serve in their hour of greatest need. Leadership and vision we have in blessed abundance within the talented pool of our country's emergency physicians. What is required is an appropriate forum to develop such a strategy and sufficient political will to give substance to the ideas we share.

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[James Ducharme responds:]

The possibility of a 4-year common-track program, as described by Russell MacDonald, has been discussed for more than a decade. Although appealing at first glance, it faces what appear to be insurmountable barriers. The CCFP-EM 1-year program has been popular, producing the majority of emergency-trained clinicians in this country. To maintain the same number of graduates would require a large increase in 4-year residency slots, but such an increase cannot be justified under today's budgetary constraints. On the other hand, the fifth year of the Royal College program was added specifically for subspecialty or nonclinical training that was not available because of a lack of fellowships.[1] Reducing the program to 4 years would risk eliminating that aspect of training.

As is almost always the case, I agree heartily with Alan Drummond's insightful comments. With the closing of acute care beds and inadequate funding for patients needing long-term care, the health care system has been overwhelmed. EDs, rather than being a safety net for the patient, have become the safety net for a fragile system. In my own hospital we have found that to solve overcrowding problems in the ED, we must participate in finding solutions for problems in other hospital departments. Emergency medicine training programs have created expertise. Perhaps the time has come to use our vision and expertise to work with Health Canada and provincial health ministers to develop and implement the approach suggested by Drummond.

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[Ivan Steiner responds:]

I agree with Russell MacDonald's emphasis on integrating the academic knowledge of emergency medicine with a humanistic approach to patient care, and our research has confirmed the value of this approach.[1] However, I disagree with his proposal for achieving this goal. It is family physicians who are providing emergency care outside urban centres, and the humanistic education provided by family medicine programs must be supplemented by adequate acute care training, as through the CCFP-EM program. The concept of merging the 2 training streams has been debated in the past. However, accreditation is the purview of the 2 national colleges and to my knowledge they are not considering integration. Furthermore, a merger would also reduce the total number of emergency medicine training

positions (because of the formula for provincial allocation of funds for postgraduate training positions in family medicine and specialties). Emergency medicine is already short of training slots, and such a loss of positions would be disastrous. The solution to the issues raised by MacDonald is to improve the existing educational tracks.

The Commentary format of my article[2] precluded discussion of the topics that Alan Drummond has raised. Indeed, the quality of emergency care in Canada is negatively affected by all of the factors he describes. I would welcome a comprehensive strategy that would alleviate these problems. I also maintain that the quality of emergency medicine training is a crucial issue. The credibility of the specialty is based on our ability to advocate for patients and on our capacity to develop high-quality clinicians, educators, researchers and administrators.

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1. Steiner IP, Yoon PW, Kelly KD, Diner BM, Donoff MG, Mackey DS, et al. Resident evaluation of clinical teachers based on teachers' certification. *Acad Emerg Med* 2003;10:731-7.
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Clarifying my letter

During the editing process, a shift occurred in content of my letter to the editor[1] that I wish to correct. The statement that we need to stop "pharmaceutical companies from controlling information about treatments" suggests the onus is on industry to present balanced education. My submitted title, which was changed during editing to "Drug marketing priorities," was "Where is the marketing for effective and cost effective psychotherapies?"

The emphasis of my letter is that we, as administrators, educators and clinicians are responsible for providing and learning about a balanced psychological, social and biological approach to patient care. Given strong evidence for brief psychotherapies in a broad range of conditions, physicians should be afforded equal opportunity to learn about these treatments side by side with pharmacotherapy options. Moreover, patients should be aware of and have access to these cost-effective and safe therapies where they choose. The onus is on us who provide programs, edit journals or coordinate medical faculties to be certain we are facilitating this balance in medical education and practice.

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The heart of the matter

Sandeep Arora and associates[1] recommend extracardiac biopsy and other diagnostic modalities instead of heart biopsy for diagnosis of cardiac amyloidosis. However, endomyocardial biopsy remains an excellent method of demonstrating this problem, and false-negative results are uncommon in patients with heart failure.[2]

Immunohistochemical typing of the amyloid may be prognostic. Primary (amyloid light-chain [AL]) amyloidosis with resultant heart failure is associated with a poor prognosis, and up to 40% of such patients die of heart disease.[3] In contrast, senile amyloidosis, which is common, is often uncomplicated, and treatment with cytotoxic agents may not be required.[4,5]

Algorithms have been proposed to diagnose amyloidosis.[5,6] Depending on the amyloid type, the results of extracardiac staining may not accurately indicate the presence of cardiac amyloid.[3] Furthermore, in a study of patients with AL-type amyloidosis who had positive results on endomyocardial biopsy, the extracardiac biopsy results were not always positive.[3]

In patients with severe heart failure, biopsy-proven extracardiac amyloid site, characteristic electrocardiographic findings and characteristic echocardiographic changes, most clinicians feel confident in attributing cardiac dysfunction to amyloidosis.[3] However, doing so may underestimate or overestimate cardiac involvement, depending on the patient population. Endomyocardial biopsy may be the only way to diagnose amyloidosis if it is confined to the heart. Immunotyping of the biopsy specimen may add prognostic information. Heart biopsy is also useful in distinguishing restrictive myocardial abnormalities from constrictive pericardial disease.

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Nouveau mécanisme de présentation des lettres

Le site amélioré des cyberlettres du *JAMC* est désormais le portail de réception de tous les textes destinés à la chronique Lettres. Pour rédiger une cyberlettre, consultez un article sur le site www.jamc.ca et cliquez ensuite sur le lien «Lettres électroniques : répondre à cet article», dans la boîte en haut à droite de l'article. Toutes les cyberlettres seront étudiées pour une éventuelle publication dans le journal imprimé.

Les lettres répondant à un article publié dans le *JAMC* sont plus susceptibles d'être acceptées pour publication imprimée si elles sont présentées dans les deux mois de la date de publication de l'article. Les lettres acceptées pour publication imprimée sont révisées en fonction du style du *JAMC* et raccourcies au besoin (elles doivent habituellement compter au maximum 250 mots).