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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References

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2. Abu-Laban RB. Emergency medicine certification in Canada: the years march on but the questions remain the same. CJEM 2008;10:101-3.

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