



I AM Emergency Medicine

I read with great interest Douglas Sinclair's Commentary¹ 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.

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 cen-



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

tres? 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, FR-CPCs, 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 Zyl¹ 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.

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