Alternatives to lindane

I read with personal interest Eric Wooltorton's article on lindane,[1] having a few years ago shared a half dozen daily baths with two lousy dogs and lindane shampoo. Inadequately labelled animal shampoo obtained through a veterinarian may in fact be a common source of lindane exposure.

Given the problems with lindane, I wonder why nicotine is not used instead. I remember helping my mother and grandfather to treat dogs with heavy flea infestations. The treatment was used for nursing bitches and unweaned puppies as well. We rubbed a ìteaî made from chewing tobacco into their coats, left it for several hours and then rinsed it off. This home remedy was used for flea and lice infestations of any fur-bearing animal. However, you cannot buy nicotine shampoo for lice-infested children.

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Reference
1. Wooltorton E. Concerns over lindane treatment for scabies and lice. *CMAJ* 2003;168(11):1447-8.

I can't say for certain that it would be any safer than lindane[1] — we are, after all, talking about killing little buggers (mites and lice) — but an alternative might be a decoction of the common pokeroot (*Phytolacca americana*). Works for me.

For any treatment of external parasites, an important consideration is the timing of the second treatment. If this is applied more than 3 weeks after the first treatment, another generation will have appeared, and there will be a need for many treatments — and hence excessive exposure to the toxicants.

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Reference
1. Wooltorton E. Concerns over lindane treatment for scabies and lice. *CMAJ* 2003;168(11):1447-8.

How to train emergency docs

I fully support the notion, expressed by James Ducharme,[1] that emergency physician training through the Royal College of Physicians and Surgeons of Canada (RCPSC) specialist program and certification by the College of Family Physicians of Canada (CFPC) complement each other by virtue of the differences between the 2 educational tracks. I am the end-product of a defunct "hybrid" program combining the CFPC and RCPSC programs, which was intended to balance the principles of an in-depth academic knowledge of emergency medicine with a humanistic approach to patient care. Today, it seems that trainees must choose between these 2 aspects. I recommend that the RCPSC and the CFPC join forces to develop a single emergency medicine training program with 2 tracks: academic and clinical. Fundamental humanistic values would be instilled early in the program, through a model of primary care delivered in suitable urban, rural and remote training sites. Trainees pursuing a predominantly clinical practice would undertake a 4-year program and receive significant clinical exposure to all services and subspecialties. This would alleviate the training time constraints highlighted by Ivan Steiner.[2] Trainees pursuing a predominantly academic career would undertake a 5-year program, receiving similar clinical exposure but with additional training in a specialty field of their choice (e.g., emergency medicine services, public health, education). This would formalize training in the nonclinical expertise that Ducharme mentions.[1]

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References
1. Ducharme J. Preparing emergency physicians for the future [editorial]. *CMAJ* 2003;168(12):1548-9.
2. Steiner IP. Emergency medicine practice and training in Canada [editorial]. *CMAJ* 2003;168(12):1549-50.

I enjoyed reading the opinions of James Ducharme[1] and Ivan Steiner,[2] 2 respected leaders within emergency medicine, even though I disagreed with the basic premise of these commentaries.

Human resources are indeed an important component of emergency care, but I believe the crucial question is not how to train the physicians who will staff our nation's emergency departments (EDs) but rather how to improve the quality of care given to individual patients presenting for emergency care. No matter how well trained our emergency physicians, they will ultimately be unable to have a sustained, meaningful impact on patient care if they find themselves unsupported, working in overcrowded emergency departments EDs and stressed to the point of burnout. Unfortunately, these 3 factors constitute the "new norm."

There are currently no enforced performance standards for any ED in Canada. This means that many physicians find themselves working in departments with insufficient numbers of nurses, inadequate equipment, inaccessible diagnostic tools and limited consultant support. Overcrowding in EDs has perversely come to be accepted as routine. The problem has been reported in Canada since the mid-1980s[3,4] and, despite a clear understanding of the causes and solutions,[4-6] there appears to be no political will to solve this public health hazard. Finally, a lack of attention to the wellness of emergency physicians has contributed to the dreadful loss of many talented colleagues at the peak of their clinical, academic and administrative careers.

More than a debate on training, we need a comprehensive strategy to give Canadians the emergency care they de-

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