Joint Communiqué

Update from the Royal College of Physicians and Surgeons of Canada (RCPSC) Specialty Committee in Rheumatology

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

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

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

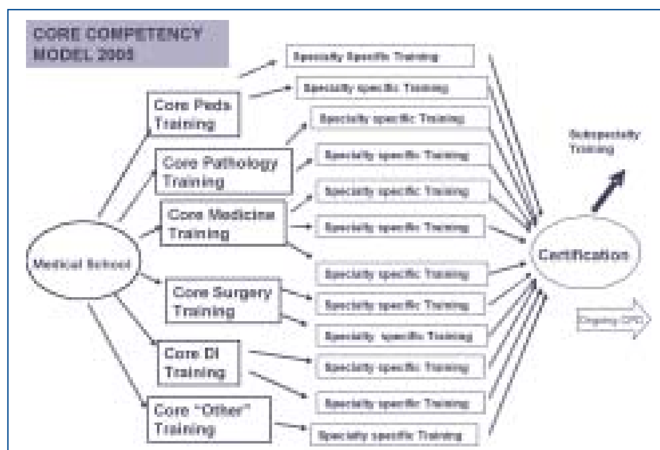


Figure 2: Core Competency Model, 2005

The RCPSC will be asking all specialties to review and redevelop objectives of training for their specialty and to ensure that their core competences are maintained and enhanced during training. This process requires a reassessment of all specialty-specific training requirements, including the length of time required for each discipline. Areas of significant overlap may necessitate the merging or streamlining of some disciplines. It is believed that identification of the core competencies in specialty core curriculum will allow better recognition and transfer of educational credit between residency programs. At present, the RCPSC is facilitating meetings for

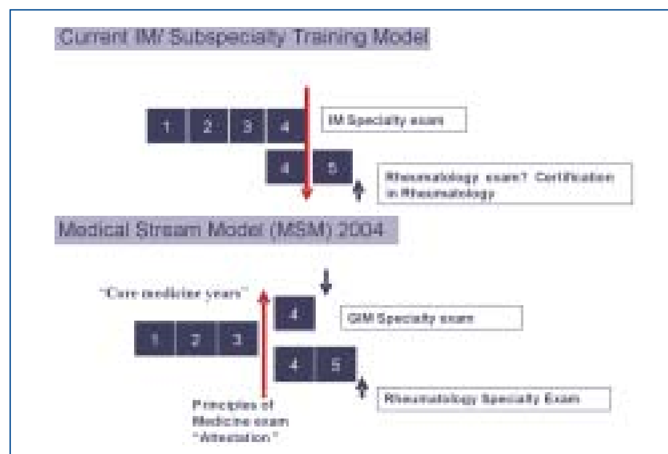
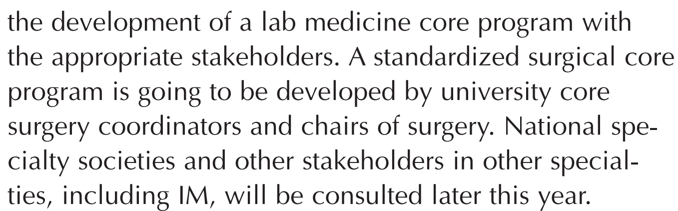


Figure 1: Proposed Medical Stream Model, 2004



the development of a lab medicine core program with the appropriate stakeholders. A standardized surgical core program is going to be developed by university core surgery coordinators and chairs of surgery. National specialty societies and other stakeholders in other specialties, including IM, will be consulted later this year.

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

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

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

Regional News

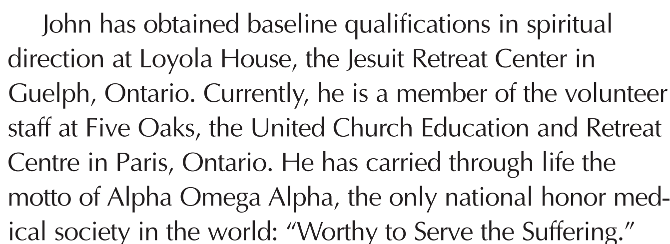
Kitchener, Ontario: A Tribute to Dr. John Lochead's Retirement

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

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

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

John exerts higher standards for himself than for others. Over the years he has become a fitness enthusiast and works out four times a week at the gym. During the winter months he remains an avid skier. During the summer months he is noted for his trips to Nepal, where he has trekked to the Annapurna base camp, Gokyo Ri, and Langtang. There he has befriended his Sherpa and the local villagers. He has used his leadership skills and compassion for people to attend to the peoples' health services; his work has become known over a wide region. A notable consequence of his contributions is the special tribute that Sir Edmond Hillary wrote to John for his recent retirement.



John has obtained baseline qualifications in spiritual direction at Loyola House, the Jesuit Retreat Center in Guelph, Ontario. Currently, he is a member of the volunteer staff at Five Oaks, the United Church Education and Retreat Centre in Paris, Ontario. He has carried through life the motto of Alpha Omega Alpha, the only national honor medical society in the world: "Worthy to Serve the Suffering."

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

– Brian D. Hanna, MD, FRCPC

Rheumatology in St. Catharines/Niagara, Ontario

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

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

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

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

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

The biggest drawback here would be the primary-care physician shortage. An estimated 20% of people do not have family physicians. As a result, there is a "trickle-down" effect on our specialty. There are too many inappropriate consult requests. Moreover, partly because of the primary-care physician shortage, general practitioners (GPs) are pressured into seeing too many patients and, not surprisingly, problems that should normally be addressed by the GPs are being directed to the rheuma-

tologists. It is hard not to sympathize with some of these patients, however, this sort of routine puts added stress on a practice schedule, not to mention the inability to get fair reimbursement out of a highly restrictive provincial fee coding system. Adding to the problem, there has been a shift of GPs moving from private offices to walk-in clinics, which only worsens referral quality and follow-up care.

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

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

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

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

Greg "the Terminator" Griffiths
(as in, "I terminate fibromyalgia")

John "Elbows" Dickson and
Saeed "the Hammer" Shaikh

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

– Saeed Shaikh, MD, FRCPC

Campus News

University of Calgary

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

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

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

– Liam Martin, MB, MRCPI, FRCPC
Associate Professor
Chief, Division of Rheumatology

Campus News

The McGill University Arthritis Center

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

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

Figure 1: 2004 Summer Camp: "Les os en fête"

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

Teaching. A survey of our medical students showed that they are good in theoretical rheumatology but not comfortable with the neurological and musculoskeletal (MSK) examinations. Our undergraduate program is thus being overhauled to remedy that situation. We have utilized training-the-trainer sessions (Henri Ménard), expanded the Patient Partners® in Arthritis

Opportunity for Interaction

1st
Mexican-Canadian Congress of Rheumatology

34th
Mexican Congress of Rheumatology

61st
Annual Meeting of the Canadian Rheumatology Association

The Hilton Hotel
Sessions:
08:00-13:30 daily

CANCUN
17-21 february 2006

IMPORTANT
Abstract deadline:
September 30, 2005

CRA
The Arthritis Experts

program (Michael Starr), organized an MSK day involving all MSK specialists and Allied Health personnel (Michael Starr, Mary-Ann Fitzcharles) and used a web-based program (Michael Stein, project for MSc in Medical Education). The post-graduate program (Michael Starr, Director) is not as popular as it should be but we are looking at making more use of the fabulous transdisciplinary McGill resources. For rheumatology residents, general rheumatology is targeted in the first year. The second year focuses on disease-oriented, multidisciplinary research clinics: the Lupus/CTD clinic with Ann Clarke and Christian Pineau; the Bone Center clinic for inherited and acquired metabolic bone diseases with David Goltzman, Richard Kremer, Francis Glorieux and Suzanne Morin; the inherited and acquired Muscle clinic with Angela Genge; the Early Arthritis and Scleroderma clinic/registries with Murray Baron and David Langleben; and the Pain clinic with Mary-Ann Fitzcharles and Mark Ware.

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

Research. The clinician-scientist cannot be a Renaissance person anymore. Clinical research is

now based on bidirectional knowledge translation between clinicians and scientists, both being essential. As Head of the University Division and responsible for recruitment, this author is taking a proactive stance by training and recruiting complementary duo teams from the onset. Epidemiologists, by the nature of their expertise, can be recruited independently and grafted on those dynamic duos. This approach has been implemented for the past three years in all the multidisciplinary disease-oriented clinics already mentioned. We will favor investigator-initiated research and collaborative efforts on consensual themes. Participating in the Early Arthritis National Initiative is one example. Preparing for that, Professor J. Sharp gave a half-day Master class to rheumatology and radiology residents and staff to illustrate the strengths and limitations of the Sharp radiological scoring system (Figure 2).

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

Left to right: Ronald Asherson, Visiting Professor, University of Capetown, South Africa; Dr. H. Ménard, McGill University; Dr. Ali Al-Shirawi, Visiting Scientist and Director, Division of Rheumatology, Sultan Qaboos University, Oman

Figure 2: Dr. A. Al-Hazmi, Rheumatology Resident; Dr. M. Baron, Rheumatology Staff; J. Sharp, Visiting Professor; A. Assaf, C. Pham and M.L. Doyon, Radiology Staff; E. Hazel, Rheumatology Resident; C. Pineau and H. Ménard, Rheumatology Staff; R. Khouqeer, Clinical Immunology Resident

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

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

– *Henri A. Ménard, MD*
Professor of Medicine
Director, Division of Rheumatology
McGill University
Montreal, Quebec