CRAJ

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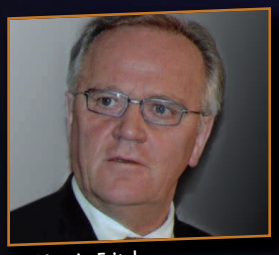
Dr. Alfred Cividino

Dr. Brian Feldman

Dr. Earl Silverman

Dr. Hani El-Gabalawy



Dr. Marvin Fritzler

Focus on Celebrating Our Rheumatology Stars

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New Kid On The Blog

By Philip A. Baer, MDCM, FRCPC, FACR

After twelve years of stellar leadership, Glen Thomson has retired as editor of the *CRAJ* (see the Fall 2011 issue for Glen's valedictory editorial). I have been asked to take over the Editor-in-Chief position by the CRA Board. As the last thing I edited was a guide for first-year medical students, put out by McGill's second-year medical students over three decades ago, I assume the board approached me based on potential, rather than any actual accomplishments as an editor. Maybe someone remembered from an advisory board that I am a good proofreader of PowerPoint slides.

I confess I have never been a member of the CRAJ Editorial Board. Chairing a committee or a board without any experience as a member is nothing new to me, however. I started small, chairing a hospital Library Committee. As we had a tiny budget, and printed medical books and journals were facing a secular decline, I couldn't get into too much trouble in that position. From there, I went on to chair a hospital Pharmacy and Therapeutics Committee without any experience. My major talent was in keeping the meetings to the allotted time. The professional pharmacists really ran the operation. Moving on to CRAJ, I am sure the editorial board members and the professional staff at STA Healthcare Communications will help me find my editorial feet.

By way of introduction, I attended medical school at McGill University, where Cathy Flanagan was a classmate; so we produced at least two rheumatologists out of our class. I trained in Internal Medicine at the Montreal General Hospital, first meeting up with John Esdaile, the late David Hawkins, and Hy Tannenbaum there. Other colleagues and mentors in Montreal included Bob Terkeltaub, later of gout fame, Julie Paquin, and the late Jeff Shiroky. Rheumatology beckoned as a career, so I moved to Toronto to complete a rheumatology fellowship a few years ahead of Glen. My initial stop was in the relatively calm world of Sunnybrook Hospital, with the late Hugh Little and Adel Fam. Then came the higher voltage world of the Wellesley Hospital, familiar to many Canadian rheumatologists and well-described in Glen's last editorial.

I considered further training in epidemiology, but was dissuaded by Hugh Smythe's opinion that we already had too many rheumatologist-epidemiologists. Judging by the developments in that field, I don't think he was correct, but no harm done. Basic science did not beckon either. My only real experience with that had been a summer in a lab at McGill studying an atherosclerosis model in rabbits. I was a small cog in a 25-year enterprise which produced never-ending grant support to the professor in charge, but

1980: Trying to look older

2011: Failing to look younger

little in the way of concrete results other than a substantial reduction in the laboratory rabbit population.

That left clinical practice in rheumatology, which worked out very well. A rheumatologist in eastern Toronto had just left his practice to move back to Ireland. He tried to sell his practice to me, but I already "knew" a rheumatology practice had no monetary value. Hanging out the proverbial shingle was enough to generate a steady stream of referrals. I was confident enough that, after seeing my first referral, with an empty appointment book staring at me, I told the patient they did not need to follow-up with me and could return to their family doctor!

This year, I completed my 25th year in practice. I still have the same secretary I started with, so I can't be a terrible boss. She reminds me that our initial interview consisted in part of me asking her if she smoked, and administering a typing test on my then state-of-the-art ATARI computer. I probably could not get away with either of those today.

A wise physician once said that medicine is the only profession which puts intelligent people in an isolated office for 40 years, restricts their interactions with their clients to the emotionally detached clinical encounter, and then wonders why they burn out. That wisdom and my libertarian desire not to be solely dependent on the state as my employer have kept me involved in numerous activities outside of the office. I started a career as a consultant in the insurance industry at the same time I opened my office. I worked as a general internist at a hospital for over 15 years. I have also done my share of research (involving patients, not rabbits), medico-legal work, and CME delivery over the years.

More recently, with my children getting older, I have had a chance to be involved in a very rewarding way in our professional organizations. I was a founding member of the Ontario Rheumatology Association (ORA), together with Carter Thorne and Algis Jovaisas. I am currently completing my term there as Vice-President. I will continue to chair the Section on rheumatology of the Ontario Medical Association (OMA), where our small specialty has had a chance in recent years to create specialty-specific fees which are starting to narrow the traditional income gap between rheumatologists and other specialists. I had a prior stint at the Canadian Rheumatology Association (CRA) as co-Chair of the Therapeutics Committee. Of course, I joined as co-Chair with no prior experience as a member of the committee, but it really helps to have a world leader in rheumatology like Vivian Bykerk as the other co-Chair.

I look forward to building on the accomplishments of Glen and our prior *CRAJ* editors (Barry Koehler and Art Bookman) as the *CRAJ* celebrates its 20th anniversary in 2012, confident that the journal has a long and successful future ahead. To start, let me encourage any of our *CRAJ* readers to become a *CRAJ* writer by submitting an article on any subject related to rheumatology to me or our staff at STA Healthcare Communications —all submissions are welcomed.

Philip A. Baer, MDCM, FRCPC, FACR
Editor-in-chief, CRAJ
Scarborough, Ontario

Greetings from the CRA President

By James Henderson, MD, FRCPC

Another Christmas season is upon us. I would like to take this opportunity to wish all our members a wonderful holiday greeting. I hope everyone is able to spend quality time with family and friends over the holidays.

CRA President Dr. James Henderson

The Canadian Rheumatology Association (CRA) board has had a busy season tending to the many facets of the organization. Dr. Joanne Homik and the scientific committee are working to organize our annual meeting in Victoria this coming March. Many of the details are finalized and the program should be exciting for all members. The weather should be spring-like and will provide welcome relief from the winter ahead.

We have a new chair for the website committee, with Dr. Mark Matsos from Hamilton currently supervising an upgrade to the website that will allow us to do more than previously. We are aiming to have educational programs on the site once the upgrade is complete. Registration for the annual meeting will be done online. We are looking forward to the launch.

Dr. Shahin Jamal has taken over the reins of the Therapeutic Committee and there has been a buzz over the recent publication of the CRA guidelines. This has been a product of significant work by a subcommittee headed by Dr. Vivian Bykerk. The guidelines serve to solidify the best practices for treatment of rheumatoid arthritis. Congratulations to Vivian and her group on a job well done.

The *Journal of Rheumatology (JRheum)* continues to be successful in paying down the debt we incurred with the purchase. Dr. Arthur Bookman (along with Dr. Michel Zummer and Dr. Gunnar Kraag) are managing the journal on our behalf. The board gets reassuring updates on a regular basis.

The board now has the responsibility of running the Canadian Initiative for Outcomes in Rheumatology Care (CIORA); Dr. Paul Haroui is chairing the committee that supervises the activities. We will be funding projects for our fifth season this year.

I am happy to report that the organization is strong, and with many members volunteering their time and energy, we are moving confidently into the future.

Merry Christmas and a Happy New Year.

James Henderson, MD, FRCPC
President, Canadian Rheumatology Association (CRA)
Chief, Internal Medicine, Dr. Everett Chalmers Hospital
Teacher, Dalhousie University
Fredericton, New Brunswick

President Henderson reeling in his yearly greetings!

Greetings from the CRA Vice-President

By Carter Thorne, MD, FRCPC, FACP

As noted in the last issue, the Canadian Rheumatology Association (CRA) has applied to become an official accrediting agency of the Royal College. This evolution as a professional organization began in 1994, when the CRA annual general meeting (AGM) became independent of the Royal College. Since then, there has been:

1. Change as the CRA AGM has moved from single to multi-sponsor;
2. Development of a completely independent program, with multiple learning formats;
3. Selection of sponsored symposia based on CRA members' needs;
4. Collaboration with our Mexican colleagues to develop an international network, and the development of the second CRA symposium at the 2012 Pan American League of Associations of Rheumatology (PANLAR) congress;
5. Enhanced manpower development activities in collaboration with industry, including summer student programs (Abbott and Roche) and fellows (UCB Pharma Canada, GlaxoSmithKline [GSK], Canadian Network for Improved Outcomes in Systemic Lupus Erythematosus [CaNIOS], and The Arthritis Society [TAS]);
6. Ongoing support of the Alliance for the Canadian Arthritis Program (ACAP) and its maturation into the Arthritis Alliance of Canada (AAC), with CRA responsibility for Access to Care, one of the three pillars of the framework, with an emphasis on Models of Care;
7. Development of the *Canadian Rheumatology Association Recommendations for Pharmacological Management of Rheumatoid Arthritis with Traditional and Biologic Disease-modifying Antirheumatic Drugs*, described by international reviewers as "the gold standard in terms of presentation and format" and "the most reasonable set of recommendations so far for drug treatment for RA."

CRA Vice-President Dr. Carter Thorne


The CRA has big plans for the future!

The organization must now look to the future in support of its membership and the mission of the CRA. Over the next few months, we hope to develop a more robust secretariat, responsive to the new demands imposed by these activities. Additionally, as we develop an implementation plan for dissemination of the CRA guidelines, we hope to foster a new education platform, more responsive to the needs of our membership and our new Royal College mandate of enhancing patient outcomes through Models of Care and practice support.

Finally, the Board of Directors, on behalf of all CRA members, wishes to offer congratulations to Glen Thomson for his 12 years as Editor-in-Chief of the *Journal of the Canadian Rheumatology Association (CRAJ)*. He has done a marvelous job at sustaining the interest of the members by developing new sections and new formats, ensuring inclusiveness and constructive challenges to the status quo. We welcome as the new editor Dr. Philip Baer, a community rheumatologist in Toronto, who will certainly bring his own style to your CRAJ.

Best wishes for the holidays!

PS: See you at CRA AGM in Victoria, March 28-31, 2012.

Carter Thorne, MD, FRCPC, FACP
Vice-President, Canadian Rheumatology Association (CRA)
Past President, Ontario Rheumatology Association (ORA)
Medical Director, The Arthritis Program (TAP),
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Abbott Chair in Education in Rheumatology: Dr. Alfred Cividino

What areas of research are of the greatest interest to you at the present time and why?

New oral agents for rheumatoid arthritis (RA) represent a significant advance in therapy. Current treatment options are impressive and have transformed patients' lives and the field of rheumatology. We are at the brink of a new and significant advance.

I am also interested in educational research. Our students are sometimes reluctant subjects, but now more than ever we need to evaluate how we teach them and evaluate how they learn. While the subjects remain the same, each medical school has its own curriculum. Faculties joust for control of the content and the musculoskeletal (MSK) curriculum is particularly vulnerable.

From an educator's perspective, what do you believe can be done to ensure better care for people with arthritis?

We are in the information age. Patients seek information but are perplexed by what they find on the internet and from alternative health care providers. There continues to be misinformation about arthritis care. This represents an opportunity for the medical community to once again affirm our role as the prime source of information.

Is your department working on anything you think your colleagues across the country should know more about?

As we have had some success with our undergraduate and postgraduate programs, the frontier will be the community around us. We intend to develop programs for family physicians (FPs) and general practitioners (GPs), and also patient-centered programs with disease-specific foci. A recent event for patients with scleroderma was very successful and clearly demonstrated a need for such opportunities.

Dr. Adachi and his team are looking at bone structure and quality using novel imaging and modeling with CT scans and magnetic resonance imaging (MRI) in osteoporosis and osteoarthritis (OA).

How are educators in the field of rheumatology learning from each other?

There certainly has been collaboration. Dr. Heather McDonald-Blumer and I have worked closely with Dr. Veronica Wadey, an orthopedic surgeon at the University of Toronto (U of T) on an online teaching module for inflammatory arthritis. This will be presented at the Canadian Rheumatology Association (CRA) Annual Scientific Meeting in abstract form. The rheumatology fellows' weekend and our own collaboration, spearheaded by Dr. Nader Khalidi with the University of Western Ontario (UWO) for internal medicine residents, are further examples of collaboration. More can be done, as we see educational staffing at the medical schools varies across the country. Developing teaching modules in common would be a boon to those faculties with fewer staff. We will be developing more web-based modules and I hope to export them to other programs. Having a national curriculum team would be an asset.

What have been the most profound changes you have observed in rheumatology over the course of your career?

Moving from what now seems to have been the "Dark Ages" to the modern era of rheumatology with research and development of new treatment options in inflammatory arthritis and systemic lupus and osteoporosis has been the

most significant advance for our patients. There remains much to do, however, as OA treatment has lagged behind.

The most unexpected development has been the notion that blocking a single cytokine could have such a dramatic effect on disease activity and joint damage in RA. One thing that has been lost is the Rheumatic Disease Unit (RDU). Now, more than ever, we see sicker patients with lupus, scleroderma and vasculitis being admitted to hospital; a specialized unit to care for these patients makes sense and is appropriate when trying to provide best care.

Alfred A. Cividino, MD, FRCPC, FACR
Abbott Chair in Education in Rheumatology
Clinical Professor and Division Director,
Division of Rheumatology, Department of Medicine
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Hamilton, Ontario

Canada Research Chair in Childhood Arthritis: Dr. Brian Feldman

Were there any educators who played a significant role in your journey to become a rheumatologist?

I was more attracted to the highly cognitive subspecialties — and if one considers a spectrum between the procedural and cognitive specialties, probably at the far end of the cognitive extreme is rheumatology. I am a pediatrician, and when I was training in medical school, the head of pediatrics at the medical school I was at was a fellow named Dr. Jim Boone. He was a pediatrician, but he was doing all the rheumatic care at the Children's Hospital of Western Ontario at the time. He was a fine clinician, and he turned me on to the area. When I was a junior medical student, or maybe a clinical clerk at the time, Dr. Boone gave us a lecture on the limping child, and I got really interested.

At the same time I met a pediatric resident named Ciaran Duffy who was a very good teacher; he was interested in rheumatology and eventually went on to become a pediatric rheumatologist and led the way for me. When I had the opportunity in my fourth year of residency training to do an elective in rheumatology, I met Dr. Ron Laxer, Dr. Abe Shore, and Dr. Earl Silverman and they were such brilliant clinicians and great role models that it became clear to me that that is what I wanted to do — pediatric rheumatology.

These educators have been most influential for my rheumatology training. Dr. Laxer because of his incredibly thoughtful approach, he is very meticulous and thoughtful. Dr. Silverman for his acumen and his great approach, he just knows what is going on. Dr. Shore was not with us for very long, he passed away shortly after I started to train, but he had an interest in hemophilia. He got me involved in that area and I have remained involved in hemophilia in a research capacity ever since.

The thing that I found very cool at the time was that they were the ultimate diagnosticians. For any case in the hospital, when nobody could figure out what was going on, they would call the rheumatologists. They were the real life version of the team on the television series *House*. That is basically what rheumatology is all about, right? It is deep thinking on really rare and unusual problems, presentations, putting it all together in a systems approach and figuring out what is going on.

What has happened over the years is that we have developed fantastic treatments. In the olden days, for instance when I was starting, we could not really treat a lot of things but we could be really smart about diagnosing them and figuring out what nobody else could figure out. Nowadays there is a lot of action in our specialty because we can treat a lot of diseases, and a lot of the research that we have done over the years has been to develop new treatments.

What have been the highlights of your academic career?

The major highlight of my career has been the fantastic exposure I have had to trainees and graduate students from all over the world. It has just been such a pleasure working with these fantastic students.

In addition, I have had the opportunity to be one of the founders of something called the Childhood Arthritis and Rheumatology Research Alliance (CARRA). We started to work on this during the nineties and it has really come to fruition over the last decade, as really quite a large and effective network of investigators across North America tackling some big problems in childhood arthritis. What we have done, that I am most proud of, is define treatment protocols for a number of different diseases (the one that I am most interested in is juvenile dermatomyositis), which are being applied in a standardized fashion across North America. The attempt is to do what they did for children's cancer, using a similar approach, to find cures for previously

incurable diseases. What they had done in cancer is take standardized protocols and treat patients with them until they figured out which protocol was better. Then they dropped the worst one, and used the knowledge that they gained to develop new and better protocols — they just kept going until they had cures. That is what we are going to be doing for childhood rheumatic diseases.

What have been the most profound changes you have observed in rheumatology over the course of your career?

When I was starting my rheumatology training in the late eighties, early nineties, many of the kids that I saw in our arthritis clinic had pretty serious deformities. At around that time we started using treatments like methotrexate (MTX) on a more widespread basis, and subsequently, biologic therapies; now you can come to our clinic and you just do not see that anymore, with rare exceptions. So, that is a huge change.

What I have seen happen over the last 20 or 25 years is that there has been an improved cooperation at all levels in the field; that has really raised the bar for new discoveries. Adult rheumatologists are cooperating and working better with pediatric rheumatologists, centres are working better with other centres. This idea of collaboration has really developed and blossomed over that period of time and we are seeing the fruits now.

In Canada, for example, we have now had giant multicentre studies of childhood arthritis. We had the Research in Arthritis in Canadian Children – Emphasizing Outcomes (REACCH OUT) study looking at the evolution of arthritis in children, the Biologically-Based Outcome Predictors (BBOP) study looking at the determinants and causes of arthritis, and we have had the Teens Taking Charge studies looking at arthritis self-management. These have been relatively huge collaborative studies, and that was not happening 25 years ago. We are just a young specialty, so that is probably why it just took some time to mature.

What advice would you give to rheumatologists who are interested in taking on an educational role or improving their teaching skills?

I am more of a researcher than an educator, but obviously I do a lot of teaching as well, and I would say that there is really no substitute for exposing trainees to lots and lots of clinical work. For people who want to develop their own teaching skills as educators I think there are fantastic opportunities for formal education in teaching that seem invaluable from what I have seen in my colleagues. As a trainee, I had a lot [of clinical work] but there has been a shift away from seeing patients to getting more kinds of classroom-based teaching. The available evidence would suggest that this is perhaps a backward step.

Is your department working on anything new or exciting that you think your colleagues across the country should know more about?

We have 10 pediatric rheumatologists at SickKids. Almost all of them doing research, so we have made all kinds of new discoveries. We have been developing a new understanding for childhood lupus, such as discovering new ways of measuring neuropsychological deficits in lupus, discovering the determinants of cardiovascular (CV) risk factors in young people with lupus and determinants of renal health in lupus. Regarding the mechanisms of Kawasaki disease, one of our researchers has a very successful mouse model of this disease, from which she is determining the molecular pathways for coronary heart damage in Kawasaki disease. As to the natural history of central nervous system (CNS) vasculitis, one of our researchers is looking at treatments and imaging and defining the spectrum of outcomes of CNS vasculitis. We are also looking at ways of preventing hemophilic arthritis, so for hemophilia we have introduced a special Canadian form of tailored prophylaxis to prevent arthritis or joint damage.

In medical education, we have groups working on new ways to teach the joint examination, such as using simulations. There has been more use of computerized case-based learning for teaching rheumatology, including pediatric rheumatology.

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Senior Scientist and Head, Division of Rheumatology
The Hospital for Sick Children
Toronto, Ontario

Ho Family Chair in Autoimmune Diseases: Dr. Earl Silverman

Were there any educators who played a significant role in your journey to become a rheumatologist?

When I was a resident, which was over 30 years ago, I was looking to do a subspecialty and I found that pediatric rheumatology was the most interesting because of the wide variety of patients, the intellectual stimulation, the interest in immunology, which 35 years ago was just beginning. To me, it was a very good interaction of interesting patients and care, challenging as well as intellectually stimulating.

At that time, there were almost no pediatric rheumatologists in the world, in fact. When I decided to do it, there was somebody who did it here, his name was Dr. Mark Greenberg, but he did it along with five other things. There was no division here. I then went to Stanford University and trained with Dr. John J. Miller III, who was one of the first pediatric rheumatologists in the world. Dr. Greenberg was a pediatrician, and actually pediatric oncology/hematology was what he mainly did and still does. They were role models; I respected them. I found the whole field fascinating, particularly, I think, because of the emerging field of immunology, which was of interest to me. One of the major reasons why rheumatology interested me was that you have to know everything about pediatrics; there is no focus on a single organ. You need to understand the whole body, how it interacts, and so that is what kept me interested in it.

Initially, my fellowship was supported by The Arthritis Society (TAS) of Canada; at that point in the early eighties TAS was very supportive of education and pediatric rheumatology. They were really looking to help educate academic rheumatologists and develop scientists. They realized there was a need in Canada for pediatric rheumatology.

It was a very interesting time at that point because I could clinically focus on both rheumatology and immunology. My interest, clinically, was rheumatology, and scientifically was immunology. At the time, many hospitals had a combined rheumatology/immunology division, which made it difficult for some people to separate the two. However, the two subspecialities have very different needs, so we would sometimes be at opposition almost to each other. At this time the Division Head [of The Hospital for Sick Children] was an immunologist who supported clinical immunology but needed the patient volume found in rheumatology, so it was an interesting time.

Over time it became obvious that immunology and rheumatology were two distinct fields; luckily, the Department Head saw the same thing and we became our own division in 1986. This is when the division really grew; we could focus really on rheumatology and hiring people only to do rheumatology and not immunology or allergy. As a result, we blossomed into what is now one of the leading pediatric rheumatology divisions in the world, initially lead by Dr. Ron Laxer. He was the Head who really had the vision of how an independent division of rheumatology could become a leader in pediatric rheumatology. What I learned from Dr. Laxer was, what is good for the group is good for all of us. That has become our motto.

What have been the highlights of your academic career?

When I was a fellow, I described a syndrome that has now been recognized as being an important cause of significant morbidity and even mortality in patients with autoimmune disease. It has got another name now, macrophage activation syndrome, but I feel proud of having recognized it early.

I think I was one of the first pediatric rheumatologists in the world to get an endowed Chair, in recognition of my research. I feel very special, I feel very lucky to be put

in that position. Then a couple of years ago I won the distinguished investigator award from the Canadian Rheumatology Association (CRA). The fact that it is a peer-group recognition, and being one of the few pediatric rheumatologists to ever have received it, again I feel a great sense of accomplishment. In 2007, I received a teaching award from the hospital and then in 2008 I received what is called the Hope award from the Lupus Association, from the patient group. I have always felt that there are three things to do as an academic physician and that is clinical care, research, and teaching. So I feel very lucky to be honoured for the three things that are important in academic medicine.

What have been the most profound changes you have observed in rheumatology over the course of your career?

Things have changed very, very dramatically really from when there was very little we could do to help patients from a medication point of view, beyond physiotherapy, to now having very powerful medicines that can really make significant differences in people's lives, particularly in children with juvenile arthritis. There has been tremendous progress in being able to control the disease. That has dramatically changed my practice. The introduction of a simple drug like methotrexate (MTX) was a really dramatic change and now the era of biologic therapy has made life even better. The future looks even brighter.

Drugs are now being tested in children, and trials are being run in children, and that has been a very dramatic change. Without testing drugs in children, we do not know their safety, or how effective they are, because children are not just small adults. So it is very important to do drug trials in children of new medications because we cannot just assume they work.

Are you working on anything you think your colleagues across the country should know more about?

One of the things I am proud of that we are doing now is we are looking at how one of the problems with lupus is that sometimes adults will have early atherosclerosis and heart attacks; what we are looking at is assessing how children do, to see if there are any risk factors we can identify and try to treat prior to it developing.

Another thing we are looking at in childhood lupus is really, we know that during the time when we follow them, the prognosis changes dramatically. One of the things that we are very interested in, and there is very little known about, is how they do when they are 20, 30 and 40 years old. The problem with studying most pediatric diseases is that patients morph into the adult world with many different caregivers. It is therefore very difficult to find out what happens into adulthood. We are looking at long-term outcomes.

The last thing we are doing, that I am very proud of too, is we are looking at the problems in children born to mothers with lupus. There is something called neonatal lupus, where the child itself does not have lupus but the antibodies go from the mother to the fetus. Some of these children will develop heart problems, what is called heart block, where they have problems with the conducting system (*i.e.*, problems with their heart beat). We have been world leaders in trying to improve that outcome. We have been looking at how these children do over time as a result of having these antibodies, and whether they are too at risk of developing lupus.

What advice would you give to rheumatologists who are interested in taking on an educational role or improving their teaching skills?

What have I learned is to listen to people you are teaching, to change how you teach and what you say depending on the audience. I have really found that personally I support all new ways of teaching but nothing beats one-on-one teaching and one-on-one communication. This is particularly true in subspecialties, nothing can be better than one-on-one teaching and listening and learning and taking the time to go over things and educate.

Earl D. Silverman, MD, FRCPC
Ho Family Chair in Autoimmune Disease
Staff Rheumatologist, Rheumatology,
The Hospital for Sick Children
Professor, Departments of Pediatrics and Immunology,
University of Toronto (UofT)
Toronto, Ontario

Endowed Chair in Rheumatology: Dr. Hani El-Gabalawy

What attracted you to the field of rheumatology? Were there any other fields of medicine that you considered?

When I was an internal medicine resident at McGill University I had some very good mentors. As with most people, it is usually a mentor who inspires you, as opposed to necessarily a specific kind of personal liking. During that time I had some very good mentors, and I did a research project, in fact, with one of them and got some very exciting results. As a result of it I was hooked on both investigation and the field of rheumatology and immunology. They were new, they were things that people had not seen before, and I was caught up in the thrill of discovery. We were working on immune responses in the cord blood to see if the lymphocytes behaved any differently from other lymphocytes and how this may potentially explain why autoimmune diseases get better during pregnancy. As a result of that I got to understand a little bit about the biological basis for autoimmune diseases and rheumatic diseases and I was really hooked.

I was looking also at respirology, chest medicine, for similar reasons. But I think I was drawn more toward rheumatology because I got engaged with my mentors at McGill University and wanted to continue working with them. At that time, there were three people who probably had the most influence on me: one was Dr. Kirk Osterland, the other was Dr. Norbert (Nobby) Gilmore, who was an immunologist, and the other person was Dr. Jacob (Jack) Karsh. They were pretty influential in my decision to go into rheumatology. I trained with them, and though I really never did any more research with any of them, they were my inspiration for always asking questions.

I actually did have a bit of a circuitous route, in that when I was finished my residency, primarily because of personal circumstances, I went into practice for a number of years before I came back to the academic environment. For five years I was in private practice and then when I came back into the academic environment, here at the University of Manitoba, many of the same questions that I had were still lingering in my mind from my training period. I had actually tried to pursue [these questions] on my own in a non-academic environment, but I felt that if I was going to do them justice and be able to be an effective investigator I needed to be in a university setting where I could have collaborators and I could have facilities and so on.

What areas of research are of the greatest interest to you at the present time and why?

My questions have always focused on rheumatoid arthritis (RA), and very broadly speaking they are: why does the disease start and why does the disease not stop? I spent a lot of time trying to understand the mechanisms of inflammation in the joint by looking at samples of synovial tissue in the joint and became quite an authority on the synovium and how it becomes inflamed, how it potentially causes damage to the joint, to the point where I have written chapters in the textbooks of rheumatology on synovial inflammation and so on.

More recently, I have been interested in why the disease starts, and so my research has taken me to the aboriginal community, who frequently get severe RA at an early age. We got some funding a number of years ago to look at the family members of First Nations people with RA. We are particularly focused on the population in Manitoba and Saskatchewan, the Cree and Ojibway population, in which RA is quite common and severe. So, we look at their family members, and consider genetics and environmental factors, and how the immune system becomes abnormal before the disease develops, and then how these abnormalities evolve to become the clinically detectable disease. We are now working with a consortium of international investigators based in the U.S. and in Europe on ways of preventing RA in these high-risk individuals. We have actually got a very exciting new protocol that is under development, in which we hope to develop preventative strategies for individuals at

high risk for disease development. Studying the First Nations people has been really instrumental in allowing us to get to this point; we have a big research group working in this area and we go up to Northern communities in Manitoba. We feel that it is also important, as we do our research, to improve the rheumatologic care of these communities by providing them early access to specialized care. So, it has really worked out quite well.

In today's uncertain economic climate, what concerns do you have about the recruitment and training of new rheumatologists and what do you think should be done?
I have been program director, and I have been a division head over the last number of years; in this time, I have seen an erosion of interest in the area of rheumatology, particularly in Canada, at a time when things are just becoming really exciting in terms of therapeutics and what we have to offer. Now, part of that is related to some financial disincentives, in that it is a thinking specialty as opposed to a procedure-orientated specialty. There are, however, a number of factors that are complex, that have interacted to really impact on our ability to get the best and the brightest. Dr. John Hanly has done work at Dalhousie for the past 15 years, getting surveys out every year and keeping track of manpower in Canada in rheumatology. Over the next five years, it is estimated that 25% of the academic rheumatology manpower is going to disappear and we are very concerned as to who is going to replace them. Who are going to be the teachers? Who are going to be the researchers? Who are going to be the educators?

We have been more successful at getting individuals to go into clinical practice. I think we have almost held our own in terms of producing enough rheumatologists to meet the clinical needs. Almost, but I do not think that we are there yet. Where we are really struggling is getting people who are going to stay in the academic environment and compete for grants, and compete to publish papers. This is where we are in very, very big trouble.

I think that what young people see is that there is a big challenge to sustaining a research career and academic career. They see their role models struggling to get grant funding, which has hit historic lows. They see a low-paying specialty, where you have little autonomy in an economic environment to change your ability to generate income. It becomes a real disincentive for an individual to want to stay in an academic environment in rheumatology, where the specialty is at the bottom third of the remuneration scale and any success in the academic environment is predicated on being lucky and tenacious and working against the odds and constantly swimming upstream, so to speak, to get funding. Now, some of that is not unique to rheumatology, but I think we have been particular victims of that and I see very few people interested in academic rheumatology in this country. There are some individuals, no question, but particularly in research I think we are really struggling.

I had the privilege of spending some time in the National Institutes of Health (NIH); I spent three years there from 1997 to 2000. The NIH team has phenomenal rheumatology researchers and they are unbelievable at being able to recruit gifted young people into the specialty; that's one of the reasons they have become real leaders in the research world. I think Canada is falling behind in the ability to get the best and the brightest in rheumatology. As far as I can see, there are two main differences. Some of them have to do with integrating research training with clinical training; it is all done during the post-graduate period when promising young individuals are given research training at the same time as they are given their clinical training and thus they have projects that they're working on throughout their education. There, academic medicine is highly valued. In fact, the differences between remuneration in academic medicine and in private practice are actually quite modest in the U.S., so there is no major incentive to go out and practice and make more money, whereas if you are good, and you show promise in terms of being an academic physician, an academic rheumatologist, you are given every opportunity to hone your research skills and become a competitive investigator. That is the big difference.

I think what needs to be done here is we need to integrate research training, seamlessly, into our post-graduate training. We need to have clinical departments award research degrees, such as Masters and PhDs, so that the projects are focused on clinical questions. We need to identify people at a very early stage who have potential and nurture them and provide them with funding opportunities and give them uninterrupted support and funding until they become established researchers. The problem right now is that we fund certain parts of that process, and then the individual is left to collapse and go out with the wolves. And so, if there is a big, bare period during the evolution of that academic rheumatologist or clinician scientist, if there is any extended period lacking in support, they will leave and do something else and we will lose them to the research community.

It is going to take planning from multiple levels, including faculties of medicine, divisions of rheumatology, support from local funding agencies to give graduates a good start and the training that they need. It is going to take support from the major funding agencies, from the Canadian Institute of Health Research (CIHR), from The Arthritis Society (TAS); it is going to take everybody working together

to make sure that those people are identified early and nurtured during the process, given state-of-the-art training so that they can compete with their American colleagues and with their European colleagues. It is a very competitive world we live in. I have not even started to mention the enormous competitiveness occurring in Asia right now. I am an Associate Editor of the top arthritis journal in the world, *Arthritis & Rheumatism*, and I am on the editorial board of most of the other journals, and we are getting flooded with outstanding work from China, from Southeast Asia, from Japan, from Korea. We are already way behind the Europeans and the Americans, so we have a real uphill climb here. So what I see is a trickle of good, solid research from Canada going into those journals. Now, we are lucky in that we have the *Journal of Rheumatology* (*JRheum*), which is a Canadian journal that most of us have published in. Every journal is getting bombarded with excellent work from Asia—and there has always been excellent work from Europe and the U.S. We have to wake up to the reality of who we are competing with here.

How are educators in the field of rheumatology learning from each other? What can be done to encourage an even more open, collaborative atmosphere among rheumatology training programs across the country?

I think the first thing that they have got to do is they have got to acknowledge the fact that we have a very big problem in academic rheumatology. The problem is our ability to recruit the best and the brightest young people, and once we recruit them, to actually provide a path for them. The Canadian Rheumatology Association (CRA), TAS, CIHR, the network of Canadian rheumatologists, we all need to get together and discuss solutions. But not only this, we cannot put our heads in the sand and say we are going to have these unique, made-in-Canada solutions. We have to look around at what our international colleagues are doing. We have to look at models of how they are successful in getting the best and the brightest young people, and in turn, look at how we can change things at the local divisional level, at the faculty level, and at the national level to make it more permissive.

The positive thing that has happened in Canadian rheumatology is the establishment of networks through organizations like the Canadian Arthritis Network (CAN), the Lupus Network, the Canadian Network for Improved Outcomes in Systemic Lupus Erythematosus (CaNIOS), the Scleroderma network, and the Canadian Scleroderma Research Group (CSRG). These are highly effective networks, and I think that this has been a real legacy of success in Canada. It is going to be through these groups that we are able to address some of the problems. Do not get me wrong; I am not sitting here saying it is all doom and gloom. We have done an enormous amount, of which the most positive outcome is these national networks focused on different diseases. They are able to get cohorts of individuals to bring everybody's clinical experience together to form biobanks and research cohorts that can effectively compete with the big clinical consortia that we are seeing in Europe, in particular. In order to understand major patterns of disease, and major changes in treatment and causes and so on, we have to have big numbers. Being a country with a low population density like ours, national collaboration and networks are a must; they are not just an option. I think that the Canadian rheumatology community has really embraced these things.

To what extent do you believe there should be a focus on the development of educational programs focused on rheumatology outside the university setting?

I am a person who feels that educational programs are best suited for a university setting, where you can find individuals with a lot of resources; my focus is to help those institutional resources to get the best educational packages and programs that we can.

In my opinion, I do not think that you can train academic rheumatologist outside the context of an educational setting. You can certainly have educational programs, with individuals who are potentially more effective clinicians and better integrated with clinical activities and potentially clinical research. I think there have been some good examples in Canada, for instance, the Canadian Rheumatology Research Consortium (CRRC), which has organized clinicians across the country to do clinical trials; they have really taken those out of the academic setting and have clearly identified that it is the doctors in private practice who are the ones seeing all the patients and who are the best source of study subjects for the clinical trials. This has been an important shift in paradigm. I think, though, that the real innovators, the investigator-initiated researchers who are going to be competitive, have to be trained in an academic environment.

Hani S. El-Gabalawy, MD, FRCPC
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Arthritis Society Endowed Research Chair in Rheumatic Diseases/ Rheumatology: Dr. Marvin Fritzler

What attracted you to the field of rheumatology? Were there any other fields of medicine that you considered?

It kind of begins when I was a graduate student. I am perhaps a little bit unusual in that I did my PhD degree before my MD, and so I was in a PhD program at the University of Calgary at about the time that the new medical school was starting. One of the graduate students in the lab where I was doing my PhD was an MD working on her Master's degree in genetics. As part of her genetics research, she was studying genetics of Hutterites in Alberta. One day she asked me whether I would like to go to one of the Hutterite colonies and help her out; I went along, and she had me doing the Snellen vision test on the little Hutterite kids, then doing their heights and weights and things like that. I would say that kind of then captured my interest in clinical medicine. Up until then, I just thought I would do medical research or teach and that was about it. In fact, on my office wall I have a picture of two Hutterite girls as a reminder of where I sort of started my adventure in clinical medicine.

Then, as I mentioned, the new medical school in Calgary was just starting. So I applied and was accepted into the second class at the new University of Calgary medical school. In those days it was basically a one-room classroom on the top floor of the Foothills Hospital. In my second year we moved to the brand-new medical school, which was immediately adjacent to the hospital. And the very, very first patient I saw in my first year was a patient with systemic lupus. Up until then all of my research interests had focused on DNA stability in cancer. When I saw this lupus patient and learned she had antibodies to DNA, that became the stimulus for my interest in rheumatology, I got much more interested in patients with antibodies to DNA than cancer patients, where their DNA was thought to be altered and "messed up." When I eventually went into practice that same patient became my first patient. She became the focal point for my interest in rheumatology and really a life-long interest in lupus and other autoimmune diseases that are part of rheumatology practice.

The person that took me to see that first lupus patient was Dr. Ian Watson; he was from McGill but had trained at the Scripps Research Institute in La Jolla, California. His primary clinical practice was clinical immunology, rheumatology, and allergy. He always had in mind that we would [work together] in Calgary, where he would continue to focus on allergy and I would do rheumatology and look after lupus patients. Later on, after I moved to the University of Colorado from Scripps, Dr. Watson was diagnosed with cancer and died within months; when I came on Faculty in Calgary in 1978, I basically inherited his entire clinical practice, which included allergy, clinical immunology and rheumatology. So it took me a few years to get focused on my real area of interest, which was rheumatology and looking after lupus and other patients with autoimmune diseases, such as rheumatoid arthritis (RA), scleroderma, and so on. Eventually, the allergy patients I looked after were referred to other specialists and that basically oriented my entire clinical practice to rheumatology.

In the late seventies, the number of rheumatologists in Calgary was small. I was the only rheumatologist at that time at the Foothills Medical Centre, which was the second major hospital in Calgary. At the time, the Division of Rheumatology was based at the Calgary General Hospital across town, which was basically led by three rheumatologists. When I began at the new University of

Calgary medical school, which was adjacent to the Foothills hospital, I was the only rheumatologist at this hospital. So I was on call 24/7, 365 days a year, which some people don't believe, but that's the way it was in those days. People now who have to be on call a few days a week think they're hard done by ...

What motivated you to establish an academic career in Canada? Was it a conscious choice or did you fall into it by accident?

As part of graduate studies, you are given the opportunity to teach undergrads in laboratory courses; I had taught laboratories in cell biology, comparative anatomy, and that sort of thing. Teaching as part of even your graduate PhD program was expected and considered normal, or at least it was then. Gradaute Research Allowances (GRAs) and Graduate Teaching Allowances (GTAs) was basically how you earned your keep. Because I had a PhD, I continued to do research all the way through medical school; the research I did as a medical student focused on lupus and diagnostic testing for lupus, with a focus on antibodies to DNA.

Eventually, I finished my internal medical training and started rheumatology training, and then in the fall of 1976 transferred to the Scripps Research Institute in La Jolla, California, to work more closely with experts in the field of lupus and autoimmune disease diagnostics. There I hooked up with Dr. Eng Tan, who was and still is a world-famous, researcher in cell and molecular immunology. He had a very active lab and many of the people I worked with in his lab are still my collaborators today. His lab included people from all around the world: Japan, China, Australia, Mexico, Germany — we had a very international lab. After starting with Dr. Tan in La Jolla, he moved to the University of Colarado Medical Center in Denver, Colorado, and I moved with him, but then about one year later I was recruited to the University of Calgary. And I guess the rest is history. After my training with a world-class leader like Dr. Tan, I was able to establish my own research lab and my own research interests, and that is what I have been doing basically for the past 30-40 years.

I was not exactly attracted back to Calgary, I was pushed; my wife thought Calgary was the epicenter of the world. I did want to come back; my family was here in Canada, my wife is from Alberta, and I would suggest that she had a stronger desire to come back than I did. The University of Calgary basically made it easy to come back: they gave me a nice lab that had some of the basic equipment that I needed for my research. I applied and got a research grant from what was then called the Medical Research Council. My job profile was basically 50% research, 20% teaching and the rest was clinical activity. I was involved in clinical activity from the beginning, although the weight of the clinical load that inherited was unexpected because of the death of Dr. Watson. He was only 40-years-old at the time, so his passing was quite unexpected. I have had several offers elsewhere, primarily in the U.S., some of them quite attractive. But my wife wanted to stay in Calgary and I was, let me say, pliable. I was able to be convinced to stay, and I have not regretted it.

The teaching load I had at the University was eventaully split between other clinical rheumatologists in private practice and at the university; there was a group of very good clinician teachers in Calgary.

With the prevalence of arthritis on the rise among Canada's aging population, how do you think the roughly 375 rheumatologists scattered across this country can do a better job meeting the growing need for their expertise?

Well, that is a long, long, long discussion. I think first of all, obviously we have to keep training young people to become rheumatologists. I doubt that the practice of rheumatology is saturated anywhere in this country. Gratefully, in the last five years or so there has been an upswing in the number of trainees who are showing an interest in rheumatology. We have to make sure we are focused on giving them a quality learning experience and preparing them to be competent rheumatologists.

Secondly, I think clinical rheumatologists have to work within a system that is not always efficient in our country. We tend to be trapped in healthcare systems, and that is in part due to lack of infrastructure, meaning hospitals and appropriate healthcare facilities. Some of the regulations we have to work under, for one thing, the Canada Health Act, need serious revisions and re-examination to be more appropriate for our times, so that we are not engulfed in a system where we really cannot efficiently and effectively deliver quality care to rheumatic disease patients. We need to collectively sit down and have a vision for what the ideal care of a rheumatic patient is, and then move toward that ideal, rather than trying to readjust the current system. I think it requires an examination

of what we have, re-evaluating the rules and regulations that we operate under. It also requires a much clearer vision of the future and the desired future of clinical care for rheumatic diseases patients.

How are educators in the field of rheumatology learning from each other? What can be done to encourage an even more open, collaborative atmosphere among rheumatology training programs across the country?
I think the biggest challenge for educators is keeping abreast of the changes; when I look back 30 years ago to when I started, the dynamics of rheumatology and the change in information was much different then than it is now. Now there is so much new information and if you're teaching young people, who are going to be the leaders of rheumatology in the future, you need to keep abreast of these changes. That is where the dynamic of learning from others in rheumatology becomes important. One person on their own just cannot keep up with the entire field; you end up being more and more and more focused on what you claim is your area of expertise. When you are teaching, however, you have to have a very broad and strong foundation, and that is where you rely on other educators to educate you. Not only do you educate the trainees, but we also have to educate each other.

The challenge now is that rheumatology educators, and we are not unique in that way, have what I call a virtual smorgasbord of opportunities as to how we can maintain our level of expertise and competence. It ranges from virtually daily internet sessions to meetings all over the world (probably too many meetings), but certainly online educational opportunities have opened this up. You do not have to be there at the time, you can go online and tap into a lecture that somebody gave two weeks or two months ago, and update your information; the quality of that information is so much better than it was 30 years ago. So the challenge there is management of your opportunities and your time, to access this panoply of wonderful things you could be doing. I am learning to manage through trial and error. Some of it is very, very good; most of it is excellent. Then the problem again becomes finding the time to pick from that extensive menu.

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Arthritis Society Endowed Research Chair in Rheumatic Diseases/Rheumatology
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University of Western Ontario

By Andy Thompson, MD, MHPE, FRCPC

The Division of Rheumatology at the University of Western Ontario (UWO) continues to hum along nicely. Under the excellent guidance of "the Pope" the division is as academically and clinically busy as ever! We have been very fortunate to have two new rheumatologists join the fray. Dr. Lillian Barra joined the division a few months ago and is a very welcome addition. Dr. Barra is stepping into some big shoes (left behind by Dr. David Bell) as she is working with Dr. Ewa Cairns in the lab. Dr. Barra is also travelling back and forth to Boston where she is attending Harvard University (really cool). Dr. Sara Haig joined the division at the end of September and we are really excited to have her back. After a brief stint in the community, Dr. Haig realized that "the Pope" would come calling and calling she did. "The Pope" worked her magic and voilà, Dr. Haig is back. Her strengths in teaching and clinical care are a huge asset to our division.

The twins, Drs. Gina and Sherry Rohekar (a.k.a chit and chat) are also busily working away on research. Dr. Sherry Rohekar took the bait (hee hee) and is now our new Program Director — she is doing an amazing job. This leaves me a wee bit more time to focus on our undergraduate program. Dr. Nicole LeRiche continues to work diligently, participating in clinical trials and taking care of a large rheumatology practice. Not many people know this but Dr. LeRiche was voted the best-dressed rheumatologist in Canada (she narrowly beat out Dr. Gunnar Kraag).

Dr. Janet Pope (a.k.a. "the Pope") continues to do 384 things at once (well, actually maybe it is 385 to be fair). This woman is unbelievable and we are all so privileged to have the opportunity to work with her everyday. We are also really lucky to have Bob Harris (nurse practitioner) and Marlene Thompson (advanced clinician practitioner in arthritis care [ACPAC] therapist) working with us caring for a large population of inflammatory disease patients.

As for myself, this was a year of reflection as I turned 40. So Marlene and I threw a huge toga party. Why? Because I have never actually been to a toga party. It was a blast. If you want to see cool inflammatory diseases and work with a group that really likes each other (I think they like me?) then UWO is the place to be! Beware, "the Pope" could come calling for you.

Andy Thompson, MD, MHPE, FRCPC
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The team at UWO do it up, toga-style.

Click here to comment on this article

Update from Winnipeg

By Ramandip Singh, MD, FRCPC

As 2011 winds down, it has truly been a year to remember in Winnipeg. The hopes of sports fans were finally realized this spring with the return of our Winnipeg Jets. The euphoria surrounding the return of the NHL to our city was something to behold. We took advantage of the hot summer to take long bike rides in Fort Whyte and Assiniboine Park. Plays at the Fringe Festival and Shakespeare in the Park provided great entertainment during the warm (and mosquito-free) summer evenings. Autumn, so far, has also not disappointed.

At the University of Manitoba, Dr. David Robinson accepted the position as rheumatology section head, which is only one of the many hats he wears. Dr. Navjot Dhindsa is the latest addition to the rheumatology community in Winnipeg. She joined the University of Manitoba staff in 2009 after completing her fellowship in Winnipeg and divides her time between out-patient practice, internal medicine, clinical teaching unit (CTU), and rheumatology call. On the education front, we have two second-year trainees in the fellowship program. Electives in rheumatology are a popular choice for trainees keeping us busy with resident teaching. Community practice in rheumatology continues to provide unique challenges and rewards. Rheumatology ward coverage, inpatient consult service and resident teaching offer both a change of pace and variety in pathology.

Rheumatologists in Manitoba provide care to patients of this province, Northwestern Ontario, Nunavut and occasionally southeastern Saskatchewan. The bulk of our manpower remains concentrated in Winnipeg. A few rheumatologists make regular trips to smaller towns and reserves, while Dr. Ricardo Cartagena practices in Brandon.

We have a vibrant community of rheumatologists in Manitoba shaped by contributions from individuals with varied personalities and interests in rheumatology. For me, this makes Winnipeg a great place to practice and call home. With the return of our beloved hockey team, even our much maligned winter will seem more palatable this year. GO JETS GO!

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Where CRA Activities Fit in the Royal College's New MOC Program

The following information has been provided by the Royal College of Physicians and Surgeons of Canada to help you understand the features and benefits of its new Maintenance of Certification (MOC) Program and how Canadian Rheumatology Association (CRA) activities can earn you credits.

Canadian physicians with an interest in rheumatology can now document a wider variety of learning activities within the Royal College's new Maintenance of Certification (MOC) Program, which came into effect in January 2011.

More Choice and Flexibility in Earning Credits

The new MOC Program is evidence-informed, streamlined and more flexible than its predecessor. For example, it is now organized under three learning sections — group learning, self-learning and assessment — and incorporates a wider range of learning activities than before, offering program participants greater opportunities to earn credit.

Where Do My Activities Fit?

The following table summarizes the learning sections under the new MOC framework and the activities associated with each. More information about the new credit system is available on the Royal College website *royalcollege.ca/moc*, where you can also access a more comprehensive framework online that explains each section in more detail.

Incentives to Diversify Learning Activities

No minimums have been mandated; however, MOC Program participants may earn a maximum of 75% of their required credits from any one section over the five-year cycle. For example, this means that participants can claim a maximum of 300 credits per five-year cycle under Section 1.

To provide individuals with more control over planning and managing their continuing professional development, the new MOC Program does not require that learning activities come from all three sections. However, the new credit system offers greater incentives to participate in Sections 2 and 3 where self-learning and assessment activities reside. Key findings from the medical education research literature suggest that these learning strategies contribute to improvements in knowledge, performance and health outcomes.

Higher Credit Ratings

Some learning activities in Sections 2 and 3 now have higher credit ratings. For example, you can earn two credits per hour for traineeships and personal learning projects (PLPs) under Section 2. As well, knowledge and performance assessments under Section 3 are rated at three credits per hour. Participating in learning activities such as these is easier than one might think as everyday activities, such as journal reading and teaching evaluations, can seamlessly integrate within the new framework.

A Learner-centred MAINPORT

To complement the MOC Program improvements, the web application MAINPORT, where activities are documented, has also been redesigned. In the new MAINPORT, MOC Program participants can now set practice goals, including plans and dates for completing them, and link their learning activities to CanMEDS Roles. They can also partially enter activities, returning later to complete them.

The Royal College has also built MAINPORT Mobile (available at *royalcollege.ca/apps*), which enables users to enter continuing professional development (CPD) activities from their BlackBerry, Android, iPhone or iPad.

Find out more about the new MOC Program and MAINPORT

Read more about the new MOC Program and MAINPORT on the Royal College's website at *royalcollege.ca/moc*

Log in to the new MAINPORT at *mainport.royalcollege.ca*

Download MAINPORT Mobile at *royalcollege.ca/apps*

Regional and Centralized Support

To ease the transition from the former system, the Royal College is providing MOC Program participants with several training opportunities. These include a MAINPORT flash tutorial, one-on-one sessions with our Membership Services Centre, and help from 13 regional CPD educators recruited from across the country. More information is available on the Royal College's website at *royalcollege.ca/moc*.

MOC Program participants are encouraged to try the new MAINPORT at *mainport.royalcollege.ca* before January 31, 2012, the deadline to submit 2011 activities. Please don't hesitate to email *cpd@royalcollege.ca* with any comments or ideas for improvement. Your feedback will help the Royal College ensure it is able to meet your needs and expectations.

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA | MOC PROGRAM enhancing learning, advancing care

Framework of Continuing Professional Development Activities

SECTIONS	CATEGORY	EXAMPLES	CREDIT RATING
Section 1: Group learning	**Accredited activities** Conferences, rounds, journal clubs or small-group activities that adhere to Royal College standards. Accredited group learning activities can occur face-to-face or web-based (online).	• *Accredited rounds, journal clubs, small groups* • *Accredited conferences*	***1 credit per hour***
	Unaccredited activities Rounds, journal clubs or small-group activities in the process of meeting the educational and ethical standards; rural or local conferences that have no industry sponsorship.	• *Unaccredited rounds, journal clubs, small groups* • *Unaccredited conferences without industry support*	***0.5 credits per hour (maximum of 50 credits per cycle)***
Section 2: Self-learning	**Planned learning** Learning activities initiated by the identification of a need, problem, issue or goal, either at or separate from the point of care, leading to the creation of a learning plan developed independently or in collaboration with peers or mentors.	• *Fellowships* • *Formal courses* • *Personal learning projects* • *Traineeships*	***100 credits per year*** ***25 credits per course*** ***2 credits per hour*** ***2 credits per hour***
	Scanning Resources that physicians use to enhance their awareness of new evidence, perspectives or findings that may be potentially relevant to their professional practice.	• *Journal reading* • *Podcasts, audiotapes, videotapes* • *Internet searching (Medscape, UpToDate, DynaMed)* • *InfoPOEMs, CardioCLIPs*	***1 credit per article*** ***0.5 credits per activity*** ***0.5 credits per activity*** ***0.25 credits per activity***
	Systems learning Activities that stimulate learning through contributions to practice standards, patient safety, quality of care; curriculum development; or assessment (examination boards, peer review).	• *Practice guideline development* • *Quality care/patient safety committee* • *Curriculum development* • *Examination development* • *Peer assessment*	***20 credits per year*** ***15 credits per year*** ***15 credits per year*** ***15 credits per year*** ***15 credits per year***
Section 3: Assessment	**Knowledge assessment** Programs accredited by Royal College CPD providers that provide data with feedback to individual physicians regarding their current knowledge base to enable the identification of needs and the development of future learning opportunities relevant to their practice.	• *Accredited self-assessment programs*	***3 credits per hour***
	Performance assessment Activities that provide data with feedback to individual physicians, groups or interprofessional health teams related to their personal or collective performance across a broad range of professional practice domains. Performance assessment activities can occur in a simulated or actual practice environment.	• *Simulation* • *Chart audit and feedback* • *Multi-source feedback* • *Educational/administrative assessments*	***3 credits per hour*** ***3 credits per hour*** ***3 credits per hour*** ***3 credits per hour***

This table summarizes the learning sections under the new MOC framework. A MOC Program participant may earn up to 75 per cent of their required credits from any one learning section. Activities submitted via MAINPORT are converted automatically into credits.

JOINT COUNT

Credits, Credits, Everywhere!

Congratulations to this issue's Joint Count survey winner, Dr Christine Peschken from Winnipeg, Manitoba

By Philip A. Baer, MDCM, FRCPC, FACR

With credits, credits everywhere, respondents are certainly taking advantage of the multiple sources of Continuing Medical Education (CME) credits on offer! The top three sources of CME credits participants identified were accredited learning activities (100%), unaccredited learning activities (80%), and literature scanning (59%). The range of areas specified was quite diverse, as you can see (Table 1).

Of those surveyed, 72% said it is never a challenge to obtain their yearly CME credits (Table 2). For those respondents who occasionally have trouble fulfilling their quota, perhaps consider some helpful suggestions from your colleagues. When asked to describe how they ensure obtaining sufficient credits, nearly half (48%) cited conference and annual meeting attendance, while a third (33%) found attending clinical rounds to be a great source of credits (Table 3).

The Royal College has recently expanded their repertoire of accredited learning activities within the MOC Program, providing even more opportunities for participants to earn credits (see article in this issue of the *CRAJ*). With all the available possibilities, a third of you (33%) noted that no additional sources for credits were necessary, as you accumulate ample credits through your customary activities. Informal review of cases with colleagues (19%) and industry-sponsored talks (13%) were mentioned as potential activities for which participants would like to receive credits (Table 4).

Philip A. Baer, MDCM, FRCPC, FACR
Editor-in-chief, CRAJ
Scarborough, Ontario

Table 1. Of the options listed below, please indicate your Top 3 sources of CME credits:

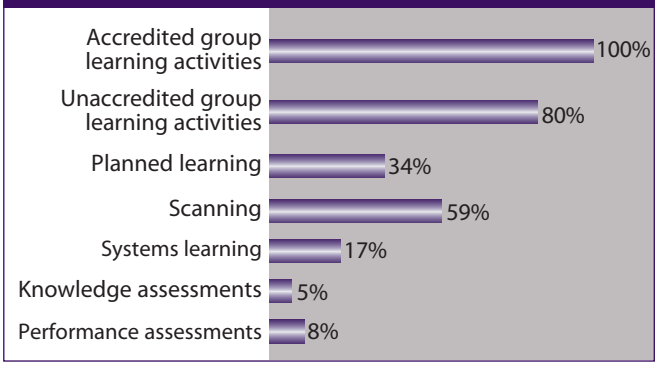


Table 2. Do you find it a challenge to obtain your required yearly credits?

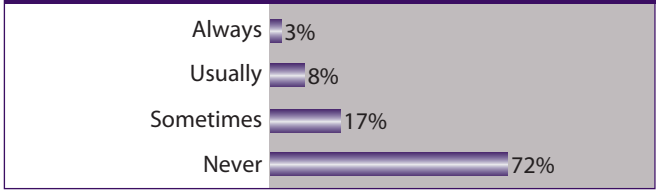


Table 3. How do you ensure that you get a sufficient number of credits?

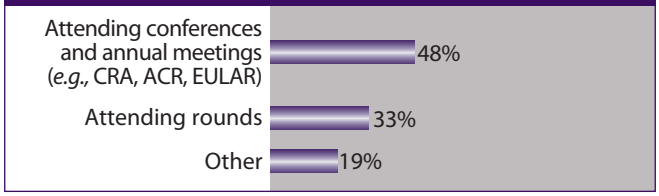
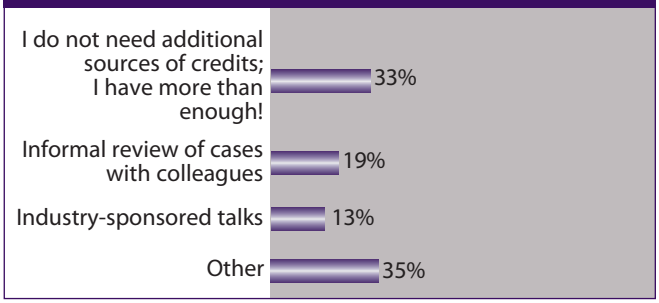


Table 4. Where else do you wish you could receive credits?



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