trend, but I now think that it is a good idea and it will give strength to our movement. Having many FPs sitting around the table with each representing his or her subspecialty will make us stronger than having just a few representing us all. Also, when someone asks for more money for his or her small section for something specific, such as a new billing code, it only affects a few of us and is barely a blip on the overall budget; this will add to our billings as compared with our other specialist colleagues.

I would advocate for special recognition of the subspecialties, similar to emergency medicine doctors getting an EM designation beside their names. Any subspecialty requiring an extra year of training (ie, PGY3), should get this as well. Such subspecialties for GPs and FPs, which are different from Royal College specialties, should include geriatrics and anesthesia. Developmental disabilities, environmental and community health (distinct from complementary, occupational, and environmental medicine), alternative funding programs (ie, those doctors in family health groups, networks, teams, and organizations), hyperbaric medicine, and rural or remote practice are other subspecialties to consider. Some of these are already recognized by provincial organizations, such as the Ontario Medical Association.

What constitutes a subspecialty, as Dr Gutkin suggested,[1] should be special training: a recognized third postgraduate year for younger graduates and a grandfather clause for older GPs and FPs, conferences and workshops, and a journal, website, or list server for each subspecialty. Other factors include having special billing codes and having each subspecialty recognized by local provincial jurisdictions.

—Richard Denton MD CCFP FCFP
Kirkland Lake, Ont

Reference

1. Gutkin C. Meeting today's challenges; preparing for tomorrow's. *Can Fam Physician* 2009;55:1266 (Eng), 1265 (Fr).

Correction

In the January 2010 issue of *Canadian Family Physician,* an error appeared in the byline of the Web Exclusive article "Developing a national role description for medical directors in long-term care. Survey-based approach."[1] The order of authors should have been as follows:

Sherin Rahim-Jamal, MSc, Tajudaullah Bhaloo, MHA, and Patrick Quail, MB BCh, DHC, DRCOG, CCFP.

Reference

1. Rahim-Jamal S, Quail P, Bhaloo T. Developing a national role description for medical directors in long-term care. Survey-based approach. *Can Fam Physician* 2010;56:e30-5.

Correction

In the article "Drug management for hypertension in type 2 diabetes in family practice,"[1] which appeared in the July 2009 issue of *Canadian Family Physician,* the authors would like to add the following:

Acknowledgment

The authors wish to thank the Nova Scotia Health Research Foundation in Halifax, the Dalhousie Medical Research Foundation in Halifax, and the Prince Edward Island Health Research Institute in Charlottetown for the generous funding provided for this research.

Reference

1. Putnam W, Buhariwalla F, Lacey K, Goodfellow M, Goodine RA, Hall J, et al. Drug management for hypertension in type 2 diabetes in family practice. Survey-based approach. *Can Fam Physician* 2009;55:728-34.