Physicians of Canada is based on the assumption that family medicine is a discipline defined by setting. Chan gives the impression that family medicine cannot be practised anywhere but within the confines of a clinic with strictly scheduled patient visits. The notion that family physicians hang up their family medicine knowledge, skill set and principles at the door when they enter an emergency department is at best naive.

In 1980 the College recognized that emergency medicine is a core part of family medicine and that a formal training and certification program should be provided to those wishing to practise both family medicine and emergency medicine or full-time emergency medicine.[2] Indeed, the considerable overlap between these disciplines makes clear the need for physicians certified in both. Through its residency and certification programs in emergency medicine across the country the College has done an outstanding job in fulfilling its mandate to "provide family physicians the opportunity to bring enhanced skills in emergency medicine to their communities."[3] Graduates of CCFP(EM) programs certainly use their family medicine background to provide high-quality medical care in emergency departments and other practice settings. Thus I strongly disagree with Chan's conclusion that his study demonstrates "an incongruity between the CCFP(EM) program's objective and the practice choices of its graduates."

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[The author responds:]

Family medicine can of course encompass multiple settings outside the office, including the emergency department, case room and hospital ward. Yes, family physicians bring important knowledge and skills to these environments. However, when a family physician restricts almost all of his or her practice to an emergency setting, that individual resembles not a family physician but a specialist. He or she does not bring to these settings the perspective of long-term relationships with patients, as are cultivated in the physician's office, and is not as well positioned to act as a bridge between the office and hospital environments. The emergency department performs many important functions, but continuing care, preventive services and chronic disease management — all core functions of family medicine — are not among them.

No one disputes that physicians with CCFP(EM) certification who do full-time emergency medicine are providing an essential service, and my paper[1] suggests many plausible reasons why these physicians would choose such a career path. Nonetheless, this study has raised some important questions about the CCFP(EM) certification program. Do we want our community hospital emergency departments to be staffed by full-time emergency physicians? If yes, is 2 years of family medicine plus 1 year of emergency training appropriate, or should there be more emphasis on the latter? If no, then are the candidates selected for the CCFP(EM) program people who want to do family medicine, rather than those looking for the fastest route to full-time emergency practice? Have we inadvertently created a culture where family physicians without this certification are made to feel unwelcome or underskilled for work in the emergency department? All of these questions merit careful consideration.

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Reference-based refinements

The claim by Sebastian Schneeweiss and colleagues[1] that "between 1995 and 1997, when [reference-based pricing] was actively expanding, increases in PharmaCare's costs were contained" disagrees with data published by the Canadian Institute for Health Information[2] (CIHI). According to CIHI, BC PharmaCare's expenditures increased from $329 million in 1995 to $410 million in 1997, a 25% increase in 2 years. Over the same period, total provincial and territorial spending on public pharmaceutical benefits for the rest of Canada decreased by 2%, from $2720 million to $2668 million.[2] Furthermore, Schneeweiss and colleagues' failure to observe negative health consequences from reference-based pricing may result from the fact that only 5353 of 37 362 subjects switched from a restricted to a reference angiotensin-converting enzyme (ACE) inhibitor when the policy was established. The majority chose to pay the difference in cost themselves or received exemption through special authority. The resulting lack of statistical power meant that a 19% increase in hospital admissions for "switchers" in the 2 months after implementation of reference-based pricing for ACE inhibitors was considered insignificant because the confidence interval was –1% to 42%.[3] Therefore, the argument that reference-based pricing was not associated with negative health outcomes is unconvincing.

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Competing interests: The Fraser Institute has received charitable donations from a number of pharmaceutical manufacturers; these donations make up less than 3% of the Institute's budget. Mr. Graham has received travel assistance and an honorarium from one of these companies.

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