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.