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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References

1. Sinclair D. Subspecialization in emergency medicine: Where do we go from here? [editorial]. Can J Emerg Med 2005;7(5):344-6.
2. Inspired by the Molson Canadian "I AM. Canadian" campaign. Available: www.itstartshere.ca/home (accessed 2005 Oct 25).

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.