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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References

1. Ducharme J, Innes G. The FRCPC vs. the CCFP(EM): Is there a difference 10 years after residency? CAEP Communiqué 1997;Fall:1-4.
2. The FRCPC vs. the CCFP(EM) [letters]. See exchange of Letters in: CAEP Communiqué 1997-98;Winter:7-13.
3. Etherington J. An immodest proposal: the future of emergency medicine training in Canada. CAEP Communiqué 1997-98;Winter:16-9.
4. The FRCPC vs. the CCFP(EM) [letters]. See exchange of Letters in: CAEP Communiqué 1998;Spring:7-9.
5. Grunfeld AF. The Task Force on Emergency Medicine Training. CAEP Communiqué 1998;Summer:1-2.
6. On unified EM training [letters]. See exchange of Letters in: CAEP Communiqué 1998;Summer:7-11.
7. Gray S. Emergency residency training [letter]. CAEP Communiqué 1998;Fall:5.
8. Murray M. CAEP's 20th year wraps up. CAEP Communiqué 1998-99;Winter:1-2.

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.

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References

1. Listen to the people on health, PM told. Ottawa Citizen 2003 Jan 27.
2. Report of the Regional Coroner from the inquest into the death of Kyle Martin. Inquest rep no. 9801205. Toronto (ON): Ont Ministry of Health: 1998.
3. Chief Coroner, Province of Ontario. Inquest touching the death of Joshua Fleuelling. Jury verdict and recommendations. Sept–Nov, 2002 (Toronto).
4. Romanow RJ. Building on values: the future of health care in Canada. Saskatoon: Commission on the Future of Health Care in Canada; 2002. Available: www.healthcarecommission.ca/
5. Kirby M, chair, Standing Senate Committee on Social Affairs, Science and Technology. Study on the state of the health care system in Canada. 2002. Available: www.oma.org/pcomm/kirby.htm

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.