An Interview With Dr. Hugh Smythe

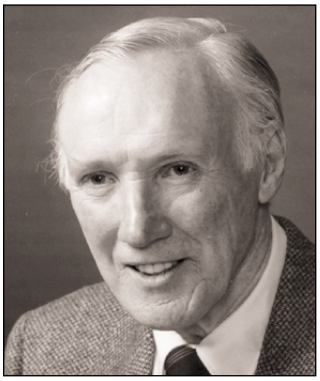
The Journal of the CRA is looking at the history of rheumatology in Canada through the eyes of its elders. We will reflect on the history of this specialty by interviewing the most experienced members of our community.

Q *Dr. Smythe, what encouraged you to choose rheumatology as a career when so little was known about the specialty?*

In fact, much was known within the specialty. In 1950, rheumatology had already entered one of its most dramatic periods of discovery and program development. The rheumatoid factor and LE cell test had been developed and the stunning therapeutic effects of cortisone had just been described. The links between streptococcal infection and rheumatic fever had firm laboratory support and antibiotics were rapidly being discovered, which would forever change the impact of infectious agents.

Major research units had been developed in the U.S. and U.K., and a special feature was the openness of the international community. Debate was often fierce, but was free and special efforts were made to attract and include a new generation. The international collaborations developed during the second world war and by the Marshall Plan, were strongly paralleled in the rheumatology community. The World Congress of the International League Against Rheumatism was awarded to Toronto, and held in 1956.

However, none of this was visible to us undergraduate students. Rheumatology was represented by one lecture, and the few patients to be found on the teaching wards were so badly deformed that it was clear the new therapeutics would be of little value and, therefore, of little interest.



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Given that background, why did I choose Rheumatology? The short answer is Sunnybrook. The brilliant team of clinicians/teachers/researchers had developed at Sunnybrook with the best post-graduate learning environment I have experienced. The tone of Grand Rounds and the clinical pathological conferences was set by a sign stating "Where all think alike, no one is thinking".

In contrast to the lack of development of rheumatology in the major general teaching hospitals nationwide, there was recognized to be a strong need for a major treatment unit for veterans with various forms of arthritis. At Sunnybrook, there was a 90-bed ward for patients, plus a 12-bed clinical investigation unit where metabolic balance studies could be performed. The treatment model was that of the sanitarium; patients with active disease would be kept in hospital until their disease was under control.

The average length of stay in this unit was (can you believe it?) about 6 months. In addition, veterans claiming or receiving pensions were followed as outpatients on at least an annual basis. All research were available, from the time of enlistment.

As a resident, I was pushed (willingly) to compare the heart disease in patients with spondylitis and other diseases and was able to establish the unique clinical and pathologic features of spondylitic heart disease. We soon moved on to the mechanisms underlying the excess risk of cardiac involvement in patients with gout and mechanisms possibly linking vascular disease with the overproduction of uric acid.

My intent in all this detail is to underline another feature of rheumatology that is almost unique amongst subspecialties. Within rheumatology, you must use all of the hard-won skills of general medicine. You need not, indeed cannot, abandon cardiology, neurology, endocrinology, renal physiology, infectious diseases or dermatology.

While all of this was happening at Sunnybrook, nothing comparable was being developed for non-veteran patients. Precisely the same staff members and residents functioned within the Toronto General Hospital, but the evolution of a rheumatic disease program in this major teaching hospital had specifically been reversed in 1949, in the interest of general medical wards. The focus was on undergraduate

training in preparation for community practice. It was specifically stated that the activities of staff rheumatologists at Sunnybrook were outside the sphere of interest of the Chairman of the Department of Medicine at the university. At the Toronto General, few referrals to rheumatologists came from colleagues inside the Department of Medicine and virtually none form Orthopedic Surgery. Nevertheless, a pressure for change was developing and received strong support from The Arthritis Society and the McLaughlin Foundation.

When I was first invited to join the staff of the Toronto General Hospital, I was offered a post in neurology. The chairman and my wife were equally surprised when I chose rheumatology instead.

Q *What was the state of rheumatology when you first started?*

There were many opportunities and a few problems. Money was certainly one of them. I had received support from the Arthritis Society while training, but none was available for junior staff investigators. There was no National Health Insurance Plan and I looked after most of my patients in the Arthritis Clinic and the teaching wards for free.

Nevertheless, I was allowed to use the office of the department chairman for a half day per week for my consulting practice and referrals came quickly. I was also appointed to the staff of Sunnybrook Hospital, serving on a general medicine ward, as well as the Arthritis Service. I was granted funds and space to do studies in uric acid metabolism, studies which led to a fruitful collaboration with Fraser Mustard on platelet turnover and the effects of diet, smoking, sulfinpyrazone and later, the effects of acetylsalicylate on platelet economy.

I was flattered and stimulated by invitations to join the Communications Committee of the American Rheumatism Association and similarly joined the Board of Directors first of the Ontario Division and then the National Board of the Arthritis Society.

Apart from this, I very much enjoyed my role as Team Physician for the Toronto Maple Leafs. At first, I was a junior partner to the team surgeon, ensuring warm friendships with surgical colleagues that might not have developed within the teaching hospital. The diagnostic challenges we faced influenced my reading and studies for later careers that were then totally unanticipated (and unsought). Before returning to Toronto, I had spent a year in England, primarily with Bywaters and Ansell, but also with Professor Kellgren, whose work on referred pain was still evolving.

As a group of rheumatologists, our main challenge was to create facilities for non-veterans comparable to those which had proved so powerful at the veteran's hospital. Several efforts to develop facilities within the Toronto General were rebuffed. A treatment unit was opened at the Home for Incurables (renamed the Queen Elizabeth Hospital) but still remote from University Avenue. This experience taught us simply that an academic service must be centrally placed within major teaching hospitals to have any major effect.

Q *How has the practice of rheumatology evolved (academic or community settings) since you started?*

In 1961, the Arthritis Society (then the Canadian Arthritis and Rheumatism Society) prepared a submission to the Royal Commission on Health Services. There was, of course, broad input, but the task of drafting this submission fell largely on Edward Dunlop and myself. From the English, American and Sunnybrook models, we knew we wanted a strong focus on education and research as well as on treatment. However, the context as a national plan required a formulation that would be meaningful to donors and patients in every community across Canada. Ivory towers were not enough; a clear link between the proposed university-based Rheumatic Disease Units (RDUs) and diagnostic and treatment programs available to every Canadian had to be clearly visible. Edward Dunlop's genius lay in his ability to translate objectives and strategies into specific tactics stated in terms of places, times and dollars. He was very good at leverage. Every dollar raised and spent by the board of the Arthritis Society resulted in about $20 newly available for the care of patients with arthritis. Due to the educational component, exemplary care of a patient in an RDU influenced the care of future patients because of the rapidly expanding family of rheumatologists, orthopedic surgeons, allied health professionals and researchers brought into the field.

Parallel with these events, the Wellesley Hospital was being rebuilt as a university teaching hospital. A special effort by the Arthritis Society Directors raised about 20% of the funds required for the rebuilding of the Wellesley

Hospital and ensured that a major RDU could at last be made available for non-veterans. Plans for rebuilding were being drawn in 1961. With the creation of a 40-bed ward, plus a metabolic study unit and a wing of research labs, plus a fellowship program and a major role in undergraduate and graduate training of physicians and allied health personnel, we could begin establishing what Met Ogryzlo later claimed would be "The best Arthritis Program in the world". Hearing the budget figures, the distinguished treasurer of the Arthritis Society diffidently asked "How much would it cost for second best?"

The Wellesley unit first opened in rented space at Sunnybrook Hospital in 1964 and finally moved to its new home in November 1996. We did not forget our community commitment. Our colleagues in British Columbia were ahead of us, but I had the opportunity to join Phil Gofton in a study of the prevalence of ankylosing spondylitis among aboriginal people in Bella Coola. This led to collaborations to establish and perform blind readings of population survey films with John Decker and others in the United States as well as John Lawrence from England.

Wallace Graham, the Director for the Toronto Rheumatic Disease Program, died suddenly in 1962. At that time, he was the author of three of the chapters in Hollander's Text Book on Arthritis. Met Ogryzlo took responsibility for the chapter on ankylosing spondylitis and I was asked to write the section on fibrositis.

This had not been an area of interest to me. I felt more confused after reading the literature and, in 1966, I attempted a fusion between the American concept of tension rheumatism and Kellgren's studies on referred pain; recognizing that these two concepts were not obviously compatible. My own experience in acute musculoskeletal medicine, my knowledge of the extensive works on spinal pathology written by my friend Ian McNabb, and the epidemiological studies of Kellgren and Lawrence all pointed to the neck and low back as the source of referred pain.

Shortly thereafter, Harvey Moldofsky began working with us. He (and others) showed that the muscles in the regions of pain were electrically silent. Terms such as "tension rheumatism" or "tension headaches" are misnomers, as defined electrophysiologically. How this evolved is another story. In this account, it illustrates the easy collaborations which could develop within a framework in which there are large numbers of patients available to study, in a setting in which hypotheses are framed so that they may be challenged.

This brings us to the early 1970s, by which time rheumatology was still not a recognized subspecialty in Canada. There was great research productivity. The Journal of Rheumatology Publishing Company was formed in the fall of 1973. By 1976, RDUs were established in all of Canada's medical schools and the rapid expansion of community rheumatology was well underway.

Q *How do you see the future of rheumatology evolving in Canada?*

The political momentum is changing and it is clear that Canadians wish to repair the damage to health care. Rheumatologists have certainly shown they care and wish to act in collaboration with their colleagues in solving problems both geographic and interdisciplinary. A deep concern is a loss of access to undergraduate students.

Q *What advice would you give to those following in your footsteps?*

Perhaps I can reduce it to three short statements:

- Give yourself time to become a really good doctor.
- Dare to be different.
- Make sure you enjoy what you are doing.

The first and last phrases are linked. If you are a good doctor, you can be flexible enough to change direction to take advantage of opportunities or overcome obstacles. If you are enjoying what you are doing, then you don't mind taking time, even though immediate rewards may not be apparent.

Q *Would you choose to become a rheumatologist in 1999?*

First, I am not bright enough, so they probably wouldn't let me in. Second, if I were bright enough, there are many alternative careers which I would equally enjoy. I like challenges, but perhaps there are not the first rate opportunities that were present 20, 30 and 40 years ago. Convince me otherwise practice managers, hospital presidents, medical politicians and ministry officials!

In rejecting (once again) one of my research applications, the reviewers for the Medical Advisory Committee of the Arthritis Society (of which I was then chairman) explained: "It is difficult to separate Dr. Smythe's contributions from those of his colleagues". This will serve nicely as my epitaph.