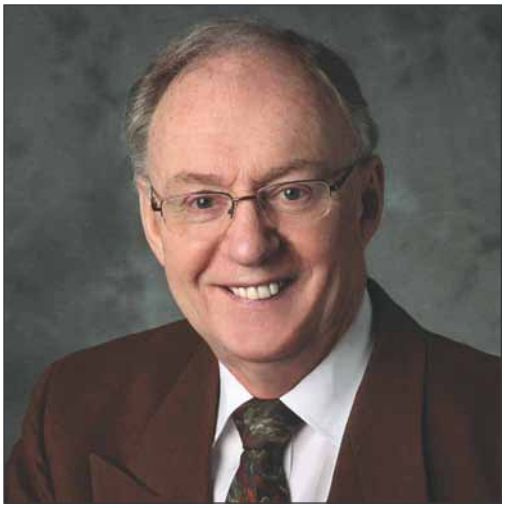
An Interview with the 2010 Distinguished Rheumatologist: Dr. Martin Atkinson



1. Congratulations on your well-deserved nomination for the 2010 Canadian Rheumatology Association's (CRA) Distinguished Rheumatologist Award. What do you believe are the qualities of a distinguished rheumatologist? Moreover, how do they apply to you?

The terms of reference of this award stipulate that the candidate must be a CRA member in good standing and an accomplished Canadian rheumatologist of high professional caliber who has significantly furthered rheumatology in Canada in either patient care and/or service to the benefit of patients with rheumatic disorders and/or professional creative activities.

When I look at the accomplishments of people who have won this award, my own are dwarfed in comparison. However, I have practiced rheumatology in Calgary for 35 years, initially as a community rheumatologist and later as a geographic full-time appointment at the University of Calgary. Having had the opportunity to practice an equal amount of time in both camps, I feel I have a unique perspective of rheumatology. It is interesting that this year's CRA debate at the annual meeting was entitled: "What is the Best Type of Practice: Academic or Community?" The answer is obvious: both types of practice are essential to the health and sustainability of rheumatology in Canada.

Also, I was one of the founding fathers of the rheumatic disease units (RDUs) at the University of Calgary in 1973, and have been heavily involved in medical teaching at the undergraduate and graduate level.

2. Before practising in Calgary, you studied under Dr. Charley Smyth at the University of Colorado Medical Centre in Denver. Why did you decide to study in the U.S.? How was it learning under Dr. Smyth?

I did my undergraduate and post-graduate training in internal medicine at the University of Alberta. However, I think it is important to get away and see how medicine is taught and practiced in other parts of the world so one doesn't develop tunnel vision in one's views. I chose to go to Colorado as this was the centre where Dr. John Percy had recently trained. Dr. Percy, the first head of the RDU in Edmonton, was recruited when I was chief resident there in 1968. He became a mentor and encouraged me to become a rheumatologists as it would give me the opportunity to be involved in a discipline of medicine where immunology (a great interest of mine) was pivotal. As for Dr. Smyth, he was one of the elder statesmen of American rheumatology and it was a great privilege to learn under his tutelage.

3. You are well known for your teaching involvement at the University of Calgary. What have been the highlights of your academic career? Your private practice?

When I first returned to Calgary in 1971, I joined Dr. D.L.G. Howard in private practice. Dr. Howard was the only rheumatologist in Calgary and was instrumental in developing the RDUs when the University of Calgary's Medical School was established in 1968. Whilst in private practice, I had a clinical appointment with the university's medical faculty and was heavily involved in teaching, not only rheumatology, but the spectrum of internal medicine at the undergraduate and post-graduate levels.

In 1985, I joined the Faculty of Medicine as a geographic full-time member. The highlights of my academic career were being the Academic Head of the Division of Rheumatology from 1993 to 1998 and the Associate Dean, Clinical Affairs from 1999 to 2007.

In addition, I was a member of the Council of the College of Physicians & Surgeons of Alberta from 1983 to 1994, as well as President of Council for three consecutive years.

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4. You have had the opportunity to see many changes in rheumatology over the course of your career. What do you believe have been the most profound changes?

I have seen many changes, both positive and negative. The negative changes include the demise of the RDUs with their dedicated beds for patients with rheumatic diseases. Another negative change has been the abolition of Clinical Fellowships by The Arthritis Society. This was the chief mechanism for training academic rheumatologists. Now, we are faced with an enormous dearth of qualified people to assume academic leadership positions.

The positive changes include our increased understanding of the mechanism and course of rheumatoid arthritis (RA) with the adoption of early aggressive treatment regimes that ameliorate joint damage, preserve function and prevent deformity. Another huge advance was the recognition, in the 1970s, of the effectiveness of methotrexate in RA, which has become the standard initial therapy in this disease.

The development, in the 1990s, of monoclonal antibodies (*i.e.,* biologics) against a wide variety of cytokines that are part of the inflammatory cascade, has revolutionized the treatment of RA and other autoimmune diseases.

5. Due to recent economic trials, Canadian medicine is facing challenges now and in the future. Do you think that the economic downturn of the next few years will significantly alter recruitment and training of new rheumatologists? What can be done to mitigate this possibility?

I think medicine is essentially recession-proof and the problems to do with recruitment and training are unrelated to the economic downturn. The recent astronomical increases in medical tuition rates will change the demographics of our students. Faculties of medicine will become more and more the purview of the children of the wealthy.

Furthermore, because of the limited exposure of students to rheumatology in their undergraduate years and the fact that rheumatology is one of the lower paying specialties, recruitment has been a constant challenge. This just underlines the importance of developing role models and mentors for young doctors considering a career in rheumatology.

6. What do you foresee as challenges to Canadian rheumatologists in the future and what can individual rheumatologists and the CRA do to meet these challenges?

The big challenges facing rheumatologists in the future include the impending manpower shortage due to the reasons given above. Another huge challenge is convincing government authorities that treating chronic diseases like RA and osteoporosis early, often with expensive drugs, is a good investment with considerable cost-savings down the road. For example, the vast majority of hip fractures in the elderly are due to osteoporosis. If we could reduce the fracture risk by 50% as a result of early and effective treatment the cost-saving and social benefits to society would be immeasurable.

Quite clearly, we are just on the cusp of the biological era and many more effective drugs are on the horizon, not just for RA, but for other rheumatic diseases as well. However, they will come at a price and we and the CRA need to constantly advocate for our patients with rheumatic disease to ensure they get the best possible treatment as early as possible in their disease.

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Awardees at the 2010 CRA Annual Meeting

Distinguished Investigator:
Dr. Earl Silverman,
University of Toronto

Best Overall Presentation:
Dr. Nigil Haroon,
University of Toronto

Philip Rosen Award, Best Clinical Presentation:
Dr. Rita Lung,
University of British Columbia (medical student)

Ian Watson Award:
Dr. Amanda Steiman,
University of Toronto

Best Basic Science Presentation:
Dr. Mohammed Uddin,
Memorial University

Medical Student Poster Award:
Dr. Sarah Harding,
University of Western Ontario

- Provided by Dr. Proton Rahman