focus on  Pediatric Rheumatology

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With the Spirit of A Child…

If Canadian rheumatology “punches above its weight” internationally, this is certainly even more true of Canadian pediatric rheumatology. In this issue, we focus on our colleagues who deliver arthritis care to children from coast to coast. In the deep mists of time, I remember one of my professors who liked to get a rise from pediatric rheumatologists by referring to them as “childish rheumatologists.” If this means that our colleagues retain their sense of exploration, enthusiasm and joy, then I wish we were all childish rheumatologists. Dr. Ross Petty exemplifies and amplifies these traits. His colleagues recently held a symposium in honor of his retirement. This issue of the CRAJ profiles his career and contributions to rheumatology in Canada (pages 4-6). The lasting legacy of a pioneer like Ross Petty is the continuing work of excellence by those whose lives and careers he has touched. The REACCH initiative (page 8) and the profiles of physicians in the interior of British Columbia (page 10) and in Newfoundland and Labrador (page 11) demonstrate that pediatric rheumatology is alive and well in Canada.

In our continuing coverage of the regions of Canada, we profile another of our venerable and most pleasant colleagues who is retiring: Dr. John Lochead (page 13). Dr. Lochead’s hands have touched many an arthritic joint and we have learned that his vocal cords have sated many a yearning ear in the Kitchener-Waterloo area. The latter, alone, may put him in the running for the Fickle Finger of Fame Award. Congratulations on a job well done!

Dr. Saeed Shaikh also gives us the score from the hockey-playing rheumatologists in the mists of Niagara (page 14).

In campus news, Dr. Liam Martin provides the view from the shadow of the Rockies at the University of Calgary (page 16). Dr. André Ménard is not retiring and has outlined all the tasks ahead of him at McGill University (page 17).

I’m sure we will have enough time in future issues to lament or praise the recent Supreme Court ruling on access to healthcare in Canada. I am sure that Drs. Dianne Mosher and Gillian Hawker will have this issue high on the agenda for the arthritis summit meeting being held this autumn. But now it is summer and a time to escape from the politics and the pressure for a while. Smell the roses, swat a few mosquitoes, do something exciting that you dream about but never get around to doing. And while you’re doing it, bring along your copy of the CRAJ and send us a picture! We’ll be back in the autumn with some practical advice about what to pack for your trip to Cancun for the Canadian-Mexican rheumatology meeting in February.

Glen T.D. Thomson, MD, FRCPc
Editor-in-Chief
Pediatric Rheumatologist, Dr. Ross Petty, Retiring: A Tribute

Dr. Ross Petty’s impending retirement prompts us to reflect with admiration and gratitude on his extraordinary career and invaluable contributions. Seldom do we have the privilege of encountering a colleague who so exquisitely blends expert, compassionate and empathetic patient care with scholarly and productive research and inspiring and exemplary teaching. Over the past three decades, Ross, among the earliest pediatricians to be formally trained as a rheumatologist, has played a vital role in nurturing and cajoling the subspecialty from its infancy to the mature, vibrant and essential discipline it is today.

After graduating from the University of Saskatchewan medical school in 1965 and completing his internship in Saskatoon, Ross moved to Ann Arbor, Michigan. He undertook his postgraduate pediatric training in Ann Arbor and then, under the tutelage of Jim Cassidy and Donita Sullivan, there completed his rheumatology training. He then traveled to London, England where he obtained his doctorate in immunology. In 1976, he returned to Canada and went to Winnipeg, Manitoba. There he established Canada’s first formal pediatric rheumatology program. Since then, Ross has emerged as one of the world’s most respected pediatric rheumatologists, renowned for his insight and clinical judgment, his highly relevant and prolific research and writings and his extraordinary gift as a teacher.

Canada’s integral role in the development of pediatric rheumatology worldwide is due predominantly to Ross’s influence. Almost all of Canada’s pediatric rheumatologists have emanated directly or indirectly from Ross’s training programs. Further, Ross has been among the most influential teachers of pediatric rheumatologists throughout the world. He is responsible for disseminating pediatric rheumatologists to establish programs in many North American centers, as well as in Australia, Austria, England, Germany, Kuwait and Saudi Arabia. Frequent invitations to visit and share his knowledge with colleagues worldwide attest to his international renown. He has a prolific publication record representing an eclectic expertise. His contributions to medical/scientific literature, which have had a huge impact on enhancing the care of children afflicted with rheumatic diseases, have included recognizing an association of antinuclear antibodies with uveitis in juvenile rheumatoid arthritis, highlighting the importance of enthesitis in juvenile spondyloarthopathies, documenting the efficacy of intra-articular corticosteroids in managing juvenile arthritis, demonstrating methylprednisolone’s role in treating dermatomyositis and defining the clinical importance of juvenile psoriatic arthritis. Recently, he chaired the International League of Associations for Rheumatology (ILAR) Working Group to define a new classification system and nomenclature for chronic childhood arthritides. He co-authored, with Jim Cassidy, Textbook of Pediatric Rheumatology—the premier pediatric rheumatology reference book.

As a clinician, Ross’s interaction with patients has consistently demonstrated a special gentleness and humor. His insight, decisiveness and thoroughness convey a confidence that is reassuring and comforting to patients and their families, as well as to colleagues who seek his advice.

Ross is a renowned educator. He has the inherent skill to convey not only the science of medicine but, by example, the art of medicine. He teaches students at all levels, including his professional colleagues, with precision, clarity, vigor and respect, such that learning from him is both inspiring and inevitable.

Throughout his career, Ross has served on numerous administrative committees, helping to shape, promote and advocate the pediatric component of rheumatology. While he may be retiring “officially,” there is no doubt that Ross will continue to have a major impact on the field of pediatric rheumatology.

— Alan M. Rosenberg, MD, FRCPC
Professor
Department of Pediatrics
Section of Rheumatology
University of Saskatchewan
Ross Petty: Personal Impressions and Reflections

Why did you leave your hometown of Saskatoon, Saskatchewan for Ann Arbor, Michigan?
While I was doing my first year of pediatric residency at the university hospital in Saskatoon, Dr. John Gerrard, the professor of pediatrics, said, “If you really want to be a pediatrician you must go elsewhere to receive the best training.” I thought this was a generous attitude since I was the only pediatric resident in the institution at the time and I was learning a tremendous amount. Had it not been for Dr. Gerrard’s suggestion, I would probably have stayed in Saskatoon. Ann Arbor was selected for two reasons: two of my mentors in Saskatoon (Drs. Hardy and Ives) had trained there, and there was a program in pediatric rehabilitation—an area in which I was very interested and which, I found out later, included pediatric rheumatology.

What has given you the most satisfaction in your academic career?
I am a clinician at heart and never happier than when I am seeing patients. The satisfaction of working with fellows in pediatric rheumatology has also been extremely rewarding. We have been fortunate to have worked with more than 30 excellent trainees and we take great satisfaction in watching their careers develop and witnessing the impact they have in the development of the field of pediatric rheumatology.

What advice would you give a medical student interested in a career in pediatric rheumatology?
Do it! I think pediatric rheumatology is the most interesting area in pediatrics. It is at the beginning of a new era, both therapeutically and in terms of our understanding of the pathogenesis of disease. Pediatric rheumatology offers opportunities from the bedside to the bench. It challenges the best minds to harness the mediators that cause and control inflammation, and to provide comprehensive care to children and youth with chronic illnesses. It has changed from a specialty in which so little could be done to one in which so much can be done. Be part of it! The best is yet to come!

How will the field change over the next 10 years? If someone had asked you this question 10 years ago, what might you have said?
Ten years ago I think I would have said that the next decade would see discoveries of the etiology (i.e., specific causes) of diseases. With the exception of Lyme disease, that has not proven to be the case. Today I would say that the next 10 years will be characterized by recognition that the interplay of genes and environmental triggers is more important than specific etiologic agents. Exploiting the tools of genomics and proteomics will allow us to control pathogenic mechanisms, irrespective of specific causes. Of course, I was wrong 10 years ago!

You have had the opportunity to travel the world in your career. Can you tell us about some of the most interesting places that you have seen?
All places are interesting. I can’t think of one place to which I’ve been that I would not like to visit again. I have yet to see Antarctica. It is the impressions, rather than the places, that are most important, I think. My travels have provided tremendous learning opportunities. I have been impressed by both the differences and similarities of childhood rheumatic diseases throughout the world. I have been troubled by the inequalities that exist and the fact that “accidents” of geography are such important determinants of health outcome in children with rheumatic diseases. Those of us in North America and Europe have a great deal to learn from our colleagues in the developing world and the patients they see. I have been impressed by the need for North American and European pediatric rheumatology communities to be more active in training pediatricians from the
This Fall, arthritis stakeholders from across Canada will meet in Ottawa for “Rock This Joint 2005: Bringing Together Arthritis Knowledge and Action.” There will be three high-level arthritis conferences: the international meeting of the Bone and Joint Decade, the Canadian Arthritis Network (CAN)’s Annual Scientific Conference, and the Summit on Standards for Arthritis Prevention and Care.

The Summit’s objective is to establish concrete, clear and definitive recommendations for policy makers and policy implementers—standards that will be evidence-based, pragmatic and actionable; standards for people with arthritis wherever they are in Canada. Where standards are called for, but evidence is lacking, these will be prioritized for research so that the necessary evidence will be forthcoming.

The Alliance for the Canadian Arthritis Program (ACAP; see membership below) is organizing the Summit. The Summit will take place November 1-3, 2005 in Ottawa. It will bring together 250 invited participants from Canada’s arthritis community, including people with arthritis, physicists, allied health professionals, volunteer organizations, scientists, as well as government and industry.

A Planning Committee, with representatives from the entire arthritis community, is actively overseeing the development of teams that will do the work of developing draft standards for discussion at the Summit. More than ever before, people with arthritis will be strongly represented in planning, attending and promoting the Summit, and in helping to shape its recommendations and oversee their implementation.

So what is a “standard” and how can it help us? A standard is a definitive statement that lays out our expectations about an aspect of healthcare. For example, if an individual with osteoarthritis (OA) has no contraindications to exercise, then he/she should be recommended an exercise program since exercise has been shown to reduce pain and disability in OA. Benchmarks follow...
from a standard as the tool by which physicians, physicians, patients, policymakers and others can measure or evaluate how well (and if) the standard is being achieved. Success in achieving benchmarks is increasingly being used by government to determine resource allocation and, in particular, funding.

Standards should be distinguished from practice guidelines, which are recommendations for patient management designed to assist practitioners and patients reach decisions about appropriate healthcare for the specific clinical circumstances addressed by the guideline. For example, the Canadian Medical Association has recently come up with standards for joint replacement surgery. These define maximum waiting times for surgery but do not recommend who should have surgery. The latter would require a practice guideline.

The Planning Committee has identified nine key areas for the development of standards. These areas include two Prevention domains (physical activity and injury prevention); four Management domains (access to a diagnosis, models of care and manpower, access to medication, access to surgery); and three Awareness domains (participation [including work, school and leisure], general public and consumer awareness, and healthcare professional education). Each of these nine areas will be headed by two co-leaders. They are responsible for establishing the teams that will assemble and review the evidence, draft the standard(s) and develop an implementation plan for consideration and discussion at the Summit.

As a founding member of the ACAP, the Canadian Rheumatology Association (CRA) has been a strong proponent of the need for the Summit and is taking a leading role in its development. The four co-chairs of the summit are Dr. John Esdaile, Dr. Gillian Hawker, Ms. Cheryl Koehn and Dr. Dianne Mosher. Members of the CRA serve on the Planning Committee and many more have volunteered their time to lead or be involved in the standard development teams. The CRA executive has not only demanded that the Summit move forward, but is supporting the conference with in-kind and financial support to the tune of $100,000.

There is tremendous excitement about the Summit from across the arthritis community; government, physicians, surgeons, allied health professionals, scientists, industry and people with arthritis are helping. Everyone believes the time is right for action!

To obtain more information about the Summit, visit the ACAP website at www.arthritisalliance.ca.

– Cheryl Koehn
– Gillian Hawker, MD, FRCPCC
– Dianne Mosher, MD, FRCPCC
– John Esdaile, MD, FRCPCC
The juvenile idiopathic arthritis (JIA) classification represents an international effort to unify what has previously been referred to as juvenile rheumatoid arthritis (JRA) in North America and juvenile chronic arthritis (JCA) in Europe into a single classification of all chronic childhood arthritis. JIA affects approximately 10,000 Canadian children and adolescents at any given time and recent data suggest that active disease persists into adulthood in more than 50% of cases, resulting in significant life-long disability. This represents a significant healthcare burden. While there are outcome studies focusing on disease remission, disability and health-related quality of life (HRQOL) in JRA and JCA, the published data vary widely and there are no such studies that focus on new-onset disease in a clearly defined, prospectively assembled, large cohort of JIA. Being cognizant of these facts, the Canadian Pediatric Rheumatology Association (CPRA), decided to develop a research initiative that we have now entitled the REsearch on Arthritis in Canadian CHildren (REACCH) initiative.

In Vancouver in August 2003, a meeting, organized by this author, brought together most Canadian pediatric rheumatologists and others interested in research in JIA, as well as representatives from the Canadian Rheumatology Association (CRA), The Arthritis Society (TAS), the Canadian Arthritis Network (CAN), the Canadian Institutes of Health Research (CIHR) and consumers for a two-day brainstorming session. The meeting was highly successful and led to the formation of a Steering Committee whose mandate was to drive the REACCH initiative forward. The first undertaking was to submit a grant application to the CIHR New Emerging Team (NET) competition at the Institute of Musculoskeletal Health and Arthritis (IMHA), which focuses on impact on QOL of individuals with arthritis and related disorders. The grant application was successful and will fund a total of $1 million over five years (2004-2009). The principal investigators of the REACCH initiative are Ciarán Duffy, Kiem Oen, Rae Yeung and Lori Tucker, however, its success depends on the contribution and collaboration of some 37 individuals from across Canada in a huge effort that includes all Canadian pediatric rheumatologists, some adult rheumatologists and a number of clinical epidemiologists and biostatisticians.

Children with new-onset JIA will be studied to assay the clinical determinants of disease outcome and HRQOL and, more specifically:

- to determine short-term (two-year) and medium-term (five-year) outcomes (i.e., remission rates, physical function, pain and HRQOL) and to determine whether early disease suppression is an independent predictor of time to remission;
- to study four specific measures of HRQOL to ascertain their relative discriminant validity and responsiveness, and to evaluate their ability to predict the above-noted outcomes.

This research will entail assembling a cohort of 2,000 patients over five years to have sufficient power to be able to study the various onset types of JIA. Since this study has a specific focus on outcomes, it is referred to as the REsearch on Arthritis in Canadian CHildren–Focusing on Outcomes (REACCH OUT) study. Demonstration of earlier and better remission rates together with improved outcomes, especially HRQOL outcomes, may justify a more aggressive treatment approach. Identification of the best measure of HRQOL will facilitate future outcome studies. The current proposal represents an important stepping stone with the formation of a new research team and research network, as well as the fact that the established JIA cohort will be the basis for future studies of this REACCH initiative.

A clear opportunity exists to build on this initial cohort study and to incorporate some mechanistic studies. To understand, precisely diagnose, treat and prevent JIA, a more thorough understanding of the distinctive biological basis of the various subtypes of JIA is necessary. Microarray technology for monitoring gene expression has proven useful in some forms of cancer; distinctive gene expression profiles correlate with underlying pathophysiology and predict disease outcome in B-cell tumours. Thus, by discovering distinctive JIA-subtype specific gene expression profiles, deoxyribonucleic acid (DNA) micro-
array technology will permit precise categorization of JIA subsets and help to identify pathogenetically important molecular pathways. Our cohort study situates us ideally to pursue this work, given our potential to obtain biologic specimens on treatment-naïve patients. Rae Yeung, Earl Silverman, Alan Rosenberg and Kiem Oen will now lead the way on a series of studies that we have called the REsearch on Arthritis in Canadian Children—Focusing on Mechanisms (REACCH ME) study. A grant on this issue is in the process of being written to be submitted to the TAS National Research Initiative (TAS NRI), for a deadline of November 2005. If successful, this grant has the potential to be funded up to $1.5 million over five years, and will include some 40-50 co-investigators and collaborators.

Finally, this whole initiative has created the opportunity to build research capacity within JIA with the establishment of a research training program. Rae Yeung has led the way here by bringing together a broad array of investigators/mentors from across Canada and from a variety of backgrounds (e.g., clinical, fundamental, epidemiologic) with the express purpose of attracting trainees to conduct research in JIA. A training grant was submitted to CIHR and is currently under review. If successful, this will fund $1.8 million over six years with the potential to be expanded by the CAN.

The success of this work depends on a highly organized infrastructure comprising a steering committee, a scientific committee, a training committee and a patient advocacy/knowledge transfer and exchange committee. Several of the individuals already mentioned above are very active on these committees. Three individuals who also deserve special mention are: Brian Feldman for his contribution to the REACCH OUT grant, Ron Laxer for moving the process along with patient advocacy and Ross Petty for his contribution to the education/training component.

This series of initiatives has the potential to dramatically change the lives of children with JIA and we are very excited about the prospect of being able to do so.

– Ciarán M. Duffy, MD, FRCPC

Due to the outstanding feedback received, the CRAJ is pleased to announce the Fickle Finger of Fame award is up and running for 2005! As before, your 10 minutes of glory are nigh if you are, well, “interesting”—yes, that’s all—interesting. We want to find Canadian rheumatologists who do more than just count joints, draw graphs, pipette cells and write long diatribes. The CRAJ is searching for rheumatologists with the most interesting pastimes, hobbies, locations, aspirations, vacations, facial hair, tattoos, children, you name it, etc. to be featured in our Holiday 2005 issue. Tell us about yourself or nominate a colleague in a brief note (photos are a bonus!). The CRAJ Editorial Board will then decide on this year’s most interesting arthritis specialist. The usual evanescent paraphernalia for such a prestigious and fleeting accomplishment will be presented at an appropriately effervescent time.

Please send your message and/or nomination today to stephe@sta.ca.

Once again, we extend our congratulations to the 2004 Fickle Finger of Fame Awardee: Alphonso Verdejo!
Since its inception as a subspecialty, pediatric rheumatology has been the domain of academia and practiced predominantly in university-affiliated, tertiary-care facilities. Adult rheumatology, on the other hand, has a large contingent of purely clinical physicians who bring arthritis care to more remote communities.

Having completed my subspecialty training in Vancouver with Drs. Ross Petty and Pete Malleson, I moved to the Okanagan Valley in 1990 to work in the Penticton Regional Hospital as a consultant pediatrician. I wanted to maintain my general pediatric skills and clinical practice was my forte, rather than research. In Penticton, I was fortunate to have Dr. Robert Offer as an adult rheumatology colleague. He had established an excellent adult service in the Penticton Hospital with a fully staffed Arthritis Service facility serving the people of the South Okanagan valley and funded by the Canadian Arthritis Society.

With the support of my Vancouver colleagues, I established a small outreach program for children with rheumatic diseases in the southeastern area of British Columbia. The clinic runs two afternoons per month and is staffed by a nurse clinician, occupational therapist, physiotherapist, social worker and myself. The funding comes from The Arthritis Society (TAS). Patients are referred from throughout the Okanagan Valley, including north to Revelstoke, and from the Kootenay Valley to the Alberta border. Some patients travel six to eight hours by car to reach the clinic, although if they were to go to Vancouver for this service it would be a 10-12 hour drive.

It has been a rewarding experience and it is gratifying to develop a long-term relationship with families, especially as we have so much to offer them nowadays in terms of disease control. At any one time I have about 20-30 children with inflammatory joint disease in the program and a further group of patients with musculoskeletal complaints, such as benign hypermobility syndrome, pain amplification syndromes, and rarer entities, such as Stickler’s syndrome.

Challenges to this type of practice include maintenance of competence, although the improvement in computer-based learning programs and the availability of online journals has made this much easier in the last 10 years. The Pediatric Rheumatology Bulletin Board is my regular “daily dose” of rheumatology continuing medical education. Teaching is part of daily life as we always have a first-year resident on a pediatric rotation; the first-year residents find the arthritis clinic to be an eye opener, as they have had little exposure to childhood rheumatic disease and to pediatric musculoskeletal exams.

There is also the challenge of sorting out a general pediatric referral that is, in fact, rheumatologic (e.g., the teenage girl with chronic fatigue, migraine headaches and proteinuria that turns out to have central nervous system lupus and membranous nephropathy; or the nine-year-old with abnormal gait that has a leg length discrepancy, straight back, enthesitis and sacroiliitis at presentation).

There are also teasing scenarios where one wishes for more ability to do research: each time I get a little cluster of patients with new-onset, polyarticular, rheumatoid factor-positive juvenile idiopathic arthritis, it seems to coincide with a cluster of new diabetics.

I have some advantages over the tertiary centre these days, as I can usually see a new referral within two to four weeks. And if I want to do an in-hospital assessment, I can usually get a bed within one to two days. The orthopedic surgeons are very accommodating and will make room on their surgical lists for add-on multiple joint injections whenever needed.

As the specialty of pediatric rheumatology grows, there will likely be more graduates who look to do my style of practice. I’ve learned there are many musculoskeletal complaints in general pediatrics for which my training has been useful and benefited the children. There are still the multisystem unstable patients who are best served in a tertiary-care setting.

The social issues and complexities surrounding rheumatic complaints still lend themselves best to a team approach in terms of management. Outreach programs will be best if developed in concert with tertiary centres and with allied health support.

– Katherine Gross, MD, FRCPC
Consultant Pediatrician and Pediatric Rheumatologist
Penticton, British Columbia
Practicing Pediatric Rheumatology in Newfoundland and Labrador

When I was asked to write an article about establishing a pediatric rheumatology program in Newfoundland and Labrador, my first thought was of how well cared for the children in this province have been for many years, largely thanks to the dedication of pediatrician Dr. Chaker Hobeika. It was with his encouragement that I embarked on my fellowship training in Montreal, with the plan to return to Newfoundland to begin work at the time of Dr. Hobeika’s retirement. In the fall of 2003, my mentor graciously handed me not only a well-organized rheumatology practice, but also his office, and his very comfortable chair.

It has become a pleasure to work among a population that is both grateful and forgiving, with patients travelling to the clinic from such colourfully named communities as Heart’s Delight, Leading Tickles or Witless Bay. The population also presents challenges, as it is spread out over more than 400,000 square kilometres—an area larger than New Brunswick, Nova Scotia, and Prince Edward Island combined—with communities dotting the 17,000 kilometres of rugged coastline. A silent pause after asking a patient to “drop back into the clinic in a couple of weeks” tells me that I still haven’t learned the geography well enough. This has partially been overcome by the initiation of outreach clinics to Corner Brook on the west coast and video-conferencing with communities as far away as Nain on the northern coast of Labrador.

The rheumatology team at The Janeway Children’s Hospital in St. John’s has some unique advantages, principally in that everyone is nearby and, hence, easy to find. We have very talented and dedicated physio- and occupational therapists who attend periodic team clinics. Social work and psychology are readily accessible. Communication with orthopedists and ophthalmologists is greatly facilitated as their clinics and offices are literally around the corner. We are still hoping to add a nurse to the team in the future, although this may hinge on some small matter like the Atlantic Accord deal being signed. In the interim, the nurses in our Medical Daycare Unit have learned to do education around medication injections, in addition to running intravenous infusion therapies and helping with joint injections.

At a university centre, responsibilities don’t end with clinical work. In addition to the regular resident and medical student teaching, I have also taken every opportunity to spread the word about arthritis in children. Lectures have been given to family physicians, nurses and allied health professionals, and at various public forums organized by The Arthritis Society.

After all of 18 months since completion of my fellowship, what advice can I offer to others about setting up a pediatric rheumatology practice?

If you will also be starting a solo practice on an island in the Atlantic, there is something you should know. You may occasionally be “fogged in” but you will not be alone. Pediatric rheumatologists are spread out from coast to coast across this country and we have a tremendous impact on the well being of children in our communities. Support can be found through email, telephone calls and conference meetings, which will maintain your connection with this dedicated group of professionals.

– Paul Dancey, MD, FRCPC
This time last year, I reported on the development of a proposed change (the Medical Stream Model) in the streaming of internal medicine (IM) residents through their three core years into their fourth and fifth years of either general internal medicine (GIM) or another subspecialty, such as rheumatology. There had been discussion of future core IM residents writing an “attestation” exam in core IM at the end of three years, and then choosing either to enter GIM or another subspecialty. Only residents choosing GIM would take the RCPSC exam in IM at the end of the fourth year and be regarded as qualified subspecialists in IM. Other subspecialty residents would take their respective subspecialty exam at the end of their fifth year and then be qualified only in their subspecialty area. Through this process, IM would not be the default specialty, but rather its own subspecialty (Figure 1).

This model had implications on whether subspecialty trained residents, with their three years of core IM and their attestation exam, could practice IM in the community. It was not known then how governing and licensing bodies would regard this qualification. Other issues that were contentious included the specific objectives of the fourth year of subspecialty IM training, the objectives of the three core years, and how/which trainees in their core years would be taught. With these questions, the debate grew between the GIM Specialty Committee, the other Specialty Committees of IM and the RCPSC Committee of Specialties (COS).

The RCPSC recognized that the principle issues being discussed in the arena of IM were relevant to all specialties. Issues regarding the core competencies in the core training of all specialties needed to be evaluated. As a result, the Medical Stream Model has now evolved into the “Core Competency Model” (Figure 2).

The RCPSC will be asking all specialties to review and redevelop objectives of training for their specialty and to ensure that their core competences are maintained and enhanced during training. This process requires a reassessment of all specialty-specific training requirements, including the length of time required for each discipline. Areas of significant overlap may necessitate the merging or streamlining of some disciplines. It is believed that identification of the core competencies in specialty core curriculum will allow better recognition and transfer of educational credit between residency programs. At present, the RCPSC is facilitating meetings for
the development of a lab medicine core program with the appropriate stakeholders. A standardized surgical core program is going to be developed by university core surgery coordinators and chairs of surgery. National specialty societies and other stakeholders in other specialties, including IM, will be consulted later this year.

It is hoped that the definition of core competencies in IM will help define the capabilities of core IM residents who enter into specialty training, such as in rheumatology. This may facilitate clarification of their relative capability to practice IM along with rheumatology, in comparison to residents who train in the GIM stream.

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Our document, “Objectives of Specialty Training in Rheumatology 2002,” is a detailed and carefully drafted document that identifies the breadth and depth of knowledge areas in rheumatology and the skills required to care for patients with rheumatic diseases. This document establishes what makes rheumatology distinct from GIM and other subspecialties. It should stand us in good stead in the RCPSC review of core competencies of specialty areas.

– Avril Fitzgerald, MD, FRCPc
Associate Professor
University of Calgary

Regional News

Kitchener, Ontario:
A Tribute to Dr. John Lochead’s Retirement

Dr. John Lochead’s career in rheumatology has spanned some 30 years and has taken him from the Montreal General Hospital, in Montreal, Quebec, to St. Clare’s Mercy Hospital in St. John’s, Newfoundland and, finally, to the Kitchener-Waterloo, Ontario area where he settled with his wife, Jean, and his two daughters. John is well known for his energy, enthusiasm and compassion. His “extra-curricular” interests of worthy comment include music, media and trekking.

John has been a member of his Trinity United Church choir for 20 years. Each Wednesday evening his attendance at choir practice has pre-empted more professional concerns. An avid enthusiast of the local Philharmonic Choir and a donor to Opera Ontario, his love of music has taken him far-a-field. Presently, he is complimenting his vocal talents by honing his skills on the piano. These attributes make him extremely popular at parties. John also volunteers in his church’s “Out of the Cold” program, working two overnight shifts per month. He is a master at seeking out the rich personalities within the different types of people he meets, with a keen ear to their idiom, which he may recite. He has a great compassion for those less fortunate in society.

A leader by nature and with a passionate disposition, John has been quick to comment on apparent professional injustice, incompetence or ignorance. The media are attuned to his clear diction and unique ability to communicate. They have regularly called upon him to provide expert opinion, to which John has acquiesced. A peculiar technique that he uses to enhance his comments is to follow his statement with a grand simile, so providing a humorous touch that enlightens his initial assertive position. He used this technique in 1990, at a time when the price of methotrexate dramatically quadrupled. After a national news address, he succeeded in his campaign to rollback the price of this drug; and in 1991, received a distinguished service award from The Arthritis Society for his advocacy.

John exerts higher standards for himself than for others. Over the years he has become a fitness enthusiast and works out four times a week at the gym. During the winter months he remains an avid skier. During the summer months he is noted for his trips to Nepal, where he has trekked to the Annapurna base camp, Gokyo Ri, and Langtang. There he has befriended his Sherpa and the local villagers. He has used his leadership skills and compassion for people to attend to the peoples’ health services; his work has become known over a wide region. A notable consequence of his contributions is the special tribute that Sir Edmond Hillary wrote to John for his recent retirement.
John has obtained baseline qualifications in spiritual direction at Loyola House, the Jesuit Retreat Center in Guelph, Ontario. Currently, he is a member of the volunteer staff at Five Oaks, the United Church Education and Retreat Centre in Paris, Ontario. He has carried through life the motto of Alpha Omega Alpha, the only national honor medical society in the world: “Worthy to Serve the Suffering.”

Beloved and respected by his colleagues and his patients, we wish John good health in his retirement. We have no doubt that he will add many more chapters to this brief summary of a life that has enriched so many people.

– Brian D. Hanna, MD, FRCPC

Rheumatology in St. Catharines/Niagara, Ontario

I came to the Niagara region in the summer of 2002 and located an office up the street from John Dickson and Greg Griffiths. We function as the “trio” of rheumatologists serving the “peninsula.” We are all located in St. Catharines. Our patients mostly come from St. Catharines, Niagara Falls, Welland, Thorold, Fort Erie, Niagara-on-the-Lake, Port Colborne, and Lincoln County—incorporating a population of about 400,000. On an interesting note, the rheumatology trio could also very easily have been John Dickson, Algis Jovaisas and Carter Thorne, as all three grew up in St. Catharines.

I arrived in St. Catharines with a reasonable knowledge of the area, since I was born and raised in Toronto. I was aware that quite a few retirees were settled in the region and that it was the second oldest community in Canada, after Victoria, British Columbia. Therefore, I wasn’t surprised that polymyalgia rheumatica was pretty much endemic. I also later learned that a study showed St. Catharines to be the “most obese” city in Canada. Apparently we have the most donut stores per capita. This, no doubt, helps explain all the patients with back pain and osteoarthritis of the hips and knees! And, unfortunately, with many of the obese patients, any therapy that involves exercise or self-motivation does not seem to be an option. In addition to the above facts, it is well acknowledged that there are some formidable wineries in the Niagara region—hence, the explanation for all the gout sufferers!

There are some positive and negative factors about being a rheumatologist in this environment. We have three consultants, and call is manageable. We only do rheumatology consults. No admitting and no internal medicine call. Waiting lists are reasonable—generally under six weeks.

I personally see urgent consults on my Fridays (a tip recommended by Jamie Henderson). This makes early arthritis and acute flares of disease readily accessible. I have also chosen to see pediatric rheumatology cases and this offers a nice break from the regular cases. I also enjoy seeing sports medicine cases and have foot orthotics and knee braces done directly through my own office. Greg Griffiths is involved with performing independent medical exams. We have access to an infusion clinic a few blocks from our respective offices. Our highly specialized care patients are usually sent to either Hamilton or Toronto.

We seem to have an abundance of dual-energy x-ray absorptiometry (DEXA) machines, so getting a bone mineral density scan is pretty easy, however, reading the scans is another story, as there is a real “territorial” attitude surrounding this practice. It quickly became apparent to me that “word of mouth” travels very fast in these communities. So it can be quite rewarding to give your patients that added “personal touch.” Generally, I can say that I truly value the fantastic relationship I have with many of my patients.

The biggest drawback here would be the primary-care physician shortage. An estimated 20% of people do not have family physicians. As a result, there is a “trickle-down” effect on our specialty. There are too many inappropriate consult requests. Moreover, partly because of the primary-care physician shortage, general practitioners (GPs) are pressured into seeing too many patients and, not surprisingly, problems that should normally be addressed by the GPs are being directed to the rheuma-
It is hard not to sympathize with some of these patients, however, this sort of routine puts added stress on a practice schedule, not to mention the inability to get fair reimbursement out of a highly restrictive provincial fee coding system. Adding to the problem, there has been a shift of GPs moving from private offices to walk-in clinics, which only worsens referral quality and follow-up care.

Provincial physiotherapy cutbacks are also having an impact. Individuals aged between 18 years and 64 years cannot get provincial health coverage for physiotherapy unless they have just been discharged from the hospital. Many patients don’t like to pay for anything “health-related” and choose to forego therapy even though it is recommended. Invariably, more time is spent explaining/instructing exercise techniques. Finally, government/insurance paperwork, especially for biologics, has added to an already stifling amount of paperwork; this type of stuff is what I blame for making my hair become more gray since finishing my Fellowship a few years ago.

In the future, the Niagara region rheumatologists are thinking about starting an osteoporosis clinic that will be linked to the fracture clinic run by the orthopods. We have also toyed with the ideas of a Clinical Trials Unit and perhaps incorporating our own “peer-reviewed” physiotherapy clinic. It would be satisfying to see some of these ideas come to fruition.

Overall, private practice can be very rewarding. Organization is the key, however, a lot of extra time has to be devoted to the non-patient care aspects. Having a “rock” of a secretary has made it much less of a headache for me.

Outside of the office, Greg Griffiths can often be found out on one of the peninsula’s fine golf courses or perhaps sampling a vintage wine. It is a good bet one might find John Dickson manning his barbeque or at a local hockey rink watching one of his three sons. John is also an accomplished hockey player and both he and I play on the local Niagara doctor’s team, which performs admirably in the Ontario Medical Association’s annual tournament. I am a hockey “junkie” and play about three times a week during the winter. I am in the midst of passing on the finer points of the game to my two kids. During the summer, I generally enjoy “pumping iron” and doing some golfing. In the end, we are all family guys and enjoy the leisure amenities of the Niagara region.

The atmosphere here is very good and I place a lot of value on my relationship with my fellow constituents, John and Greg. Looking onwards, practicing rheumatology in the Niagara region will continue to evolve and new challenges await that will hopefully make a good thing become even better.

– Saeed Shaikh, MD, FRCPC
The Division of Rheumatology at the University of Calgary has been given an exciting opportunity through the institution of an alternative funding plan. Unlike other alternative funding plans, which are in place across the country, this plan includes all Division of Rheumatology members, both at the university and in private practice. In fact, the plan gives private-practice members a stipend to cover some of their office costs—an innovative idea, you must admit. The philosophy behind the alternative funding plan is that all plan members would contribute to developing innovative ways to deliver healthcare in the Calgary Health Region. Further exciting news was received in April 2005 when it was announced that we would be given operating funds to change the way we deliver rheumatology care in southern Alberta, in general, and in the Calgary Health Region, specifically. This money will allow us to hire at least one nurse practitioner and also increase the number of occupational therapists and physiotherapists that work with our patients. We would also have the opportunity to hire a psychologist or social worker and a pharmacist to assist our patients with their many different problems. Division members are obviously excited about the opportunity with which they have been presented. They also realize that there will be a significant amount of work involved on their behalf as we put plans into place to improve our service delivery.

Recruitments. We have been very lucky to recruit Dr. Sharon LeClercq away from our neighbors in Edmonton. Sharon arrived in Calgary and began practice at the University of Calgary in August, 2004. Since then she has brought her unending enthusiasm to the Division. Sharon has received funding to develop the Tele-Health program in rheumatology. This funding is for a pilot project to determine how well the Tele-Health program will work in a rheumatology environment. Sharon will be working hard over the next two years to develop this program with physician champions in two communities: one in the Pincher Creek area in southern Alberta and one in the Rocky Mountain area in the mid-west portion of the province. Kudos to Sharon for her efforts.

Future Recruits. The Division of Rheumatology is apparently seeking a rheumatologist with an interest in research and immunology or inflammation. This opportunity arises through funds from the alternative funding plan which allows our Division to recruit one member to the alternative funding plan each year for the next three years. We are also desperately trying to recruit residents to our training program. We have found it exceedingly difficult to recruit residents, despite the fact that residents who rotate through our program during their three core training years enjoy the experience that they receive. This year, for the first time, we presented a “Resident Day in Rheumatology,” under the leadership of Dr. Chris Penney. This program was a joint venture with the University of Alberta and took place here in Calgary on Saturday, April 2, 2005. Rheumatologists from the University of Alberta and the University of Calgary participated in this all-day event. There were 31 residents in attendance. The residents were very enthusiastic about the opportunity they were offered and the program received very good evaluations. This program will be an annual event and will alternate between both cities (Edmonton and Calgary). It will be interesting to see if this effort helps to attract trainees to the training program over the next few years.

– Liam Martin, MB, MRCPI, FRCPC
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Social Issues. In an effort to rationalize medical manpower distribution to improve access to care all over the territory, the Quebec government has established Plans Régionaux d’Effectifs Médicaux (PREM). PREM is rigidly fixing the number of MDs in each specialty, in each hospital and in each region! In rheumatology, the net effect is rationing. Once the McGill teaching hospital PREM head count (not the same as a full-time-equivalent count) is achieved, a new recruitment is only possible if someone retires or dies. Moreover, PREM is coupled with another initiative called Réseaux Universitaires Intégrés de Santé (RUIS), whereby each of the four Quebec medical schools is accountable for providing specialized services to its specific region (région universitaire). Clinically oriented PREM may thus shortchange teaching and research. Moreover, to save money, the number of PREM positions has been established on a historical basis (i.e., usually below the projected needs of the University and the community). The bottom line is that access will be as difficult on the island of Montreal as on the eastern shore of James Bay, which is part of the McGill RUIS.

These issues are anxiously being discussed at the university, hospital and Association des médecins rhumatologues du Québec (AMRQ) levels. To be followed closely.

Recruitment. Before the PREM/RUIS era, we recruited Marie Hudson, MD, MSc (Epidemiology, Columbia University) and Sasha Bernatsky, MD, PhD (Epidemiology, McGill University). Dr. Hudson works on pharmacoepidemiology and Dr. Bernatsky works on cancer and systemic lupus erythematosus (SLE). Dr. Hudson spent some time in Africa and Dr. Bernatsky spent some time in Asia (with Doctors Beyond Borders) before they each started their McGill appointments in 2005. Both doctors have been highly successful in obtaining salary and research support from the Canadian Institutes of Health Research (CIHR), the Canadian Arthritis Network and The Arthritis Society (TAS). We wish them well in their careers. We also recruited Sarah Campillo, who completed pediatric rheumatology at McGill under the able mentorship of Dr. Ciarán Duffy. After a traveling fellowship, she made her flamboyant debut by organizing the first Canadian summer camp for children with arthritis in the Laurentian Hills north of Montreal (Figure 1). This is a seminal initiative for kids and a great fundraising tool for TAS.

We are offering a PREM position to Peter Panopalis, who completed his core rheumatology training at McGill last year, and to Elizabeth Hazel, who will complete her core rheumatology training this year. Dr. Panopalis is an excellent clinician and will complete a degree in Epidemiology, targeting the field of vasculitis, during his fellowship. Currently, in wet laboratory training, the Montreal University Health Centre has two clinical immunologists and one PhD rheumatologist/cell immunologist targeting the biology of dendritic cells.

Teaching. A survey of our medical students showed that they are good in theoretical rheumatology but not comfortable with the neurological and musculoskeletal (MSK) examinations. Our undergraduate program is thus being overhauled to remedy that situation. We have utilized training-the-trainer sessions (Henri Ménard), expanded the Patient Partners® in Arthritis
program (Michael Starr), organized an MSK day involving all MSK specialists and Allied Health personnel (Michael Starr, Mary-Ann Fitzcharles) and used a web-based program (Michael Stein, project for MSc in Medical Education). The post-graduate program (Michael Starr, Director) is not as popular as it should be but we are looking at making more use of the fabulous transdisciplinary McGill resources. For rheumatology residents, general rheumatology is targeted in the first year. The second year focuses on disease-oriented, multidisciplinary research clinics: the Lupus/CTD clinic with Ann Clarke and Christian Pineau; the Bone Center clinic for inherited and acquired metabolic bone diseases with David Goltzman, Richard Kremer, Francis Glorieux and Suzanne Morin; the inherited and acquired Muscle clinic with Angela Genge; the Early Arthritis and Scleroderma clinic/registries with Murray Baron and David Langleben; and the Pain clinic with Mary-Ann Fitzcharles and Mark Ware.

Laeora Berkson saw her Clinician Teacher Award renewed by TAS. She works out of the Jewish General Hospital, one of the major teaching hospitals of the McGill University network. There, she received the Teacher-of-the-Year Award from the Department of Medicine. Laeora designed and single-handedly implemented a McGill-wide Rheumatology Curriculum targeting the core-medicine residents. She was very influential with Elizabeth Hazel, a first-class McGill graduate who chose rheumatology as her medical subspecialty. Elizabeth joined the McGill Rheumatology Training Program this year. In recognition of her efforts, Laeora has been named to the 2005-2006 Faculty Honor List for Education Excellence. She was thus invited to participate in a Symposium on Education in the Health Sciences entitled, “Promoting Educational Excellence At McGill.” Congratulations, Laeora!

Research. The clinician-scientist cannot be a Renaissance person anymore. Clinical research is
now based on bidirectional knowledge translation between clinicians and scientists, both being essential. As Head of the University Division and responsible for recruitment, this author is taking a proactive stance by training and recruiting complementary duo teams from the onset. Epidemiologists, by the nature of their expertise, can be recruited independently and grafted on those dynamic duos. This approach has been implemented for the past three years in all the multidisciplinary disease-oriented clinics already mentioned. We will favor investigator-initiated research and collaborative efforts on consensual themes. Participating in the Early Arthritis National Initiative is one example. Preparing for that, Professor J. Sharp gave a half-day Master class to rheumatology and radiology residents and staff to illustrate the strengths and limitations of the Sharp radiological scoring system (Figure 2).

Our rheumatology-oriented basic scientists all had a productive year: M. Newkirk chaired the scientific committee meeting of the Federation of Clinical Immunology Societies (FOCIS) last summer in Montreal. J. Rauch (Antiphospholipids), J. Dibattista (Signaling and Chondrocyte Biology), E. Rahme (Large Data Bank Mining), and D. DaCosta (Fatigue in SLE and Other Systemic Rheumatic Diseases) are all supported by the CIHR and surrounded by their own teams.

On a personal note, I am also supported by the CIHR and was invited to Japan to discuss my work on citrullinated-vimentin (the Sa antigen) at a symposium on citrullination of proteins in rheumatoid arthritis. This year will be my last to serve on the Board of the Institute of Musculoskeletal Health and Arthritis of the CIHR. My health was shaky during the past year but I got by “with a little help from my friends.” Many thanks to all!

The McGill Rheumatology Program is being built on solid ground, hopefully for the long term. It presents a multitude of opportunities for learning, personal growth and international networking. We love to learn about, reinvent, teach and practice rheumatology. Come and visit us!

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