-2.6)§	0	0.5 (0.2-1.0)	0.43 (0.2-0.9)	0.6 (0.2-1.1)
EM	159	1.3 (0.2-4.4)	0	0	1.3 (0.2-4.4)	0
Anesthesia	Cell numbers too small to report					
Elderly or palliative care	Cell numbers too small to report					
NOFM or NOMP	22	0	0	0	0	0
All others	168	0	1.8 (0.4-5.1)	0	10.1 (6.0-15.7)*	0

CI—confidence interval, EM—emergency medicine, NOFM—Northeastern Ontario Family Medicine Program, NOMP—Northwestern Ontario Medical Program, PGY2—postgraduate year 2.

Data from the Ontario Ministry of Health and Long-Term Care, April 2006.

*Significantly greater than a hypothesized value of ≤ 1% (1-sided test of proportions), $P < .0001$.

†Significantly greater than a hypothesized value of ≤ 1% (1-sided test of proportions), $P < .001$.

‡Significantly greater than a hypothesized value of ≤ 1% (1-sided test of proportions), $P < .05$.

§Significantly greater than a hypothesized value of ≤ 1% (1-sided test of proportions), $P < .01$.

Figure 7. Proportion of total billings derived from work in the emergency department for graduates of core 2-year family medicine programs (seeing ≥ 50 emergency medicine patients/y) in Ontario

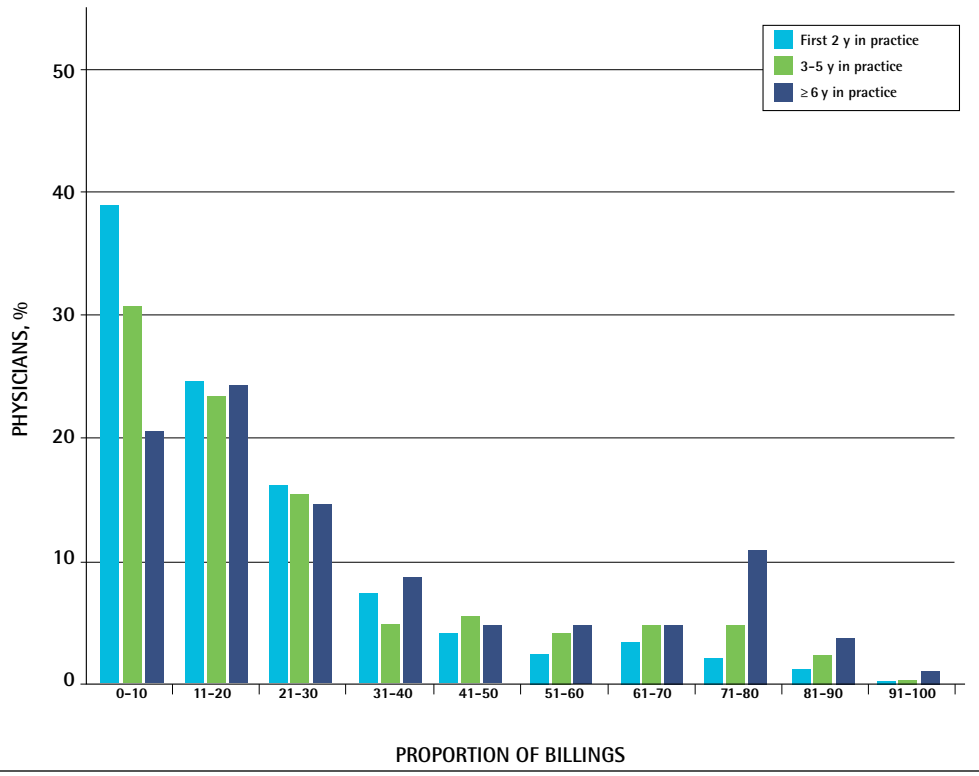


Figure 8. Proportion of total billings derived from work in the emergency department for third-year emergency medicine program graduates (seeing ≥ 50 emergency medicine patients/y) in Ontario

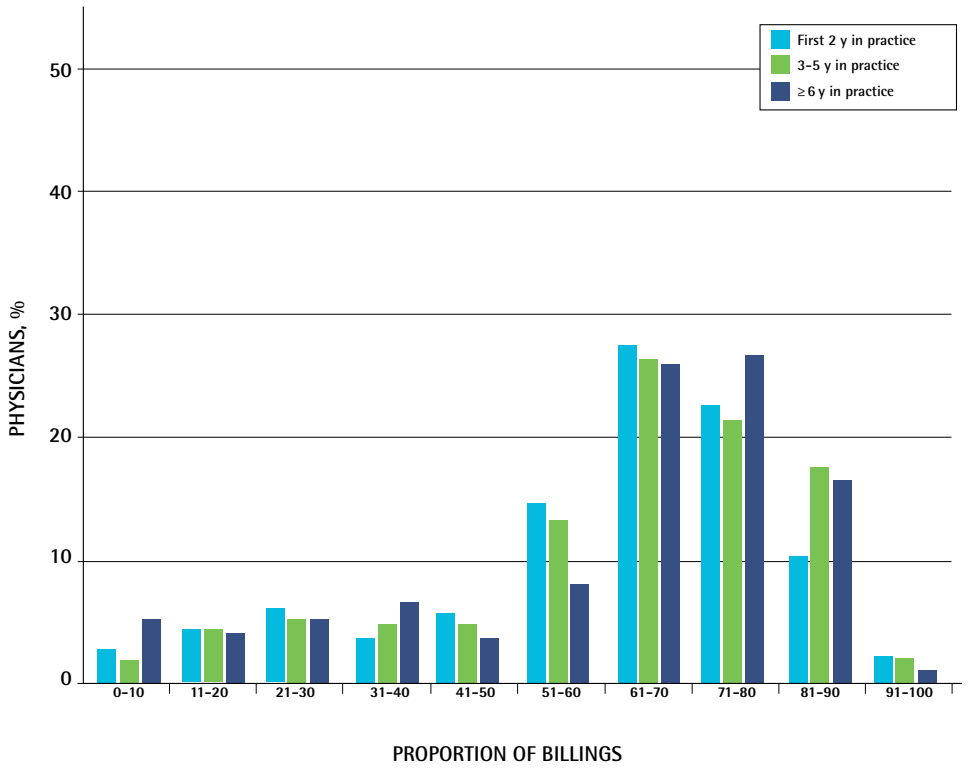


Figure 9. Proportion of total billings derived from work in the emergency department for third-year anesthesis program students (seeing ≥ 50 emergency medicine patients/y)

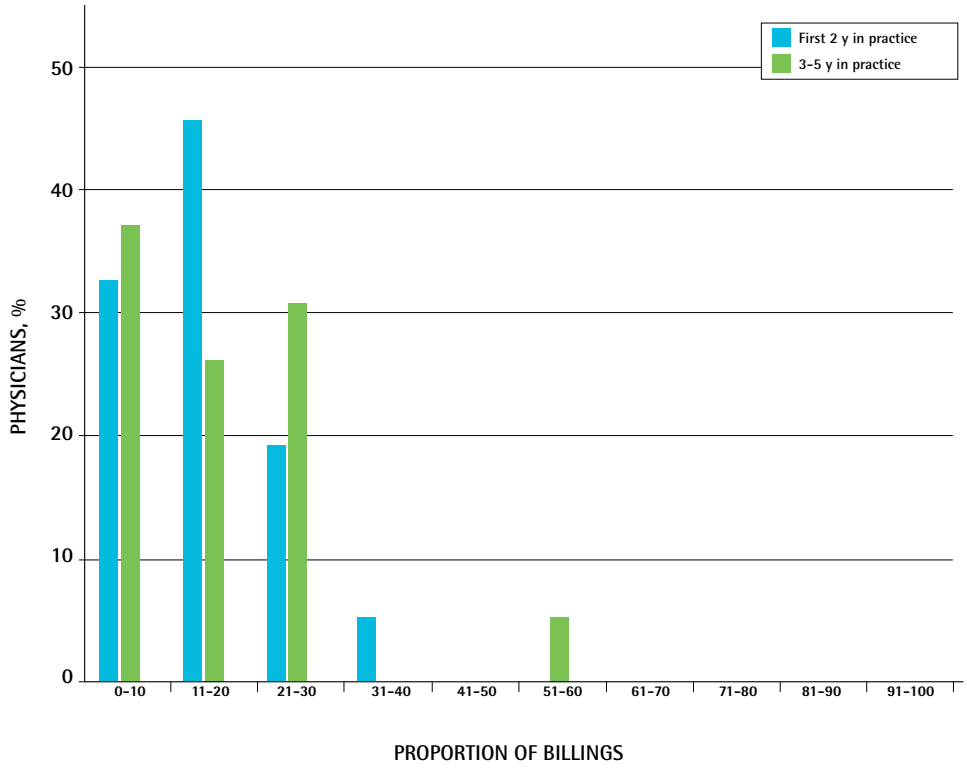


Figure 10. Proportion of total billings derived from work in the emergency department for third-year care of the elderly and palliative care program graduates (seeing ≥ 50 emergency medicine patients/y) in Ontario

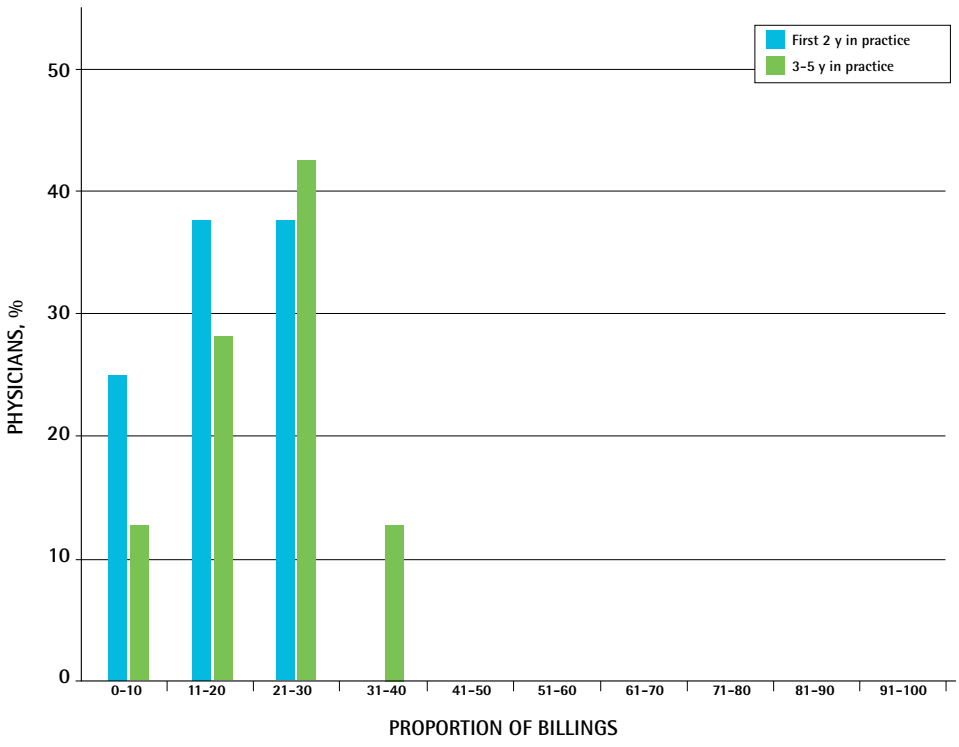


Figure 11. Proportion of total billings derived from work in the emergency department for third-year program graduates from the Northeastern Ontario Family Medicine Program or the Northwestern Ontario Medical Program

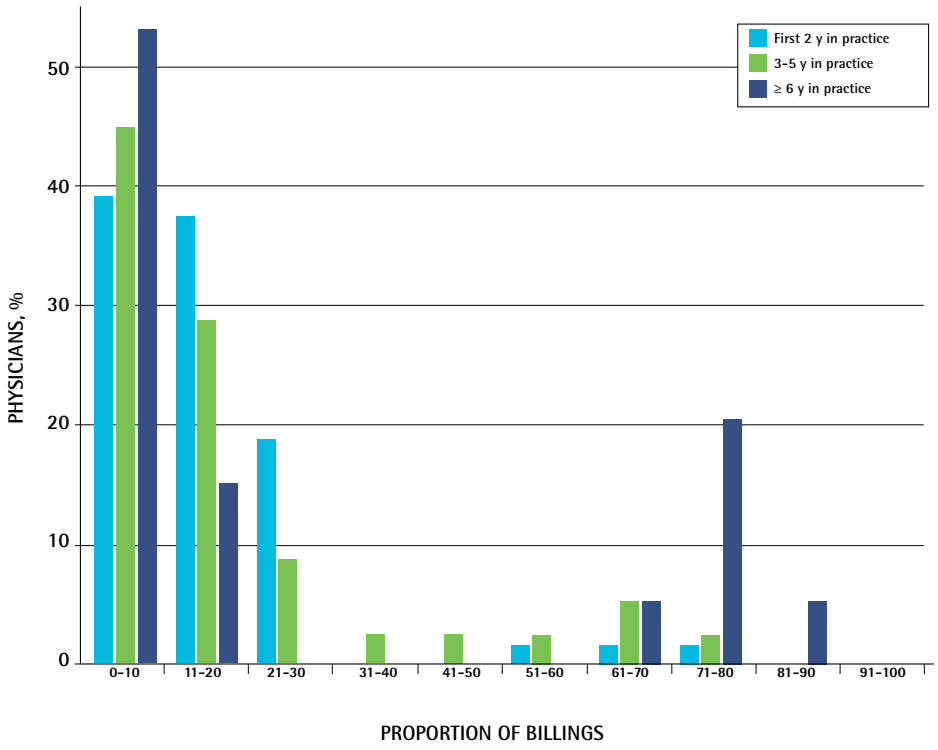
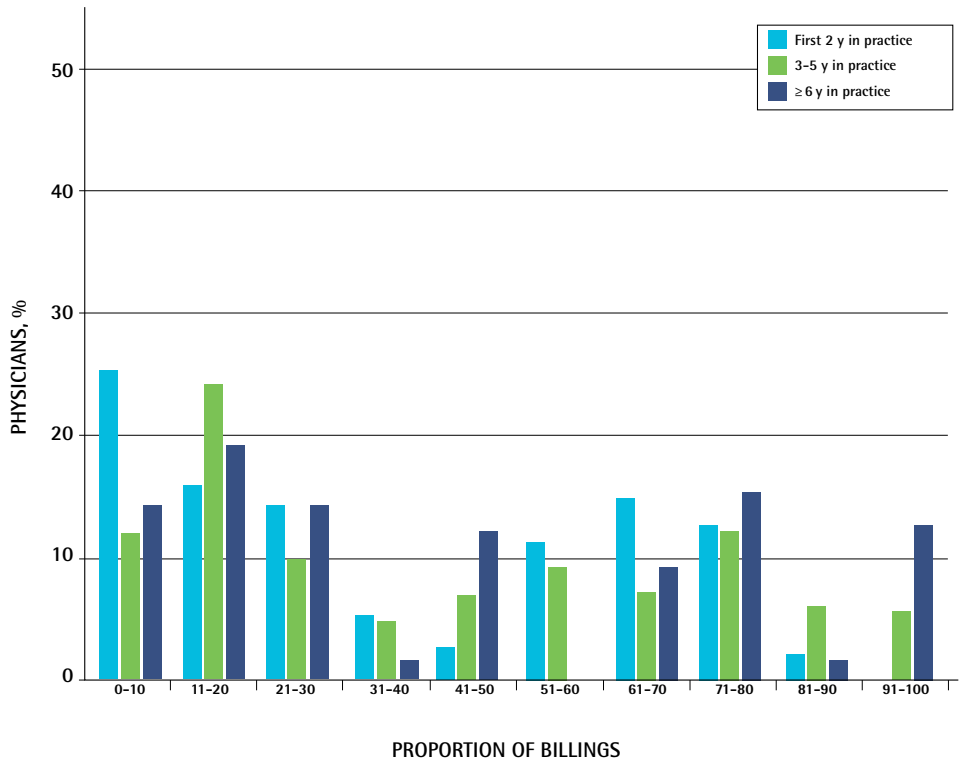


Figure 12. Proportion of total billings derived from work in the emergency department for graduates (seeing ≥ 50 emergency medicine patients/y) of all other third-year programs (excluding emergency medicine, anesthesia, care of the elderly or palliative care, or northern programs)



logistic regression analyses to examine the effects of possible confounding variables such as age, sex, or rural location of provider on our outcomes of interest. In addition there was a relatively limited follow-up period, with a maximum of 9 years of practice being possible given the start date for our study cohort. Changes in practice patterns were noted between the earliest and latest practice periods for many of the groups and there is good reason to believe that these trends will continue over time. This is of particular importance when considering how we think about those physicians who place a large emphasis on one area of practice initially (eg, EM program graduates in the "mostly" or "almost all" EM categories or anesthesia program graduates with a quasi-specialty designation in that area). Some have argued that they are not really family physicians, but actually specialists in their areas.[8] Our data show that participation in out-of-office care is in fact the norm, rather than the exception, in FM and that work profiles of PGY3 graduates evolve toward more office-based practice over time. As any specified value for the amount of traditional office-based family practice required to be considered a family physician is arbitrary, we think that an inclusive view that embraces all family physicians, regardless of their area of specialization is more appropriate. In addition, it is important to recognize that while receiving additional training is associated with increased participation in certain areas of practice, it is not necessarily causal. As resident interest is the primary driver for participation in these programs, it is quite possible that many of these individuals would pursue their interests even in the absence of additional training.

Conclusion

Participation in PGY3 training is strongly associated with increased participation in care outside the office. This effect is greatest in their areas of specialization, but for many trainees it also extends to other areas, particularly those based in hospitals. While this is not the only possible definition of comprehensiveness of care, it is one that can be measured and that addresses the needs of the public for access to a range of health care services. Access to additional training, particularly resident-driven category 2 programs, might be one way to ensure that comprehensive FM continues to be a vital component of our health care system. While we think that EM program graduates should be thought of as family physicians with a special area of interest, they generally devote most of their time to practising EM, at least in the first 9 years of practice. The need for EM physicians should therefore be an important factor in determining the number of positions offered in this area.

Dr Green is an Associate Professor in the Department of Family Medicine and the Department of Community Health and Epidemiology, a member of the Centre for Health Services and Policy Research, and Associate Director of the Centre for Studies in Primary Care at Queen's University in Kingston, Ont. **Dr Birtwhistle** is a Professor in the Department of Family Medicine and the Director of the Centre for Studies in Primary Care at Queen's University. **Mr MacDonald** is the Associate Director of Administration and Management with the Centre for Health Services and Policy Research and Assistant Professor in the Department of Community Health and Epidemiology at Queen's University. **Mr Kane** is a Research Associate at the Centre for Health Services and Policy Research and **Mr Schmelzle** is a Research Associate at the Centre for Studies in Primary Care at Queen's University.

Acknowledgment

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Competing interests

Dr Green, Dr Birtwhitle, and **Mr MacDonald** all received consulting fees from the Ontario Ministry of Health and Long-Term Care and the Council of Ontario Universities to conduct this research.

Contributors

Dr Green, Dr Birtwhistle, and **Mr MacDonald** all contributed to the study design. **Dr Green** and **Mr Schmelzle** performed the key informant interviews and conducted the analysis of survey results. **Mr Kane** and **Dr Green** performed the analysis of administrative data. All authors contributed to the drafting and revising of the manuscripts.

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Emergency Physicians Dual Certification Survey – Online Survey Results

Report

September 2009

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Background and Objectives

CAEP is an association that represents the interest of emergency physicians in Canada. CAEP plays an important role in providing continuing medical education and advocates on behalf of emergency physicians and their patients. Furthermore, CAEP, in cooperation with other specialties and committees, plays a vital role in the development of national standards and clinical guidelines.

Recently, CAEP was called to look at issues related to the current training system via editorials in CJEM. Feedback was required from the emergency medical community regarding the dual certification system of emergency physicians' training in Canada. To address this issue, CAEP conducted an online survey with various members of the emergency medical community across Canada.

The overall objectives of this research were to:

- ✓ Evaluate satisfaction of the current dual certification training system in Canada;
- ✓ Evaluate the emergency medical community's openness to changes to the current training system;
- ✓ Evaluate the importance of changing the current training system in relation to other issues related to emergency medicine;

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Methodology

•A total of 616 surveys were completed among members of the emergency medical community. The table below features the number of completed surveys for each designation:

	MD	CCFP	CCFP (EM)	FRCPC	Other & No Answer
# of completes	64	53	294	127	78
% of sample	10%	8%	48%	21%	13%
TOTAL:	**616**				

•CAEP designed the questionnaire and posted it online on the SurveyMonkey.com website. The survey was available in French and English. Respondents were given the option to answer the survey in the language of their choice.

•Once the data was collected, CAEP requested the services of the research firm Harris/Decima to analyse the results and write a report of the findings.

•Data collection for this survey was conducted from May 14 to May 29, 2009. The margin of error of the survey is +/- 3.95 per cent.

•The duration of the survey was approximately 5 minutes.

Detailed Survey Results

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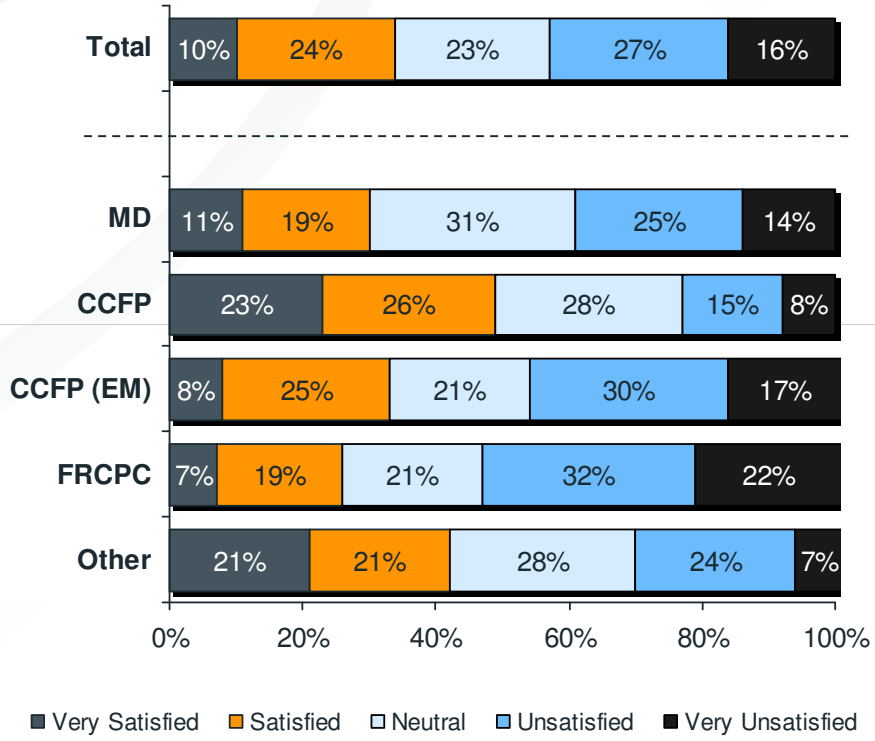
Dissatisfaction with Current Canadian Dual Certification Training System

1) How satisfied are you with the current two College, dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada?



Base: n=614

- More than 4 out of 10 respondents claimed they were dissatisfied with the current two College dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada (27% said unsatisfied and 16% said very unsatisfied).
- However, respondents aged 40 years old or older were more likely to be satisfied with the current system than younger respondents aged 20 to 39 (38% vs. 28%, respectively).
- Also, CCFP's were more likely to be satisfied with the current system as is.

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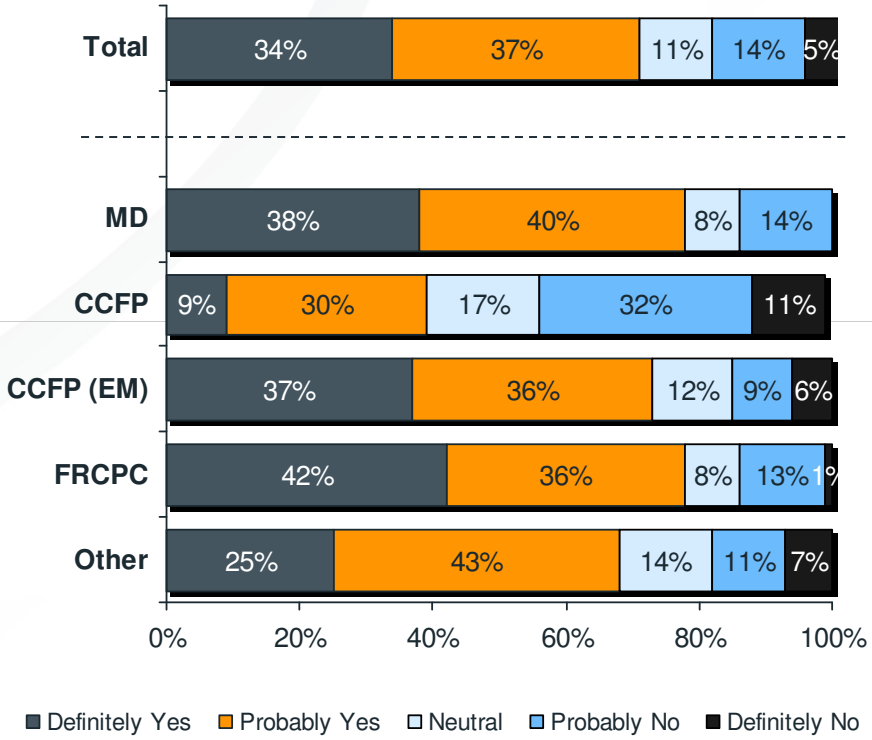
Changes Beneficial to Current Canadian Dual Certification Training System

2) Do you feel changes to the current two College, dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada would be beneficial to emergency medicine in Canada?



Base: n=612

- The majority of respondents (71%) felt that changes to the current two College, dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada would be beneficial to emergency medicine in Canada.
- All designations felt this way except CCFPs who were more likely to disagree with this statement.

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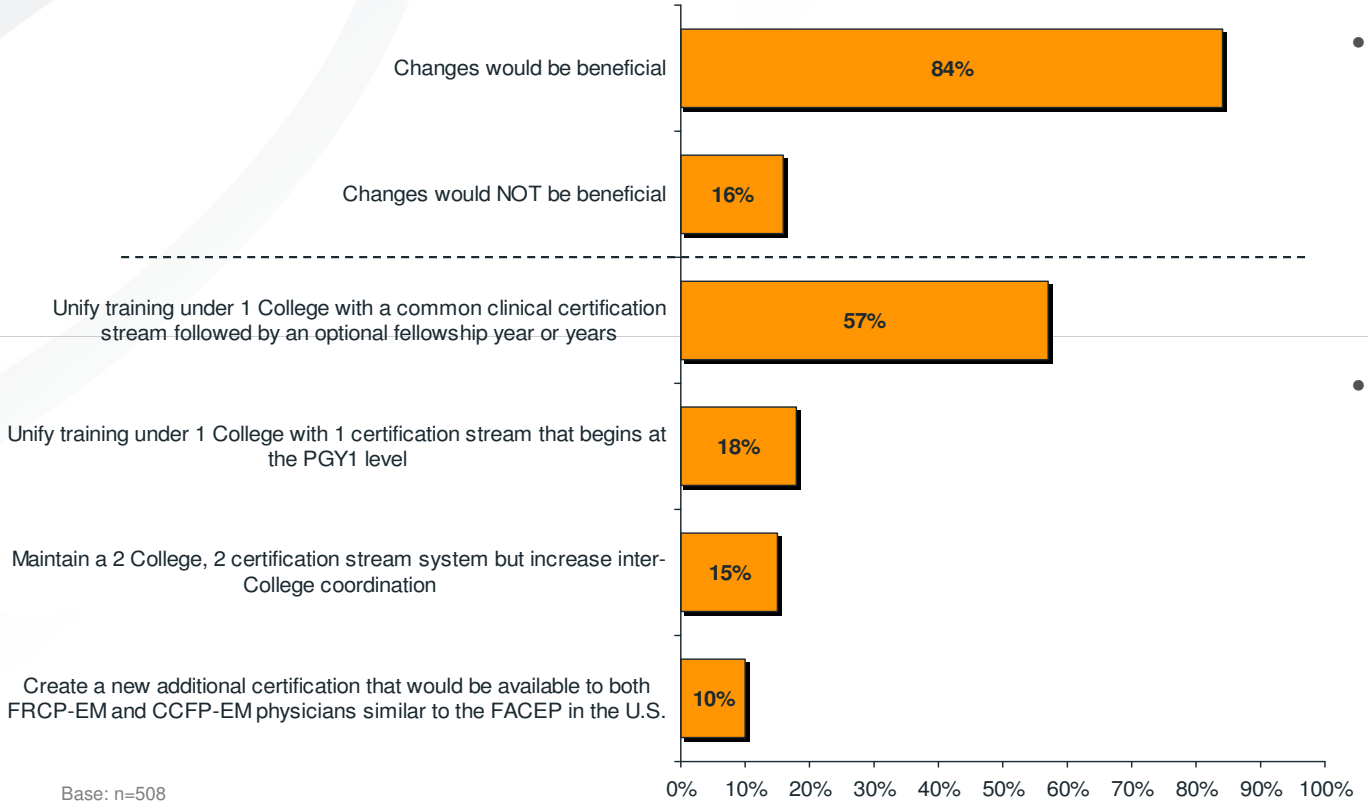
Changes that Would be Supported (Overall)

3A) If you feel that changes to the current two College, dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada would be beneficial, please indicate what change or changes you would be supportive of.



Base: n=508

- The majority (84%) believe that changes to the current certification system would be beneficial.
- More than half (57%) would be supportive of unifying the training under one College with a common clinical certification stream followed by an optional fellowship year or years.

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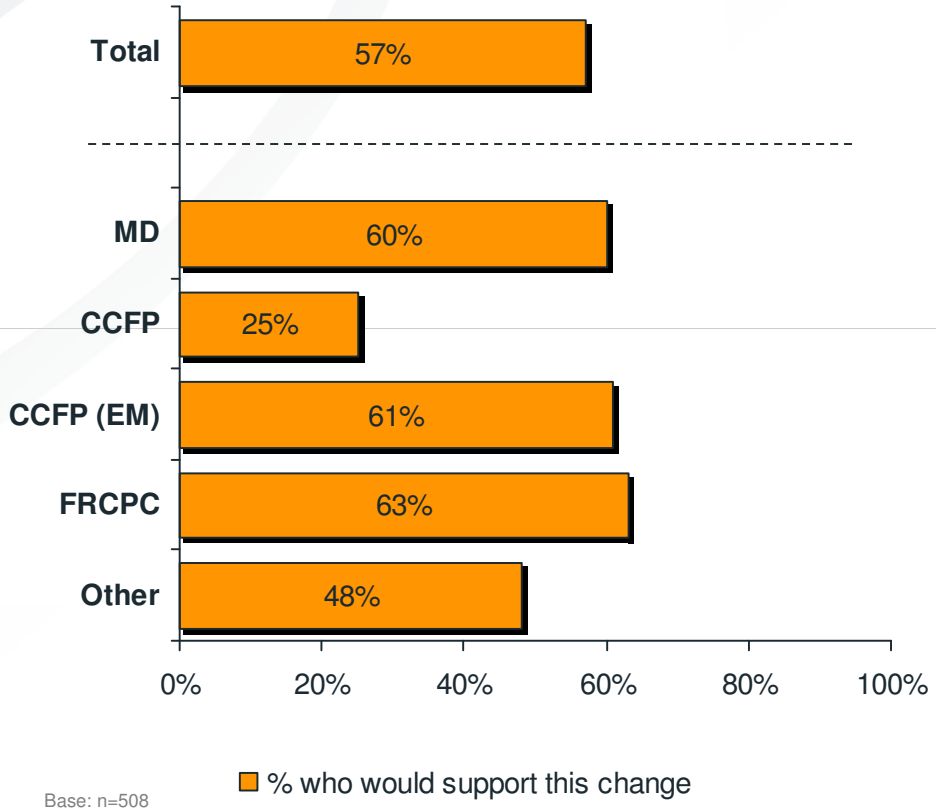
Unify training under 1 College with a common clinical certification stream followed by an optional fellowship year or years

3A) If you feel that changes to the current two College, dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada would be beneficial, please indicate what change or changes you would be supportive of.



- MDs, CCFP (EM)s, and FRCPCs indicated they would be more likely to support this initiative than CCFPs. By far, this change was the most supported among all changes proposed.
- Younger respondents (20-39 years old) were more likely to support this change than older respondents (40+) (62% vs. 52%, respectively).
- CCFPs were the least likely to support this. Only one quarter of CCFPs (25%) stated they would be supportive of this change.

Base: n=508

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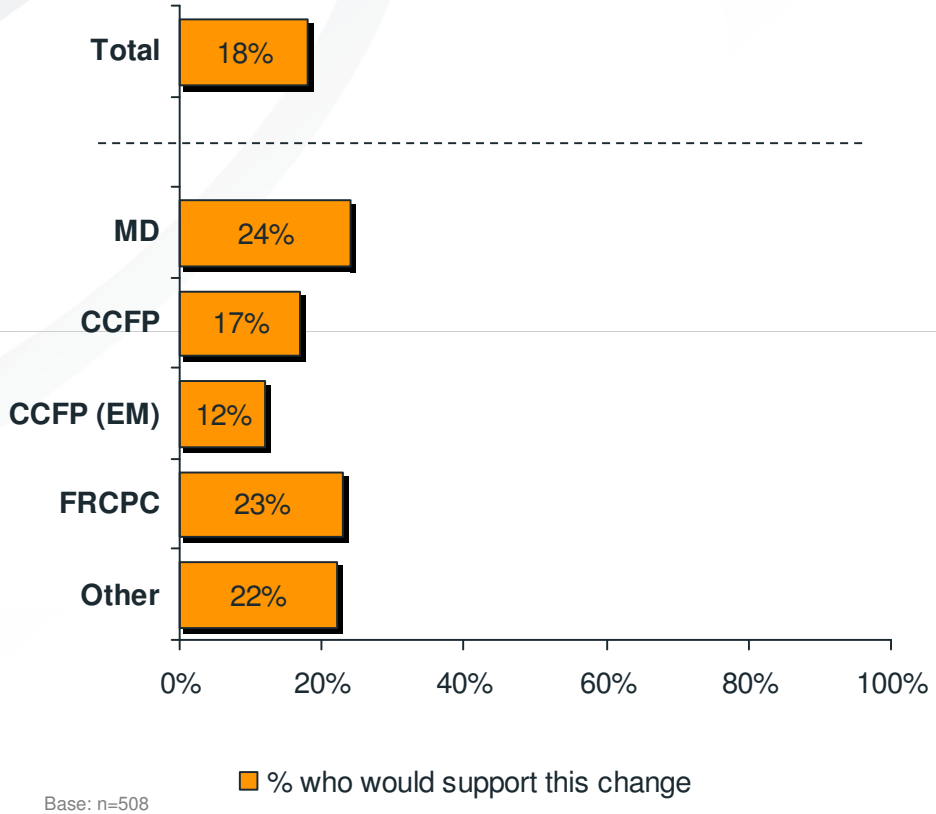
Unify training under 1 College with 1 certification stream that begins at the PGY1 level

3A) If you feel that changes to the current two College, dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada would be beneficial, please indicate what change or changes you would be supportive of.



Base: n=508

- Less than one in five respondents (18%) supported the idea of unifying training under one College with one certification stream that begins at the PGY1 level.
- CCFP (EM)s were the least likely to support this change given that only 12% said they would.

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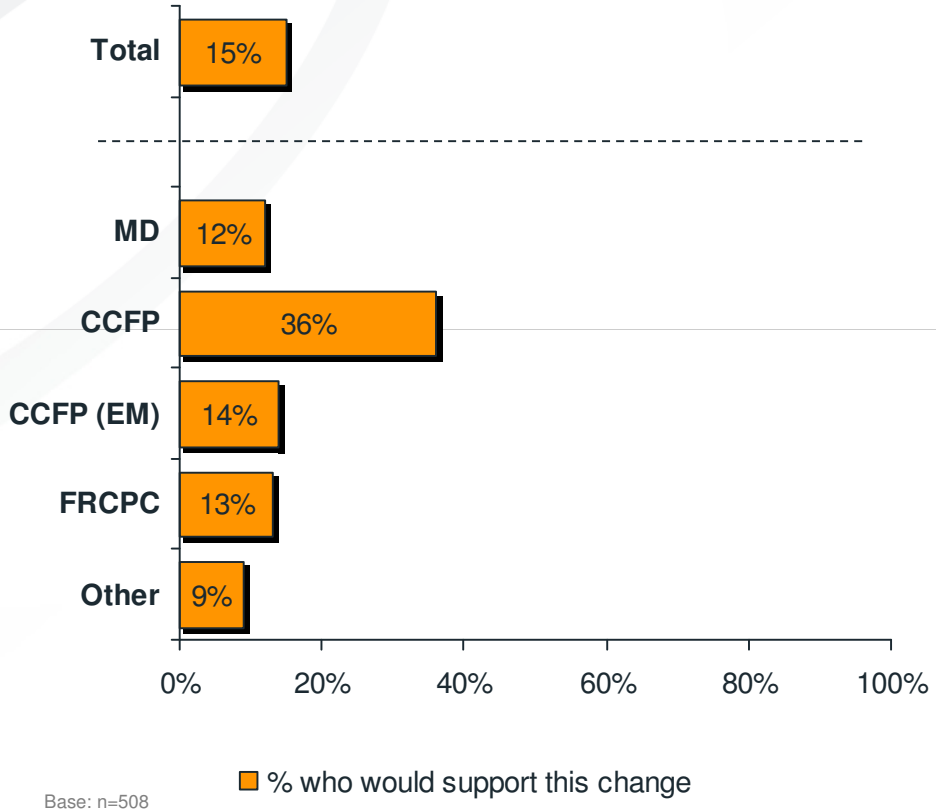
Maintain a two College, two certification stream system but increase inter-College coordination

3A) If you feel that changes to the current two College, dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada would be beneficial, please indicate what change or changes you would be supportive of.



- Only 15% of respondents supported the idea of maintaining a two College, two certification stream system but increase inter-College coordination.
- However, more than a third of CCFPs (36%) supported this change; more than any other designation.

Base: n=508

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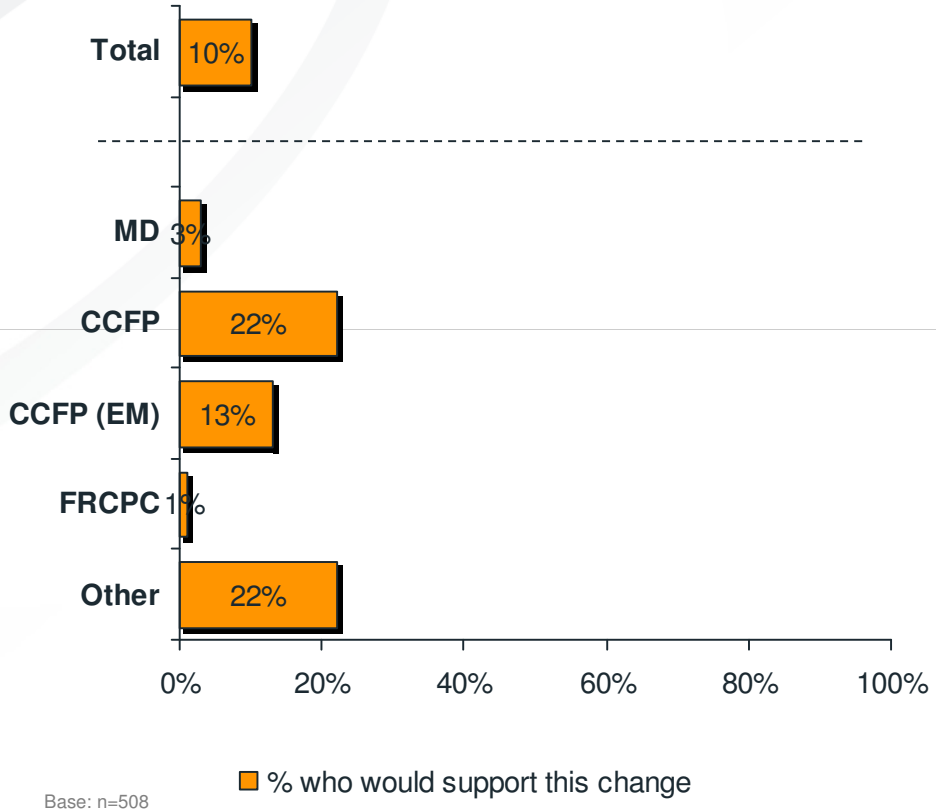
Create a new additional certification that would be available to both FRCP-EM and CCFP-EM physicians similar to the FACEP in the U.S.

3A) If you feel that changes to the current two College, dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada would be beneficial, please indicate what change or changes you would be supportive of.



Base: n=508

- Overall, only 1 in 10 respondents stated they would support the idea of creating a new additional certification that would be available to both FRCP-EM and CCFP-EM physicians similar to the FACEP in the United States.
- However, CCFPs (22%) and CCFP (EM)s (13%) reacted more favourably to this change than MDs (3%) and FRCPCs (1%).

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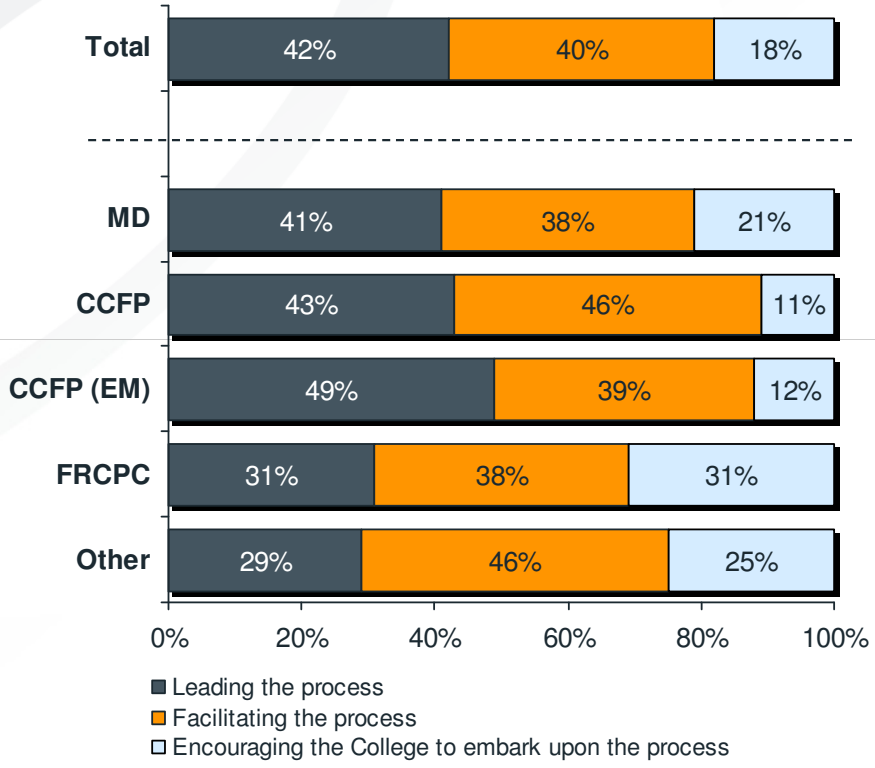
Role of CAEP

4) If you feel that changes to the current two College, dual certification (FRCP-EM, CCFP-EM) system of EM training in Canada would be beneficial, please indicate what role, if any, you feel CAEP should play in such an initiative.

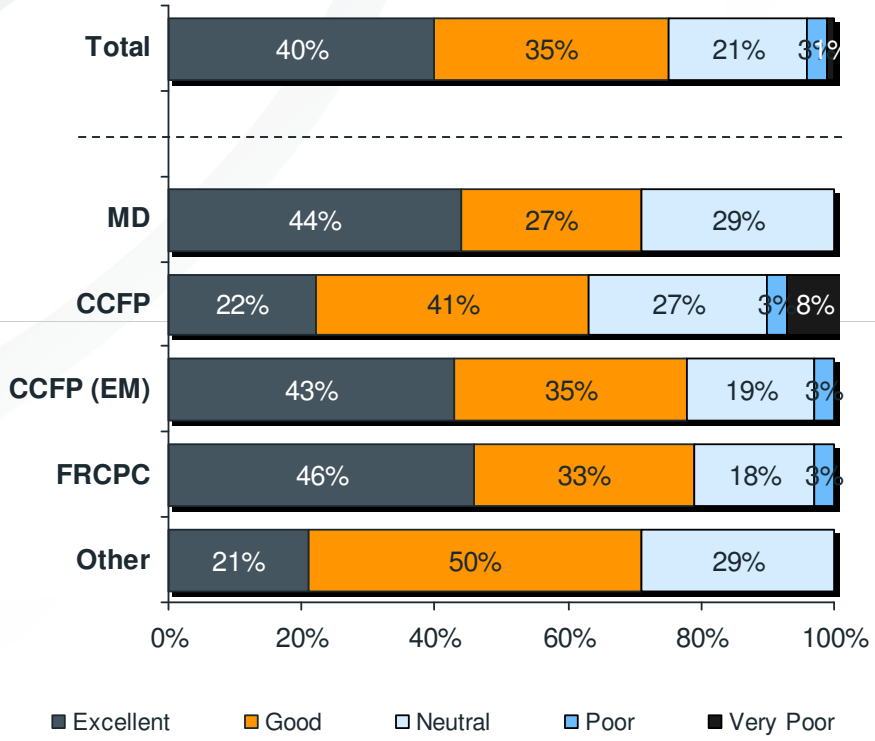


Base: n=519

- Respondents would like to see CAEP play an active role in such an initiative either by playing a leading role (42%) or a facilitating role (40%).

Current Timing of Embarking on Such a Process Considered to be Good

5) If you feel that changes to the current 2 College, 2 Certification stream system in Canada would be beneficial, please indicate your opinion on the appropriateness of the current timing of embarking on such an process.



Base: n=529

- Three quarters of respondents (75%) agreed with the current timing of embarking on such a process.
- MDs, CCFP (EM)s, and FRCPC were more likely than CCFPs to state that the timing of embarking on such a process was excellent.

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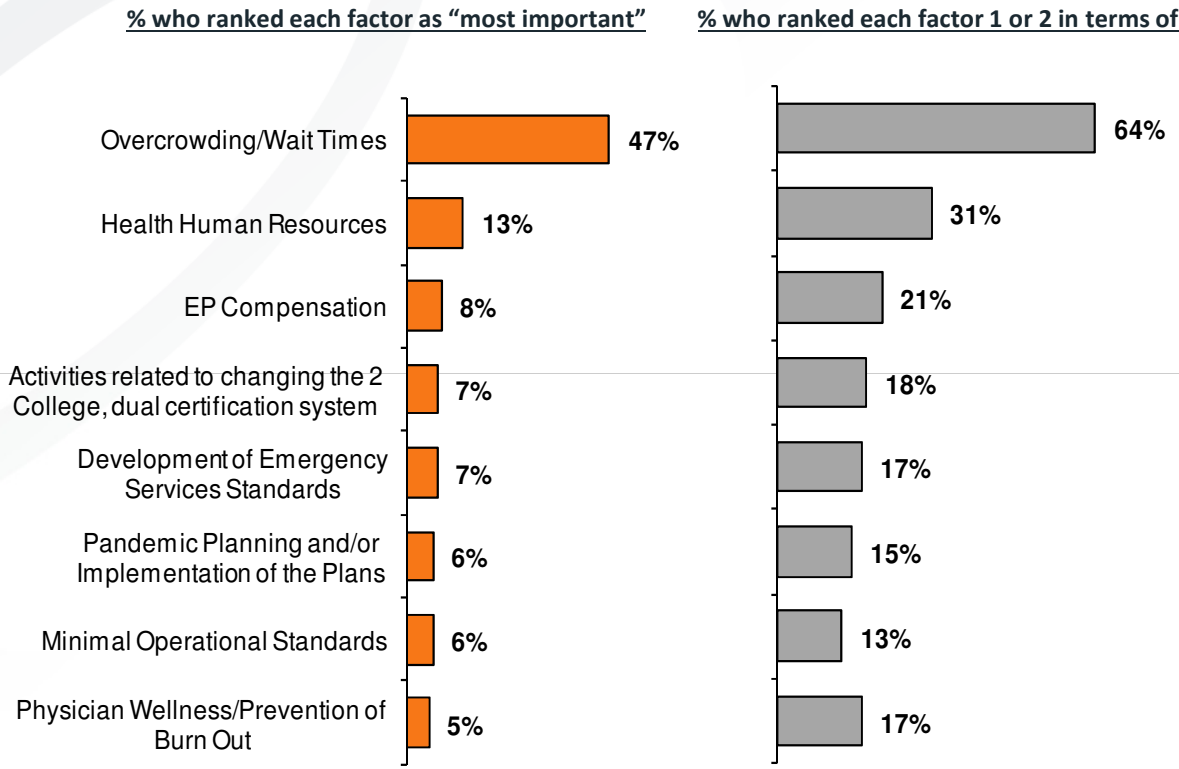
Importance of Dual Certification in Comparison with Other EM Issues

6) How important is this issue to the EM community in comparison with the other issues it is facing (please rank from 1-8)?



Base: n=518

- *It is worth noting that, when providing additional comments at Q8, some respondents mentioned that this question was unclear. The structure of the question and the fact that a scale was not defined to respondents during the survey may have led to this confusion. Therefore, results for this question should be interpreted with caution.*
- Overcrowding/Wait times was considered the most important issue to the EM community; particularly for FRCPCs who, for 59% of them, ranked this issue number one.
- Changes to the Dual Certification system was considered the 4th most important issue, tied with the development of emergency services standards.

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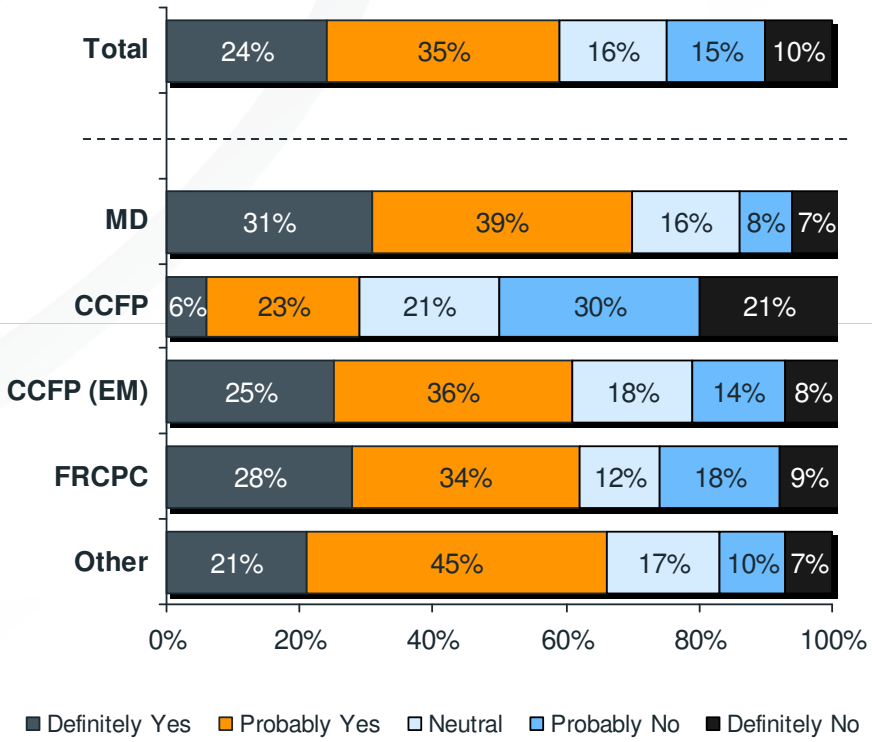
Support for Diverting Resources from other CAEP activities

7) If undertaken, this project would likely be resource intensive. Would you support diverting resources from other CAEP activities in order to complete this task?



Base: n=580

- Almost three out of five respondents (59%) said they would support diverting resources from other CAEP activities in order to complete this task.
- Older respondents (40+) were also less likely than younger respondents (20-39 years old) to support diverting resources (30% vs. 20%, respectively)
- CCFPs are the least likely to support this when compared to other designations.

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Conclusions

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Conclusions

- Overall, the majority of respondents believed that changes to the current two College dual certification (FRCP-EM, CCFP-EM) emergency medicine training system in Canada would be beneficial. Also, the timing to make changes to the training was considered to be good for most. However, there was some resistance from the CCFPs and older respondents (40+) who claimed they were satisfied with the system as is.

- The most supported change was to unify the training under one College with a common clinical certification stream followed by an optional fellowship year or years; particularly for younger respondents.

- Although several other issues within the EM community are deemed higher in importance, particularly when it comes to “overcrowding/wait times”, the dual certification training was among the top five most important issues that needed attention.

- Furthermore, the majority of respondents would support diverting resources from other CAEP activities in order to complete this task; less so for older respondents than for younger respondents.

Appendices

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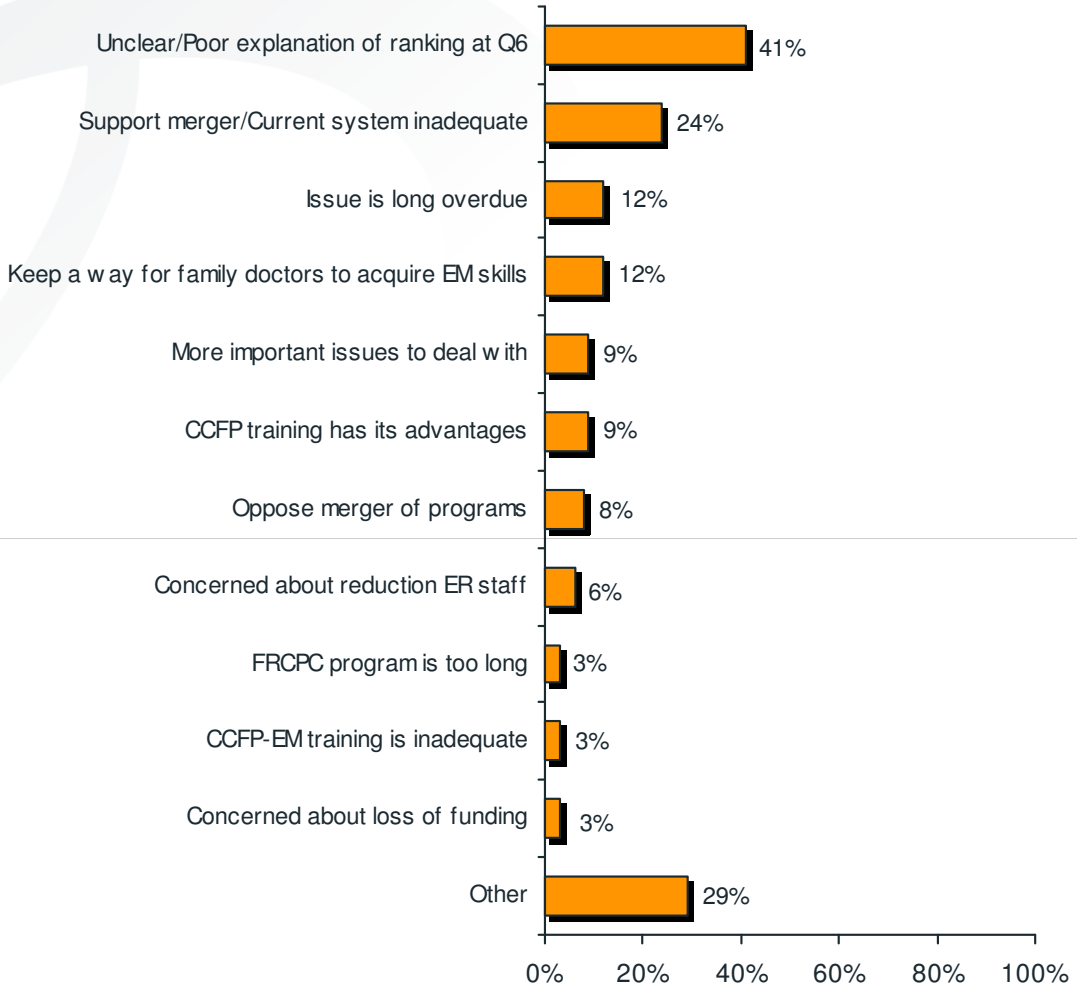
Q8 Additional Comments



Base: n=66*

Caution: Results to be interpreted with caution due to small base

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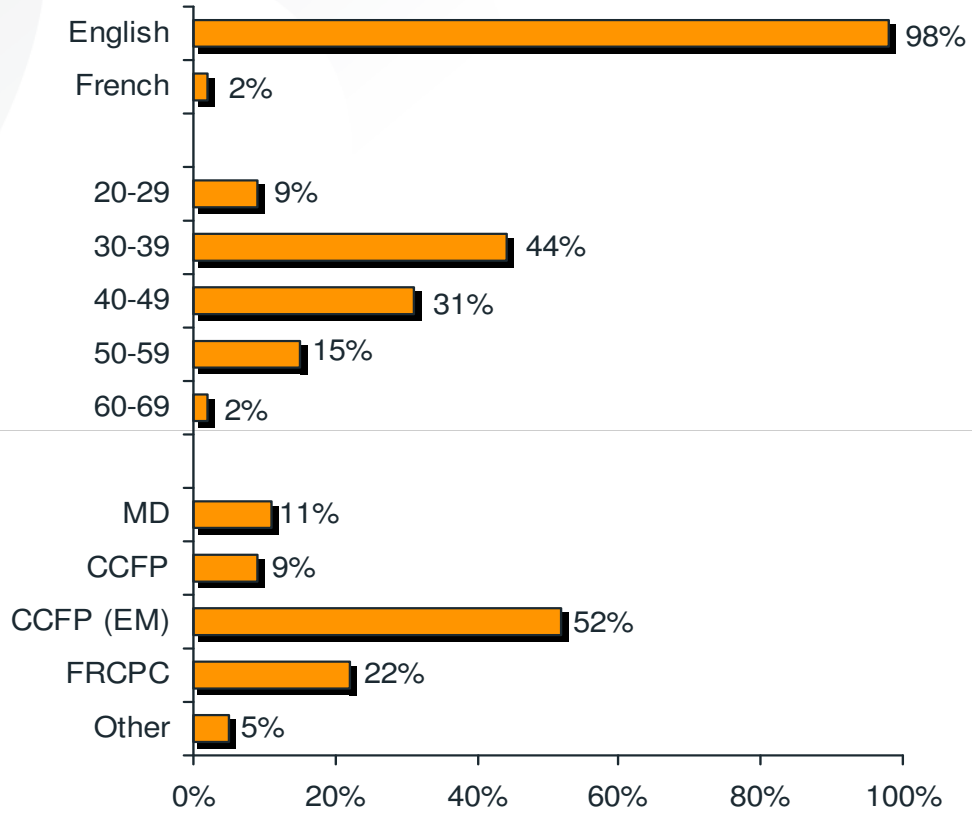
Socio-demographics



Base: n=616

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Thank you.

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CAEP Survey Results
Two College, Dual Certification Systems of EM Training in Canada

CAEP members were sent an invitation to complete an on-line survey in May on the issue of the current two college, dual certification system of EM training in Canada. A total of 603 members answered the survey (a 35% response rate). Below are highlights of the data collected. Additional analysis is being completed on the data and comments which may affect the overall interpretation of the survey results. The results of the analysis will be shared with the membership once complete. The numerical data is being presented in its entirety in the interest of transparency even though it has come to the CAEP Board's attention that there may have been methodological issues with a couple of the questions. This will also be a part of the ongoing analysis of the results. Below is a summary of the responses to the survey. The complete numerical data is available on the CAEP website in the members only section.

• 43% of respondents indicated that they were unsatisfied or very unsatisfied with the current system and 34% were satisfied or very satisfied with the current system.

• 71% of respondents felt that changes (definitely yes and probably yes) to the current two college, dual certification system would be beneficial to the emergency medicine in Canada and 19% (probably no and definitely no) felt that changes would not be beneficial to emergency medicine in Canada.

• Of those who felt a change would be beneficial 57% supported unifying training under one college with a common clinical certification stream followed by an optional fellowship year or years; 15% felt that a two college, two certification stream system be maintained with an increase in inter-college coordination and collaboration; and 11% felt that unifying training under one college with one certification stream that begins at the PGY1 level would be the preferred method of training.

• Of those who felt changes to the current dual certification system of EM training would be beneficial, 42% felt that CAEP should be leading the process, while 40% felt CAEP should be facilitating the process. 18% felt that CAEP encouraging the colleges to embark upon the process would be appropriate.

• 75% of respondents felt that now would be a good or excellent time to embark on such a process and 4% felt that it would not be an appropriate time to embark on such a process.

• The majority of respondents (75%) of respondents were between the ages of 30 and 49.

• 63% of respondents were CCFP(EM) or CCFP and 24% were FRCPC.
The survey was undertaken to determine the perspectives of the membership on this matter in order to help the CAEP Board determine what action should be taken in response to the editorials and call to action published in CJEM in March 2008. The results are being carefully considered by the CAEP Board and future action(s) will be shared with the membership.

Montreal Task Force Report – Emergency Medicine Training in Canada

Introduction

The Montreal Task Force was brought together by the CAEP Board of Directors to consider three questions with respect to Emergency Medicine (EM) training in Canada. The composition of the Task Force was carefully considered by the CAEP Board, and the ultimate structure of the Task Force was intended to represent the broad membership of CAEP. All non-appointed Task Force members (12 out of 20 total task force members) were elected by the CAEP membership via an election process. Extensive background information was assembled for review and discussion. The Task Force was chaired by Dr. Doug Sinclair, and the two hour meeting was very productive. Representatives from the College of Family Physicians of Canada (CFPC) and the Royal College of Physicians and Surgeons of Canada (RCPSC) were in attendance. The membership of the Task Force is attached as Appendix 1.

Question #1: *Does the existing Emergency Medicine training and certification system in Canada, with two independent routes to certification run by two colleges, best serve the current and future needs of the emergency medicine community, the specialty of emergency medicine, and the citizens of Canada?*

There was broad support for the concept that the status quo was not acceptable, and the existence of two training programs did not serve the current and future needs of the emergency medicine community, the specialty of emergency medicine, and the citizens of Canada.

It was felt by the group that a renewal of educational programs would enhance the standards of care for emergency medicine in all settings. It was recognized that family physicians will continue to deliver a significant proportion of emergency care and the specialty should support their ongoing continuing professional development. It was felt that the existence of two training programs, with EM certification by two colleges, leads to dilution of the political will to move EM forward and creates ongoing cultural barriers. Each training program has strengths and weaknesses that could be enhanced.

It was also recognized that there are risks associated with moving away from the status quo. It appears that the Royal College is interested in new models, but that the College of Family Physicians of Canada has significant concerns about any changes to the current structure. The need for advanced fellowship training in subspecialty areas will need to be protected and enhanced in any new process. Any new program will need to ensure that academic leaders continue to be trained and mentored.

Question #2: *If no, should CAEP initiate and lead a process to attempt to improve the system?*

The Task Force felt that CAEP should take the lead on initiating a process that would result in a more optimal approach to the training of emergency physicians in Canada. Both the Royal College and the CFPC will need to be key partners, since they are the only bodies that can accredit postgraduate training in Canada. CAEP will need to be a leader and strong advocate to move this agenda forward. Other key partners identified during the discussion include the provincial sections of Emergency Medicine, which have variable interest in this subject at the present time.

Question #3: *If so, what process might best lead to success, and what are the next steps?*

The Task Force recognized that there are many issues to consider as this important project moves forward. Our Task Force did not have time at our short meeting to consider the details of new training

models, but did discuss a number of principles that would meet the diverse needs of the current and future EM community.

The key steps for the CAEP Board of Directors will be:

- Articulation of a clear vision for educational programs in emergency medicine to be achieved within a defined time line
- Development of a set of principles to guide the program development
- Early engagement of key partners, including the RCPSC, CFPC, and provincial sections of EM
- Utilize the Task Force membership in this important work, with CAEP Board direction and head office support.

Respectfully Submitted

Doug Sinclair MD CCFP[EM] FRCPC
Past President – CAEP-1999-2001

June, 2010

Summary for CAEP Members:

Montreal Task Force – Update

As you may know, CAEP convened a Task Force in Montreal on May 30th, 2010, on emergency medicine training in Canada. The Task Force included twenty (20) key emergency medicine leaders, over 50% of whom were elected by the CAEP membership.

The Task Force concluded that the current training systems will not optimally serve the future needs of the emergency medicine community, the specialty of emergency medicine, and the citizens of Canada, and that CAEP should initiate and lead a process to attempt to improve the system.

The CAEP Board will form a working group whose mandate is to develop strategy around the approach that will be taken and to examine the various options relating to optimizing EM training in Canada. The working group's recommendations will be vetted by the Montreal Task Force members, and subsequently sent to the CAEP Board for decision.