Confessions of a Peripatetic Rheumatologist

Having completed my internal medicine and rheumatology training in 1973, I was confronted with a dilemma that was concerning but not unhappy. Should I accept a position in an academic centre, a comfortable choice since that was the world in which I had been working for the last five years, or go to a community where I would be the first and only rheumatologist. It was certainly a decision that my professor, Metro Ogryzlo, thought should be obvious; I should choose the academic career. However, I was of a mind that, in a manner of speaking, it might be more fun to be “a big frog in a small pond.” Thus, I chose to start my rheumatology career in Thunder Bay. Was this a good choice or not?

One of the negative aspects, as time passed, was the necessity of participating in internal medicine call. In the first several years, secure in my general internal medicine training, this was not so bad. As the years passed, however, I began to develop an uneasiness, not that I was necessarily practising poor general medicine, but that I was no longer at the “cutting edge.” This was the major impetus to make a change to a different locale, as you shall see.

However, I had the great opportunity to make a lasting impact on a community. With the strong support of the Sisters, a rheumatic disease unit was established at St. Joseph’s Hospital, a unit that survived my departure and still functions today. The first physiotherapist on that unit is still working in the area of arthritis, and the occupational therapist who started shortly before I left for Thunder Bay still works on the unit. I worked with colleagues who were practising at a level of which any academic unit would have been proud. Through the Northwestern Ontario Medical Program, I was involved in the teaching of medical students, medical residents, and even a rheumatology fellow, while keeping at arm’s length from any university and its attendant politics. I did miss the opportunity to interact on a daily basis with other rheumatologists, but this certainly compelled me to make the effort to attend the annual meetings of the Canadian Rheumatology Association (CRA) and the (now) American College of Rheumatology.

After 10 years, I moved to a much more academic environment as Medical Director of the British Columbia and Yukon Division of The Arthritis Society. With this came membership in the University of British Columbia (UBC) Division of Rheumatology, much more teaching, less patient care, and much more administration. (To my amazement, I had also seemingly become much, much smarter. I was invited to sit on research review panels and to be a Royal College examiner!) Of course, the interactions with my rheumatology colleagues were stimulating and rewarding.

However, I realized that a life of administration was not for me. I returned to a clinical practice. Never wishing to miss an opportunity to introduce rheumatology to another community, I established this in the Vancouver suburb of Richmond. This has been, in many ways, the best of all possible worlds. The only administration I do is of my own practice. I was joined by an excellent colleague 10 years ago. I have maintained a clinical appointment with the UBC Division of Rheumatology, attend the weekly educational rounds of the Division, continue to do some teaching and research, and interact with a very good outpatient arthritis service at our local hospital.

Throughout much of this time, I had the great good fortune to participate in the activities of the CRA Executive as a member at large, secretary-treasurer, vice president, and president. To put lie to the above comments about administration, this was one area where it was a pleasure. Interacting with colleagues in a positive and active milieu such as the CRA is something all rheumatologists should plan to do at some stage in their career.

Is there a message to this story? Certainly it does show that rheumatology is a specialty with much opportunity to explore the various facets of practice. The mythology that a move to community practice forever excludes you from entering the academic milieu is clearly untrue.

What should you do when setting up practice? Getting a good secretary is critical. I’ve had the good fortune of never having had a bad one. However, if you do, lick your wounds, send him/her off with your best wishes and move on. Hire a good accountant and a good investment advisor; you may be a good physician but the odds are that you are lousy at these two areas. Enjoy your patients: they are generally a good bunch of folks who deal with stresses much better than you or I do. (When you get the occasional bad apple, have him/her move on to join your old secretary.) Never forget that the healthcare system could function reasonably well without administrators but would shut down rapidly without healthcare professionals.

If there is one moral, it is that one should always have fun with his/her professional career. When it stops being fun, look for a greener pasture—and it is usually there.

Barry Koehler, MD, FRCPC
Richmond, British Columbia
Please describe your current practice.
I have been practicing in Lethbridge, Alberta for one year. I moved to the city and settled into my solo practice after the Chinook Health Region offered me this position. I am the only rheumatologist covering the region between southern Alberta and eastern British Columbia. The last rheumatologist in the region left in 1998. The Chinook Health Region had not had a rheumatology practice since then.

I started my practice working at the Lethbridge Regional Hospital. After almost nine months of working at the hospital while trying to set up my own office, I finally got my office established and running.

I started a biologic clinic and currently am training a nurse who will be actively involved with it.

I am also in the process of setting up an electronic medical records system. I also would like to be involved in trials in the near future.

What made you decide to practice in your current setting? If you previously were a full-time university appointment, why did you change your practice setting?
I am originally from Argentina and did most of my training there (internal medicine and rheumatology). I did one year of clinical research in the United States and two and a half years of fellowship at the University of Calgary. I spent one of those years with Dr. Steven Edworthy, working on Telematics, and the other year and a half being specifically trained to practice in Lethbridge. I have also done a rotation in pediatric rheumatology.

The Chinook Health Region had made it a high priority to hire a rheumatologist to open a practice in the region. In order to be able to set up my practice, I had to fulfill all the requirements and assessments established by the rheumatology department of the University of Calgary. When I moved to Lethbridge, I had no infrastructure but many consults ready for me to see.

What are the negatives in your practice that you would like to change? What has been the worst experience in your practice?
A daily frustration I experience involves the lack of resources to support some projects I want to work on. Lack of clinical discussion in my daily practice is something that I miss as well. It is also difficult to get connected with bigger centres when your own needs haven’t been contemplated in their projects.

What is your perception of the case mix in your practice? How does it compare with your experience during your training?
I have not had difficulties with my training in my clinical practice. Finding a way to do my own research has been more difficult. The decision is often based more on opportunity than my own needs.

Do you participate in general medical call in your community? Is this an advantage or a disadvantage in your opinion?
I do not participate in general medical call. I think this is a big advantage. If I was taking calls, I would not be able to manage my practice in the manner I wish.

Living my own challenge and doing what I like give me the greatest satisfaction. Having had the chance to build up my own practice from scratch and being able to work on my own projects make it very enjoyable.

Not having been born in Canada has made things very challenging. It has taken a lot of courage, conviction and positive thoughts to fulfill the challenge.

What brings you the most joy in your practice? What has been the best experience that has ever occurred in your practice?
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In addition to your clinical service, do you participate in other medical activities, such as teaching or research?

Currently, my practice is 80% clinical work and 20% administrative work. However, I am trying to participate in sponsored clinical trials and, if possible, would like to be able to do my own research. I am working on this at the present time. I will see how successful it is.

How do you pursue your Continuing Medical Education (CME) in rheumatology? What are the challenges for rheumatologists outside the university to obtain their CME hours?

The best way for me to stay up-to-date is to attend conferences outside the region or participate in rounds from academic institutions like the University of Calgary. Also, subscription to journals and other scientific sources of information has become necessary. Being in contact with pharmaceutical representatives has been helpful as well.

If you had to do it all over again, how would you set up your practice differently?

I would set up with two or three more rheumatologists in a better connected research and teaching network. This would probably bring more economic support and opportunities to do research and provide a better quality of care in my region.

What advice would you like to share with rheumatology trainees who are having to make decisions about their future practices?

Try to practice in an environment where you can have your own experience and make your own decisions. Follow your own challenge and maintain a team-working spirit. If you like your clinical practice, the combination of research and clinical work will result in the best quality of care you can give.

What advice would you like to give rheumatology fellowship coordinators in the university training programs?

Teach your fellows to explore opportunities that will provide future benefit with respect to developing a better quality of care for patients.

Christopher J. Atkins, MD, FRCPC

Please describe your current practice.

I’ve been in solo practice in British Columbia since 1971 after completing my training as a fellow at the University of Southern California.

What made you decide to practice in your current setting?

It was the beauty of British Columbia and the wonderful sailing that is so accessible. Initially I set up my practice in Nanaimo, but after 11 years we moved down to Victoria where I’ve been practicing ever since.

What brings you the most joy in your practice? What has been the best experience that has ever occurred in your practice?

I love practicing in Victoria. Working with the medical community here has been, without exception, a delight. I have a shower in my office and try to go out for a run each lunch hour. The greatest pleasure of all is seeing patients who I’ve followed for many years respond to the biologics.

What are the negatives in your practice that you would like to change? What has been the worst experience in your practice?

I miss working in the same building with other rheumatologists, enjoying a cup of coffee together and discussing cases together more often. My worst experience in Victoria is seeing my patients with spondyloarthopathies being denied tumour-necrosis-factor-alpha inhibitors because they’re not covered by British Columbia Pharmacare.

What is your perception of the case mix in your practice? How does it compare with your experience during your training?

I mainly see patients now with rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis and osteoarthritis. During my training, the emphasis was very much on rehabilitation of rheumatic disease when I was completing my residency at King College Hospital in London, England. At that time, the specialty of rheumatology in the United Kingdom was linked to rehabilitation.
Do you participate in general medical call in your community? Is this an advantage or a disadvantage in your opinion?
The rheumatologists do not participate in general medical call but we cover for each other when one of us is out of town.

In addition to your clinical service, do you participate in other medical activities, such as teaching or research?
I do carry out research with Dr. Adam Zielinski at the Electric and Computer Engineering Department at the University of Victoria. Our research is on developing pain-measuring devices. Five years ago I was made Adjunct Professor at the Electrical and Computer Engineering Department at the University of Victoria. I am presently involved in a field study in Sri Lanka with Dr. Lalith Wijayaratne to test the efficacy of a simple questionnaire (text combined with mannequin) to identify patients with early inflammatory arthritis. I’m also involved in several industry-sponsored clinical trials involving biologics.

How do you pursue your Continuing Medical Education (CME) in rheumatology? What are the challenges for rheumatologists outside the university to obtain their CME hours?
I find that the best venue is the annual meeting of the American College of Rheumatology. Also, being involved in clinical research has forced me to keep up with the latest developments in those disease conditions for which we’re carrying out clinical trials.

If you had to do it all over again, how would you set up your practice differently?
I would have taken a half-day off a week early on in my practice. For the last five years I have had the satisfaction of working with rheumatology nurse clinicians. I wish I had organized this many years ago.

What advice would you like to share with rheumatology trainees who have to make decisions about their future practices?
If you don’t know what it is you want to do, start working at a university and you can always go into practice later. If you don’t know where you want to live, start in a big city and you can always move to a smaller one. It’s very difficult to do these the other way around.

What advice would you like to give rheumatology fellowship coordinators in the university training program?
I would like to advise rheumatology fellowship coordinators in the training programs that the annual American College of Rheumatology meetings are excellent venues for Continuing Medical Education. Strong mentorship should be developed particularly when finding a suitable place to practice, and this should be continued for at least two years after setting up practice. In my day, this would have been greatly appreciated.

Finally, I would advise rheumatology fellowship coordinators to make a clear distinction to the fellows between what is best for their patients and what is available. Blurring the two results can develop that Faustian side of our nature which says, “You know what? Even though my patient can’t get this service in a timely manner, it probably wouldn’t have made any difference anyway.”

please describe your current practice.
I practice in Winnipeg, Manitoba in a multispecialty group practice of approximately 60 physicians. The practice has two full-time administrators who handle all business aspects of the clinic.

What made you decide to practice in your current setting?
The freedom of independent practice is what held the most appeal to me when I made my decision to practice in this setting. My current setting of a large multispecialty practice has both benefits and drawbacks. The most obvious benefit is not having to worry about the administrative aspects of running an office. I can focus my attention on practicing medicine. Arranging for referrals is also facilitated by our multispecialty format. However, there are drawbacks to this large group format as well. As with any large clinic, there are differences of opinion with regards to how the clinic should function. Thus, changes to clinic operations, or activities such as renovations, can be difficult to institute.

What brings you the most joy in your practice? What has been the best experience that has ever occurred in your practice?
The most joy in my practice comes from seeing the dramatic difference that one can make in a patient’s life by successfully treating their disease. Unfortunately, with the...
advancements in our therapeutic options for inflammatory
disease, along with the increased availability of these
therapies, this success is a much more frequent
occurrence than even just over five years ago when I
began practicing.

What are the “negatives” in your practice that you would
like to change? What has been the worst experience in
your practice?
Similar to most rheumatologists, whether they are in
community or full-time academic practice, the
negatives in my practice involve the struggle to
access increasingly limited resources; the increased
administrative burden that we face with regards to
demands from insurance companies as well as from
government for documentation of disability issues;
access to medications; and, finally, the lack of value
that is placed on rheumatology as a profession based
on our relative fee schedule compared to other
medical and surgical specialties.

What is your perception of the case mix in your
practice? How does it compare with your experience
during your training?
I feel that I see a broad variety of cases. I likely see less
patients with complex multisystem vasculitis and
connective-tissue diseases than my colleagues at the
university. I think that the referrals I receive in Winnipeg
are, on average, somewhat more challenging than what I
saw during my training in Saskatoon. I believe that this is
because in view of the marked shortage of rheumatologists
in Winnipeg, family physicians in Winnipeg are less likely
to refer noninflammatory or soft-tissue cases.

Do you participate in general medical call in your
community? Is this an advantage or a disadvantage in
your opinion?
I do not participate in general medical call in my
community. This is an advantage for me. I think it is
challenging enough staying current in rheumatology, let
alone staying current with all of the advances in general
internal medicine

In addition to your clinical service, do you participate in
other medical activities, such as teaching or research?
Aside from clinical service, I participate in teaching
through the university. I host residents and rheumatology
fellows in my clinic. I am also quite involved in
Continuing Medical Education (CME) for family
physicians (FPs) and have participated in a number of
local, regional and national CME programs for FPs. I
particularly enjoy this aspect of my practice.

How do you pursue your Continuing Medical Education
(CME) in rheumatology? What are the challenges for
rheumatologists outside the university to obtain their
CME hours?
I attend the weekly rheumatology rounds and monthly
journal club at the university. I also generally attend the
Canadian Rheumatology Association and Western Alliance
of Rheumatology meetings, as well as one international
meeting (American College of Rheumatology, American
Society for Bone and Mineral Research or European
League Against Rheumatism) yearly. I also stay current by
preparing for my CME presentations, as well as scanning
journals over the Internet and reviewing the articles which
I find interesting.

If you had to do it all over again, how would you set
your practice up differently?
Become an ophthalmologist. Just kidding. I’m still in the
junior stage of my career so I believe my practice is set
up to my liking. Ask me again in five years and I may
have a much different answer!

What advice would you like to share with rheumatology
trainees who are having to make decisions about their
future practices?
I would advise that trainees get career advice from as
many different rheumatologists as possible. Take
advantage of the collegial format of the Canadian
Rheumatology Association national meeting and meet
more senior rheumatologists who can provide mentorship
and career guidance opportunities. Try and arrange
multiple electives outside of your home institution to give
you exposure to different philosophies of practice in
different regions of Canada. Even at our larger institutions
in Canada, the rheumatology divisions are still quite small,
so one’s contacts in only one’s own institution are limited.

What advice would you like to give rheumatology
fellowship coordinators in the university training
programs?
Similar to my advice for trainees, I’d recommend that
program directors offer trainees the option of off-site
electives. A community experience should be a
mandatory part of all rheumatology training programs.
Please describe your current practice.
For 25 years, I have been practicing at the Centre Hospitalier Sacré-Cœur de Montréal—a centre affiliated with the University of Montreal. This is a part-time job (50%). Group practice in a private office occupies the other half of my time.

What made you decide to practice in your current setting? If you previously were a full-time university appointment, why did you change your practice setting?
The medical staff at the Centre Hospitalier Sacré-Cœur did not have a rheumatologist in 1980. Since I had done my first two years of residency in internal medicine there, I was offered a position within the medical body. I did my fellowship in rheumatology at the Royal Victoria Hospital in Montreal and the Royal Mineral Water Hospital in Bath, England.

What brings you the most joy in your practice? What has been the best experience that has ever occurred in your practice?
I am currently participating in teaching at the University of Montreal. I have had the opportunity to teach pregraduate (first-year) students and I must say that this has brought me as much satisfaction as teaching residents in the internal medicine program. Providing relief to patients suffering from musculoskeletal pain has also been gratifying, especially since therapeutic agents have made a breakthrough between 1985 and 2000.

What are the negatives in your practice that you would like to change? What has been the worst experience in your practice?
Misdiagnosing patients has proven to be a bad experience, especially in the presence of cancer pathologies manifesting themselves as rheumatology syndromes; the severity of aggressive systemic lupus erythematosus, just like scleroderma, also brings about irreparable consequences or death, especially in young patients.

The health system funding problem in Quebec leads to frustrating constraints in daily practice. In fact, I have not seen any improvements at all since the beginning of my practice.

What is your perception of the case mix in your practice? How does it compare with your experience during your training?
Case mixes and therapeutic progress have made current practice interesting, while residency training involved severe cases (rheumatoid vasculitis, cardiac disease) that are rarely found today, thanks to a better therapeutic arsenal.

Do you participate in general medical call in your community? Is this an advantage or a disadvantage in your opinion?
I was on call in internal medicine for 20 years. For the last five years, my work has been exclusively for rheumatology, which makes the practice more pleasant in general.

In addition to your clinical service, do you participate in other medical activities, such as teaching or research?
I have participated in subsidized and independent clinical research with interest and pleasure. Nonetheless, I think that teaching will take up more of my time in the future.

How do you pursue your Continuing Medical Education (CME) in rheumatology?
Participating in post-graduate courses, participating in Canadian and provincial conventions, and reading medical journals are pivotal to my CME.
Please describe your current practice.
My practice is solo, located in North Vancouver, British Columbia and serving the North Shore area. This area is geographically very large: up the west coast to Whistler and beyond to Powell River. The area is also geographically separated from greater Vancouver by two bridges, which also increases the demand for my services since the older patients with disabling arthritis do not want to travel across the bridges.

I moved to North Vancouver from Toronto, Ontario at the end of 2000. In Toronto, I spent 10 years in full-time academic practice at the Sunnybrook Hospital/University of Toronto. Here in North Vancouver I am in private practice and haven’t made a formal connection with the university, although I have been approached by the University of British Columbia.

What made you decide to practice in your current setting? If you previously were a full-time university appointment, why did you change your practice setting?
I was recruited by the Lions Gate Hospital which wanted an experienced rheumatologist to be the Head of the Division. Several factors influenced my choice to move here: I have family in British Columbia, including a brother in North Vancouver where I now live; the area is stunningly beautiful and provides so much opportunity for outdoor adventure; and at the time I was deciding whether to take the position, the Lions Gate Hospital had won the Macleans magazine award, for two years in a row, as the best hospital in Canada (for its services and record of exemplary care for its population).

I left the geographic full-time (GFT) academic practice as there were too many headaches I could not control. I could not see more patients than I was already of other Joint Research Laboratories (JRLs) in Canada, seem to be at international levels; nonetheless, it is always beneficial to do an internship abroad.

What advice would you like to give rheumatology fellowship coordinators in the university training programs?
Regarding university training programs, I think that every director should give the fellow the opportunity to pursue a training program based on his/her interests and abilities, be they clinical or research. Obtaining scholarships must have precedence over this.

What advice would you like to share with rheumatology trainees who are having to make decisions about their future practices?
In my opinion, the residency-training program at the University of Montreal, as well as the training programs of other Joint Research Laboratories (JRLs) in Canada, seem to be at international levels; nonetheless, it is always beneficial to do an internship abroad.

If you had to do it all over again, how would you set up your practice differently?
I think that group practice, teaching and clinical research are activities in my practice that have been very rewarding since the beginning; I would willingly do these same things all over again.

Catharine Dewar, MD, PhD, FRCPC
booking (nine half-day clinics per week and all were teaching clinics) and, therefore, could not increase my income. Yet every year I was finding it more difficult to meet the minimum income required to stay a member of the financial practice plan of Sunnybrook Hospital. For specialists with procedures it was very easy to belong to the plan and receive all the benefits from it, however, for myself it was very difficult. Transfer payments to the hospital from the federal or provincial governments and even the University of Toronto were being cut back, so the hospital dealt with the loss by passing the costs to the physicians who had their offices within the hospital. That included all the GFT academic physicians, including myself. The Head of Medicine at the time (Dr. John Edmeads) was extremely supportive of those with financial difficulties in the practice plan. He was a neurologist and was sympathetic to rheumatology, and he personally found “bonus” funds to award to me for my annual performance. If he had not done that I would have had to leave the hospital several years earlier. As it was, I had to take a large loan from the Department of Medicine to pay my share of the practice plan. I found that my academic income was staying the same, however, the costs of staying in the hospital practice plan were going up yearly. And I could not control those costs. As an example, I was told by hospital unions how much to pay my secretary and I also was responsible for all her benefits (about $500-$600 per month just for those extra costs), and yet I could not personally choose who worked for me. That being said, the practice plan was different in each teaching hospital in Toronto and there was clearly a much better plan at other hospitals. In deciding to leave, I simply felt that I could not carry on billing the Ontario Health Insurance Plan (OHIP) as my only source of income as an academic and have that OHIP income managed by the practice plan to pay me a salary, plus the rent for the hospital office and exam room plus the unionized staff expenses, etc. This problem of making academics earn their own salary (especially clinician-teachers) has been outlined in detail in many publications both in Canada and the United States. The University of Calgary has its rheumatologists on a salary now and it is a great solution. A few other universities in Canada (e.g., Queen’s University) also have alternative funding plans for medical academics. Young academics would be wise to look for these financial arrangements.

In private practice here in British Columbia, I have wonderful, hand-picked and trained office staff, and the office and business costs are completely controllable. I am better off financially, and not just because I have incorporated my office practice. Even without the tax relief from incorporation, I am far ahead financially in my own private practice. And I have a stunning view of the Burrard Inlet from my office!

I stayed in academic medicine as long as I could because I truly loved teaching and influencing young doctors in their career choices. I can think of 10 internal medicine residents who spent an elective with me and then chose rheumatology as a career. And a great highlight of my years in academic medicine was being awarded the Clinician Teacher of the Year Award in 2000 at Sunnybrook Hospital. I left academic practice with mixed feelings but I could not keep trying to find more
ways to earn OHIP money to pay the practice plan that was required of me.

*What brings you the most joy in your practice?*
My sources of joy are grateful patients, challenging cases, interactions with my colleagues at city-wide rounds, and teaching. The teaching I do now is mainly to very grateful patients and family doctors in my community—and it is well-remunerated as it is usually sponsored by a pharmaceutical company. Another source of joy is control over my time. I am now resuming hobbies and activities which were put on the back burner while I was in academic medicine. I have far more time to socialize and do fitness activities. I have a mountain—or rather a “hybrid”—bike as there is no excuse not to do biking here in North Vancouver, which is world-famous for biking and hiking. And I am still writing and publishing poetry, which is a great source of joy for me.

*What are the “negatives” in your practice that you would like to change? What has been the worst experience in your practice?*
A negative aspect about private practice is missing the interaction with many specialist colleagues all day long, since private practice centers around being involved with patients and office staff most of the time. I know how important it is for me to make the interactions with my colleagues at Continuing Medical Education events, conferences, city rounds and social events.

I have also noted that there is a respect that comes to a specialist in a hospital office, especially a teaching hospital. When you are in private practice in the community, you must really earn that respect and trust, as patients are not cowed by the hospital atmosphere. I think the illusion of knowledge from the Internet drives some patients to be very demanding and it takes far more patience and skill to deal with these patients now than it did 10 or 15 years ago.

The worst experience in my practice? I have more than one, unfortunately. I recall one secretary who used my office telephone for a sex-line on the weekends... need I say more. Because she was a member of a hospital union, it took me nine months to formally document all her failings as a secretary before I could convince the union and the hospital she had to go. Meanwhile, I had to keep her in my office even though she and I both knew the score (pardon the pun). I also recall a bizarre patient from Toronto who called me long-distance from Europe expecting me to diagnose and treat her new and disabling pains over the telephone. Despite my apologies and sincere advice to visit an emergency department in Germany, she felt I had betrayed her and wrote me the most scathing letter about my incompetence. I noted a year later, in an article in the Toronto papers, that she was a “nouveau” artiste, sculpting figures of women with their private parts mutilated by evil forces, etc., and that she was having a showing in Toronto. I didn’t go to the opening...I thought one of the figures might be a bit too familiar!

*What is your perception of the case mix in your practice? How does it compare with your experience during your training?*
My case mix includes everything from A to Z in the rheumatology literature. The extremely ill patients tend to find their way to the teaching hospitals across the two bridges from the North Shore, but that is not to say I do not have difficult cases. The North Shore is home to many retirees, therefore, I have many patients who are a challenge due to age and complex comorbidities. In British Columbia we receive an annual printout of our case mix and I’ve noted the average age of my patients...
has shifted to the older population (by 10 years at least) and the “degree of difficulty” of my patients is also greater. This means I have more patients requiring all my skills from internal medicine and rheumatology. I’ve diagnosed relapsing polychondritis, atypical sarcoid, Lyme disease, rheumatic fever, atypical reactive arthritis, multiple osteochondromatosis, adult-onset Still’s disease, Behçet’s disease and cryoglobulinemia with hepatitis C all within the last year. My case mix compares reasonably well with my rheumatology training at the University of Western Ontario in London, Ontario. However, the extra 10 years in academic practice in Toronto was, for me, a wonderful opportunity to continue learning from my senior colleagues and an extended exposure to very rare diseases. I have as much variety and challenge now as I had in academic medicine.

Do you participate in general medical call in your community? Is this an advantage or a disadvantage in your opinion?
I do not do general medical call, which is an advantage and a relief for me. I spent more than half of my time in academic medicine doing call for both, and it became more stressful as time passed. I now have more time to do the things I want to do in rheumatology as well as my personal life.

In addition to your clinical service, do you participate in other medical activities, such as teaching or research?
I am more involved with pharmaceutical companies now than I was as an academic physician. I do more teaching (as mentioned above) and I also do more clinical trials.

How do you pursue Continuing Medical Education (CME) in rheumatology? What are the challenges for rheumatologists outside the university to obtain their CME hours?
I do not have trouble getting the CME credits that I need for the Royal College of Physicians and Surgeons of Canada (Maintenance of Competence credits). I attend many weekly city-wide grand rounds plus conferences and CME events in Vancouver. I also get the needed credits with journal club, personal learning projects, external conferences, etc. I find I have more control over my time to pick and choose which CME events I wish to attend, now that I am not constrained by the obligations of an academic life.

If you had to do it all over again, how would you set up your practice differently?
I wouldn’t change anything in my current practice as it suits me nicely. With the experience that I have now, I can see how I may have done some things differently 10-12 years ago, early in my academic career. However, being a new member of the academic staff, one has to put in one’s dues, and it is hard to control one’s fate in all circumstances. The burden of many clinical/teaching/administrative duties falls on the newest members of staff. However, under a well-run alternate funding plan, there is protected time (which is remunerated!) available to all members, so that junior as well as senior careers can be advanced. I think I would not have found my last five years in academic medicine in Toronto so difficult if the alternate funding plan promised for Sunnybrook Hospital in 1995-1996 had not fallen through with provincial health restructuring.

What advice would you like to share with rheumatology trainees who are having to make decisions about their future practices?
For rheumatology trainees today I would advise electives which also include community rheumatology. Exposure to physical medicine, rehabilitation and sports medicine electives would also be ideal, especially if one is planning on a community practice. There are very successful community rheumatologists throughout Canada and sometimes the training programs are too focused on research electives within the academic milieu. In my experience, I have seen trainees feel guilty for selecting options other than research or specialty academic electives, and this is not appropriate. Not all trainees can become (or need to become) academics, and many more are needed out in the communities. A healthy interaction between the academic and community rheumatologists is needed to allow the trainees to make a sound career decision. I am seeing more academics choose to leave the teaching hospitals for many of the reasons I mentioned earlier. These are former academics in areas other than rheumatology. I saw many internationally recognized colleagues go through the added stress of not being able to obtain yearly grant monies to support laboratory staff, despite excellent grant proposals. I have seen colleagues find alternative sources of revenue for clinical or bench research, and sometimes the consequences have been disastrous. Any trainee trying to make decisions regarding his/her career path needs to do the research ahead of time and talk to as many individuals as possible, before committing to a choice.
Please describe your current practice.
I have a group practice of two in an in-hospital clinic in Moncton, New Brunswick. I have been there for 14 years. I maintain close relationships with other hospital-based specialists and community family practitioners. The hospital offers excellent support and a high-tech wireless information service for picture archiving and communication systems (PACS)/lab/consults, etc., so all patient information is readily available.

What made you decide to practice in your current setting?
I like the progressive and growing community, as well as the central location in the Maritimes. The medical community here is excellent.

What brings you the most joy in your practice? What has been the best experience that has ever occurred in your practice?
I enjoy patient care and administrative involvement. My best experience was in 1992 when we saved a young woman (mother of two) who had severe Wegener’s granulomatosis.

What are the negatives in your practice that you would like to change?
The pace and volume of work.

What is your perception of the case mix in your practice? How does it compare with your experience during your training?
The case mix is very broad, although there is little regional or soft-tissue rheumatism due to priorities of long waiting lists.

Do you participate in general medical call in your community? Is this an advantage or a disadvantage in your opinion?
I participate in general medical call one day every two weeks—mostly intensive care unit- or cardiac care unit-type consultations. I enjoy it but call can be brutal with approximately three hours of sleep per night.

In addition to your clinical service, do you participate in other medical activities, such as teaching or research?
I am involved in teaching and have a collaborative research appointment as a lecturer at Dalhousie University. An additional 30 hours/week are also put towards administration.

How do you pursue your Continuing Medical Education in rheumatology?
I stay up-to-date through online resources at the hospital, literature searches, rounds and conferences.

If you had to do it all over again, how would you set up your practice differently?
I would not make major changes although I would like to slow down before my kids get too old.

What advice would you like to share with rheumatology trainees who are having to make decisions about their future practices?
Balance your life and, when choosing where to practice, remember there are interesting cases and practices outside an academic centre.

What advice would you like to give rheumatology fellowship coordinators in the university training programs?
Community/non-academic exposure should be mandatory.

Please describe your current practice.
I have been a community-based rheumatologist in Fredericton, New Brunswick for 24 years.

What made you decide to practice in your current setting?
When I was first looking to establish a practice, I searched the country for job openings. The province of New Brunswick had one rheumatologist (Verin Khanna) working in St. John and the load was heavy. I had to find a community that had jobs for both me and my spouse (my wife is a neonatologist). We decided on Fredericton as we knew it would also be a great place to raise a family.

What brings you the most joy in your practice? What has been the best experience that has ever occurred in your practice?
I enjoy the contact with patients, particularly the long-term relationships that develop with patients who have chronic illnesses. I have the opportunity to be involved in these patients’ “journeys” over many years.

My best experience was when the family of a patient donated $250,000 to arthritis research out of gratitude for care provided.

What are the negatives in your practice that you would like to change? What has been the worst experience in your practice?
I am bothered by the increasing incursion of bureaucrats interfering in decision making, and the requirement of ever-increasing paperwork for drug coverage, disability, and legal woes.

A low point in my career occurred when my hospital chief executive officer implemented cost-saving measures by deciding that the region would not provide anti-tumour necrosis factor drugs unless the patients had outside coverage. He then terminated the treatment in the two patients the hospital was paying for. One lady never walked again and never got home. She bounced around the hospital system from facility to facility and finally died one and a half years later. The callousness of the interference gave me a glimpse of the future after the bureaucracy seizes control of the agenda.

What is your perception of the case mix in your practice? How does it compare with your experience during your training?
My practice is confined to inflammatory disease of all descriptions (e.g., rheumatoid arthritis, connective tissue diseases, vasculitis, spondylitis, etc). Unlike my training, I do not see fibromyalgia, back pain, or disability cases. I find the case mix challenging and rewarding.

Do you participate in general medical call in your community?
I do not do general medical call.

In addition to your clinical service, do you participate in other medical activities, such as teaching or research?
We participate in pharmaceutical-sponsored clinical studies. We do accept family-practice residents for electives. I believe that rheumatology residents training in academic sites should arrange electives with community-based rheumatologists to get a broader perspective on what private practice is like.

What advice would you like to share with rheumatology trainees who have to make decisions about their future practices?
Given the long wait times and the need to see rheumatoid arthritis early, everyone should build a three-hour block into their weekly schedule that they do not book until the day before.
Please describe your current practice.
At present, I have been in independent practice in Saskatoon, Saskatchewan for 18 years. At certain points I had partners, but two of them moved to other Canadian cities and one joined her husband’s practice.

What made you decide to practice in your current setting?
I should start from the beginning. I came to Saskatchewan in 1983 with my wife and three children (my daughter was seven years old and my twin boys were three years old). We moved to Canada from England after I completed one year of research at the Royal Free Hospital (post-PhD grant). Originally, we lived in Poland where I worked as a hematologist for about eight years and was involved in clinical practice and research.

As an immigrant to a new country, “you lose everything but the accent.” Luckily enough, during my residency in internal medicine at the University of Saskatchewan, I met my future mentor: Dr. Earle DeCoteau. Some “older” rheumatologists may still remember him. He convinced me to quit hematology and consider a rheumatology fellowship. So, my plan was to finish my rheumatology fellowship and stay at the university as a rheumatologist. However, after I received my certification in internal medicine, I heard that in order to stay at the University of Saskatchewan it would be necessary for me to extend my fellowship by another (third) year. After previous research for eight years along with my PhD research, this proposition was not “talking” to me. The same day I received this message I decided to go into independent practice, and I still consider the day I made this decision as the best day of my professional life.

In summary, my decision to go into private practice was due to that request to continue fellowship for one more year and, as well, due to obstacles related to university bureaucracy with respect to starting clinical research.

What brings you the most joy in your practice? What has been the best experience that has ever occurred in your practice?
I love the fact that I don’t have a boss! And I have been successful in creating a general rheumatology practice, an injection clinic and, finally, the Osteoporosis Centre (the only one in Saskatchewan). However, the best experiences in my practice include having satisfied patients, as well as satisfied students and residents—a compliment to my teaching skills.

What are the negatives in your practice that you would like to change? What has been the worst experience in your practice?
The negative aspect of independent practice is still related to the “old” concept of university physicians being considered more “academic” than those involved in non-university-based activities. At one point, a long time ago, I had difficulty continuing my independent research simply because my Osteoporosis Centre was not university-based.

What is your perception of the case mix in your practice? How does it compare with your experience during your training?
I have tailored my cases and now have a mixture of general rheumatology, joint injection days, and osteoporosis. It is my impression that in independent practice, you may create your own “practice profile.”

Do you participate in general medical call in your community? Is this an advantage or a disadvantage in your opinion?
I participate in rheumatology call in Saskatoon but I do not intend to take part in general medical calls. I don’t think rheumatologists are trained to do general medical calls unless they have trained that way from the beginning.

In addition to your clinical service, do you participate in other medical activities, such as teaching or research?
I am involved in teaching activities and various types of research and analysis (clinical, industry-sponsored, as well as independent). I also hold an appointment at the University of Saskatchewan as a Clinical Professor of Medicine. Our Centre has also been participating in a government-sponsored epidemiologic study (representing Saskatchewan). The study is known as the Canadian Multicentre Osteoporosis Study (CaMos).

How do you pursue your Continuing Medical Education (CME) in rheumatology? What are the challenges for rheumatologists outside the university to obtain their CME hours?
I don’t feel that rheumatologists outside the university face any challenges in obtaining CME hours, other than the fact that our time away from the office certainly affects our income.

If you had to do it all over again, how would you set your practice up differently?
Generally speaking, I wouldn’t do things much
Please describe your current practice.
As community rheumatologists, Barry Koehler went to Thunder Bay in 1975, and I went to Peterborough, Ontario in 1976. I joined a 20-physician multispecialty clinic at that time, and stayed with it until I left clinical rheumatology in 2003.

What made you decide to practice in your current setting? If you previously were a full-time university appointment, why did you change your practice setting?
Part of my post-graduate training was at New York University (NYU), where I did three years of clinical rheumatology and concurrently three years of lab research in the Department of Cell Biology. That department had more than 20 full-time PhDs, and a Nobel laureate affiliated from biochemistry. Although my intent when going to NYU had been to return to Canada as a clinician scientist, it became evident to me that, compared to the critical mass at NYU and the excellent calibre of work being done by full-time scientists, I would not be able to function at that level in the lab. I thus chose to enter full-time clinical practice.

At that time (1976), rheumatic disease units in Canadian universities were primarily interested in recruiting clinician scientists, not full-time clinicians.

What brings you the most joy in your practice? What has been the best experience that has ever occurred in your practice?
The development of the biologics in the last decade has allowed more frequent improvement in functional practice by doing a locum, for example. At present, some trainees are “kept” at the university for simple “service” reasons and don’t gain enough exposure to what one can call “real-world community service.”

What advice would you like to share with rheumatology trainees who have to make decisions about their future practices?
Before making a final decision, try to explore all the possibilities and try to get experience in independent practice by doing a locum, for example. At present, some trainees are “kept” at the university for simple “service” reasons and don’t gain enough exposure to what one can call “real-world community service.”

What advice would you like to give rheumatology fellowship coordinators in the university training program?
More flexible programs and more community-based programs are needed, as well as, perhaps, more exchange programs between centres, and maybe even two types of fellowship: university-based and community-based.

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capacities in patients with inflammatory disease. That overall maintenance of capacity has been very rewarding. Prior to that, even the multiple immuno-suppressive regimes were fraught with side effects and less effective control.

Another rewarding experience was the uncommon fibromyalgia syndrome patient who grasped the inherent external causalities of the disorder, and succeeded in the emotional, physical and social fitness work necessary to regain/maintain symptom resolution and life enjoyment.

*What are the negatives in your practice that you would like to change? What has been the worst experience in your practice?*

Purchasing power from practice revenue was maximal around 1982, and relative income per hour of practice compared to the other multispecialties (in what was latterly a 30-physician group) seemed to decrease with each partnership annual financial statement. The temporal efforts necessary to obtain Ministry of Health and Long-Term Care (MOHLTC) approval for new therapies during the late 1990s seemed to even more negatively affect relative practice revenue because of the time consumed.

*From 1995 to 2003, I acted as a peer reviewer for rheumatology for the College of Physicians and Surgeons of Ontario and had the privilege of seeing 28 other Ontario rheumatology practices (approximately 1/3 academic practice and 2/3 community practice). Only one of the 18 community rheumatologists had not developed another revenue-generating activity besides clinical rheumatology.*

*What is your perception of the case mix in your practice? How does it compare with your experience during your training?*

My rheumatology training at McGill University and New York University utilized specific outpatient clinics and a now uncommon entity then known as an inpatient bed. Essentially, all patients seen had inflammatory arthritis/immune complex disease, or pre- and postsurgical level osteoarthritis (OA) and were admitted to orthopedics. There was no exposure to chronic pain disorders, regional pain disorders or nonsurgical OA. There was very little pediatric exposure. In community rheumatology, one needs a certain facility with these other common entities.

*Do you participate in general medical call in your community? Is this an advantage or a disadvantage in your opinion?*

All Fellow of the Royal College of Physicians of Canada (FRCP)-bearing physicians in our department of medicine (seven in 1976 and 15 in 2003) took part in general medical call. There were different models of medical call through the years but it was part of the communal and community responsibility in that location to be on-call. The population served was approximately 250,000, so there was no need for a purely rheumatology call schedule.

Through the 28 years, I likely became less effective on general medical call. There were no rheumatology patients on call with whom I was uncomfortable in assessing and treating, but I became less confident that my general medical skills were of the standard that a patient in the emergency room would receive from a cardiologist or respirologist or procedural gastroenterologist, should that be the area of the patient’s primary presenting problem.

I left clinical practice in 2003 to do a tour as a Task Force surgeon with the Canadian Forces deployment in Bosnia. On my return in 2004, I took up my present position as full-time Chief-of-Staff in one of the nine Nova Scotia district health authorities.
In addition to your clinical service, do you participate in other medical activities, such as teaching or research?

After taking my turn at the usual medical staff organization and department of medicine posts, I did a part-time Master of Public Administration (MPA) at Queen’s University in the late 1980s, with a focus on health economics and program evaluation. I chose to do this because the “writing on the wall” said that the era of physician eminence in healthcare decisions was about to pass. Thus, I hoped that with the MPA, I could be a “bridge” for physicians between the Ministry of Health and Long-Term Care (MOHLTC) and the developing administrator class in hospitals.

Subsequently, I had the chance to work as a health management consultant (concurrent with office rheumatology and general medicine on-call) with a number of health management companies from the late 1980s to the early 2000s. I have also had the chance to work on a variety of interesting part-time medical/hospital administration planning tasks. (Incidentally, most of these activities generated more revenue per hour than clinical rheumatology.)

I have also been a reservist with the Canadian Forces for 22 years and had the privilege to serve on two peacekeeping tours within the last 10 years, utilizing both clinical skills and medical planning abilities in creating healthcare for our troops in rather strenuous and somewhat uncontrolled environments.

How do you pursue Continuing Medical Education (CME) in rheumatology? What are the challenges for rheumatologists outside the university to obtain their CME hours?

I’ve obtained my CME hours through written journals, regular clinical rounds, annual Australian Rheumatology Association (ARA) meetings in the 1970s and case-based learning through the easily accessed Internet.

The attributable cost to a fee-for-service physician of attending meetings (e.g., the American College of Rheumatology) is relatively greater now than in the 1980s and early 1990s, to the point of being an impediment to the Canadian rheumatologist.

If you had to do it all over again, how would you set your practice up differently?

An interprofessional team is the model that I would establish.

What advice would you like to share with rheumatology trainees who are having to make decisions about their future practices?

• Don’t try to do it all yourself.
• Utilize the other relevant healthcare professions for the overall good of your patient.
• Do careful cost and revenue analyses of the activities that your interprofessional team offers to your patients, so that you clearly understand how to be both effective and efficient.

What advice would you like to give rheumatology fellowship coordinators in the university training programs?

Review the physician demographics in the country and your province, and then review potential new models of point-of-care for patients. Teach your trainees the necessary competencies to work within their scope of practice within interprofessional teams.
TAKING THE BIG LEAP

I made my decision to transfer from a full-time university academic appointment to private practice in 1999. As many of you know, this decision was prompted by the lack of a suitable position in Saskatoon, Saskatchewan for my wife, who had recently completed her training in cytogenetics at the University of British Columbia (UBC). Moreover, she had been offered a very attractive position as Director of the Cytogenetics Laboratory at a major hospital in Vancouver, BC. Although I continued to enjoy my work at the University of Saskatchewan, I was also at a stage in my life where I felt it was important to rejuvenate my own career pathway. While I would have preferred a lateral move into an academic posting at UBC, this was not possible as both existing academic positions were currently occupied.

I became intrigued by the possibility of reinventing myself as a private, community-based rheumatologist, although it was very important for me to maintain a strong academic connection. Quite fortuitously, one of the most highly respected community rheumatologists in Vancouver was forced to retire unexpectedly for medical reasons. I was generously offered the opportunity to take over his very busy practice on relatively short notice. I had always been in a salaried position and, thus, my learning curve for transitioning to the business of private practice was extremely steep.

One of the key factors in facilitating this transition process was my decision to retain the existing medical office assistant who was extremely experienced and knowledgeable both with regard to the business side and, more importantly, the clinical aspects of the practice. As it was critical for me to assume the practice with minimum interruption, I also chose to commute on a “one week in, one week out” basis between Saskatchewan and BC. This allowed me to wind down my Saskatchewan practice and rapidly assume my new Vancouver practice which included many highly complex patients.

Another factor which was immensely helpful in facilitating my successful transition was a “Dear Patient” letter prepared by the retiring physician. He sent the letter to all of his patients prior to my arrival. This letter provided both an introduction as well as a strong personal endorsement of my clinical skills and experience. I have no doubt that this letter was the single most important factor which led to the retention of more than 80% of the existing practice.

Five years have since rapidly elapsed and I could not be more pleased with my decision and how well my practice has evolved. I think that I derive my greatest satisfaction from the sense of being my own boss and being wholly responsible to myself for the success of the operation.

In coming from an academic posting, I have also been sensitized to the reality of rheumatology as being one of the lowest paid specialties. It is regrettable that the billing system actually penalizes physicians who see complex multisystem diseases, which characterize the majority of the patients in my practice. Furthermore, because of my affiliation with a teaching hospital, I have taken on a number of academic and administrative responsibilities which in many ways are similar to those of my duties in Saskatchewan. These include being invited to assume the role of Division Head, as well as director of undergraduate and postgraduate educational activities for rheumatology at the St. Paul’s Site. This is in addition to having a regular stream of residents and medical students attend my office clinics, as well as performing regular teaching assignments and continuing medical education presentations. All of these activities are poorly remunerated, if at all, and significantly impact on my private practice revenue stream. It should be stressed that I have chosen to accept these activities because of my love for teaching and the opportunity to continue contributing to the academic growth of rheumatology. It has forced me, however, to look at alternative revenue sources in order to keep my accountant happy. This has included carving out some time for industry-sponsored clinical trials as well as contracted clinical work, such as the Traveling Consultation Service and Therapeutic Monitoring Clinics out of the arthritis center.

On final analysis, I think that I have molded a professional situation which is both challenging as well as immensely rewarding both from a clinical and academic perspective. Other than trying to redress the inequities in our fee structure and learning to lobby the university for fair compensation for teaching, I am pretty much the same “prairie boy” that I was five years ago...perhaps a little smarter but a heck of a lot more efficient.