the fruits of
OUR LABOUR
DEPARTMENT OF MEDICINE ANNUAL REPORT 2015–16
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All persons profiled in this Annual Report
have agreed to their appearance and have
approved their individual stories.

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with food arrangements and generously preparing
the desserts featured in this Annual Report.

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2285 St. Laurent Blvd
Ottawa, ON K1G 4K1
(613) 523-2112
the fruits of OUR LABOUR

DEPARTMENT OF MEDICINE ANNUAL REPORT 2015–16
Our Vision

To be recognized as a world leader in medicine.

Our Mission

We exist to innovate, advocate and practice the highest quality of patient-centred care, medical education and research. We develop the next generation of physicians, researchers and educators. We champion the vision, mission and values of our University, our faculty and the hospitals we work in.

We leverage our unique position as academic clinicians to accelerate knowledge transfer to the bedside and clinic in order to improve the lives of our patients. We work with all stakeholders to find solutions to mutual problems and improve internal communication.

We seek out leadership opportunities at the regional, national and international levels. We lead by example, we listen and we challenge ourselves to be better. We create communities of trust, compassion and mutual respect.

We treat patients, trainees, staff, and colleagues with dignity and equity and we value the highest standards for professionalism, fairness and transparency in an environment of accountability to the people we care for, teach and work with.

We manage the resources of our faculty, hospitals, community and region competently and wisely. We make decisions that are just and ethical. We embrace a team philosophy to problem solving that encourages maximum input and participation from all our faculty and staff.

We recruit only the best people, nurture and value them. We celebrate both individual and collective achievements. We are mindful of ways to help our faculty and employees fulfill their professional and personal responsibilities.

We foster the development of life-long learning by ensuring sufficient support for continuing education programs, research and scholarly work.

When we operate according to these principles we should achieve our vision.
TABLE OF CONTENTS

03 A Message from the Chair and Chief
06 A Message from the Chief Administrative Officer
15 What You Should Know About Dr. Alan Karovitch

25 Medical Education
33 What You Should Know About Dr. Barbara Power

43 Medical Research
57 What You Should Know About Dr. Greg Knoll

67 Quality & Clinical Services
75 What You Should Know About Dr. Catherine Dubé

85 Physician Health & Wellness
91 What You Should Know About Dr. Ed Splig

101 Areas of Focus
113 Divisional Reports
From left to right: Ted Waring (Chief Administrative Officer), Dr. Greg Knoll (Vice-Chair, Research), Dr. Alan Karovitch (Deputy Chair & Vice-Chair, Finance), Dr. Phil Wells (Department Chair & Chief), Dr. Alan Forster (Vice-Chair, Quality & Clinical Services), Dr. Barbara Power (Vice-Chair, Education), and Dr. Ed Spilg (Vice-Chair, Physician Health & Wellness).
A Message from the

DEPARTMENT CHAIR & CHIEF

It could be argued that we are at, or approaching, a crisis point in healthcare, particularly in academic healthcare. We are currently facing struggles with funding models from the Ministry of Health for physician remuneration, changing funding models at hospitals, increasing legislations and requirements in the workplace (necessary, but time consuming and a paradigm shift), increasing requirements for faculties of medicine and universities to rein in spending and be ever more focused, and, ongoing struggles with peer-reviewed funding agencies for research. These have all been substantial challenges for the Department of Medicine and healthcare in general. However, the resiliency of the members of this department continue to ‘drive us forward’—the theme of last year’s annual report. Our ability to work through these struggles—despite the challenges—has continued to allow us to bear fruit as our clinical care and academic productivity were even more bountiful than in prior years. It’s fitting then that the theme of this year’s annual report is ’The Fruits of Our Labour’; our progress and achievements are collected and described within. I am particularly proud of several important initiatives.

During this past year the Department established strategic key directorship positions to enhance resident learning and support our faculty. After listening to concerns and working with our PhD Scientists we created a new Director of PhD Research position. This new role is already making great strides through the leadership of Dr. Robin Parks. Dr. Parks is working closely with Dr. Curtis Cooper, our new Director of Resident Research. Together, I feel their efforts will bear the fruit of a highly intensive resident research program, one which will be the envy of programs across Canada. We are also in the process of creating a new program in the Undergraduate Medical Education Program at the Faculty of Medicine which will enhance student involvement and understanding of clinical research, and will dovetail into the program that Drs Cooper and Parks are developing. Most recently, our faculty have continued to take on leadership positions at the university, within the department and at the hospital. Dr. Alan Forster, our Vice Chair of Quality and Clinical Services, has recently become a Vice President at The Ottawa Hospital and Dr. Virginia Roth is now the new Senior Medical Officer and reports directly to the Chief of Staff.
“Our ability to work through these struggles—despite the challenges—has continued to allow us to bear fruit as our clinical care and academic productivity were even more bountiful than in prior years.”

— Dr. Philip S. Wells
The Fellowship Program that we launched last year is now at full stride. Most of the strategies that we developed will be adopted by the Faculty of Medicine Postgraduate Office for fellows in other departments—we are particularly proud of that. We have also developed a rigorous onboarding process to ensure that our new faculty members are equipped with the tools, direction and information they need to be productive right from the start. This new onboarding program will ensure members are engaged and aligned with the values of this department, the university and the hospital early on in their careers.

During this past year, with the contributions of my outstanding support staff in the Department of Medicine Executive Office, we developed and hosted working retreats for our Program Directors, Program Administrators, Division Head Executive Assistants and Clinician Teachers. All of which resulted in strategic work plans and solutions to further enhance our academic and clinical efforts which will ensure we remain at the forefront of departments across Canada. I am particularly thankful for all of this work.

The Department’s Executive Committee has been a particularly dedicated and hardworking group, whose efforts are making a major difference in the Department. We are particularly thankful to Dr. Barbara Power, Vice Chair of Medical Education, who consistently goes above and beyond what is asked of her to raise the level of educational academic activity and to ensure the highest quality of education in the Department. I am very pleased to have the opportunity to feature her and several others on the Executive in this year’s annual report.

In summary, I want to extend my gratitude to all faculty members, administrative staff and trainees of this exceptional Department for your outstanding efforts over the last year. I hope you can see that these efforts are not without rewards as they have resulted in many remarkable achievements, i.e. The Fruits of YOUR Labour!

Philip S. Wells
MD, FRCPC, MSc
Chair & Chief, Department of Medicine
University of Ottawa & The Ottawa Hospital
A Message from the
CHIEF ADMINISTRATIVE OFFICER

TED Talk alumnus and author Richard St. John states that success is not represented by a single point in time nor is it a one-way street. Rather it is a constant journey that requires substantial effort and some trial and error. It is only if we stop trying that we will truly fail. I can assure everyone that I see no indications that the Department of Medicine (DoM) is resting on its laurels. In fact, throughout 2015–16 the DoM continued to proactively work to make things better for faculty, staff and our stakeholders.

When it comes down to it, 2015–16 was an amazing and successful year for the Department of Medicine! Fueled by thousands of hours of effort provided by our physicians, Medical Directors, Division Heads and Executive Committee members and strengthened by our project & support staff, we were able to operationalize several important initiatives. This annual report is peppered with many examples including the successful launch of our mentorship and fellowship programs. Success is not a one way street for sure. We also looked at existing processes, roles, committees and programs and were able to reduce or eliminate those that were no longer relevant, were ineffectual or just didn’t deliver the expected results. We continued to improve financial transparency, removed many system inequities and challenged the status quo that ‘things can only get worse’. While win-win solutions seem harder to spot these days, they continue to exist if you look for them.

The DoM executive suite has always been a very busy place and the complexity and speed of change continued to challenge us throughout 2015–16. DoM HR had to deal with new workplace legislation. We were required to create a DoM Health and Safety Committee with representatives from all three campuses and this involved quickly training staff from our divisions. I would like to thank all those staff that answered our call for volunteers and to TOH HR for facilitating the training. DoM HR updated the terms of reference and working conditions for admin staff, overhauled the Letters of Appointment for new faculty, revamped the external review process and screened 1575 applications for employment. They also had time to initiate the DoM Ambassador program which celebrates an administrator for continually providing work above the call of duty.
We saw modest growth to our department over the last year. We now have 527 faculty members including 262 FTA and 45 PhD scientists. We recruited 30 new faculty members of which 18 are full-time academics. We processed 21 reappointments, 17 cross/adjunct appointments and 22 departures.

On the administrative & support side, 30 new employees were hired and 15 left the organization. We now have more than 160 administrative and support staff managed through DoM HR with many others employed at TOH and OHRI.

We continued to engage with staff in our specialty and sub-specialty programs and divisions. We coordinated two very successful program administrator (PAs) retreats and another event for Division Head Assistants. These events were intended to facilitate the exchange of best practices in advance of accreditation, to gage the readiness of programs for Competency by Design initiatives, and to improve team cohesiveness.

In 2015–16, The Ottawa Hospital Academic Medical Organization (TOHAMO) implemented a new framework for distributing alternate funding payments to TOH departments. The intent is to further enhance the academic mission by targeting a larger proportion of funding at those Departments that actually provide the teaching and do the research. DoM is already very strong academically so these changes will hopefully, in time, result in additional funding. In the interim the administration and physician leadership have committed many hours of effort to ensure that we can meet all of the new metrics required by TOHAMO.

We established the Department of Medicine Academic and Research Fund. This was made possible with the significant support of our departmental practice plan, the University of Ottawa Medical Associates, and bolstered by matching support from the University of Ottawa and the Faculty of Medicine. The fund will allow us to continue to develop the academic and research mission of the Department for many years to come.

The Department flexed its altruistic muscle by organizing, participating in and fundraising for the 2nd annual Dancing with Docs fundraiser. Close to $85,000 was raised in support of the
“I can assure everyone that I see no indications that the Department of Medicine is resting on its laurels. In fact, throughout 2015–16 the DoM continued to proactively work to make things better for faculty, staff and our stakeholders.”

— Edward Waring
Patient Urgent-Needs Fund and a Chair in Stem Cell Research. The event has proven to be so successful that The Ottawa Hospital Foundation has offered to run it hospital-wide in future years. Kudos to the organizing committee and all of the volunteers!

In closing, the DoM administration has worked tirelessly throughout the year with growing workloads, managing multiple projects and deliverables and dealing with tight timelines. They are working in the background and often without recognition. I would like to end this year’s report by shouting out a big THANK YOU to all them and I encourage you to do the same. Their level of engagement and commitment to the Department is unprecedented in my tenure and I look forward to all the ‘fruit’ their labour will provide in future years. If 2015–16 is any indication the fruit will be sweet!

Edward Waring

MBA
Chief Administrative Officer

The Fruits of Our Labour
Department at a Glance

**497 Physician Members:**
- 256 Full Time Academic (FTA)
- 170 Part Time Academic (PTA)
- 37 Scientists
- 6 Emeritus
- 28 Adjuncts

**293 FTA and Scientists (University Status):**
- 74 Professors
- 128 Assistants
- 85 Associates
- 6 Lecturers

New Faculty Positions (FTA & PTA)

Reflects period of July 1, 2015 to June 30th, 2016.

| Dr. Maryann Doyle | Endocrinology & Metabolism |
| Dr. Chantel Barrett | Neurology |
| Dr. Ivan Litvinov | Dermatology |
| Dr. Daniel Kobewka | General Internal Medicine |
| Dr. Sibel Aydin | Rheumatology |
| Dr. Antonio Cabral | Rheumatology |
| Dr. Natasha Kekre | Hematology |
| Dr. Andrea Kew | Hematology |
| Dr. Carly Kirshen | Dermatology |
| Dr. Juthaporn Cowan | Infectious Diseases |
| Dr. Caroline Nott | Infectious Diseases |
| Dr. Lisa Fischer | Palliative Care |
| Dr. Kanchana Amaratunga | Infectious Diseases |
| Dr. Kaissa de Boer | Respirology |

Division Heads

Reflects period of July 1, 2015 to June 30th, 2016.

| Dr. Rob Beanlands | Cardiology |
| Dr. Dean Fergusson | Clinical Epidemiology |
| Dr. Jim Walker (Acting) | Dermatology |
| Dr. Erin Keely & Dr. Alexander Sorisky | Endocrinology & Metabolism |
| Dr. Alaa Rostom | Gastroenterology |
| Dr. Alan Karovitch | General Internal Medicine |
| Dr. Allen Huang | Geriatric Medicine |
| Dr. Marc Rodger | Hematology |
| Dr. Jonathan Angel | Infectious Diseases |
| Dr. David Stewart | Medical Oncology |
| Dr. Peter Magner | Nephrology |
| Dr. David Grimes | Neurology |
| Dr. Lionel Zuckier | Nuclear Medicine |
| Dr. Phil Wells (Acting) | Palliative Care |
| Dr. Shawn Marshall | Physical Medicine & Rehabilitation |
| Dr. Shawn Aaron | Respirology |
| Dr. Antonio Cabral | Rheumatology |
### Postgraduate Program Directors

Reflects period of July 1, 2015 to June 30th, 2016.

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Michael Froeschl</td>
<td>Cardiology</td>
</tr>
<tr>
<td>Dr. Paul Wheatley-Price</td>
<td>Clinical Investigative Program</td>
</tr>
<tr>
<td>Dr. Cathy Code</td>
<td>Core Internal Medicine</td>
</tr>
<tr>
<td>Dr. Gianni D'Egidio</td>
<td>Critical Care</td>
</tr>
<tr>
<td>Dr. Steve Glassman</td>
<td>Dermatology</td>
</tr>
<tr>
<td>Dr. Janine Malcolm</td>
<td>Endocrinology &amp; Metabolism</td>
</tr>
<tr>
<td>Dr. Nav Saloojee</td>
<td>Gastroenterology</td>
</tr>
<tr>
<td>Dr. Heather Clark</td>
<td>General Internal Medicine</td>
</tr>
<tr>
<td>Dr. Lara Khoury</td>
<td>Geriatric Medicine</td>
</tr>
<tr>
<td>Dr. Dimitri Scarvelis</td>
<td>Hematology</td>
</tr>
<tr>
<td>Dr. Craig Lee</td>
<td>Infectious Diseases</td>
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<tr>
<td>Dr. Cedric Edwards</td>
<td>Nephrology</td>
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<tr>
<td>Dr. Christine De Meulemeester</td>
<td>Neurology</td>
</tr>
<tr>
<td>Dr. Xuan Pham</td>
<td>Nuclear Medicine</td>
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<tr>
<td>Dr. Neil Reaume</td>
<td>Medical Oncology</td>
</tr>
<tr>
<td>Dr. Chris Barnes</td>
<td>Palliative Care</td>
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<tr>
<td>Dr. Gerald Wolff</td>
<td>Physical Medicine &amp; Rehabilitation</td>
</tr>
<tr>
<td>Dr. Nha Voduc</td>
<td>Respiratory</td>
</tr>
<tr>
<td>Dr. John Thomson</td>
<td>Rheumatology</td>
</tr>
</tbody>
</table>

### Directors

Reflects period of July 1, 2015 to June 30th, 2016.

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Heather Clark</td>
<td>Director of Ambulatory Care</td>
</tr>
<tr>
<td>Dr. Nha Voduc</td>
<td>Fellowship Director</td>
</tr>
<tr>
<td>Dr. Alexander Sorisky</td>
<td>Mentorship Director</td>
</tr>
<tr>
<td>Dr. Curtis Cooper</td>
<td>Director of Resident Research</td>
</tr>
<tr>
<td>Dr. Robin Parks</td>
<td>PhD Director</td>
</tr>
<tr>
<td>Dr. Sue Humphrey-Murto</td>
<td>Director of Medical Education Research</td>
</tr>
<tr>
<td>Dr. Chris Johnson</td>
<td>Associate Director, IM program</td>
</tr>
<tr>
<td>Dr. Loree Boyle</td>
<td>Associate Director, IM program</td>
</tr>
<tr>
<td>Dr. Vladimir Contreras-Dominguez</td>
<td>Director of Clerkship &amp; UGME</td>
</tr>
<tr>
<td>Dr. Justine Chan</td>
<td>Associate Director, Clerkship</td>
</tr>
<tr>
<td>Dr. Isabelle Desjardins</td>
<td>Associate Director, Clerkship</td>
</tr>
<tr>
<td>Dr. Heather Lochman</td>
<td>CPD Director</td>
</tr>
<tr>
<td>Dr. Stephanie Hoar</td>
<td>Director PGME</td>
</tr>
<tr>
<td>Dr. Delvina Hasimja</td>
<td>Chair, Department of Medicine Quality Committee</td>
</tr>
</tbody>
</table>
Department Faculty Promotions

Reflects period of July 1, 2015 to June 30th, 2016.

<table>
<thead>
<tr>
<th>Faculty Member</th>
<th>Title and Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Marjorie Brand</td>
<td>Full Professor (PhD, Hematology)</td>
</tr>
<tr>
<td>Dr. Jeffery Dilworth</td>
<td>Full Professor (cross-appointed to Neurology)</td>
</tr>
<tr>
<td>Dr. Hillel Finestone</td>
<td>Full Professor (Physical Medicine &amp; Rehabilitation)</td>
</tr>
<tr>
<td>Dr. Dar Dowlatshahi</td>
<td>Associate Professor (Neurology)</td>
</tr>
<tr>
<td>Dr. Debra Pugh</td>
<td>Associate Professor (General Internal Medicine)</td>
</tr>
</tbody>
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2015 Recognition Ceremony Award Recipients

<table>
<thead>
<tr>
<th>Recipient</th>
<th>Award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Melissa Forgie</td>
<td>Jeff Turnbull Healthcare Advocacy Award</td>
</tr>
<tr>
<td>Dr. Rakesh Patel</td>
<td>Going the Extra Mile Award</td>
</tr>
<tr>
<td>Drs Sue Humphrey-Murto, Dean Fergusson, Bill Cameron</td>
<td>Department of Medicine Mentorship Award</td>
</tr>
<tr>
<td>Dr. Rob Beanlands</td>
<td>Department of Medicine Vision Award</td>
</tr>
<tr>
<td>Dr. Vladimir Contreras-Dominguez</td>
<td>Department of Medicine Professionalism &amp; Collegiality Award</td>
</tr>
<tr>
<td>Dr. Melissa Rousseau</td>
<td>Department of Medicine Bedside Teaching Award</td>
</tr>
<tr>
<td>Gisele Villeneuve</td>
<td>Chairman’s Cornerstone Award</td>
</tr>
<tr>
<td>Dr. Claire Touchie</td>
<td>Meridith Marks Educator Award for Innovation and Scholarship in Medical Education</td>
</tr>
<tr>
<td>Dr. Justine Chan</td>
<td>Resident’s Clinical Teaching Choice Award</td>
</tr>
<tr>
<td>Drs Roy Khalife, Sabira Valiani, Chris Tran</td>
<td>Resident Award for Excellence in Medical Education Scholarship</td>
</tr>
<tr>
<td>Dr. Adrianne Kwong</td>
<td>Peter MacLeod Ambassador Award</td>
</tr>
<tr>
<td>Drs Adam Hall, Dan Soliman, David Harnett, Aimee Li, Jessica Tomchishen</td>
<td>Chief Resident Awards</td>
</tr>
<tr>
<td>Dr. Ruth Ellen</td>
<td>Joseph Greenblatt Award</td>
</tr>
</tbody>
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What You Should Know About

DR. ALAN KAROVITCH

Dr. Alan Karovitch is afraid of thunder. He has been forever. And although he doesn’t break out in hives, his wife Lindsay says his response is psychologically just like their dog’s—he likes to lie under the bed. Surprising behavior for a man blessed with the looks and athleticism of a testosterone charged Jason Statham character. To calm him during thunderstorms his wife has threatened to buy him a ThunderShirt™, the one they make for dogs. Nothing bad has ever happened to Alan, and he’s not afraid of being electrocuted. There’s just something very visceral about that rumbling sound that he says makes him feel very anxious. As the patriarch of a large family whose main activities are outside in the wilderness he is the first to admit that this is a bad fear to have. ‘Where’s Dad?...hiding under the canoe!’

Alan may not be the ideal role model in the face of a storm, but in every other aspect of his life, both personally and professionally, he’s the guy you want holding the reins. A.K. is an excellent leader. Those who work with him attest to his almost daunting work ethic. He’s affable and uses a common sense and realistic approach to decision making, all of which have gained him the respect and reverence of his colleagues. He possesses enough self-awareness to understand his strengths and shortcomings but also enough OCD traits to push through and get the job done. He’s also a glass half-full, maybe even a glass three-quarters-full kind of guy. And on rare occasions when a touch of cynicism enters his vocabulary, it’s very easy to digest as it’s always backed by reason.

Dr. Alan Karovitch is the Head of General Internal Medicine, he is also the Vice Chair of Finance for the Department of Medicine, The University of Ottawa Medical Associates Chair, the Secretary/Treasurer of The Ottawa Hospital Medical Staff Association and an active Board Member of The Ottawa Hospital Academic Medical Organization. Wearing these high level hats combined with the rigors of call, clinic, CTU and other clinical responsibilities makes the pace of his work life at times frenetic. Yet he downplays his accomplishments. When challenged to write his autobiography in only six words he penned: Worked hard. Bar low. Jumped Bar. Here’s how he gets it all done.
On the good, the bad and the ugly of being OCD:

I don’t think you can expect people to do things that you aren’t willing to do yourself. I do try to think about that when I ask my division to do things that are difficult or unpopular or I know are going to be hard. Most of the time or almost all of the time I will put my neck out there first. I think if you’re not willing to do it then you can’t ask other people to do it.

I just read a book when I was on holidays, it wasn’t my favourite book. It was good, it wasn’t awesome, by Geraldine Brooks called The Secret Chord about King David in biblical times a thousand years before Christ. It’s a fictional account of his life’s story as told by one of his councillors. David was a bit of a crazy guy and it didn’t end well for him. He had a huge ego, but the one thing that he always did, particularly when he was young, is that he always led by example. If there was a tough battle he was the first guy running into the enemy. Almost all of his success as a young man and leading up to when he was king was because of this.

So I think I’m a very good manager, though I’m not sure I’m a great leader in terms of vision and thinking about things that have to change and where we need to go. Phil [Dr. Phil Wells, Department Chair & Chief] is very good at that. I’m a doer. We have a pretty big division with lots of tasks and I’m not afraid of delegating. I’m not so OCD that I have to have my hand in every pie. If you call me in a year from now and say you haven’t created a vision for the division for the next five years and how are you supposed to become the greatest Division in North America, I’d say ‘I don’t know’…I’m not going to be that guy for you. I can make it a good division. I can get people to work hard and play well in the sandbox and go through processes and changes that we need to do to make for good academics and patient care and all those other things, but that’s very different I think than being a visionary.

I wouldn’t say I love all my job every day. In fact, one of the big things I don’t like about my job is all the different hats I have to wear and how hard it is to juggle those things. I do it because, for me, it’s often about getting that carrot at the end of the day. If I know I’m going biking with friends and I can get out by 6:00p.m. or take a kid to a swimming pool I can get through.

And it’s those little things day to day that get me through the stress. Honestly. My wife’s very funny…she says ‘you know you’re a very simple man and it takes very little to make you happy. It’s great, all I need to do is hang this one little carrot in front of you and I know you’ll have a good week.’ We’re having family here this weekend, running in the 10K, and we have a swimming pool that probably won’t be green by then, and just those little things will get me through the week and over the fact that I have to work all weekend. I’m totally the light at the end of the tunnel kind of guy and that light only needs to be very dim.

I think the biggest challenges facing leaders are trying to juggle multiple roles, effecting change and making decisions that may be unpopular. And not doing that last one too often—deciding which ones are important enough that you can push through it while at the same time recognizing when it’s not important enough.
For example… service stuff, convincing people that we need to expand and have more coverage for patient care—that’s always initially a little unpopular simply because it requires more service. People don’t like change. So you do it first yourself, continue to be persuasive and find an objective way to explain. And once people come around and the change happens often it’s not as bad as people first thought it was going to be. Trust me, I don’t like change. So as a guy who doesn’t like change telling people they need to change is sometimes very challenging.

If I have to, I’m okay with making an unpopular decision. I wouldn’t want to do that very often and I wouldn’t want it to be a huge game-changer for people. I’d really have to reflect on whether that was the hill I wanted to die on. I think people don’t often do that enough. What battle do you want to fight? And again, not that I don’t sweat the small stuff. Trust me, I’m so OCD that I sweat small stuff every day, but making people do things is different than sweating it yourself.

“In Trust me, I don’t like change. So as a guy who doesn’t like change telling people they need to change is sometimes very challenging.”

On simpler times and working hard:

I grew up in Laval, north of Montreal, in a small working class neighborhood with an equal mix of Jewish and Greek families.

In the 70s and 80s it was an underdeveloped place with plenty of open fields and empty lots. I would not want to grow up in that neighbourhood now. It’s still a working class neighbourhood but with no space. My memory as a kid was playing outside in the woods and fields after school with any of the 30 local kids in and around my age. As a kid we were always outside. We had no computer, no iphone and maybe two TV channels with nothing on during the day. There was very little organized sports; no community swimming pool and people didn’t go away on holiday.

My Dad worked hard, he had maybe two or three weeks of holidays a year and with no means to travel we stayed home. But it was fine, I thought that was normal and it was very low stress. Nowadays I think that our kids are so stressed out with technology and organized activities—we’re as guilty of that as anybody—those carefree do nothing days, they’re gone. I look at what my kids have now and I can’t believe how spoiled my children are. If I had said to my parents ‘What are we doing this summer?’, they’d be like ‘what are you talking about?! If you’re lucky I won’t smack you in the head this summer’.

I didn’t grow up with a lot of sport. I’m actually not very athletic and I have terrible hand eye coordination. Seriously, I can’t golf and I can’t hit a baseball, and I’m a terrible skater. But that’s different than being active and really enjoying the outdoors.

It was always important for me to work and make some money. My family didn’t have any money so I started working at a very young age. I remember in grade 9 tutoring older kids in math and making a fair bit of money.
on that. I remember walking to their houses in the middle of winter and they’d each pay me $10 an hour and there were five of them so I was making $50 an hour! I was rolling in money. And they all passed.

I think I was 15 when my uncle got me my first summer job in the industrial part of Montreal at a coat factory. I can laugh about this now, I’m not sure I laughed at the time. I remember my first day… it’s basically this hot, terrible place in the middle of the summer and this guy brings me down to the basement room in this factory. It’s one room about the length of a football field and he brings me to the first rack and its black ski jackets—identical. In my memory the rack is 300 yards long. It’s packed tight, tight, tight with these black ski jackets and there are no other empty racks. So the guy says to me ‘I need you to have this rack sized from XS to XL by the end of the day’, and he leaves the room and leaves me standing there. So I go to the first coat and it says ‘medium’ and I’m like, ‘what do I do now?’ So I walk 150 yards down and I put it in the middle. I’m trying to create enough space around it so I know where I am, but I can’t because they’re packed so tight. So I just squeeze it in and I go back to the beginning and it says ‘large’ so I walk three-quarters down the rack… I’m trying to create a system without an empty rack to help. I did that for the whole summer in this hot stinking basement.

I always had summer jobs. I wanted to go to a partially private CEGEP called Marionopolis College—I think it was $1000/year for tuition. I remember telling my parents I wanted to go there instead of public CEGEP. You needed to have high academic marks to get in and a lot of my smart friends were going there. I don’t even remember why I wanted to go, probably because I could. And my parents said, ‘that’s great’ and then I told them it was $1000 a year and my father said ‘great’ as in ‘good luck to ya son’ with a little pat on the shoulder.

The next summer I remember my uncle saying, ‘well, you’re going to come back and work at the coat factory’, and I said no way am I coming back to work there so I decided to get a job myself working with my friend Dan. So you know what my job was the next summer? Working at this company that sold siding. The way they used to make siding was to take two pieces of metal siding and fill them with insulation. It was kind of like an ice cream sandwich. They’d put pieces of siding in a machine and fill the flat piece of siding with insulation, then the next piece of siding would go over it and this big machine would come down and squeeze them together generating this huge amount of heat. At the end you’d have this completed ice cream sandwich and the machine would push it out. My job that summer was after that ice cream sandwich got pushed out of the machine and the machine was opened, my friend Dan and I had to jump into this steaming hot machine with knee pads and gloves and scrape out the insulation that was stuck to the metal so they could put the next ice cream sandwich together. I did that for a whole summer. It was definitely not a step up but I liked it better than the first one because I got to work with my friend and ride our bikes to work. I worked hard that summer and I made that $1000 and went to Marionopolis College. And then I went to McGill.
On his love of math, peanut butter and other things:

I was a total geeky nerd, very academic, tape on the glasses, pocket protector—that guy. Actually, not quite that bad. I was quiet but not overly shy. I had a cohort of friends through elementary and high school who were also the geeky guys so we just stuck together right through. I’m still friends with some of them.

If not for medicine, I probably would have become a teacher. High school. Probably math. I think I would have been pretty happy teaching kids math…and maybe even happier than I am now. I love math, really [pulls out his ipad with a math app that you can ask anything]. Best app ever!

I eat a peanut butter sandwich for lunch every day. Everybody says ‘why don’t you have something different?’ Then when I have a different sandwich I’m eating it thinking I wish this was peanut butter. My wife Lindsay will say ‘you need to branch out’ so sometimes I add cheese whiz. I know it’s not real cheese, it doesn’t even need to be refrigerated and everyone thinks it’s crazy but it’s this great combination of sweet and salty. Every single person who tries it—and not many will—has come back to me and said you were right. A well-toasted bagel with peanut butter and Cheez Whiz… you will be in love [laughs].

One of the problems right now at home is that we have no Cheez Whiz. I don’t know who’s in charge but they’re going to hear about this.

I’m a little embarrassed to talk about my morning routine because people usually think I’m crazy or I’m bragging or some combination of that. So, I get up pretty early most days, partially because my kids are competitive swimmers. I wake up at 4:30 a.m., organize some of my stuff, get the kids up at 4:40 a.m. and in the van. Some days I pick up four other kids in the neighbourhood, drive to the swimming pool at Brewer Park—they have to be on deck by 5:15 a.m. That’s when I tend to do my exercise. I’ll go for a 10k run around the canal. In winter I’ll skate downtown and back or I’ll do it a couple of times. Then I’ll come to work. On Fridays, Executive Committee meeting starts at 7:00 a.m.!

“I hate shopping. The internet fairy buys my clothes for me. They just appear.”

I haven’t turned my television on in months. I have two beautiful TVs in my house and I never watch them. Who has time for TV? I get home, have dinner, hang out, walk the dog, feed all our animals, talk to my kids and get caught up. If you have four kids there’s a lot of catching up to do. I read a lot, practice my guitar, go to bed at 9:30, that’s my day. Nothing fancy but a great day, a very full day.

I hate shopping. The internet fairy buys my clothes for me. They just appear. But I’m a very good gift buyer. Ask Lindsay.
She’s a shitty present buyer. She never gets the right thing but I’m pretty good because I’m a good listener. Her birthday’s in August and in January she’ll say something very off the cuff in part of a conversation, and maybe again it’s my OCD, but I’ll make a point of putting it in that memory space, and when July rolls around, I’ll remember and get it, and she’ll be like ‘holy shit how did you know that?’

I’m also pretty amusical. I’m the most uncoordinated, arythmic man alive, that’s why I will never participate in Dancing with the Docs. It’s not like my parents discouraged me. In fact, my grandmother, my mother’s mother, who I was very close with, who died two years ago at age almost 101, was a piano teacher. In fact, I have her piano in my house. We restored it and I think she bought it during WWII to teach piano lessons. Like most affluent families, all my kids took music lessons—piano, guitar. Two of them play saxophone, and at age 40 I said, ‘you know what, I’ve always wanted to play guitar, I want to play guitar.’ So my parents bought me a guitar for my 40th birthday, and it sat in the corner for eight years collecting dust. Then two or three years ago, one of my kids was taking guitar lessons with a guy in the neighbourhood and I decided to start taking guitar lessons. I’d never played a musical instrument in my life. I didn’t know how to read a note of music, and at age 49, I started guitar lessons and am still taking lessons with the same teacher. I love it. Hardest thing in my life, absolute hardest thing in my life. Nothing harder, nothing more challenging. I’m a complete garbage guitar player and I love it. I’d love to be a good guitar player. I’d love to be reincarnated as someone who is musical or who had a childhood where I learned music and played music from an early age. Of course if I could, I would have been a 1960s/70s British rock guitarist!

**On being a physician:**

I’m embarrassed to say that my decision to become a doctor was in some part because I had good marks. If I’m honest, I can’t say I ever had this deep, deep rooted love of medicine and that all of my life I knew I wanted to do this and I wanted to help people. I don’t even know why I applied to medical school, I think it was because it was what all the smart kids were doing. I was so unprepared. The total surprise question in my medical school interview… I didn’t see this question coming at all was, ‘so why do you want to be a doctor?’ I was totally unprepared and I didn’t get in. Could you imagine that? Shocking! [laughs].

Today people ask me ‘should I go into medicine’ and I say ‘yes’. Medicine is a great profession and will continue to be a great profession for a long time. There’s not a lot of people who have what we have.

What I love about medicine is the job security and the day to day challenges. It’s never a boring job. If I’m looking at the clock, it’s because I’m worried about getting out on time. I would die in a job where I had to kill time. So we all have very exciting driven jobs, great flexibility in our lives. We have a hundred bosses but really no bosses. I can change up my day. I can change up my schedule and choose to do things that I feel passionate about. I can stop doing things that I don’t like doing. There’s not a lot of people
who work for other people and have all that flexibility and all that choice.

I think that’s what really enables people to be happy—when you feel like you have control in your life.

I’ve gotta tell you, I think I’ve had an easy career and an easy life so far. I feel blessed. People who complain about their lives around here, it drives me nuts. We have nothing to complain about. We are lucky, we are privileged, and maybe I’m just projecting my own feelings onto everybody else, and I know people have hardships in their lives that I’m probably unaware of, but we live in a complaining culture, right? We have houses and clean water and food, we work with nice smart people, we have great jobs. I just think that despite the things I’ve had to do to get here, I feel like I’ve had a privileged life. I don’t think I’ve had a lot of adversity to overcome in my life. Every day I feel lucky that I am where I am—honestly I do…socially, family, work wise. I don’t ever feel like I have to put a life jacket on.
Choice words:

Which living physician do you most admire? My wife, Lindsay. Compassion, empathy, skilled, huge amount of CME commitment. Her colleagues and patients love her. What technical advance do you most anticipate? No clue. Something that will make us even less social? What is your favourite activity outside of the hospital? Outdoors. Away from it all. Friends, family. Skiing, canoeing, camping, mountains. What is your idea of misery? Going to the mall. Shopping. What faults in others are you most and least tolerant of? Not tolerant of much. Least tolerant of laziness and sloppiness. I also hate greed—the root of much of our world problems. What is your greatest extravagance? My kids. Actually it’s all the activities that my four kids get to do that I did not get a chance to do growing up. If you could change one thing about your family, what would it be? I would love my girls to keep their bedrooms tidy. But as they point out, they are not pregnant, in jail or on drugs…so I should just chill. If your home were on fire, what prized keepsake would you grab on your way out? I am not very sentimental and don’t really place much value on things…so probably nothing. I’d make sure we got all the kids and animals out. Name one thing you never leave the house without, and why? My bear claw. So I was canoeing in the Yukon and I was attacked by a bear and I had to kill it with my bare hands…I’m just kidding. [laughs] It was during one of our earliest camping trips with our family in Northern Quebec and my oldest son, he was 6 at the time, he saw this black leather necklace with a bear claw on it and liked it, so I bought it. For me it’s a talisman of a memory of when the kids were very young and we did a lot of family stuff together particularly outdoorsy, camping stuff. It’s part of my morning routine, I put my watch on, I put my bear claw on and away we go. It’s habit now—it’s been a long time because my oldest son is now 19. Wow, forever ago. Again, maybe it’s my OCD coming out again. Name a book (fiction or non-fiction) that has made a lasting impression on you, and why? I read a lot but only about 20% of what my wife reads. She passes along what she thinks I’ll like. Some of my favourites that have left lasting impressions are: Three Day Road by Joseph Boyden. It’s a great Canadian book about WWI, the Ojibway people, misery and ultimately salvation. Cutting for Stone by Abraham Varghese—a great story about medicine, Ethiopia and family. The author is a very well-known internist in California whose main interest is preserving the art and science of the bedside physical exam. But my answer goes back a few years: Call of the Wild by Jack London. The first “real” book I read as a kid. Still love it. I’ve read it to my children—poignant, sad, thoughtful. What’s one thing that will always make you laugh? The movie “This is Spinal Tap”. What food do you detest the most? Beans. Specifically, lima beans. Ask my mum! We had quite a few stand-offs over that. What is a little known fact about you? I cannot make the Spock Star Trek salute with my fingers. If you were to die and could choose what to come back as, what would it be? My kids or dogs. What a wonderful life of privilege, love and adventure!
Dr. Alan Karovitch’s

Upside-down Pear and Walnut Gingerbread Pudding

What to add:

**GINGERBREAD**
- 4 oz flour (½ cup)
- ½ tsp baking soda
- 2 tsp cinnamon
- 1 tsp ground ginger
- Pinch ground cloves
- Pinch ground nutmeg
- 1 egg
- 4 oz brown sugar (½ cup)
- 3 oz molasses
- 4 oz milk (½ cup)
- 2 oz melted butter (½ square)

**TOPPING**
- 2 oz butter (½ square)
- 4 oz brown sugar (½ cup)
- 1 tin of pear halves drained
- A few walnuts

What to do:

1. Make topping first: Melt butter and brown sugar together and stir for 1–2 minutes.
2. Pour into 9-inch glass oven-proof pie dish—GREASED!
3. Then arrange pears and walnuts over mixture.
4. Mix flour and dry ingredients.
5. Mix together egg, sugar, molasses, milk and melted butter well.
6. Add dry ingredients and mix well.
7. Spoon entire mixture over the pear/walnuts/topping in the dish. Smooth evenly.
8. Bake at 350 degrees for 40–50 minutes.
9. Serve warm with whipped cream or ice cream.
Medical Education
Medical Education

It is exciting to be reporting to you for the second time in my role as Vice Chair, Education. Medical education has been very busy this year as we continue to work on ensuring the department achieves its comprehensive strategic plan while also preparing for accreditation of our training programs. We are well positioned due to the hard work and commitment from our program directors. I would like to thank all of these extraordinary individuals for their tireless energy and initiatives to ensure the training programs have addressed any concerns highlighted by the internal review process. In the past year one of our main efforts was to provide extra emphasis on ensuring the program directors and program administrators felt supported and connected to Department of Medicine. Through organized and regular retreats, we now have better internal linkages and appreciation for the challenges our programs face. It is through this partnership that we have implemented initiatives to address some of the common issues such as ensuring the CanMeds objectives are being met.

Over the last year, the Core Internal Medicine program has continued to prepare for the transition to CBME and for the Royal College accreditation visit in November 2016. Dr. Loree Boyle has joined the program leadership team with an initial focus on revamping the program’s Academic Half Day format and content. Several changes to Academic Half Day have already been implemented for this academic year including, with the assistance of Dr. Curtis Cooper, the implementation of a research/critical appraisal curriculum and, with the assistance of Dr. Delvina Hasimja and Dr. Krista Wooller, the implementation of a patient safety and quality curriculum. The program has also focused on expanding resident training in use of bedside ultrasound. The resident’s first POCUS (Point of care ultrasound) course was held in March 2016 under the leadership of Dr. Hassan Mustafa and has since been expanded for this upcoming academic year to be integrated into the Academic Half Day curriculum.

Once accreditation is completed the next wave of challenge for our training programs will be the implementation of competency based education. In the past year we have developed a CBME committee and have been partnering with the Postgraduate office at the Faculty of Medicine. We are also looking at developing a director position to assist all our programs in moving CBME forward. Medical oncology is the first training program in the Department to implement
this new form of assessment and evaluation, effective July 2017. Drs Neil Reaume, Xinni Song and Tina Hsu have provided strong leadership to this initiative and their commitment to this process will provide support to other programs.

Many of our residency programs are developing fellowship programs that are being accredited through the Royal College as programs of “Added Focus of Competence”. Dr. Nha Voduc as Director of Fellowship is providing guidance and leadership to these programs. Over the past year, he also organized four educational dinner sessions for Department of Medicine fellows, with the participation of Drs Robert Bell and Rakesh Patel. He has worked in conjunction with Drs Greg Knoll and Sue Humphrey to establish an academic scholarship program and has established a funding plan for our fellowship programs. This achievement has made us leaders in ensuring the success of our fellows.

It has been a hectic year for our under-graduate medical program as it continues to grow in student numbers. Students in General Internal Medicine now have a more extensive and focused orientation at the beginning of their rotation with increased counseling and supervision. Under the direction of Dr. Vladimir Contreras-Dominguez the program is currently revamping the content of the Problem Assisted Learning sessions (PAL); the Preceptor orientation pamphlet; matching and reviewing the curricula content proposed by the university with current formal teaching activities during CTU; exploring opportunities for ambulatory care for our students and reviewing the one year experience of the evaluation cards to assess the student and preceptors’ clinical interactions and supervision.

Our Department is pleased to be providing funds to support three members to the Faculty of Medicine’s Distinguished Teachers Program—Drs Amel Arnaout (Endocrinology & Metabolism); Justine Chan (General Internal Medicine) and Steven Nadler (Nephrology). This is the second year for these individuals and they continue to dedicate up to 140 hours per year to teaching. The Distinguished Teachers Program (DTP) remains under the leadership of Dr. Robert Bell, a member of the Department of Medicine. This innovative program is designed to select and recognize excellent teachers within the faculty, to provide them with extensive development
and teaching opportunities as well as invite them to become part of a community of dedicated teachers. 39% (12/31) of all people who are or have passed through the program are from this Department of Medicine which again demonstrates the support we give to education.

The Department of Medicine continues a strong tradition in medical education scholarship under the direction of Dr. Susan Humphrey Murto. Medical Education Research awards were given to nine physicians this year; Drs Nancy Dudek, Debra Pugh, Susan Humphrey-Murto, Carol Gonsalves, Isabelle Desjardins, Heather Lochnan, Samantha Halman, Anne McCarthy, and Anna Byszewski. Dr. Pugh completed a one-year sabbatical, which included six months working at the Centre for Health Education Scholarship (CHES) at the University of British Columbia in 2015. I am proud to highlight that during that time, she published nine papers and received four grants including grants from the Medical Council of Canada and the Royal College of Physicians and Surgeons of Canada. Department of Medicine members continue to be actively involved in The Health Education Scholars program (HESP) at the Faculty where 24 people have completed the program (17 faculty, 7 learners) and we currently have five Department members enrolled (1 Faculty, 1 PGY4, 3 Fellows/Clinical Scholars).

Education faces challenges with the ongoing economic changes and hospital pressures that influence our physicians and training programs. Lack of time coupled with the volume and complexity of work is impacting our clinician teachers. Meeting these challenges calls for new priorities in education, including a much stronger emphasis on the role and contribution of the clinician teacher. Whilst continuing to be innovative and imaginative in our delivery of medical education we must also be practical and pragmatic in trying to balance service delivery pressures with academics. In the past year, I am proud that the Department has focused on the importance of the clinician teacher. The team led by Dr. Rakesh Patel identified the concerns of the clinician teachers and has been a strong voice for their needs. The Department recognised the importance of these challenges by focusing a Department retreat on the Clinician teacher which brought forward possible solutions for some of these concerns. This will continue to be a focus for our department in the coming year.

The funding model for education will evolve over the next few years as TOHAMO changes its metrics to acknowledge academic activities. In the education portfolio there will be increased funding support for undergraduate teaching; medical trainee days, ITER completion rates and the delivery of CPD activities. This change in the funding framework will highlight the strong and continued contributions of this Department to the Faculty of Medicine and how, despite the clinical challenges, our department continues to be a leader in medical education locally and nationally.
Recognition of Outstanding Faculty

Members of the Department of Medicine are recognized both locally and nationally for their excellence in medical education. Awards & recognition given to Department of Medicine staff in 2015/16 include:

- The *Meridith Marks Educator Award for Innovation and Scholarship in Medical Education* recognizes excellence and commitment to scholarship in this domain. This past year it was awarded to **Dr. Claire Touchie**. Claire is a leader and mentor in Department of Medicine. Her role at the Medical Council of Canada has led to the implementation of the new blueprint for the qualifying examinations and will lead to changes in the delivery of undergraduate and postgraduate education across Canada.

- **Dr. Vladimir Contreras–Dominguez** received the 2016 CAME/ACÉM Certificate of Merit Award. The aim of this award is to promote medical education in Canadian medical schools and to recognize and reward faculty’s commitment to medical education.

- **Dr. Justine Chan** received the *Department of Medicine Resident Choice Teaching Award*.

- **Dr. Barbara Power** received the *Faculty of Medicine UGME Educator Award for Collaborator Competency, Anglophone Stream*. This is awarded to a faculty member who demonstrated a high level of collaboration with peers, students and/or administrative team members.

- **Dr. Steve Glassman** received the 2015 PAIRO Excellence in Clinical Teaching.

- **Dr. Danny Lelli** received the 2016 PAIRO Excellence in Clinical Teaching.

- **Dr. Alaa Rostom** received the Education Excellence Award from the Canadian Association of Gastroenterology.

Key publications in education over the past year include:


**Leadership Roles in Education**

Members of the Department of Medicine continue to be leaders in education at the Faculty of Medicine and nationally.

**Undergraduate Medical Education**

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<th>Name</th>
<th>Title</th>
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<tbody>
<tr>
<td>Dr. Melissa Forgie</td>
<td>Vice Dean Undergraduate Medical Education</td>
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<td>Dr. Heather Lochnan</td>
<td>Associate Dean, CPD</td>
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<td>Dr. Robert Bell</td>
<td>Director of Curricular Delivery</td>
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<td>Dr. Heather MacLean</td>
<td>Pre-clerkship Director, Anglophone Stream</td>
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<tr>
<td>Dr. Michael Schlossmacher</td>
<td>Director, MD/PhD Program</td>
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<td>Dr. Barbara Power</td>
<td>Director of Clinical Skills, Anglophone Stream</td>
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<td>Dr. Robert Bell</td>
<td>Director, Distinguished Teacher Program</td>
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<td>Dr. Anna Byszewski</td>
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<td>Dr. Anne McCarthy</td>
<td>Leader, Global Health</td>
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<td>Drs Jean-Francois Marquis and Robert Bell</td>
<td>Unit Leaders, UGME</td>
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<td>Unit Leader, UGME</td>
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<td>Dr. Nadine Gauthier, Dr. Genevieve Lemay, Dr. Bob Bell, Dr. Arleigh McCurdy, Dr. Heather McLean, Dr. Nav Salooje, Dr. Heather Lochnan</td>
<td>Content experts</td>
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Nationally

Dr. Claire Touchie  
Medical Education Advisor for the Medical Council of Canada

Dr. Debra Pugh  
Vice-Chair of the Central Examination Committee at the Medical Council of Canada

Dr. Catherine DeMeulemeester  
Chair of the Royal College Examination Committee in Neurology

Dr. Jolanta Karpinski  
Associate Director of the Specialties Unit at the Royal College of Physicians and Surgeons of Canada

The upcoming year will bring new and exciting challenges with the start of implementation of CBME, the changes to the academic half day sessions, the review of the undergraduate curriculum, the expansion of resident research and the increasing numbers in the fellowship programs. The education leadership team will continue to review the needs of the clinician teacher and ensure these issues are kept at the forefront of discussion for the hospital and Faculty.

I would like to take this time to acknowledge and show appreciation for the commitment, and hard work I receive from the Department of Medicine Education Executive Committee and the Department of Medicine administrative team. It is through their ongoing support and enthusiasm that the Department has continued to flourish.

I would also like to say a special thanks to the following people: At the end of 2016, Dr. Chris Johnson will be completing his tenure as Associate Program Director for Internal Medicine. We thank him for his many years of dedication and commitment to the trainees and to the program. Dr. Heather Lochnan, who kept us believing in the importance of Medical Grand Rounds and who expanded the CPD program for the Department, and Dr. Stephanie Hoar for her role as Postgraduate Director where she expanded the resources for the subspecialty programs and harmonized the teaching of CanMeds.

Barbara Power
MD, FRCPC  
Vice Chair, Medical Education
10 minutes with Barbara Power and you quickly realize her inside is exactly like her outside—the same graceful, attractive, full of light, compassionate soul one would expect of a woman who has devoted her life to practicing Geriatric Medicine. However, nothing about Dr. Power’s polished exterior would have you believe that her morning routine includes tuning into the rap station on satellite radio. Her favourite rap lyric is by Drake:

*Started from the bottom now we’re here / Started from the bottom now my whole team … here / Started from the bottom now we’re here*

She doesn’t like the derogatory words in that song, or in any rap song for that matter, but those first few lines of the chorus really resonate because of how they define her own life. Growing up, Barbara weathered the death of her mother at age 9 and endured the absence of her father, a fisherman, who spent weeks at a time at sea. As second youngest of seven, living on a farm in a port town in eastern Prince Edward Island, she was raised by her siblings.

And in this harsh rural environment, life was, at times, extremely tough.

Looking back on that period however, she never had a Gatsby-like desire to transcend her origins. She didn’t know any different. In her community, parents were either fishermen or farmers, everyone had similar challenges, no one ever felt that they were less than anyone else, as everyone struggled. Her father taught her that as a female, whatever she should do with her life was equally as important as her brothers. And that as a woman, her voice was likewise as significant. She learned from a very young age that there were no boundaries with what she could do, and as a result, she felt a great sense of freedom.

Barbara is now a Geriatrician. She is married, to another physician, Joel, a Cardiologist, and they have three children between the ages of 16 and 25. She is busy, and as organized as you can be when you have a demanding practice and so does your husband. Over the years they have figured out a way to make it work, and for each of them to become successful in their chosen fields. This success is apparent
in Barbara’s sprawling CV: Clinician of the Year Award from The Ottawa Hospital; multiple teaching awards from the Faculty of Medicine; Department of Medicine’s Going the Extra Mile Award, the list goes on and on. She’s held key leadership roles such as Director, Clinical Skills; Chair of the Royal college exams and Division Head of Geriatric Medicine. Now she is the Vice Chair of Medical Education, overseeing a substantial portfolio for the entire Department.

Today Barbara is also a woman comfortable in her skin and very content with her lot. While she likes nice, pretty things, she’ll never be defined by them. She appreciates art, beauty and creativity in all its forms from architecture to furniture, to clothes and music and the environment. While her past feels intensely private, her initial reluctance to share her family’s story didn’t survive much past the first few minutes, she’s a lover of storytelling after all. Hers is a beautiful tale of someone who has overcome considerable early obstacles by virtue of her own drive. Her 6-word memoire—’no matter the pace, keep forward’ is a testament to her positive attitude and genuine optimism. Despite the pain that was conjured up while formulating the answers to many of her interview questions she answered them all obligingly. Many times her voice modulated to a whisper, occasionally it amped up to the altitude of a leprechaun on crack. Below, Dr. Power talks about her affection for the sea, the value of team work, and why her most significant accomplishment to date—is simply surviving and moving forward!

**On the importance of team work:**

My mother died just after I turned nine. I was still a little girl so I never got to know her. I was someone who grew up with little parental guidance so it’s kind of like being raised by wolves, and when you’re the second youngest they sort of forget about you. You learn survival skills and to get along when you don’t have parents around because you’re essentially orphans. You learned to look out for each other and protect each other. You learned to do “chores” and do your role as part of the family team. It was this early introduction to teams that cultivated one of my life long skills. We cooked our food on a wood stove, and yes, the kettle was always on top. We ate mainly fish, potatoes and root vegetables. It’s all we knew. We had food, ya we didn’t have a lot but I was happy—it was all good. I don’t really remember sad times because we had each other and the bond between my siblings was strong. It still is today.

I was born kinda smart. But I’m also a very hard worker. When you grow up in a rural area with lots of siblings, you learn quickly to work hard. You have no choice. But you don’t work hard with the goal of getting something or somewhere better—it’s about survival. When I was 16, my life changed. One of my older sisters who was living in BC at the time, mailed me a clip from MacLeans magazine about Lester B. Pearson College and told me to apply. So I filled out the application forms and wrote essays about international and global issues. My only awareness of those issues was from the CBC and we had a subscription
to National Geographic. Then I had to go to Charlottetown for an interview. It was about an hour and ten-minute drive so I hitchhiked. I used to hitchhike everywhere in PEI because nobody ever drove you anywhere. I had my dress in a backpack, got changed in the bathroom, went in for the interview, and won the scholarship to attend the school—fortunately, it included airfare. I left PEI after Grade 11 so I didn’t graduate from high school. I got on a plane in Charlottetown, said goodbye to one island only to land on another - Vancouver Island. I stayed in a residence and I never got back home again for a whole year. We just didn’t have money to fly me back home for the holidays.

Lots of times I was very lonely there…and sad. It was the first time that I became aware about poverty. It was the first time that I got exposed to the differences in wealth because when you grow up in a small town and in a rural area, everybody’s kinda poor. When I was on PEI, I felt that I could do anything in my life, go anywhere, be anything. It was my first exposure to differences based on wealth, and that wealth was linked to opportunities. I came to recognize that sometimes people had skills, not because they had natural talent but because they had the opportunity to develop that skill. It was the first time that I became aware of differences based on wealth and the first time I got exposed to a kind of discrimination. I never knew that from my world. It was the most maturing part of my life—those two years. It framed me more than any other part of my growth as a person. I had to grow up on my own, away from any kind of connection to my roots, and to weave my own way through the experience and figure out my values while also being a teenager. The experience gave me a great sense of gratitude for the struggles I had had and I was grateful for my upbringing.

**On her love of the sea:**

I miss the ocean, and I miss the salt air and the wind. And the winter storms, because when the storms would come in we’d have to go down and help Dad tie up the boats. It was hard but it was beautiful. The power and energy of the storm is a beautiful thing; you can’t control it. Growing up, weather had big implications on your work, your income and your safety at sea. I learned about the partnership with nature and the sea from my father. In the boat he was a professional. He didn’t talk much. The language he knew best was the sea and the fish. They were his brothers. After my first year at University, I worked in the Beaufort Sea in the Arctic, on an oil drilling ship. I worked in the galley for four and a half months. I knew a guy who said they were looking for people to go up North. So I applied on a lark and got the job. I was one of four women on the boat. I worked six weeks on, two off, 12 hour shifts, seven days a week. Looking back, I can say I loved every minute of it. I learned a lot about the life on a rig, the hardness of it, the challenges of being at sea, the challenges some of the men face with addictions, and again, the influence of climate.

Early on I wanted to be a marine biologist because I wanted to understand more about marine life, seaweeds and different types of plankton. That’s actually why I went into science. But then I found out that to be a marine biologist you should be able to dive
and because I have asthma I can’t dive. So that was a limiting factor. I’m someone who’s kind of fallen into things, I didn’t necessarily have a path but instead jump when I see there are new things to do. When I couldn’t become a marine biologist I thought I’ll become an engineer and I did engineering physics, maths and chemistry. But the people in my organic lab were all applying to medicine. At the time I also had a brother in med school. So I thought, I’ll write the MCATs. I didn’t even really know what an MCAT was. I’d never seen a practice question, looked at any booklets, or taken any of the courses. But I went and I did well. So then I thought maybe I’ll apply to med school. I didn’t actually know what I was getting into. I got in after two years of university. Looking back it was the best thing that could have ever happened and in so many ways I was prepared for it as a career. When I was little I wanted to be a doctor because my mother was ill. She was in the hospital and then she was on home oxygen. So I had exposure at a very young age to chronic illness and to death. I also liked hospitals because everything was really organized and smelled really clean. There was something comforting about that when you come from a home of chaos. Also when I was in high school, before it was required, I used to volunteer at an old age home. Maybe that’s when I first discovered my love for Geriatrics.

I was always a reader. I love a good story. As kids, before we went to sleep at night, one of my older brothers and an older sister used to make up stories. It became part of our upbringing. One of the reasons I was attracted to Geriatric Medicine was because I realized I liked elderly persons’ stories. Many of them have been through lots of pain, suffering and losses. And in geriatrics, people don’t just suffer physical losses but they have emotional losses, losses of spouses and children and siblings, and they may have financial losses because they’re no longer living in their home. I have always been fascinated on their survival skills and what makes some keep going despite the adversities they have faced. I am always looking to find out the secret to survival. I am not interested in the individuals who have had good luck whether it is because of financial security or good health. I mean why do some suffer multiple losses and keep smiling? To me this is a great badge of honour. I admire people who can actually keep trucking, adapt to change and bounce back from adversity. They don’t let the losses scar how they look at life. I find these people interesting. Hopefully I can be that way.

”One of the reasons I was attracted to Geriatric Medicine was because I realized I liked elderly persons’ stories.”

I’m of Irish and Scottish heritage. I went to a convent for the first three years of school and continued to be taught by nuns through the rest of my education including high school. Through this type of upbringing you learn to be reflective. Confession is a form of reflection on your behaviour—although sin has a negative connotation it can also be about what you did wrong and how can you do better. I still practice that approach today —how can I be better as a person?
It’s also about believing that there’s something greater than yourself. To me it is comforting to know I am still connected with my deceased parents and my sister.

**On her contributions to medical education:**

I always enjoyed teaching as I’ve always enjoyed learning so it was just a natural evolution for me that I was asked to become engaged and involved in formal teaching. As someone who likes to be involved, I went from being a teacher to participating on committees and then it just grew from there. I joined committees because I wanted to help. I've always valued the importance of taking a good history from a patient, the narrative of a patient’s story and the importance of the physical examination of the patient. It is this connection with the patient that establishes trust and allows you to unravel the mysteries of their illnesses. So because of that I gravitated towards being involved in clinical skills in the undergraduate medical education program. And I eventually became the Director of Clinical Skills at the University of Ottawa and Chair of the national clinical skills group. And within that role I brought changes to the curriculum. And I’m proud of those changes—it blended well with my own values. I was able to do something that was really important to me as a physician and bring that to both the medical students and to the medical school. I hope my passion has influenced learners. I hope I have been a role model to students about the importance and the value of taking time to listen to the patient.

In my role as Vice Chair I feel very privileged to provide leadership to the medical education community in our department. I’m very excited that this year the fall retreat for our Department was focused on the role of the clinician teacher. I’m really proud to be part of that process. It is the clinician teacher who, at the bedside, is influencing patient care and who helps make The Ottawa Hospital function. They’re also the ones who influence the learners because they’re one-on-one on the ward doing the teaching with medical students, residents, with patients and their families. It’s really hard to quantify what they do. When you are on the ward you see their energy and you also feel their connection with the teams. But you also sense their stress. So I think for me as Vice Chair, since I’m a clinician teacher as well—it’s bringing a greater focus to this role that is so important. It is bringing recognition and value to a group that has felt marginalized in some ways. This is not to say that the role of the researcher is less important or less valued but it is to elevate the role of the clinician teacher to be equally recognized and valued throughout the faculty as well as the hospital. I’m proud to be a part of the clinician teacher role.

“I hope I have been a role model to students about the importance and the value of taking time to listen to the patient. I had to grow up on my own, away from any kind of connection to my roots, and to weave my own way through the experience and figure out my values while also being a teenager.”
of this process and I hope to see change and to see our Department take the lead. I also hope that we can increase the number of people in the Department who are involved in medical education research. I would like to see a Research Chair in Medical Education to bring it to the same level as other aspects of research. Having a Chair position would help this.

**On being resilient and surviving:**

I’m married to a full time, hardworking physician and I’ve also been a hardworking, full time physician. And we did this without any parents or local family support. We did it on our own. I’m not sure many others can say that. And we made it work. It required communication, respecting each other’s needs and appreciating the importance of what the other person is doing and valuing that. And we had to try and balance activities everyday between personal goals, your spouse’s goals and your kid’s goals. That requires reflection every day. And I think the fact that we’ve been able to do it shows our survival skills and our resiliency as people. Joel, my husband, was someone who respected what I was doing as his partner and he never prevented me or said I don’t want you to do something, he always encouraged and supported me. As a working woman, who’s also a mother, and a spouse you try to do everything extremely well and that means being the best physician, the best teacher, the best Mom, the best house cleaner, okay maybe not the best spouse but…that everything had to be done well. At some point along the way you have to recognize that good is good enough in some areas and that perfection is the enemy of good. You can be great in some things but you have to choose those things. I also learned to lean on my family and my friends for support. I’m inspired by them and I would be nothing without them.

I’ve never known a life where I didn’t work. I grew up working. I had my first full time job when I finished Grade 9. I was exempted from my final exams so I started working in June. I worked at a lobster factory. Even though I was 14 and underage, I worked 10–12 hours a day. I shared a room with my younger sister. That summer she wouldn’t sleep in the room because of the stink. But despite the hard work, I have had an amazing life—filled with so many opportunities. I have travelled all over the world. I have had a very blessed life. But I also have had many losses including the death of my sister 14 years ago. I still think of her every day. I miss her. But I know she is looking out for me.

I’m most proud of the fact that despite growing up in a house with nine people, in a small little house on a farm, with one bathroom, that I kept trucking, and that I allowed life to lead me in all kinds of directions, and that I always believed in seizing the moment. And that despite adversity and losses and challenges I never let it get me down. I’m most proud that I’ve learned to adapt and to be resilient and positive. I try to instill that positive energy in my relationships with other people. Having been through lots of struggles, I have a great sense of gratitude.
Choice Words:

Which living physician do you most admire? My husband. He has supported me through all the good and bad times and being married to a full time working wife and raising three kids cannot have been easy for him. He is also an amazing bedside clinician which to me is the heart and art of medicine. 

Which talent would you most like to have that you currently don't possess? I'd like to be a singer. I love music. 

What is your favourite activity outside of the hospital? I pretty much love to do anything. But mostly I like doing things with people I love—friends and family. I like anything related to design that has a creative element to it. I love looking through design and architectural magazines, I love my garden, constantly reshaping and relocating and redesigning the plants and the colours, just like I do with my clothes I guess. Even the design of food put on a plate, I find that really interesting. I love exercise, swimming, biking and skiing and of course I love music. I listen to music all the time. I love all types of music and the type varies depending on my mood. It’s probably the thing I know the most about. That’s why I actually like some rap because I think rap is a form of poetry. I don’t like the swearing and negativity towards women, but good rap tells a story. It is reflective of our cultural times. But if I am alone I may listen to everything from current music, to Jazz, to coffee house music, to the blues…. I love finding out about new artists and watching where their careers take them. So I love YouTube. 

What is your idea of misery? Mental health issues. The pain and suffering that comes with mental health issues and addiction. I’ve seen it first-hand both as a physician and in my personal world. 

What childhood fear do you still have as an adult? Drowning. I’m very comfortable in the water but when you see the ocean everyday outside your window…. I knew people who drowned. 

Which historical figure do you most admire? Eunice Kennedy Shriver. The mother of Maria Shiver (married to Arnold Schwarzenegger). Eunice was the sister of John F. and Robert Kennedy and was married Seargent Shriver. I think Eunice was so amazing because she had a very affluent privileged upbringing yet she went to University and got a science degree as a woman in the 1940s. Despite her privilege she worked in a woman’s shelter and is the founder of the Special Olympics. She had this incredible compassion and empathy to work with individuals who were less fortunate than her. She believed that we all have a role to give back. And she turned it into something so meaningful that it affected the world internationally. She also got a degree in an age when women didn’t get science degrees and used it to better the world. When her husband developed Alzheimer’s disease, she spoke out about it. She brought the disease out in the open. She once said that she had no time ever to take vacation, that it was very self-centered because there was so much to be done in the world. She is one of my heroes, as is her daughter Maria who continues to champion and be a voice for the importance of Alzheimer’s disease. 

What is your principal fault? I talk too much [laughs]…. some would say that. 

What do you dislike most about your appearance? My abs. 

What is your greatest extravagance? Things…probably clothes, shoes and bags but don’t put that in, it will make me look so superficial. Clothes and shoes, don’t put the purses…. maybe just put shoes….and stuff. Okay… pretty things. 

What is your current state of mind? Optimistic. I truly treasure every day that I’m alive. That’s not phony I truly do. I start everyday being thankful that I’m alive, probably because I’ve been surrounded by a lot of loss.
If your home were on fire, what prized keepsake would you grab on your way out? A keepsake my mother gave me when I was a little girl. It would be the only thing that would be really important to me. What do you most value in your friends? Love, honesty, compassion and lack of judgement. Name one thing you never leave the house without, and why? A good feeling or a smile. I could also say lipstick but…that wouldn’t be entirely true, I go for a walk and not have lipstick with me. Would you describe yourself as a “foodie”? Do you prefer to go out to eat, or cooking at home? I’ve been a vegetarian for 30 years. I love the art of what you can do with vegetables. I prefer to cook at home because you can do veggie dishes better at home than in restaurants. If you could have dinner with anyone (dead or alive) who would it be? And where would you take them? My sister Carol who died, I would make her a meal at home. I’d make strawberry rhubarb pie—her fave—for dessert. Name a book (fiction or non-fiction) that has made a lasting impression on you, and why. I love to read, always have and just like I love design I love the way people put words together to form new ideas. I’m always fascinated that you can take the same words that you and I speak and put them into a sentence and create a different image. My favourite book is ‘The Heart is a Lonely Hunter’ by Carson McCullers. I love that book because it was written by a girl who was only 23 at the time of publication and it profiles the power of listening and the spiritual connection between people. What movie would you want to be transported into? Gladiator maybe, or Braveheart. I probably know many lines off by heart…’every man dies but not every man really lives’…when she tries to put the morphine in his mouth to ease the pain. I am not a huge fan of Mel Gibson, but I was a huge fan of that movie. Which actor would portray you in a movie about your life? Oh my gaaad! Who would I choose? Julianne Moore. She can be funny, serious, take daring roles like “Far from Heaven” and of course she played the patient with Alzheimer’s in “Still Alice”. Also, don’t you love her hair?!!! What 1990’s fashion trend do you miss the most? I’m not a trend person, never was a trend person when it came to clothes. I always just did my own thing, so even though there were trends in the 1990s I might still wear those same clothes today. Flared pants were part of the 90’s and I still wear them now. Do you see this outfit I have on [pretty pink ensemble]? I’ve had this outfit for 30 years. I do miss palazzo pants—I thought they were kinda cool with the big wide leg. If you were to die and could choose what to come back as, what would it be? I’d come back as me but surrounded by all the people I love and lost.
Dr. Barbara Power’s

**Strawberry Rhubarb Pie**

**What to add:**

**CRUST**
- 2 cups flour
- 1 tsp salt
- 2 tsp sugar
- 1 cup butter, cubed
- ½ cup sour cream

**FILLING**
- 3½ cups rhubarb
- 2 cups strawberries
- ¾–1 cup sugar
- 4 tbsp quick-cooking tapioca
- ¼ tsp salt
- 1 tsp orange zest

**What to do:**

1. In a large bowl, whisk together the flour, salt and sugar.
2. Add the butter. Use your hands to squish the flour and butter together until it resembles a course meal with some pea-sized bits of butter.
3. Incorporate the sour cream with a fork.
4. Form the mixture into a large ball of dough and cut into two even pieces. Form each piece into a disk, wrap with plastic wrap and refrigerate for 30 minutes.
5. Preheat oven to 400°F.
6. Cut rhubarb into ½-inch pieces, trimming away the ends and the poisonous leaves. Stem and slice the strawberries. In a large bowl, combine the rhubarb and strawberries with the sugar, salt, tapioca and orange zest. Let sit for 10 minutes.
7. Roll out one disk of the dough to line a pie dish, trimming the dough about ½ an inch from the edge of the pie dish. Add the filling to the pastry-lined dish.
8. Roll out the second disk of dough and place over the pie, trimming the edges to about 1 inch from the edge of the dish.
9. Tuck the top crust edges over the bottom crust edges and use a fork to crimp the edges together. Cut slits in the pie top to allow steam to escape.
10. Optional: For a nice glaze on your pie, brush a thin layer of egg white or cream over the top of the pie.
11. Place in the middle rack of the preheated oven with a baking sheet on the bottom rack to catch any juices. Bake for 20 minutes at 400°F, reduce heat to 350°F, and bake for a further 40–50 minutes. The pie is done when nicely browned and the mixture is thick and bubbly.
Medical Research
The Department of Medicine (DOM) remains a national and international leader in medical research. As in previous years, our members have contributed to the advancement of medical research with high-impact publications that will define or change clinical practice. Novel ideas and hypotheses are being evaluated and tested using funds received from external grant competitions. The continued success of DOM members in obtaining peer-reviewed funding is remarkable given the increasing competition for these scarce dollars.

The DOM is proud to support its members in achieving excellence in health research. In the past year over $4.7 million was given to DOM members in the form of research salary awards, operating grants, and fellowship grants. A critical component of this funding was the $4.36 million given in the form of direct salary support which provided much needed protected time for our researchers to remain international leaders. In the sections below I have highlighted some of the major research successes over the past year.

Greg Knoll
MD, MSc
Professor of Medicine (Nephrology)
Vice-Chair Research, Department of Medicine
**Resident Research**

Over the past year a number of important changes have taken place to enhance the research experience of our trainees. Dr. Curtis Cooper was appointed Director of Resident Research to oversee all aspects of resident research throughout the DOM including the development of a novel comprehensive trainee research program. The Annual Resident Research day was expanded to include trainee presentations in both basic and clinical science. Dr. Robin Parks, a DOM basic scientist, worked closely with Dr. Cooper on all aspects of the Resident Research Day and was instrumental in the successful integration of basic lab presentations. Drs Phil Wells, John Bell and Jonathan Angel were the keynote speakers and provided outstanding talks at the Research Day. A record number of abstracts (>80) were submitted by the residents and trainees this year. The oral and poster presentations were quite impressive highlighting the work and preparation by all of our trainees. I would like to thank all of the residents and trainees who contributed to this outstanding forum by submitting and presenting their work and to the supervisors who have invested their time to ensure a valuable research experience for the trainees. The award winners from this year’s Resident Research Day are listed below.

**Oral Presentation Winners**

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<thead>
<tr>
<th>Category</th>
<th>Award Winner</th>
<th>Supervisor</th>
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<tbody>
<tr>
<td>Basic Science</td>
<td>Katelyn Landon</td>
<td>Dr. Christina Addison</td>
</tr>
<tr>
<td>Clinical Science</td>
<td>Dr. Pietro DiSanto</td>
<td>Dr. Benjamin Hibbert</td>
</tr>
<tr>
<td>Clinical Science</td>
<td>Dr. Vignan Yogendrakumar</td>
<td>Dr. Dar Dowlatshahi</td>
</tr>
<tr>
<td>Epidemiology</td>
<td>Dr. Januvi Jegatheswaran</td>
<td>Dr. Cedric Edwards</td>
</tr>
<tr>
<td>Quality and Safety</td>
<td>Dr. Karine Gauthier</td>
<td>Dr. Marc Rodger</td>
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</table>
Poster Presentation Winners

<table>
<thead>
<tr>
<th>Basic Science</th>
<th>Bratati Saha (supervised by Dr. Robin Parks)</th>
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<tbody>
<tr>
<td>Clinical Science</td>
<td>Anisha Lynch-Godrei (supervised by Dr. Rashmi Kothary)</td>
</tr>
<tr>
<td>Clinical Science</td>
<td>Dr. Genevieve Casey (supervised by Dr. Carl Van Walraven)</td>
</tr>
<tr>
<td>Clinical Science</td>
<td>Dr. Irena Druce (supervised by Drs Hussein Abujrad and T.C. Ooi)</td>
</tr>
<tr>
<td>Clinical Science</td>
<td>Dr. Wayne Huang (supervised by Dr. Rob Beanlands)</td>
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In addition to the presentations at Resident Research Day, several core internal medicine residents had their work published in peer-reviewed journals. Highlighted below are the papers in which a DOM resident was the first author.


**Honours & Awards**

**Dr. Marc Carrier** received the OHRI Chrétien Researcher of the Year Award for his trial that was published in The New England Journal of Medicine on screening for occult cancer in patients with venous thromboembolism. This work was also selected as one of the “Notable Articles of 2015” by the New England Editors—a remarkable achievement given the number of highly influential studies published in this prestigious journal each year.

**Dr Jeremy Grimshaw** made the list of the world’s top 3,000 researchers. This puts him in the top 0.03% of all researchers worldwide. The list of “The World’s Most Influential Scientific Minds” is compiled each year by Thompson Reuters. The rankings are based on the number of times the researcher’s work has been cited.

**Drs Robin Parks** and **Jodi Warman**, Co-Directors of the University of Ottawa Centre for Neuromuscular Disease, received the Dr. George Karpati Award from Muscular Dystrophy Canada in recognition of exemplary contributions to neuromuscular research, and the advancement of care of people with neuromuscular disorders.

**Notable Publications**

Once again DOM researchers published an amazing number of high-impact publications this past year. A selection of the outstanding papers from 2015–16 is presented below.

**Drs Harry Atkins** and **Mark Freedman** have published a landmark paper in The Lancet showing that immunoablation followed by stem-cell transplantation can facilitate lasting recovery in patients with aggressive multiple sclerosis. Other DOM co-authors include **Drs David Allan**, **Isabelle Bence-Bruckler**, **Christopher Bredeson**, **Lothar Huebsch**, **Mitchell Sabloff** (all from Hematology) and **Dr. Dean Fergusson** (CEP).

Dr Ruth McPherson (Cardiology) was the senior/corresponding author on a paper published in *Nature Genetics*. In this study they showed that genetic susceptibility to coronary artery disease is largely determined by common single-nucleotide polymorphism of small effect size.


**Dr. Michael Rudnicki** (Neurology) and his team published a paper in *Nature Medicine* that has changed our understanding of Duchenne muscular dystrophy. It was previously thought that weakness with this condition was primarily due to a problem in the muscle fibre; this new study showed that the weakness was also due to an intrinsic defect in the function of the muscle stem cells.


**Dr. Glen Goss** (Oncology) was the senior author on the world’s largest clinical trial comparing two targeted therapies for advanced squamous cell carcinoma of the lung. The study, published in *Lancet Oncology*, found that a newer therapy called afatinib decreased the risk of cancer progression and the risk of death by 19% compared to an older therapy called erlotinib.


**Dr. John Bell** (Oncology) published a paper in *Cancer Cell* showing that VEGF induces the production of PRD1-BF1 which in turn suppresses anti-viral defenses tumor vascular endothelial cells. This finding helps explain the unique susceptibility of malignant tumors to certain viruses. Other DOM co-authors include Dr. Harry Atkins (Hematology) and Dr. Christina Addison (Oncology).


**Dr. David Birnie** (Cardiology) published a paper in the *Journal of the American College of Cardiology* showing that clinically significant hematoma following cardiac implantable electronic device surgery was associated with a significantly increased risk of infection requiring hospitalization. The findings will spur investigators to develop strategies to reduce hematomas in an effort to improve patient outcomes.

Drs Greg Knoll (Nephrology) and Dean Fergusson (CEP) published a systematic review in the *British Medical Journal* on the safety and effectiveness of generic immunosuppressants in solid organ transplantation. Despite the potential for huge cost savings there was very little high-quality evidence supporting the use of generic immunosuppression for this indication.


Drs Greg Knoll (Nephrology) and Dean Fergusson (CEP) published an international randomized trial which found that, contrary to expectations, a commonly used antihypertensive called ramipril had no benefit for kidney transplant patients and was associated with potentially dangerous side-effects. The study was published in *The Lancet Diabetes & Endocrinology* and included DOM co-author Dr. George Wells.


Dr. Michael Rudnicki (Neurology) was the senior author on a study published in *Nature Neuroscience* showing that a protein called oncostatin M receptor is required for glioblastoma tumours to form. The study also showed that blocking the protein in brain tumour stem cells prevented them from forming tumours. Other DOM co-authors include Dr. Ian Lorimer (Oncology).


Dr. Dean Fergusson (CEP) published a study in *JAMA Internal Medicine* showing a novel association between the age and sex of blood donors and clinical outcomes in transfusion recipients. The study found that patients who received female donor red blood cells had an eight percent increased risk of death per unit transfused compared with recipients of male donor red blood cells. Other DOM co-authors include Drs Alan Tinmouth (Hematology), Shane English (Critical Care), Kumanan Wilson (General Internal Medicine), Greg Knoll (Nephrology), Carl van Walraven (General Internal Medicine), Lauralyn McIntyre (Critical Care), and Alan Forster (General Internal Medicine).

Dr. Alexandre Stewart (Cardiology) published a study in *Circulation* showing that a certain region of DNA plays a crucial role in regulating the proliferation of vascular smooth muscle cells. Other DOM co-authors include Dr. Hsiao-Huei Chen (Neurology).


Dr. Jeffrey Dilworth (Neurology) has published a paper in the *Journal of Clinical Investigation* showing that a protein called UTX plays an important role in muscle repair and regeneration. They found that UTX is used to erase the cellular memory of adult muscle stem cells allowing them to be reformatted as healthy new muscle fibers. Other DOM co-authors include Dr. Marjorie Brand (Hematology).


Dr. Lynn Megeney (Cardiology) published a paper in *Cell Discovery* that identified X-ray cross-complementing protein 1 as a key DNA repairing mechanism essential for muscle differentiation. Other DOM co-authors include Drs Robin Parks (ID), Michael Rudnicki (Neurology), and Jeffrey Dilworth (Neurology).


Dr. Marjorie Brand (Hematology) has reported that a compound called GSK-J4 can selectively kill TAL-1 positive acute lymphoblastic leukemia cells quickly, efficiently and with no short-term side effects. The study, published in *Genes and Development*, suggests that GSK-J4 may be a promising epigenetic therapy for TAL1-positive leukemia. Other DOM co-authors include Dr. Jeffrey Dilworth (Neurology).


Dr. Duncan Stewart (Cardiology) published promising results of the first clinical trial in the world of a genetically enhanced stem cell therapy for pulmonary arterial hypertension. The study, published in *Circulation Research*, showed that patients had improved blood flow in the lungs in the days following the therapy, as well as enhanced ability to exercise and better quality of life at six months. Other DOM co-authors included Dr. David Courtman (Cardiology).

Drs Hsiao-Huei Chen (Neurology) and Alexandre Stewart (Cardiology) reported on a novel genetic pathway that controls vascular inflammation, through proteins called IRF2BP2 and KLF2, expressed in specialized immune cells called macrophages. The study was published in *Circulation Research* and included other DOM co-author Dr. Ruth McPherson (Cardiology).


**Noteworthy Grants**

This past year DOM researchers were once again successful at obtaining highly competitive peer-reviewed grants. This included the first round of the CIHR Project Grant competition and the second round of the Foundation grants. A special mention goes out to Dr. Marc Rodger who was awarded two successful Project Grants. Principal Investigators from these two CIHR competitions are listed below this paragraph. Dr. Kevin Burns (Nephrology) was a Principal Investigator on one of the SPOR Networks in Chronic Disease grants. This grant (*Canadians Seeking Solutions and Innovations to Overcome Chronic Kidney Disease*) received $12,450,000 from CIHR and a similar amount from other partners including the Kidney Foundation of Canada. Dr. John Bell (Oncology) was the Program Leader of a successful team grant awarded by Prostate Cancer Canada. The group received $4,990,498 to develop a targeted oncolytic virus vaccine for the treatment of metastatic prostate cancer. Dr. Michael Rudnicki (Neurology) received $1,350,000 from the United States National Institutes of Health to continue his research into the biological mechanisms behind Duchenne Muscular Dystrophy. Dr. Guy Ungerechts (Oncology) was awarded $450,000 from the Terry Fox Research Institute to study the novel pairing of two oncolytic viruses.

**CIHR Foundation Grants**

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<thead>
<tr>
<th>Investigator</th>
<th>Project Title</th>
<th>Funding</th>
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<tr>
<td>Dr. Michael Rudnicki (Neurology)</td>
<td>Molecular regulation of muscle stem cell function in regenerative myogenesis</td>
<td>$4,865,298</td>
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<tr>
<td>Dr. John Bell (Oncology)</td>
<td>Investigating Virus-Host Interactions to Design Viral Anti-Cancer Therapeutics</td>
<td>$3,702,580</td>
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<td><strong>CIHR Project Grants</strong></td>
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<tr>
<td><strong>Dr. Michael Schlossmacher</strong> (Neurology)</td>
<td>Investigating Parkinson disease-linked genes in brain health following infections. $1,330,231</td>
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<tr>
<td><strong>Dr. David Park</strong> (Neurology)</td>
<td>Novel pathways underlying degeneration in Parkinson’s disease $955,625</td>
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<tr>
<td><strong>Dr. Lynn Megeney</strong> (Cardiology)</td>
<td>CT1, an inductive cue for beneficial remodelling of the heart $707,164</td>
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<tr>
<td><strong>Drs David Birnie, Rob Beanlands and Pablo Nery</strong> (all from Cardiology)</td>
<td>Cardiac Sarcoidosis Multi-Center Prospective Cohort $600,135</td>
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<tr>
<td><strong>Dr. Marc Rodger</strong> (Hematology)</td>
<td>Statins for Venous Event Reduction in patients with venous thromboembolism $424,298</td>
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<tr>
<td><strong>Dr. Peter Tugwell</strong> (Rheumatology)</td>
<td>When should systematic reviews be replicated, and when is it wasteful? $382,252</td>
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<tr>
<td><strong>Dr. Marc Rodger</strong> (Hematology)</td>
<td>Safely Ruling out Deep Vein Thrombosis in Pregnancy with the LEFT Clinical Decision Rule and and D-dimer: A Prospective Cohort Study $282,865</td>
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<tr>
<td><strong>Dr. Ruth McPherson</strong> (Cardiology)</td>
<td>TRIB1 in the regulation of hepatic lipid metabolism: From GWAS locus to function $263,753</td>
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<tr>
<td><strong>Drs Dean Fergusson</strong> (CEP) and <strong>Shaun Kilty</strong></td>
<td>Endoscopic Polypectomy performed In Clinic for chronic rhinosinusitis with polyps $240,818</td>
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<tr>
<td><strong>Dr. Mario Tiberi</strong> (Neurology)</td>
<td>Role of Post-Synaptic Density Proteins in the Integration of Dopamine and Glutamate $100,000</td>
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Internal Research Funding (2015–16)

The Department of Medicine ran two competitions for Internal Research Funding and granted awards to its Members in the following categories:

Developmental Grants

Dr. Ivan Litvinov (Dermatology) received a Developmental Research Grant in the amount of $35,000 entitled: “The use of transcriptional profiling to improve personalized diagnosis and management of Cutaneous T-cell Lymphoma (CTCL)”

Dr. Lisa Duffett (Hematology) received a Developmental Research Grant in the amount of $35,000 entitled: “Optimizing the Diagnosis of Heparin Induced Thrombocytopenia Using Quantified Anti-Platelet Factor 4 Immunological Testing: A Prospective Cohort Study”

Dr. Jodi Warman (Neurology) received a Developmental Research Grant in the amount of $35,000 entitled: “LGMDx-Seq: An Transformative Diagnostic Exome/RNA Sequencing Pipeline for Patients with Limb Girdle Muscular Dystrophies”

Dr. Sanjay Murthy (Gastroenterology) received a Developmental Research Grant in the amount of $35,000 entitled: “The Impact of a Physician Incentive Program on Continuity of Care and Health Outcomes in Inflammatory Bowel Disease and Cirrhotic Patients”
Research Chairs Currently Held by Department Members

Canada Research Chairs

Dr. Jeremy Grimshaw (Clinical Epidemiology)  Canada Research Chair, Health Knowledge Transfer and Uptake
Dr. Michael Rudnicki (Neurology)  Canada Research Chair, Molecular Genetics
Dr. Peter Tugwell (Rheumatology)  Canada Research Chair, Health Equity
Dr. Michael Schlossmacher (Neurology)  Canada Research Chair, Parkinson’s disease and Translational Neuroscience

University of Ottawa Clinical Research Chairs

Dr. David Birnie (Cardiology)  Tier 1 Clinical Research Chair in Cardiac Arrhythmia
Dr. Greg Knoll (Nephrology)  Tier 1 Clinical Research Chair in Clinical Transplantation Research
Dr. Grégoire Le Gal (Hematology)  Tier 1 Clinical Research Chair in Diagnosis of VTE
Dr. Marc Rodger (Hematology)  Tier 1 Clinical Research Chair in Venous Thrombosis and Thrombophilia
Dr. Shawn Aaron (Respirology)  Tier 1 Clinical Research Chair: Obstructive Lung Disease
Dr. Rob Beanlands (Cardiology)  Tier 1 Clinical Research Chair: Cardiovascular Imaging Research
Dr. Gonzalo Alvarez (Respirology)  Tier 2 Research Chair in Tuberculosis in Canadian Aboriginal Communities
Dr. Darryl Davis (Cardiology)  Tier 2 Research Chair in Cardiac Regeneration
Dr. Lisa Mielniczuk (Cardiology)  Tier 2 Research Chair in Heart Failure and Pulmonary Hypertension Research
Dr. Marc Carrier (Hematology)  Tier 2 Clinical Research Chair: Cancer and Venous Thromboembolism
University of Ottawa Junior Clinical Research Chairs

Dr. Girish Dwivedi (Cardiology)  Vascular Inflammation and Atherosclerosis Research
Dr. Jodi Warman Chardon (Neurology)  Novel Gene Discovery in Neuromuscular Disease

Endowed and Sponsored Chairs

Dr. Rob Beanlands (Cardiology)  Saul and Edna Goldfarb Chair in Cardiac Imaging Research and the Vered Chair of Cardiology
Dr. Marino Labinaz (Cardiology)  Chair Interventional Cardiology Leadership
Dr. Dean Fergusson (Clinical Epidemiology)  OHRI/uOttawa Clinical Epidemiology Program Endowed Chair
Dr. Frans Leenen (Cardiology)  Pfizer Research Chair in Hypertension
Dr. Ian Lorimer (Oncology)  J. Adrien and Eileen Leger Chair in Cancer Research
Dr. Ruth McPherson (Cardiology)  Merck Frosst Canada Chair in Atherosclerosis
Dr. Leo Renaud (Neurology)  J. David Grimes Research Chair
Dr. Michael Schlossmacher (Neurology)  Bhargava Research Chair for Neurodegenerative Diseases
Dr. Manish Sood (Nephrology)  Jindal Research Chair for the Prevention of Kidney Disease
Dr. Duncan Stewart (Cardiology)  Evelyn and Rowell Laishley Chair for the OHRI CEO and Scientific Director

Other Chairs

Dr. Curtis Cooper (Infectious Diseases)  Ontario HIV Treatment Network’s Applied HIV Research Chair
Dr. Rashmi Kothary (Neurology)  University of Ottawa Health Research Chair
Dr. Kumanan Wilson
(General Internal Medicine)  The Ottawa Hospital, Department of Medicine, Ottawa Hospital Research Institute Research Chair in Public Health Innovation
What You Should Know About

DR. GREG KNOLL

When he’s not overseeing the Division of Nephrology in his new role as Division Head, or caring for patients with kidney disease, or directing the Department of Medicine’s research portfolio, or working on his own successful research career, Dr. Greg Knoll is hanging out at rinks all over Ontario, Quebec and the Northeastern United States. He’s there to watch his 12-year-old daughter play hockey. He’s also the team trainer - and he loves it. Greg has always relished competitive team sports and says that being part of Heidi’s team benefits him as much as it does the girls. He knows it won’t last forever and that one day he will eventually need to get a life!

Greg himself played competitive football for ten years so he’s no stranger to the rigors of playing sports. To perform at a high level requires dedication and being regimented in your time. It also helps if you’re a naturally competitive person. Fortunately, Dr. Knoll has, and is, all of these things. And while his relationship with competition started at an early age, it has remained and served him well in his adult life, particularly in the highly competitive arena of medical research.

What makes Greg’s weighty success in this area so interesting—or peculiar—is that when he was finishing his residency, a staff Nephrologist said that he was the least likely to go into research of any resident he’d ever seen. It’s difficult to imagine that a physician like Dr. Knoll, who was granted one of the first ever Tier 1 Research Chair’s from the Faculty of Medicine, never had an epiphany that medical research was his calling. On the contrary, Greg attributes his academic career path, and in fact much of his academic life, not to passion or a burning desire, but rather to serendipity.

In his slightly gravelly voice, Dr. Greg Knoll pulls back the curtain to reveal how providence repeatedly played a role in guiding his life’s map and how fortunate he is to be happy.

On a blown-out knee and a curve in the road:

I was born in Toronto but grew up in Ottawa. I moved to New York City for a very short time because my Dad worked down there but I’ve basically been back here since I was five. I grew up in the
West End and stayed here to attend Carleton University, then Ottawa U for medical school. I interned in Halifax, did my residency back here and then because there were no jobs Ottawa, I worked for six months as a nephrologist in private practice in New Brunswick. From there I did a transplant fellowship in Alabama and was recruited back to Ottawa. For all those years I've only been out of Ottawa for two and a half of them. Originally when I left I had no idea if I was ever going to come back. My wife grew up here too, so it worked out, but I think we would have been fine wherever we were.

I'm the baby of six kids. My five siblings tell me that I was exceedingly spoiled…and my mother's favourite, so I have pretty good memories of growing up as a kid. I went to this nouveau school in Ottawa's west end. It was built in '69 and we were the first class through. It was one of those open concept schools—no walls, everyone could see each other, and I remember that the whole place was carpeted. In kindergarten we used to get our blankets and lie down on that carpet for a little nap. I think some days I'd still like to have that little nap. I like the Mexican Siesta thing because I'm very good in the morning and I'm very good in late day but I could easily have a nap from 1:00–2:00 p.m. [laughs]. In university I would just stop, put my alarm on, and have a sleep for half an hour and I'd be totally refreshed.

It's trailed off quite a bit lately but I can say I'm fairly handy. If something breaks I can fix it but I don't have time. I learned it all from my Dad. I didn't really like it as a kid because while everyone else was off playing I was helping my Dad mix concrete and stuff…and I was 12. In retrospect I learned a lot, in fact

my 19-year-old son said to me the other day, 'you know you never showed me how to use any tools or anything,' and I said 'I was trying to protect you from my tool upbringing.'

Growing up I was outgoing and had a lot of friends. I spent most of my time playing sports—anything and everything. Our house backed on to a park so I had an outdoor hockey rink right in my backyard. In grade six I used to take my golf clubs out there and belt balls around—you could get arrested for that nowadays. After school, kids would inevitably show up and we'd play football. I actually played football in a club league for ten years—for 'Myers Riders' in the NCFA—we were sponsored by Myers Motors, it still exists. Then I played five years of high school football until I blew out my knee and had to have surgery. In retrospect it might have been a blessing in disguise because I probably would have wanted to play University football. God knows I probably wouldn't have done that well in school; it takes a lot of time to play University sports and it might have changed my life in other ways. I'm not a guy that really believes in things happening for a reason but I do look back and wonder…'had I played university football maybe my marks would have been slightly lower—and then who knows?'

I started studying engineering and by Christmas that first year I realized I didn't like it. I remember going to the library at Carleton—they had the guidance section and every University had a book that you could flip through, this was obviously way before the internet—and I remember spending hours flipping through looking at different courses. I decided to apply to medicine and see what happens. It wasn't a burning desire, I had
recently had my knee surgery and been in the hospital, in fact it was kind of a vague desire to study medicine. In second year I ended up doing a hodgepodge of classes to get my prerequisite for med school and I applied and got in. If I hadn't, I really had no idea what I was going to do—I was really drifting in University. In retrospect I really have a lot of respect for engineers. I still think what they have to do in school compared to what we have to do in medical school is much harder. It's a different kind of thinking, but it's tough.

“Looking back, I'm very grateful for how things stumbled into place because I really ended up loving what I'm doing even though I didn't really have a specific drive to get there.”

I was very interested in surgery, I was actually very interested in orthopedic surgery and becoming a sports medicine physician. But because of my knee injury I found being in the operating room, standing for so long very hard. My knee ached and I was only 25 then. I thought 'there's no way I'm going to be able to do this all my life.' So I jumped ship to medicine.

When I went into medical school I didn't really know much about what I was getting into—again. And I loved it. Looking back, I'm very grateful for how things stumbled into place because I really ended up loving what I'm doing even though I didn't really have a specific drive to get there. Nephrology is almost a carbon copy; I got interested through another resident who invited me to an American Society of Nephrology meeting and promised we'd have a blast. It was kind of one of those things of serendipity and I've loved the choice ever since. Again, it wasn't any major burning desire to learn about kidneys or anything, I just stumbled into it through a friend. I couldn't imagine doing anything else now.

I got into research just like everything else…my life was very consistent. The group I was working with in New Brunswick wanted to start a kidney transplant program. They wanted me to get training so I ended up going to the University of Alabama at Birmingham which was at the time probably the biggest transplant program in the world. They did something like 300 kidney transplants a year; it was a massive program. I got accepting into their program and started my training, and then three or four months in I got a call from Dr. Steve Nadler who was the acting Chief at the time telling me they desperately needed another transplant physician in Ottawa and wanted to know if I wanted to come back. I remember coming up for some interviews with Dr. Peter Tugwell, Chief of Medicine. I remember at one point he tugged me on my tie and said 'well you'll have to do your Masters in Epidemiology in order to come back here,' and I was like hmmm…that was the last thing I wanted to do to be honest. But I accepted and after about three months I was like wow this is incredibly interesting and I really enjoyed it. Again I look back and I really have to thank Dr. Tugwell because I've loved this part of my work and I definitely would have never gotten into it because I just didn't want to go down that path, I really liked clinical medicine at the time and research wasn't really on my radar.
**On the nature of being competitive:**

I think sports and research are very similar because they’re both highly competitive. These days CIHR is only funding 10–15% of applications. I think for some people it crushes them. I’ve always lived in that setting so it doesn’t freak me out at all—I always grew up playing team sports and I’ve always been very competitive. I look around at my successful research colleagues, Phil Wells was into competitive sports, Marc Rodger was a competitive athlete—that can make it much easier to be in this environment.

Writing a grant’s tough, writing the paper’s also a bit of work but most researchers will say that looking at the data and the results—that’s the fun part. Especially in a trial that was blinded—regardless of the outcome. You always think you know what’s going to happen but it’s actually more exciting when the results aren’t as obvious because it’s kind of going against convention, and that’s always interesting.

I’ve been surprised by data. When Dean Ferguson and I opened up the results of our ACE inhibitor trial that looked at whether or not drugs have the same role they have in a subset of transplant patients with proteinuria there was no difference, that was shocking. In the non-transplant setting, in virtually any trial I can think of it showed these drugs worked. So our hypothesis was wrong and instead the results showed that the drugs really didn’t do anything - there was no benefit, yet the patients were being put at risk for side effects. In a way it was an important study because the drugs had started to be used a lot despite the evidence or lack of evidence. Our study unfortunately can’t really dig down too deep to explain why didn’t it work, it’s more of an observation that they’re not working and maybe we should be looking at something else.

With all things in medicine, multiple people will interpret our results multiple ways. I’m looking at them from a purely scientific point of view, other people might just say well the study was not definitive and we need to do another study before I’m going to stop using these drugs in my patients for example. There’s believers and non-believers in both things. It will be interesting to see in 5 years what people are doing because it takes time for results to trickle out there to change practice if they are going to.

“Writing a grant’s tough, writing the paper’s also a bit of work but most researchers will say that looking at the data and the results—that’s the fun part.”

I feel like it’s a major accomplishment but in research only time will tell if it was impactful, right now I think it’s too early to say. I’m still really happy about the achievement because back then, in 2004, I had to pull together 12 to 13 other kidney transplant programs across the country to work on this trial. No one had ever done this for an academic trial. And the trial struggled, it was tough to recruit patients, it wasn’t an easy trial to do and in the end we never got our total sample but the money was running out and we finally felt we
got enough. It was basically an eleven-year odyssey to get it done and in 2015 it was published in The Lancet Diabetes and Endocrinology.

“I think sports and research are very similar because they’re both highly competitive.”

I think I’ve been blessed with two great mentors—Kevin Burns and Dean Fergusson. They’ve guided me through lots of decisions and helped me numerous times. I certainly value their judgment and still seek their opinions. I haven’t used my mentors purely for research, some of it has been about other professional things. Good mentorship is really important so hopefully everyone can find a mentor that really works for them.

On leadership, professionalism and dressing the part:

My lab coat is always buttoned all the way to the top. I don’t like the feel if it isn’t done up, it doesn’t feel right [laughs]. I think some of this came from my year in the United States; it’s very prim and proper there. If you go to an academic health Centre in the United States any resident male wears a tie and a lab coat. The women are all well-dressed too, it’s very different than Canada. I don’t know if it’s conservatism or…there’s just a little more visual professional pride. In the United States you see a level of professionalism for the smallest job in and out of healthcare. I went down there as a no tie kinda guy and when I came back I wore a tie for about a year and then ditched it, I guess I became Canadian again.

Looking at it from the other side, if I stepped into a room to see my nephrologist and he was wearing jeans and a golf shirt, even if my dentist was dressed like that I would be like who’s this yahoo? Although it’s superficial in a way I do think it’s important. Jeans are for the weekend. I guess I feel better looking better too, I don’t know. I never really think of myself like that—a few of the nurses have said ‘your hair is never out of place’.

Being on the Department Executive Committee was a huge eye opener for me. I’m glad I put my name out for that position [referring to Vice Chair of Research]. I think I’ve learned a lot and continue to learn a lot. For important reasons I think we’re all very focused on the day to day facts that affect us the most in our own divisions. At the executive level it’s a much wider landscape; we’re looking across multiple divisions, at the university, the hospital and talking to other institutions and hospitals. That was a real eye opener because even though I’d been here my whole career I didn’t really know a lot of the stuff that was going on…especially some of the stuff in education. I think it was really important to get a view a little bit beyond my division and I think it will help me in my new role as Division Head, and to help me understand that other divisions have issues and the hospital has issues but at the end of the day we’re all working together. I think it will help around the Division Heads table having had that kind of view of the Department for two years. Even if people read about what’s going on it’s not the same as participating in it.
On making time for his kids:

I would never want to look back and say I regret not being at their games or recitals so I’ve always made time for that. For me it’s all about blocking the time, because that’s the way I operate. My wife keeps everything in her head and she does a pretty good job but I can’t do that, I’ve got to write in there ‘Heidi’s got a music class or whatever’. Everyone kind of pokes fun at me that my calendar is always full of non-work stuff but I think I’m just kind of over-organized because I can’t remember it all. Some people might think it’s a little overly structured but it’s the way my brain operates. I can’t live without my calendar. I manage my own calendar because it’s just too integral now, sometimes I don’t even remember what I’m doing in an hour. I use it as my organizer, truly, to decide if I can or can’t do something. There are very few gaps in it at the moment. In my new position there will likely be a few more no’s to requests.

I never pushed the kids into sports even though I loved it, if fact when my daughter told me she wanted to play hockey I was like ‘what do mean you want to play hockey’? So I got her used equipment from her cousin and said ‘okay you can go try it’…and she loved it. Again looking back, coaching my kids was never a chore because I always liked being around teams. Some people say ‘it’s so painful driving my kid all over town’, but I really like it. I like photography and I’ve got myself a new camera and stuff but I’m just getting into it, I’m just a very average photographer but I enjoy it and that’s something my middle daughter likes too so we’ll be doing that together.

My son once told my wife, “Dad gets up and goes to work and he’s happy, he likes to go to work, whereas all my other friend’s parents seem to be complaining about their jobs”. That’s what’s got him interested in medicine, the idea that you can still like your job after all these years. I think in a way people complain a lot about medicine and all the problems but I think in the end we have a pretty privileged life. We have a pretty good job and a chance to really make a change whether it’s through our research or teaching or directly looking after the patients. When you think about it for more than 5 or 10 minutes and get rid of the day to day stress I think we’re all pretty thankful. When I look back now I don’t think I could get a better job because as physicians we’re dealing with things that make a difference to people and their families. From a personal perspective it’s amazingly interesting and its exciting work. When I talk to my friends that are completely out of the field I sense they don’t get that kind of excitement day to day in their work.
Choice Words:

What technical advance do you most anticipate? 3D printing of fully functional, immunologically inert kidneys to give to all my patients. Which talent would you most like to have that you currently don’t possess? I’m terrible with names. I wish I could just remember everyone’s names after meeting them once! What would qualify as the afternoon of your dreams? Sitting in an outdoor café on a nice summer day reading the paper and drinking a fine cup of coffee. What is your idea of misery? Talking about myself. What childhood fear do you still have as an adult? Although severely diminished (or repressed) I have never really liked public speaking. I remember trembling in grade 3 or 4 when I had to give my first “speech” at school. Which living person do you most admire? My wife, of course. What is your principal fault? Being overly precise. What faults in others are you most and least tolerant of? Being vague and imprecise. What is your most marked characteristic? Thoroughness. What do you dislike most about your appearance? Having to stand on my tippy toes when my wife and I have our picture taken. Which words or phrases do you most overuse? Honey don’t get mad but…What is your greatest extravagance? Business Class. If you could change one thing about your family, what would it be? They no longer had functioning credit cards. If your home were on fire, what prized keepsake would you grab on your way out? Movies I made of the kids when they were young. Would you describe yourself as a “foodie”? Do you prefer to go out to eat, or cook at home? A bit of both. I really enjoy eating out but I’m also blessed to have two extraordinary chefs in my house—my wife Kelly and my son William—I love just about everything they make. If you could have dinner with anyone (dead or alive) who would it be? And where would you take them? Anthony Bourdain. His show is amazing and I would let him take me to some exotic eatery half-way around the globe. Name a book (fiction or non-fiction) that has made a lasting impression on you, and why. Outliers by Malcolm Gladwell. I’m fascinated by highly successful people and how individuals reach the pinnacle of their profession or come up with brilliant ideas. For fiction, A Fine Balance by Rohinton Mistry was a great read. India is such an intriguing place. What’s one thing that will always make you laugh? Satires, especially The Onion and The Daily Show (in the Jon Stewart era). What movie would you want to be transported into? The Bourne Identity, as Jason Bourne of course. Which actor would portray you in a movie about your life? Isn’t it obvious? What 1990’s fashion trend do you miss the most? Very loose, baggy jeans. What food do you detest the most? Chicken breast—doesn’t matter how it’s cooked, it is always flavorless. What is a little known fact about you? I used to own a 1973 Green Duster. Do you have a hidden/unknown talent? I am awesome at doing any school project between the grades of 1 to 5. How would you prefer to die? Quickly. If you were to die and could choose what to come back as, what would it be? An author, but a really good one.
Dr. Greg Knoll’s

Caramelized Apple Tart

What to add:

1 sheet frozen puff pastry
(from a 17¼-ounce package)
½ stick (¼ cup) unsalted butter, softened
½ cup sugar

3 granny smith and 3 gala apples
(3 lbs), cored, peeled and
quartered lengthwise

What to do:

1. Preheat oven to 425°F.

2. Roll the pastry sheet into a large square on a floured work surface. Cut out a 10-inch round with a sharp knife, using a plate as a guide. Chill at least 20 minutes.

3. In the bottom and along sides of a cast iron skillet or other heavy oven-proof pan, spread butter and sprinkle sugar on bottom. Arrange apples in circular pattern with narrow sides against bottom of pan. Fit apples as tight as possible.

4. On a stovetop, cook apples over moderately high heat until juices are deep golden colour and bubbling, 20–25 minutes.

5. Transfer the pan to the oven and bake for 15 minutes. Remove the pan from the oven and lay pastry round over apples.

6. Return the pan to the oven and bake tart until pastry is browned, 20–25 minutes. Transfer pan to a rack and cool.

7. To serve, warm skillet on low heat to soften caramel again. Invert serving platter over skillet and quickly flip the tart onto the platter, using oven mitts or potholders to hold two parts together tightly. Replace any apples that stick to skillet and brush excess caramel from skillet over apples. Serve immediately.
Quality & Clinical Services
Quality & Clinical Services

“The secret of change is to focus all of your energy not on fighting the old, but on building the new.”

— SOCRATES

It has been an exciting first year serving the Department of Medicine in my role as Vice-Chair. The Department physicians and staff continue to provide high standards of care to ever increasing numbers of complex patients. At the same time, they have been dealing with significant changes in the way the health system is managed and I am certain the pace of change will accelerate over the next several years. While this evolution will create challenges, I am also confident we have built the foundations to thrive in these conditions. Embracing these new opportunities will be the key to our collective success.

In this year’s report, I will focus our culture, our leadership, and our preparation for the future.

Creating a Culture of Continuous Improvement

Ensuring we continuously improve is an important goal for all of us, whether we consider ourselves as an individual physician or as an important member of a healthcare team.

Getting the basics right: In response to the new funding arrangement with TOHAMO, we have invested in building a strong quality assurance function. All divisions received funding to help one of their division members lead a division quality committee. These leaders (see Quality Leads list on page 69) have been working diligently with their hospital counterparts on a set of prescribed activities. To help them with these tasks, the Department of Medicine also funded a 1-day education session addressing many aspects of quality assurance. Collectively, these efforts will ensure all divisions are continuously tracking relevant performance measures, threats to patient safety, and feedback from patients.
## Quality Leads

<table>
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<tr>
<th>Division</th>
<th>Quality Lead</th>
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<tbody>
<tr>
<td>Dr. Delvina Hasimja</td>
<td>General Internal Medicine (Chair)</td>
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<td>Dr. Angeline Law</td>
<td>Cardiology</td>
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<td>Dr. Ivan Litinov</td>
<td>Dermatology</td>
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<td>Dr. Janine Malcolm</td>
<td>Endocrinology</td>
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<td>Dr. Catherine Dubé</td>
<td>Gastroenterology</td>
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<td>Dr. Shirley Huang</td>
<td>Geriatrics</td>
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<td>Dr. Arleigh McCurdy</td>
<td>Hematology</td>
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<tr>
<td>Dr. Kathy Suh</td>
<td>Infectious Disease</td>
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## Innovation:

Over the last several years, many Department of Medicine physicians have been at the forefront of efforts to make our health system better. This includes physician initiated innovations; many of which received seed funding from the Department (see *Examples of Innovations in Clinical Care* on page 70). There are also a large number of initiatives in which a physician is collaborating with hospital or other health system leaders as part of a system-wide improvement effort, for example working to improve our performance on Quality Based Procedures or the Health Record.
Examples of Innovations in Clinical Care
Receiving Funding from the Department of Medicine

<table>
<thead>
<tr>
<th>Lead: Dr. Sunita Mulpuru</th>
<th>Implementing a novel health-status based care pathway in COPD patients</th>
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<tbody>
<tr>
<td>Lead: Drs Suh and Nott</td>
<td>Improving individual physician antibiotic prescribing behavior and accountability through audit and feedback</td>
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<tr>
<td>Lead: Dr. Saidenberg</td>
<td>Creation and Assessment of a Transfusion Consent Patient Education Tool</td>
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<tr>
<td>Lead: Dr. D'Egidio</td>
<td>Defibrillator design and usability may be impeding timely defibrillation</td>
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<td>Lead: Dr. Kobewka</td>
<td>Prospective cohort of a multi-faceted intervention to increase the proportion of patients who complete advanced care planning (ACP) post discharge</td>
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Creating a learning environment: One of the most difficult situations in healthcare occurs when a patient experiences harm. While this is obviously difficult for the patient, research has shown that physicians can also experience negative consequences. While the guilt and shame felt by physicians is important, it is arguably more important to learn why the event happened so we can prevent recurrences. Often, the negative feelings associated with events impedes our ability to investigate what happened. Importantly, most safety events are a function of the underlying system. The Department of Medicine is currently working closely with The Ottawa Hospital to ensure we create a common response to situations where things go wrong. This program is called the “Just Culture” and it involves helping build capacity to identify safety threats and respond to them in a common way (see Characteristics of the Just Culture below).

Characteristics of a Just Culture

In order to learn from adverse events, it is necessary to ensure that all of us will have a consistent response where both the defects in the system are evaluated as well as the intentions of the person involved in the event. Fairness in response to those involved is critical and needs to:

a. Console those who make human errors
b. Coach those who have ‘at risk’ behaviour due to a mistaken believe of risk
c. Punish those who have ‘reckless’ behaviour as demonstrated by a conscious disregard for risk

The biggest threat to safety in any organization is ‘at risk’ behavior. We must therefore learn how to help each other through the development of formal and informal coaching techniques.
Creating Opportunities for Academic Excellence

Positioning the Department of Medicine for the future is our relentless effort for improvement. One highlight to focus on is the creation of a center of excellence in healthcare quality, which will enable research and training in this important area. In addition, the alignment of our research and teaching missions with our clinical care goals is critical for successfully meeting the challenges of the future.

**IQ@TOH:** The creation of a ‘center of excellence’ in healthcare quality lead by myself and Dr. Dean Fergusson, represents an exciting collaboration between the hospital and the OHRI. Called “IQ@TOH”, the center’s purpose is to encourage the use of research when solving health system design challenges. This center brings together the data, analytic, and quality methods from The Ottawa Hospital and combines them with OHRI expertise including—knowledge synthesis, decision analysis, economic modelling, research design, biostatistics and implementation science.

It is hoped that this focus will promote academic excellence in quality improvement efforts while at the same time ensuring effective decision making within the healthcare environment. The Department of Medicine will greatly benefit from the success of IQ@TOH by creating opportunities for trainees and faculty to participate in meaningful projects with adequate support.

**Training programs:** Our clinical activity continues to provide excellent training opportunities. The efforts to standardize learning objectives for trainees, to experiment with new modes of training using simulation, and to incorporate new methods of evaluation will ensure trainees provide high quality care while in Ottawa and more importantly throughout their career. These opportunities could not happen without the thousands of hours of supervision provided by our clinical teachers.

**Research:** We continue to lead all departments at The Ottawa Hospital with respect to academic productivity. This is made possible because of the relentless pursuit we all have to make patient care better. The patients we see on the wards and in the clinics benefit when we enroll them in research protocols designed to inform us as to the best way to treat them. To make it easier for this type of innovation, we will continue to work closely with our researchers to minimize barriers for enrollment in clinical trials. We will also be expanding a program to help researchers get access to clinical data they can use to justify research trials or develop hypotheses.

Leadership in Clinical Services

Our primary role is to provide high quality specialty care to patients. In partnership with our hospital colleagues, we provide leadership in many exciting advances enabling access to care for the people of Eastern Ontario. At many times our clinical work makes international headlines. At all times our doctors provide compassionate care to their patients.

**Advances in models of care:** Every year, Department of Medicine doctors are often at the forefront of expanding advancements in patient care. A few examples of this leadership are:
expanding indications for bone marrow transplants, new colon cancer screening procedures, new management algorithms for patients with venous thrombo-embolism, new treatment options for patients with pulmonary hypertension, and expanding indications and protocols for stem cell therapy. There are many other examples of these advances embedded within the division reports.

**Making transitions home safer:** A critical challenge faced by all inpatients occurs when they leave the hospital. This is becoming more concerning as patients in hospital are more complex, the number of people involved in care increases, and their hospitalization duration decreases. Through the Department of Medicine strategic planning exercise a number of teams have focused on developing a suite of interventions and capabilities designed to enhance patient care after they go home (see *Figure 1* below). Building these innovations represented a massive amount of work by many of our colleagues. In addition, it has taken a huge effort to change ward-based clinical practice for all attendings and trainees. Making these processes more reliable and efficient will now ensure steady improvements in patient safety and physician buy-in.

**Figure 1: DOM Transitions Bundle**
Ensures safe, effective, timely and patient-centred care

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Purpose</th>
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| 1  • Discharge summary initiation  
• Admission medication reconciliation              | • Create the problem list that is maintained daily throughout hospital stay  
• Ensure home medications are known at admission and enforces a rationale for any changes |
| 2  • Structured interdisciplinary bedside rounds (daily) | • Communicates daily updates on care plan to the patient and family by the whole team to ensure a unified plan |
| 3  • Daily bullet rounds                           | • Ensures all the patient’s needs post-discharge are anticipated and available at a specific date and time (preferably before 11:00 a.m.) |
| 4  • Discharge summary completion  
• Discharge medication reconciliation              | • Ensures care providers have a complete summary of all in-patient care decisions and follow-up plans  
• Ensures post-discharge prescription takes into account all information including the medications taken prior to the hospitalization; generates a prescription |
| 5  • Post-discharge phone call                     | • Ensures patient is not experiencing any problems and, if they are, resolves them as soon as possible |
| 6  • Post-discharge physician visit                | • Ensures follow-up of patient condition and outstanding investigations |
**Looking to Next Year**

It would be easy to get discouraged based on all the changes we are facing, some of which will be very challenging. However, our department is very well positioned to take advantage of these changes because of the hard work and investments resulting from the strategic planning exercises. I am confident that the resilience of our teams, their commitment to innovation, and their unwavering commitment to patient care will ensure our continued success.

*Alan Forster*

MD, FRCPC, MSc
Vice Chair, Quality and Clinical Services
What You Should Know About

DR. CATHERINE DUBÉ

In 1976, a 16-year-old Catherine Dubé, prompted by her older brother Nicolas, submitted a recipe to a popular French Canadian cooking magazine called Sel et Poivre. Too shy to enter the contest on his own, Nicolas convinced her to participate and mail in a submission as well. His was a pork fillet done up in the style of a Wellington, hers a fancy cake in the shape of a crown. It was made of whipped cream, and chestnut purée, and skillfully contained within a tower of rum soaked cookies. She called it “Le caprice de la Grande Catherine”. Weeks later they received a call—they had both won.

In 2007, a 42-year-old Catherine Dubé, an experienced gastroenterologist working for Alberta Health Sciences in Calgary, was prompted once more to throw her hat into the ring. This time, it was of an entirely different nature. Catherine was asked to take on quality. More specifically, to look at Britain’s Global Rating Scale (GRS), a tool that helps assess how well institutions provide patient-centred services, and then to determine how to adapt this web-based tool to the work they were doing in her institution. And she did it. So well in fact, she was asked by Rolland Valori, the guru and founder of GRS to travel to England to present her integration method—it was a ‘life defining time’ she recalls. Since then her career has continued to travel the path of quality, and her responsibilities have grown. Today, Catherine holds many titles related to quality, most notably Clinical Lead for Cancer Care Ontario, tasked with overseeing the revamping of the colon cancer screening program, a job which requires her to condense, but not reduce her clinical responsibilities in order to travel to Toronto on a regular basis. It’s hectic, and tiring, but worth the effort to affect this important change.

Fortunately for Catherine she has a paradise in which to recharge. Her and husband Dr. Alaa Rostom, also a gastroenterologist, share a sprawling century-old Cape Cod/Colonial house with their three kids (Myriam, Karim and Dahlia) and Lancelot, their beautifully tempered Swedish Vallhund. A single glance around and you immediately understand that this is a place of comfort. The family’s day-to-day lives are present in every room.
Two sewing machines—their projects in varying states of progress—rest on the dining room table, in the great room amplifiers are clustered around guitars, and in the summer room, a bin of well cherished toys and board games are ready to be re-explored. This is clearly a well-loved family home and an extension of Catherine’s personality—warm, inviting and full of character—a place rich in family ties, a certain indication of what she values most.

Herewith, some insights gleaned from a delightful conversation with Dr. Dubé.

**On her love of nature, family and food:**

I grew up in Beloeil, Quebec along the Richelieu River, about 20 minutes south of Montreal. It was a tiny little cooperative community in the country with lots of interesting people—two architects, a film maker, very creative types. It was complete freedom; it was a very nice childhood.

When I think about that time I remember the fragrance of being out in fields catching butterflies—I was an avid butterfly collector—and time alone in nature, those are very dear memories. Now, walking the dog is what I do to relax, I need to be outside a lot. Some days I’m really caught up in work and I find that the walk allows me to put things together.

I am four of five children—two boys and three girls. The most span between us is three years. My younger sister and I are only 16 months apart. Growing up we were this nucleus—we were very, very close. I’m a lot like my mother, we walk the same way and we’re always moving. Even if I’m at home I’m doing stuff.

In Quebec there’s a lot of tradition about food. My family always had dinner together, it was sacred. My father would wake us up in the and ask us what we would like for dinner. He loves to cook. Cooking as a family and getting together for dinner was always important. At the end of the day we’d always have that time together.

It’s the same with my own family, we always have a cooked meal. The five of us are always sitting around the dinner table. In the winter we have a fireplace in the TV room so we often watch a show together and eat. When the kids were young I never booked their activities around supper. Even now my daughter swims on Friday nights—she has practice until 7:30 p.m. so we eat afterward.

My family is extremely proud of their francophone heritage and it was important for me, and also for Alaa, that our kids speak both languages well for future opportunities. We made this really conscious decision when my son was born that I would speak to him only in French and Alaa would speak to him only in English. I had met a linguist in the park walking the dog—you meet a lot of people dog walking—who said that for kids to learn a language it’s always better that one person speaks only one language otherwise they won’t know which words belong to which language. When my son started to speak he would translate my French words to his father thinking Alaa was purely Anglophone and couldn’t keep up with the conversation!...but he’s not, he speaks French fluently. To this day the kids speak to me in French and Alaa in English.
On her road to quality:

There’s a federal agency called The Canadian Partnership Against Cancer and in 2009 they created a colorectal cancer screening network across Canada. Originally we went to this Canadian Partnership to seek funding for GRS. It was during that time that they were trying to establish their quality determinants for screening. One thing led to the other and they brought me on to their working group where we had months’ worth of meetings and did quite a lot of work to establish the standards for quality. Through that experience I got to know more people and together we created a bigger network. Now I’m 0.2 FTE with Cancer Care Ontario as their Clinical Lead for the Colon Cancer Screening Program. We’re in the process of changing our screening tests from fecal occult blood to the FIT (fecal immunochemical test). It’s much more sensitive and really good at detecting polyps and cancers. From the studies we see, this is a great test that someday may even replace screening colonoscopy.

“You know, it does not always have to be extensive and laborious to make an improvement.”

I’m overseeing all aspects of the implementation but I’m part of a big hierarchy. Once I approve and add my comments there’s still another committee above me at Cancer Care Ontario and their leadership reviews everything. We now have a launch date and we’re really hoping to get everything done by that time. I’m really thrilled to be part of this.

Locally in GI, I started using GRS for our unit. Twice a year, for the past two years we sit down with the manager and two Gastroenterologists and rate where we are as a unit, monitor what we’ve done and go back to what we’ve seen to make changes—it really implies a full wheel. One thing that I had implemented in Calgary and brought here was to give patients their own report on the day of their procedure, which is simple and makes complete sense right? And yet it’s not a common practice, it’s strange. Even though on the same day you don’t have all the answers we just have a simple template where we write down what we did, what we found, if biopsies were taken and we just write what type of follow up, the phone numbers, how long and so on—just the key information so they know where they stand and they keep that at home. So when I came here I started it and advertised it, emailed the template to others and some picked it up. But probably half and half and then we did the patient survey and it was a loud and clear thing that patients felt this was helpful and they really appreciated it. And those that did not receive it said ‘I wish I had’. So then we brought this back to the endoscopy committee and the executive decided that this was something the division was just going to implement across the board and there won’t be any option. It’s simple, it’s patient centered, it makes sense and it was an outcome of our patient survey. I love that. You know it does not always have to be extensive and laborious to make an improvement.
I’m also really happy with the The Ottawa Hospital’s plan for quality because now it gives us a really good framework. Now that quality is integrated with the hospital as opposed to just being Department of Medicine good ideas go a lot farther. It’s very nice to embed what we do in that framework. I think it will be very good for the hospital. I find it challenging to bring locally what I do at other levels because sometimes it’s more challenging to change people that you know well than to have that general influence where I give a webinar to people across the country. I think our Division is changing all the time in a good way. There’s always work to be done but we have a good group.

One key ingredient to enjoying my work is that I need change. I couldn’t do the same thing day after day, that’s clear. I like challenges, I like to make a difference. It’s sounds a bit egotistical but I like to know that the things I spend my time doing are for something helpful. I think the worst time in my life was when I lived alone as a medical resident and felt that I didn’t serve. Having things to take care of, I need that. These projects, you know it’s all taking care of things.

**On life, leadership and living with the boss:**

I’m in a phase of my life that is really work oriented. And I often think it’s not always going to be this way. The kids are growing so fast, that busyness at home, it’s not always going to be like that, so for now I really consciously devote most of my time and energy to doing a lot of chores and working. I don’t necessarily allow myself so much leisure, I play a bit of piano, I go out sometimes, it’s not a very social life. And I know it’s not going to be like that forever. Already this year I feel that I’m getting a better balance on things. I’ve learned to spend less time on some things than I used to. I think of my daughter who is 16, she’s studying so hard because she wants to know 100% of the things, and at this point she can, it’s still feasible. But in life it’s absolutely not feasible. So you pick and choose and learn what kind of work you should be doing.

“I know I don’t have a big strong voice that will just mobilize a room and I figured there’s no point in trying to change it—that’s me.”

I love to take time to read the newspaper from cover to cover—it makes me feel part of something else, otherwise you’re very much into your own little world I find. Also, on week nights I need to do a Sudoku before I go to bed. Will Shortz, for those Sudoku lovers, they’re the best. I also find that I need to stay in shape to do more. If I stop exercising I get tired. Like the middle of the winter when it’s cold, I really have little energy. I will walk the dog most days at very least for a half hour and sometimes manage to go for a run to give me more energy. These days I bike to work at least twice a week. On the weekends I’ll go for a long run and then try to squeeze one or two in on week days. If I travel I can usually run in the morning before meetings, and that’s so much fun because you discover a bit of that city.
I know I don’t have a big strong voice that will just mobilize a room and I figured there’s no point in trying to change it—that’s me. So instead I maintain an attitude where I try and pay attention to all the members of my group. It’s a bit of an emotional leadership because I like to feel that people are engaged and enjoying themselves and ensure that the work is balanced and that I’m being supportive. Leading comes naturally in terms of doing things the way I see them that’s for sure. This has been much easier to do in recent years. I’ve grown into this. I’ve really had the good fortune of having really good role models.

I don’t have that much tolerance for people who don’t keep up with the expectations. Alaa thinks I can be a bit harsh but I’ve asked around and that’s not the perception. I just physically feel intolerant to people who don’t produce, so somehow it must transpose. And, I have less and less issues saying it. I’m not rude but sometimes people don’t expect someone who is so soft spoken to really say things as they are.

There are times for sure when Alaa and I talk about work. And there are times when I know he really doesn’t want to hear it—there could be long periods like that.

And then once in a while, especially say if we go to a meeting together we may have a discussion afterwards because it’s very good to bounce things off him; he’ll approach the same thing completely different. Our secretary says we’re opposites and I never hesitate to run things off him if I need to. So I’m very fortunate. We don’t really joke about him being my boss because I’m his boss provincially!

“I don’t have that much tolerance for people who don’t keep up with the expectations.”

If not for medicine I would have done something creative, like sewing. Or have a restaurant—cooking. I like to make things with my own hands. For a while I thought I’d love to write a novel but I don’t think I’ll ever get there. I’m not artistic, I don’t have that talent of drawing but I do love to make things my own, and in my own way. Of course often that takes time… time that I just don’t have right now.
Choice Words

Which talent would you most like to have that you currently don’t possess? I’d like to be more flexible. I’m fairly set in my ways and analytical so that makes me less easy going sometimes. What is your favourite activity outside of the hospital? Being home and cooking. What would qualify as the afternoon of your dreams? [laughs] Honestly it’s just being around here [home], lounging and doing a bit of this, a bit of that. No schedule. Zero schedule. But also keeping busy. What is your idea of misery? There’s all the extremes of misery but if I’m stuck in one routine, if I have no choice in what I do next. Where it’s the same day after day after day, deadly. Which living person do you most admire? Well, my mother and my mother-in-law... for very different reasons because they are very different. My mother is an extremely good person. She’s just forever giving, she’s this extremely kind and good person and there’s no boundary to her generosity. My mother-in-law is a very spiritual person, also very generous but she also has that spirituality, that faith that’s very, very impressive. And so I have these two guides, I’m so lucky. What is your principal fault? I’m stubborn and I really like my own way and I can decide to just see what I want to see and ignore the rest. What is your most marked characteristic? When I’m into something I can be very intense. What do you dislike most about your appearance? [laughs] My chin, my eyebrows, you name it. What is your greatest extravagance? Ahh, I love clothing, I don’t do that too often but when I need to take care of my wardrobe I can really do that. What is your greatest regret? I have a large family in Montreal and with the moves and everything I haven’t been as close to them as I initially would have thought. And I’m sure there’s really a lot that I’ve missed and I continue to miss. When and where were you happiest? It happens to me a lot where I just think wow this is so nice and honestly when I’m sitting down with my family and my kids and we’re just chatting together I don’t think there’s anything better in the world. If you could change one thing about your family, what would it be? I wish in a way that I had had more assertive parents. I come from that very typical French Canadian way where we don’t necessarily ‘say’, we don’t necessarily ‘lead’, we let those in the know... you know I don’t come from a family of leaders. And sometimes I wish I had had these figures to help me. More in my professional life. What do you most value in your friends? The fact that they understand that I come and go because of work. I’m not a very steady friend. I lose contact easily and then I get back in touch years later and it’s great. The fact that friends understand that about me. Would you describe yourself as a “foodie”? Do you prefer to go out to eat, or cooking at home? I prefer to cook at home although a great meal that I have not cooked myself is wonderful. If I feel like I could do it just as well then no, it’s not worth it. Don’t waste my time. What song is guaranteed to start your day off right—what is your anthem? These days I listen to a lot of the things my kids listen to. So we have these things these days called Tame Impala, it’s a band from Australia. They call it psychedelic rock. It’s a mellow rock type of thing, it’s perfect to go running with. If you could go anywhere in the world for vacation, where would it be, and why? We’ve been to Hawaii a few times and I still think it’s paradise on earth. What’s one thing that will always make you laugh? It’s funny cause I remember in ICU working with Bob Rivington and he told a joke one day that I can still say and I can still laugh at it. I remember very few jokes, it’s a sarcastic joke. Tracy, here’s a simpler answer to the questions: One thing that will always make me laugh is to watch episodes of “Arrested Development.” What movie would you want to be transported into? I’m a romantic so probably an old English film like Pride and Prejudice, Jane Austen
What 1990's fashion trend do you miss the most? Well you see the 90s to me is so recent. My girls had to dress up in clothes from the 90s and I thought 'what's the difference with now?'. I'm too old to see the distinction. What food do you detest the most? Ready-made, I never eat boxed stuff. What is a little known fact about you? In my family my name is Cathou? And that's how everybody knows me. It's the short form for Catherine. Do you have a hidden/unknown talent? If I take my time I can sew quite well. I made my prom dress. We were five kids growing up and I really loved to dress up so I would make my own clothes and I would use anything. I had this thing about the 60s—I was a big Beatles fan so I made these striped red and pink pants from old curtains. If you were to die and could choose what to come back as, what would it be? Well my favourite animals are dogs, I love their simple kind ways so I think I'd like to be a dog.
Dr. Catherine Dubé's

**Caprice de la Grande Catherine**
*(Charlotte With Chestnuts And Almonds)*

**What to add:**

- ¾ cup fresh fruit syrup*  
  (peach, pear or apricots)
- ½ cup + 2 tbsp rum
- 2 cups 35% cream
- 1 pkg (10g) unflavored gelatin
- ½ cup cold milk
- ½ cup icing sugar
- 6 oz good quality dark chocolate, chopped into chunks
- 150 g sweetened chestnut puree
- 240 g sliced almonds, lightly toasted

**Langues de chat**

- 3 eggs, separated
- 6 tbsp extra fine sugar
- ½ cup pastry flour
- 1 tsp pure vanilla extract

* This recipe was created in August 1982, while holidaying in Georgeville, Quebec. I used the syrup from fresh sliced peaches, sugared and refrigerated for 1–2 days.

**What to do:**

1. Start by making the langues de chat:
   
   a. Preheat oven to 350°F.
   b. Beat the egg yolks and 4 tbsp extra fine sugar at high speed until light yellow—about 5 minutes
   c. Gently add flour. Add vanilla.
   d. In a separate bowl, beat egg whites with 2 tbsp extrafine sugar until stiff peaks form. Gently blend into the egg yolk mixture.
   e. Using a piping bag geared with a flat tip, place dough in 3-inch long “tongues” on a well-buttered cookie sheet.
   f. Cook about 17 minutes at 350°F, until edge of cookies is slightly golden and their center has the texture of cake.
   g. Once the cookies have cooled, they should be soft. Line the bottom of the Bundt cake mold with the cookies, placing them along the same axis as the grooves of the mold. Once the bottom is fully covered, use cookies to line the sides as well as the chimney of the mold, also placing them along the same axis. Do not trim the edges of the cookies if they are exceeding the upper sides of the mold. Keep any remaining cookies covered.
2. In a small saucepan, heat up the fruit syrup and ½ cup rum; the liquid should not simmer or boil.

3. Using a small spoon, gently drizzle ¾ of the warm syrup onto the cookies lining the mold.

4. In a small bowl, sprinkle the gelatin over the cold milk and let it swell. Transfer to a small saucepan and heat up the milk, while stirring, so as to allow the gelatin to melt. Once melted, cool the liquid in the fridge for 3–4 minutes—it should not be allowed to thicken, simply to cool.

5. Whip the cream. Add 2 tbsp rum and the cold gelatin-milk mixture. Once all combined, split into 2 equal parts.

6. Add the chocolate chunks and icing sugar to one of the two parts of the creamy gelatin mixture. Place this mixture at the bottom of the cookie-lined mold.

7. Cover the cream/chocolate chunk layer with leftover langues de chat. Use enough to fully cover the first layer of cream. Drizzle the remaining fruit-rhum syrup onto the cookie layer.

8. Add the chestnut puree and almonds to the remaining half of the cream/gelatin preparation. Place it on top of the cookie layer. Gently trim the ends of the cookies exceeding lining the molds and fold them back onto the chestnut cream mix layer.

9. Cover the charlotte and refrigerate for at least 2½ hours.

10. Unmold the charlotte by first dipping the mold in warm water for a few seconds then unmold and serve.
Physician Health & Wellness
It is truly a privilege and my sincere pleasure to once again be writing the annual physician health and wellness portfolio report for 2016. This past year has been another challenging one for many department faculty members, not least because of the ever increasing fiscal restraints to public spending as well as ever greater demands and expectations placed on our already stretched and extremely hard pressed workforce. However, I remain so very impressed with how well these challenges are being met by our faculty. This past year, we have been moving forward with a number of key themes led by many of our own faculty members within the various project teams they were assigned to. The chart on page 102 highlights some of the key wellness interventions we have been trying to address and I would encourage all readers to review these and try to absorb how much time and effort has been invested in our various departmental improvement projects.

On a personal level, I am delighted we have made genuine progress with setting out and implementing our Physician Mentorship Program. With nearly 60 mentors trained to date and 30 mentorship groupings set up, I feel we are now ready to offer the kind of support and professional advice which I know many faculty members are requesting, under the leadership of our new Director or Mentorship, Dr. Alexander Sorisky. In so doing, we hope to build a faculty for the future which feels supported and committed to the vision and strategy of the Department, Faculty of Medicine and The Ottawa Hospital. Our aim is to provide compassionate, safe and high quality clinical care whilst at the same time thriving in our individual and collective academic successes, both on a research and education front. We have funding to study the benefits the mentees get from being a participant in such a program. The data collected will help inform the usefulness of the program and enable dissemination of evidence on mentoring. Our mentorship program has already caught the attention of the Faculty of Medicine CPD Office and several other organizations across the province of Ontario and into Quebec.

Other vital projects are now beginning to bear fruit. The Succession Planning, Career Transitions and Financial Planning project teams have each delivered a charter which the Executive has developed and expanded upon to allow individual faculty to benefit from the recommendations made. Thanks to our extremely dedicated team, we now have an onboarding program being
rolled out which will be the envy of many other departments. Professionalism underpins everything we do as physicians and collegiality is a vital ingredient. Conversations around civility are starting to take place as we begin to look to improve how we communicate professionally with our colleagues both in a supportive and empathic manner whilst at the same time, through building our own resilience and improving our own wellness.

I was fortunate enough to be awarded a 2016 AMS Phoenix Fellowship to allow me to study how we can improve physician empathy, compassionate care and wellness through the development of resilience-building communities of practice and creating a culture of empathy. This will be the first time that all Full Time Physician Faculty will have the opportunity to contribute the largest physician wellness study yet to be undertaken within the Department of Medicine. I hope as many of you as possible will be able to complete the survey which you will be receiving to allow us to have enough data to make some meaningful changes.

Over the course of the coming months we aim to produce a new Professional Development Strategy which will support every faculty member of the Department of Medicine and the Department itself reach its full potential as well as enhance faculty and Department of Medicine reputations both nationally and internationally. Through a redesign of the terms of reference of the post of the now named Director of Professional Development, we hope to relaunch this important portfolio position and look forward to welcoming into it someone with the innovative, dynamic and forward thinking skills and attributes which such a post holder should possess.

Our recognition ceremony in November is a key milestone in the annual Department of Medicine calendar of events. Recognizing outstanding individuals is a key component of the department’s commitment to support individuals and celebrate their success. A full list of award recipients appears on page 12.

Engagement, recognition, mentorship, professional development are key principals through which the Department of Medicine supports its faculty. At a time when physician burnout is rising with the threat not only to physician wellness but also to physician empathy and the delivery of safe,
compassionate and high quality care, we need to recognize that while we still have a long way to go, we are beginning to make some real progress. And that is largely due to each and every faculty member within the Department of Medicine.

Thank you for helping us begin to make a difference!

Ed Spilg

MBChB, MSc, FRCP (UK)
Vice Chair, Physician Health & Wellness
What You Should Know About

DR. ED SPLIG

Sitting in a pub in Kanata, over a pint of Guinness and a salad, Dr. Ed Spilg shares the details of his life; a series of goal directed choices and measured risks. He tells his story with a thin Scottish brogue, his answers following on the heels of long pauses and several restarts. He’s a thinker. He speaks slowly and deliberately. Even in this busy pub he’s got a kind of calming force to him; there’s just something about Ed’s manner that suggests an ethos of cautious control.

To understand him, you need to know that his life’s plan was once as straight as an arrow. Ed was born in Glasgow, went to school in Glasgow, and married a woman from Glasgow. His father was a physician, and, at age 13, Ed too knew he wanted to be a physician. He started medical school at 17, finished top in his class, found his passion in Geriatric Medicine and carved out a successful life and career for himself: good job, good pension, lovely house, close family ties and most of all guaranteed security.

It’s interesting, and maybe improbable then that ‘Cautious Ed’ as he was once referred, did a complete about face nearly two years ago and gave it all up. He moved his family, his practice, his entire life 4,930 km across the Atlantic to start anew. He cast it all aside after substantial reflection on his work life balance and validation via an online questionnaire that he was at high risk for burnout.

In a wide-ranging conversation with the Vice Chair of Physician Health & Wellness, Dr. Ed Spilg talks about where he’s been, where he’s headed and the truth behind why he’s never had the courage to wear a kilt!

On what it means to be an out-and-out Glaswegian:

I am proud to call myself a Glaswegian. Growing up, we lived in a better-to-do suburb of the city. Glasgow is very much a city of different parts—both with its affluent areas and those with significant poverty and deprivation. It’s a very Scottish city. There’s a strong history in the West of Scotland going back many years involving people of Scottish and Irish backgrounds. The religious divide was at times quite apparent in Glasgow. A lot of the rivalry that I grew up around involved football which is very
big in Britain, particularly in the West of Scotland. However, I never really followed soccer to the point where I was part of that rivalry. It just wasn’t in my nature. Glasgow and the West of Scotland have an industrial past based on ship building, steel manufacturing, coal mining and other heavy industries. Things really started to change in the mid-1980s just around the time that I was starting University and that regeneration continues today. Glasgow has become a vibrant, exciting, fun city with great restaurants and lots of things to do, but it still has a past and it struggles a bit to shake that off. Historically it was notorious for being quite a violent city and not necessarily one of the safest of places to grow up in.

No, I have never worn a kilt. I’ve never really had the nerve to do it. It takes a certain amount of courage and I guess to really call myself a true Scotsman I would need to have worn a kilt. I have tasted haggis although I don’t particularly like it—I don’t really like the thought of what’s in it. I do enjoy a single malt whisky but that’s only since I came to Canada. I think it’s the cold winters that have driven me to it. I’m not mean at all and I’ve never really witnessed the stereotype of the thrifty Scot. My impression of Scottish people is that they’re not mean at all, in fact if anything the opposite is true; they’re really friendly, very welcoming although they tell it as they see it—what you see is what you get. Their harsh accents would sometimes imply a slight aggressiveness but that’s just the Scot’s accent, that’s just part of who they are. I’m very proud to be Scottish, I’m also very proud to be British and I’m looking forward to one day becoming a proud Canadian too.

On a mid-life crisis that didn’t involve a motorcycle:

Choosing the medicine path was all very conventional. My Dad, formerly a Pathologist, was a true scholar who loved to read and learn, specifically about historical events and famous people, especially from the political past. I probably took the safe option by staying in Glasgow and studying medicine, everything just kind of followed on. There wasn’t a lot of risk in many things I ever did in my life. I don’t think I ever set out to do anything other than to study medicine. I worked incredibly hard and I gave up a lot which looking back I’m not sure was a good thing. I wouldn’t advise others to do it. I was very much focused and very driven. I wanted to succeed. I don’t know if it was a desire to succeed or more of a fear of not succeeding that drove me more, but I worked hard and I surprised even myself with my results.

“There wasn’t a lot of risk in many things I ever did in my life.”

My 'big plan' was always my career. That came first. Well, my career and eventually my family of course. I always had a clear target which was to finish my training and then become a Consultant in the NHS. And I did all that after 8 years, and then another 10 years passed, I reached 40, had my mid-life crisis and was drawn back to academia again. I suppose there are worse things I could have done! Up until then, my life path had been very clear and I followed
it; then I got beyond the path and suddenly realized I was not actually sure where I wanted to go next. So, I went back to university and did another degree: A Masters in Clinical Leadership at the University of Glasgow Business School. There was an 18-year gap between my two degrees.

Around that time, the UK had just launched a program called Modernizing Medical Careers where they completely changed the curriculum for training doctors. I felt there was growing dissatisfaction with the changes by both the doctors who were in training and by the doctors who were their trainers. Both groups asked ‘how have we managed to change our system to something which seems to be so much worse than what we had before’ as happens of course in many systems which undergo major change. So I found myself in a position of being able to study that process of change through my Master’s research and subsequent dissertation.

I witnessed many people trying to bring about change. People were asking how we could ‘prove’ whether this new training model was better or worse than what we had previously. They often tried to do this by applying a medical model of problem solving and evaluation to solve problems which medicine was never designed to solve. The way you systematically work through a medical problem is not the same way you tackle a cultural problem and one that puts people and education at the heart of it. And that’s when I realized the role that social sciences could play here: to study and better understand people, behaviours, processes and change. And so I went back and I learned from social scientists and I loved it. I still don’t know how I managed to fit everything in. I did all my own research interviews, my own transcribing, and my own qualitative analysis, something I previously knew nothing about and so had to learn from scratch. At the same time, I retained a full clinical caseload and mid-way through my two-year course, I was asked to take over as Clinical Lead for Geriatrics, which I accepted, of course. After all, it was another goal along my career path, right? My Masters opened my eyes to different ways of thinking. It was heavily focused on the social sciences which I found fascinating, especially as a physician, because it challenged a lot of my own deeply held views about what science, learning and knowledge really are about. It was a big turning point and after my degree I wrote up my research into a successful publication.*


I finished my degree and I suddenly thought… now, what’s next? I was offered a post by the Dean for Postgraduate Medical Education and Training in the West of Scotland to support and help manage trainee doctors who had found themselves in some form of difficulty. He thought I could be well suited to this role. I saw young doctors in training across all specialties that had health problems, physical and psychological health issues both related and unrelated to the pressures of training. Doctors are in some ways just like anybody else but the system in which they work can be quite rigid and inflexible and sometimes it’s not always forgiving, often they don’t feel very supported, often they try to hide and solve their own problems. I think it was only really then that it dawned on me that the interplay
between a physician’s health and wellbeing and their ability to have a life out-with medicine and their ability to be successful in their career were so closely interrelated. My role was not to treat or to counsel. My role was to advocate and support and be a leader of change.

I was then asked to put together an online educational package for newly qualified doctors within NHS Education for Scotland, to make them more aware about the potential challenges that they’ll face working in a healthcare environment, working as part of a team and dealing with complex medical problems affecting real people, emotions, dealing with stress and dealing with uncertainty. At the same time, they needed to maintain a life outside of medicine with friends and family, remaining well balanced, keeping physically fit, mentally fit, planning and enjoying their career and first and foremost delivering high quality, safe patient care. It was actually in the act of researching for this project that I realized a lot of the published research in the area of physician health and wellness originated from Canada.

**On taking an almighty risk:**

It was becoming apparent to me at around this time with my own professional life that I probably wasn’t practicing what I was now beginning to preach. If I was really serious about wanting to take on a role in shaping how future doctors are going to develop in terms of their wellness I should do some more reflection into my own wellness. The picture I saw was not a pretty one. Six months later, having recognized I was at high risk for burnout, I decided the only person who could turn things around and change my direction was myself—I would have to actively do something about it. And so, to cut a long story short, we decided to up sticks and go, my wife Roanna and I just kind of looked at each other one day and just said ‘we can really do this’! And all of a sudden I went from being ‘Cautious Ed’, never taking a risk, never really doing anything without being fairly certain of the outcome, to suddenly taking the almighty risk that I could possibly take and cast aside my current life for something that was, to be perfectly honest, completely unknown. Why Ottawa? It just sort of happened that way. I was looking for a particular type of post and they were looking for someone with my skill-set and interests and it just grew from there. I guess I was just lucky to be in the right place at the right time. My academic interests were relevant to major developments and changes that were happening here within the Department of Medicine and it was a great, exciting opportunity—and I took it!

“**If I was really serious about wanting to take a role in shaping how future doctors were going to develop in terms of their wellness I should do some more reflection into my own health and wellness.”**

**On physician wellness:**

As physicians I don’t think we’re the best at managing our own health. We focus on our patients oftentimes at the potential expense of ourselves...working long hours because
we want to provide safe, high quality care, and be available when our patients need us. In a complex healthcare system that’s evolving and changing at an ever increasing pace, that can be very challenging. We need to learn how to thrive more than just survive. Surviving is good but if just surviving leads to burnout then it’s clearly not enough. It interests me that there’s a whole spectrum of physicians and some just seem to be incredibly resilient and seem to be able to do everything. They’re wonderful physicians, their patients think they’re really caring people, their colleagues really respect and admire them, they interact well with professional colleagues and learners think they’re amazing educators. Why are some people more resilient? Everyone’s working in the same system and yet some people thrive and others seem to barely survive.

There was a study published in Academic Medicine in 2013, which asked ‘if every fifth physician is affected by burnout, what about the other four’. There’s clearly something in that. I think if we can understand more about what makes some physician’s so resilient we can better help those who are struggling. I don’t see why we shouldn’t be able to change the culture of medicine although we should probably start by trying to understand what we actually mean by this. There are also some interesting recent research theories suggesting that empathy is a trait amongst physicians that can be learned and enhanced. I think that’s quite exciting, that things we thought were just innate traits can actually be modified. One theory is that if a physician isn’t taking care of his or her own well-being he or she is less likely to be empathetic. And then taken to the next level, is the study of emotion in medicine and the role of emotion regulation—where does that fit in to the delivery of high quality compassionate care and physician burnout? It’s still very much an evolving area of study and one to which I very much hope to be able to contribute. It really is of no great surprise that patients respond, react and feel better when their physician is genuinely more empathic towards them.

Recently, I’ve been awarded an AMS Phoenix Fellowship for 2016/17. My project aims to explore the level of empathy, burnout and resilience amongst academic physicians and then begin to develop strategies to address their needs in the areas of improving physician wellness by reducing burnout, building resilience and improving empathy towards patients, and improving their outcomes and experience.

I don’t know why on earth I participated in Dancing with the Docs earlier this year. It’s not at all within my personality to behave in such a way. In fact, it’s completely the opposite of my personality. I usually try to shy away from the limelight. I have to admit, however, it was one of the most amazing experiences in my life and one which I will never forget. You know, I took a risk when I came to Canada and it’s really paid off. I enjoyed the process of making the journey into the unknown and I suddenly realized that if I can do that in one area who knows what else I am capable of doing. I would never have had the confidence to perform a dance in public—let alone in front of 700 people—before I came here. It was also a great opportunity for people to identify who I was in my new role. I have a responsibility to put myself out there, that’s part of what
comes with my obligation of being Vice Chair of Physician Health and Wellness. So I think I’ve changed a wee bit, and so far, so good.

I have spent a lot more time in the last few years thinking about my own wellness, thinking about the challenges I faced, the risks towards developing burnout on a personal level and thinking about my own resilience. On the wellness scale, I would currently rate myself... well, let’s just say I’ve definitely crossed the half-way point in the right direction now. That was a challenge and something I really needed to do. It didn’t just happen by virtue of moving here, but doing so really gave me the opportunity to reappraise and prioritize what really matters to me. As I’ve told others before, changing jobs doesn’t solve problems. In order to look forward you need to reflect on the past and try and understand yourself a bit better.

My wife and I were away on a long weekend in the US in 2012 and we were in a Barnes and Noble book store looking at fridge magnets, as you do, and we came across one that said “happiness is a journey not a destination.” We bought the magnet and it’s still on our fridge at home. I think for the first half of my life everything just fell into place. And then I realized that life isn’t about succeeding and aiming for an end point because when you get to that end point you think ‘where do I go from here?’ And in fact it’s not an end point at all, it’s just a point. So the whole concept of happiness being a journey and not a destination speaks to me. I’m not looking for a point in time anymore, I’m just trying to enjoy and find meaning in what I have and trying to do the best I can for my patients, for my colleagues and for my family for as long as I can.
Choice Words

What technical advance do you most anticipate? Supersonic travel (especially Trans-Atlantic).
Which talent would you most like to have that you currently don’t possess? Self-confidence in groups of people I don’t know.
What is your favourite activity outside of the hospital? Sleeping.
What would qualify as the afternoon of your dreams? Not to have a care in the world (and time for a wee nap).
What is your idea of misery? Constant rain and grey, overcast skies.
What childhood fear do you still have as an adult? Failure.
Which living person do you most admire? My Dad.
What is your most marked characteristic? Determination.
On what occasion do you lie? When asked about my height and weight.
What is your greatest regret? That I didn’t move to Canada sooner.
When and where were you happiest? When I realized that our dream to immigrate to Canada was to become a reality. Graduating from medical school, getting married and my two kids are also very much up there!
If you could have dinner with anyone (dead or alive) who would it be? And where would you take them? Albert Einstein…I’d take him out for a Glasgow curry. Until you’ve tasted one it’s hard to explain. I miss it. The whole Indian food culture in Glasgow is tremendous. When I go back it’s one of the things on the top of my list to do.
Name a book (fiction or non-fiction) that has made a lasting impression on you, and why. Charles Dickens’ David Copperfield—helped me get through my final year in medical school.
If you could go anywhere in the world for vacation, where would it be, and why? Antarctica during summer—preferably by air rather than sea. I love the penguins.
What’s one thing that will always make you laugh? The actor Rowan Atkinson aka Mr. Bean and Blackadder—I saw him perform live in the 1980s when I was a student.
Which actor would portray you in a movie about your life? Maybe Daniel Radcliffe? My kids have grown up with Harry Potter and they love the books and movies. I read most of the books to them, particularly my son. And having visited the set at Universal Studios in Florida several times, I think it’s something that really connects all of us. Actually, I worked with J.K. Rowling’s husband when I was a Registrar and he was a Junior House Officer in Ayrshire for about 6 months in the mid-1990s. If I’d only known then…
Describe a funny/embarrassing moment that has happened to you. I went up to a waxwork dummy in front of a large queue of people at Madame Tussauds in London, age 11, and asked it for the closing time.
What 1990’s fashion trend do you miss the most? Hair mousse! If you were to die and could choose what to come back as, what would it be? A sheep on the Isle of Skye—what an amazing place to be a sheep!
Dr. Ed Spilg's

Cranachan

What to add:

- 25 g medium oatmeal (not porridge oats)
- 284 ml double cream (heavy cream)
- 2 tbsp clear honey
- 3 tbsp whisky
- 150 g raspberries
- 4 sprigs mint (optional)

What to do:

1. Spread oatmeal on a baking tray and grill until toasted. Leave until completely cooled.
2. Put cream and honey in a bowl and whisk until it just holds its shape.
3. Fold in whisky and toasted oatmeal.
4. Divide raspberries between 4 glasses, reserving a few for decoration.
5. Top with oatmeal cream and decorate with reserved raspberries and mint.
Areas of Focus
Strategic Planning Highlights

This overview identifies the Department of Medicine’s commitments made in our 2014 strategic planning process to 1) address issues and opportunities raised by our members, 2) align with our partners by advancing their priorities and 3) satisfy our departmental goals. It outlines our areas of focus and the progress we have made toward achieving our commitments. For the 30 teams and close to 180 department members who looked at the issues and evidence, and provided recommendations to the Department Executive, it also represents a tremendous amount of time and effort. Their dedication should be commended.

<table>
<thead>
<tr>
<th>FOCUS AREA</th>
<th>KEY COMMITMENTS</th>
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<tbody>
<tr>
<td>Bedside Teaching</td>
<td>To recognize exemplary bedside teaching</td>
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<tr>
<td>Clinician Teachers</td>
<td>To work towards understanding and engaging with issues of clinician teacher recognition</td>
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<tr>
<td>Collaborations in Medical Education</td>
<td>To increase access to PhD support through the Department of Innovation in Medical Education</td>
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<td>Fellowship</td>
<td>To provide opportunities for fellows to connect and collaborate with each other in the Department of Medicine</td>
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<td>To increase access to funding to support Fellowships</td>
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<td>To increase recruitment of new fellows</td>
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<tr>
<td>Competency-based Education</td>
<td>To investigate concerns raised by Competency Based Education Team regarding timeline, effort and resources for implementation, and scheduling impacts of fast-tracking residents</td>
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<td>Medical Oncology will measure the impact of evaluating trainees and of CBE on faculty time as they roll-out their new program</td>
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<td>Succession Planning</td>
<td>To implement the Talent Management checklist in the Annual Division Head review process to identify physicians who are interested in leadership</td>
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<td>Career Transitions</td>
<td>To communicate to the department members the definition of a Full time and Part time member and the privileges assigned to each</td>
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As the Department continues to build its future, we recognize that defining, implementing and funding impactful progress will not be without its complexities, but with continued dialogue and grass roots involvement we will develop new systems for improving the delivery of outstanding health care.

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<th>PROGRESS TO DATE</th>
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<tr>
<td>Bedside teaching award was introduced in September 2015</td>
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<td>The team assessing the position of a Clinician Teacher created a role description for this role outlining the numerous responsibilities and areas of focus. The Department of Medicine had a full day retreat to create solutions to address the challenges facing Clinician Teachers</td>
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<td>Department of Medicine is now providing financial support for a PhD education research position in the Department of Innovation in Medical Education</td>
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<td>A series of dinner seminars were designed specifically to meet the needs of the fellows in the Department of Medicine and covered a variety of topics. Also, a cross-Divisional Fellowship Committee was established</td>
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<td>The Department now has dedicated funding for Fellowship Programs and created minimum salaries and standardized contracts</td>
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<td>A Fellowship section was added to the Department of Medicine website and launched in the fall of 2015</td>
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<td>Our Department Chair raised issues with other Department of Medicine Chairs at the CAPM conference, with TOH and with Faculty leadership. As a result the Royal College of Physicians and Surgeons of Canada has modified the original implementation timelines for the Core Internal Medicine program</td>
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<td>Medical Oncology will implement CBME in July 2017. Core IM and Gastro are engaging with the work of developing the EPAs (entrustable professional activities) as they will start in 2018</td>
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<td>Process and checklist implemented to help identify those talented physician interested in leadership</td>
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<td>Drafted an information guide for the Division Head to help them to help their members plan for the career transition</td>
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<td>FOCUS AREA</td>
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<td><strong>Financial Planning</strong></td>
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<td><strong>Onboarding</strong></td>
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<td><strong>Professionalism and Collegiality</strong></td>
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<td><strong>Mentorship</strong></td>
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## Areas of Focus

### The Fruits of Our Labour

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<th><strong>FOCUS AREA</strong></th>
<th><strong>KEY COMMITMENTS</strong></th>
<th><strong>PROGRESS TO DATE</strong></th>
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<tbody>
<tr>
<td>Financial Planning</td>
<td>To provide guidance for department members during physician onboarding regarding key issues pertaining to financial planning</td>
<td>Compiled a “Frequently Asked Financial Questions” document to be distributed during physician onboarding</td>
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<tr>
<td>Onboarding</td>
<td>To provide new recruits with the “New Recruit Checklist and Guide” to empower them throughout the onboarding/orientation process</td>
<td>Recent recruits have participated in a pilot wherein they were given a detailed checklist of things to come in the process. Feedback has been positive thus far</td>
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<td>Buddies’ will be piloted in the new academic year</td>
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<td>To designate a divisional ‘buddy’ to new recruits to help acclimatization to clinical environments</td>
<td>New recruits now get a go-to person in the Executive office</td>
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<td>To ensure new recruits have a go-to person in the Executive office</td>
<td>New recruits get a tour of the General Campus after meeting with the Chair</td>
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<td>To provide organized tour of the facility</td>
<td>The department has connected with key department leaders in the areas of research, education, finance, our administration has documented much of the onboarding process in a relational database to ensure a consistent orientation for all new recruits</td>
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<td>To document a new recruit onboarding process, e.g., what information is being communicated when, and by whom to ensure consistency throughout the department</td>
<td>A mapping exercise has been undertaken and a database to support the onboarding process is being developed to ensure the process is complete and consistent</td>
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<td>We will be presenting to Division Heads this Fall on the Five Fundamentals of Physician Civility</td>
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<td>To simplify current dual Professionalism Reporting Systems and promote the process</td>
<td>We are investigating if uOttawa system can meet TOH needs (<a href="https://app.med.uottawa.ca/professionalism/">https://app.med.uottawa.ca/professionalism/</a>)</td>
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<td>To create an annual Professionalism award to recognize role models in professionalism</td>
<td>Professionalism award in place and running</td>
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<td>To celebrate positive role models</td>
<td>Physician profiles published in the annual report</td>
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<td>To promote meet and greet events through the year</td>
<td>The Department has posed the idea of Division’s leading meet and greet events</td>
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<td>To encourage submissions for a Faculty Development Day that focus on fostering collegiality</td>
<td>We will be working alongside Faculty CPD Office</td>
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<td>We created an easy to read Mentorship Program Guide that describes the program’s purpose and processes</td>
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<td>In collaboration with the Faculty CPD office, we trained 59 mentors in 4 interactive training sessions, with 4 more sessions offered in the Fall</td>
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<td>FOCUS AREA</td>
<td>KEY COMMITMENTS</td>
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<td><strong>Mentorship</strong></td>
<td>To hire a department Mentorship Director</td>
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<td>With permission, leverage existing programs at other institutions</td>
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<td><strong>Professional Development</strong></td>
<td>To produce a Professional Development Strategy which will support every faculty member of the DOM and the DOM itself reach its full potential</td>
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<td><strong>Transitional Care</strong></td>
<td>To bring attention to TOH that we need to accurately identify the Primary Care Provider in OASIS</td>
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<td><strong>Transitional Care</strong></td>
<td>To follow-up with TOH IT to see if the E-discharge tool could be improved without a significant rework of the product. The route to improve this tool would need to go the IM/IT clinical steer group for approval to make changes to the document</td>
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<td><strong>Link to Primary Care for Complex Continuing Care</strong></td>
<td>To invest in training our staff and residents in what should be included in the discharge summaries to primary care physicians. In the short-term there needs to be some training at academic half day to ensure the residents are performing these</td>
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<tr>
<td><strong>Link to Primary Care for Complex Continuing Care</strong></td>
<td>To continue to lobby for regional solutions to improve infrastructure associated with EHRs and communication</td>
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<tr>
<td><strong>Link to Primary Care for Complex Continuing Care</strong></td>
<td>To continue to influence and guide decisions made at the LHIN level regarding decision made on Health Links and specialists engagement</td>
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<tr>
<td><strong>Link to Primary Care for Complex Continuing Care</strong></td>
<td>Requests for assistance have been made by the Health Links via the TOH Medical Affairs. DOM will consider regional requests when approached by TOH Medical Affairs</td>
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<td><strong>Ambulatory Care</strong></td>
<td>To conduct an inventory of selected ambulatory clinics, review referrals, triaging, clinic cancelations and clinic workflows</td>
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<td><strong>Ambulatory Care</strong></td>
<td>To work with the TOH to procure a new electronic health record system</td>
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<td><strong>Ambulatory Care</strong></td>
<td>To work with TOH and divisions to use the Dashboards and data to improve ambulatory operations</td>
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<td><strong>Ambulatory Care</strong></td>
<td>To consult with divisions, and other institutions who are doing ambulatory care well, to learn best processes</td>
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<td><strong>Ambulatory Care</strong></td>
<td>To evaluate patient experience in our clinics. We are going to reach out to other institution to gather information on what they have done to address patient experience in ambulatory care</td>
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**PROGRESS TO DATE**

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<tr>
<th>Focus Area</th>
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<td><strong>KEY COMMITMENTS</strong></td>
</tr>
</tbody>
</table>
| Mentorship | To hire a department Mentorship Director  
| | Appointed Dr. Alexander Sorisky as our Mentorship Director  
| | Matched over 30 department members who requested mentorship with our newly trained mentors |
| Professional Development | To produce a Professional Development Strategy which will support every faculty member of the DOM and the DOM itself reach its full potential  
| | The TOR of the post of Director of Professional Development in being reviewed in consultation with key stakeholders |
| Transitional Care | To bring attention to TOH that we need to accurately identify the Primary Care Provider in OASIS  
<p>| | DOM suggested to hospital administration using a student to audit and update the Primary Care provider information in OASIS |
| | The team recommendations have led to a series of proposed upgrades to the e-discharge tool which are approved by IS steering Committee. The new e-Discharge tool is currently being enhanced based on recommendation. There is a planned release in November 2016 |
| | With the newly developed e-Discharge tool, there is a good opportunity to combine educational activities. While teaching staff and trainees how to use the new software application, we will also emphasize the key process that threaten a safe transition home |
| | On-going and related to the procurement of a new electronic health record |
| | The team engaged with the community Health Links program to offer to assist in the development of coordinated care of patients. |
| | The DOM Director of Ambulatory care is conducting process improvements and standards in 3 divisions to improve ambulatory care. |
| | The DOM Physicians have been engaging in key decision makers at TOH to ensure that ambulatory care physician and processes are included in the electronic health records discussions |
| | In conjunction with the TOH leadership and Data warehouse team, we developed new reports that captured complete data on ambulatory activities. |
| | On going and will be part of the electronic health record adoption process |
| | Patient experience is now part of TOHAMO metrics. The Ambulatory steering Committee has developed drafts of questionnaires we can use to address this area. We are ready to launch an electronic solution to provide this information |</p>
<table>
<thead>
<tr>
<th>FOCUS AREA</th>
<th>KEY COMMITMENTS</th>
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<tbody>
<tr>
<td><strong>Ambulatory Care</strong></td>
<td>To encourage divisions to dedicate time to telemedicine clinics</td>
</tr>
<tr>
<td><strong>Clinical Information Systems</strong></td>
<td>To support our Physician members to understand the impacts and to influence the rolling out of Clinical Information Systems</td>
</tr>
<tr>
<td><strong>Resident Research</strong></td>
<td>To recruit a Resident Research Director</td>
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<tr>
<td><strong>Interdisciplinary Research</strong></td>
<td>To review Academic Half Day, Journal Clubs and expand Resident Research Day as well as present research in progress rounds</td>
</tr>
<tr>
<td><strong>Infrastructure &amp; Regulatory Processes</strong></td>
<td>To ensure that the new services provided by the General Campus Clinical Investigation Unit (CIU) are well known, easily accessible, and competitively priced</td>
</tr>
<tr>
<td></td>
<td>To ensure measures are taken for Civic-based researchers to have access to similar services offered by the General CIU</td>
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<tr>
<td><strong>PhD Scientists</strong></td>
<td>To appoint (biomedical) PhD scientists to Department leadership position with the mandate to enhance the integration of PhD scientists into the department</td>
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<tr>
<td></td>
<td>To develop operating grant programs wherein department PhD scientists can be Primary Investigators</td>
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<tr>
<td></td>
<td>To engage department PhD scientists into department educational activities (e.g. grand rounds, half-day)</td>
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Areas of Focus: The Fruits of Our Labour

**FOCUS AREA KEY COMMITMENTS**

**PROGRESS TO DATE**

**Ambulatory Care**
Telemedicine often takes considerable time and will not completely solve our ambulatory issues. Currently 125 physicians are using telemedicine clinics. Last year, DOM doctors performed 6,500 visits using the telemedicine infrastructure.

**Clinical Information Systems**
TOH has developed a detailed plan and justification for a hospital wide HIS. Several DOM physicians were critical in this work. In the coming years there will need to be significant efforts by all doctors as this system comes on line.

**Resident Research**
Dr. Cooper is reviewing the entire resident research training process, curriculum and expectations. By late-2016/early-2017 many aspects of resident research training will have a new look and process including a novel core curriculum embedded with academic half day.

**Interdisciplinary Research**
At the 2016 Resident Research Day, the keynote speakers were focused on interdisciplinary teams and collaboration. Future Medical Grand Rounds will highlight successful interdisciplinary research teams.

**Infrastructure & Regulatory Processes**
Dr. Bill Cameron, Medical Director of Clinical Research, has been meeting with all new research recruits and many established researchers to discuss needs and available services. Dr. Cameron is committed enhancement of the CIU while at the same time making it affordable to investigators.

Dr. Cameron is meeting with all new and established researchers at the Civic campus who are interested in the CIU. A new orientation package to the CIU is being developed.

All new research recruits meet with the Department of Medicine Research Navigator, who introduces them to people with expertise in budgeting, REB, contracts, etc. and discussed their research plan.

Department of Medicine Research Navigator has a specific mandate to assist new researchers with launching of projects, assisting with grant funding etc.

**PhD Scientists**
Department of Medicine Director of PhD Research position was posted and filled via a competitive process. Dr. Robin Parks was the successful candidate and has begun working in this new role.

A new research opportunity is being developed that will allow PhD Scientists within the Department to be Principal Investigators on a DOM grant. The proposal has been approved by the Department Executive and the details are being worked on with a goal to launch early in 2017.

Department of Medicine Medical Grand Rounds will now have 1–2 presentations per year with focus on our PhD scientists. The goal is to provide and update of exciting research with links to clinical medicine.
Areas of Focus
The Fruits of Our Labour

**FOCUS AREA**

**PhD Scientists**

**KEY COMMITMENTS**

To ensure inclusion of PhD scientists and their trainees in Department of Medicine research functions (e.g. Annual Research Day)

To Improve recognition of achievements and contributions of PhD scientists in the Department (kudos, etc.)

**Research Data Repositories**

To provide a point person to identify ‘researchable’ conditions in the Ottawa Hospital Data Warehouse and in ICES uOttawa databases. This person will also assists with data analysis

---

Department of Medicine Strategic Planning Team Participants

Team Leaders are shown in **bold**.

David Allan
Jonathan Angel
Amel Arnaout
**Tim Asmis**
Harry Atkins
Louise Balfour
Christopher Barnes
Rob Beanlands
Robert Bell
John Bell
David Birnie
Redouane Bouali
Loree Boyle
Chris Bredeson
Pierre Antoine Brown
**Kevin Burns**
Ian Burwash
Shirley Bush
**Anna Byszewski**
Bill Cameron
**Pierre Cardinal**
Marc Carrier
Raphael Chan
James Chan
George Chandy
Benjamin Chow
**Heather Clark**
Mark Clemons
**Catherine Code**
Vladimir
Contreras-Dominguez
**Curtis Cooper**
Vicente
Corrales-Medina
**William Dalziel**
Christine De Meulemeester
Gianni D’Egidio
Rob deKemp
Susan Dent
Alexander Dick
Sue Dojeiji
Dariush Dowlatshahi
Catherine Dubé
Lloyd Duchesne
Nancy Dudek
Alison Dugan
Girish Dwivedi
Cedric Edwards
Ruth Ellen
Shane English
Todd Fairhead
**Dean Fergusson**
Edward Fitzgibbon
Alan Forster
Michael Froeschl
Esteban Gandara
Gary Garber
Nadine Gauthier
Glen Geiger
Steven Glassman
Chris Glover
Carol Gonsalves
John Goodall
Rachel Goodwin
Catherine Gray
Martin Green
David Grimes
Jeremy Grimshaw
Samantha Halman
Michael Hartwick
**Delvina Hasimja**
Benjamin Hibbert
Phyllis Hierlihy
Lynall Higginson
**Stephanie Hoar**
Allen Huang
Susan Humphrey-Murto
Paul James
Chris Johnson
Jolanta Karpinski
Erin Keely
Karima Khamisa
Shajia Khan
John Kim
Greg Knoll
Kenneth Kobayashi
Rashmi Kothary
PROGRESS TO DATE

Dr. Robin Parks has been appointed Co-Director of Resident Research Day to bring a Basic Science perspective to the meeting. Resident Research Day, held June 2016, included several presentations from PhD Scientist trainees as well as a keynote address from Department of Medicine PhD Scientist Dr. John Bell.

A special award for PhD Scientists has been added to the list of annual Department of Medicine awards and will be given out for the first time at the Department Recognition Ceremony in November 2016.

A plan is being developed to provide Department members assistance with Data Warehouse and ICES database projects. The goal is to establish a service that allows members to answer clinical questions relevant to their practice. The proposal has been approved by the Department Executive and the details are being worked on with a goal to launch early in 2017.

G.R. Kraag
Stephen Kravcik
Kwadwo Kyeremanteng
Grégoire Le Gal
Craig Lee
Danny Lelli
Ed Lemaire
Eugene Leung
Dora Liu
Peter Liu
Heather Lochnan

Peter Magner
Janine Malcolm

Shawn Marshall
Anne McCarthy
Arleigh McCurdy
Lauralyn McIntyre
Doug McKim
Michelle McKinnon
Ines Midzic
Lisa Mieleniczuk
Scott Millington

Nataliya Milman
Frank Molnar
Sunita Mulpuuru
Sanjay Murthy

Steven Nadler
Garth Nicholas
Jim Nishikawa
Deborah O’Keefe
Michael Ong
T.C. Ooi
Smita Pakhale
Vivien Parker
Robin Parks

Rakesh Patel
José Pereira
Xuan Pham
Barbara Power
Melanie Pratt
Debra Pugh

Neil Reaume
Leo Renaud
Marc Rodger

Gregory Rose
Erin Rosenberg
Alaa Rostom

Virginia Roth
Melissa Rousseau
Marcel Ruzicka
Mitchell Sabloff
Raphael Saginur
Nav Saloojee
Aimee Sarti
Dimitrios Scarvelis
Michel Shamy
Tom Shaw-Stiffel

Dawn Sheppard
Judy Shiau
Doug Smith
Xinni Song
Manish Sood
Alexander Sorisky
Ed Spilg
David Stewart

Grant Stotts

Kathryn Suh
Eva Tomiak
Claire Touchie
Melissa Toupin

Peter Tugwell
Michèle Turek
Jeff Turnbull

Carl van Walraven
Shailendra Verma

Nha Vodic

Peter Walker
Jim Walker
Jodi Warman
Louis Weatherhead

Paul Wheatley-Price
Kumanan Wilson
Gerald Wolff

Timothy Wood
Krista Wooller

Deborah Zimmerman
Jocelyn Zwicker
Divisional Reports
Cardiology

Prior Year’s Divisional Goals

Improve efficiency of clinic referrals and reduce wait time
Established Rapid Referral Program in collaboration with Emergency Department—implemented September 2016.

Establish stable funding for fellowship program
Established Funding support from Cardiology Practice Plan and University of Ottawa Heart Institute—Department of Medicine Fellowship Program to be instituted.

Establish external mentorship program
The external mentorship program has been established with an emphasis on the junior and mid-career faculty. Mentorship relationships have been established for 10 faculty members and the initial meetings are underway.

Define faculty expectations and workload
Preliminary work has begun to develop the Division expectations and accountability framework under the leadership of Dr. David Birnie—plans are to finalize this plan by end of 2016 for implementation in 2017.

Create a new administrative team model to enhance the efficiency of administrative support for physicians
The new team model for administrative support was implemented in the summer of 2016 which required significant reorganization. The impact and success of this model will be evaluated over the coming year.

Most Significant Divisional Accomplishments in Last Academic Year

Established Heart Teams in Arrhythmia (Birnie, Sadek), Revascularization (Glover, Chong) and Women’s Health (Coutinho, Mielniczuk, Turek) in Collaboration with Cardiac Surgery, Cardiac Anesthesia and Prevention and Rehabilitation.

Rapid referral for ER discharge urgent imaging protocol with physician-assisted test selection (Chow, Davies RA).

Development of regional programs—Renfrew Hospital Echocardiography (Burwash) and Renfrew and Cornwall Heart Failure (Mielniczuk, Stadnick).
Strong Postgraduate Program as demonstrated by dedicated leadership (Froeschl),
3 Royal College AFC programs (Interventional (So), echo (Beauchesne) and
electrophysiology (Green)) and full program (currently 12 residents and 25 fellows)

Dr. Chris Johnson was primary panelist for the Canadian Cardiovascular Society Guidelines
for Evaluation and Management of Cardiovascular Complications of Cancer Therapy, July 2016.
This was the first Canadian guidelines on this subject.

**Plans for the Coming Year**

1. Pursue faculty recruitment in heart failure, electrophysiology, cardiology-imaging, MRI,
   adult congenital heart disease, valvular disease.

2. Create and implement a faculty expectation and accountability framework to manage
   physician workloads.

3. Conduct a DoC retreat to identify solutions for key leadership and workplace issues such
   as partnership changes, physician health and wellness and faculty expectations.

4. Further develop the Rapid Referral Program after ER Discharge; expansion of regional
   HF program; explore 'physician assisted test selection' for referring MDs, develop
   AF Clinic; ensure resources to reduce wait times for EP procedures.

5. To develop a data harmonization strategy for the Division of Cardiology to enhance
   our abilities to produce quality indicators and outcomes and to perform clinical research
   utilizing our integrated data holdings.

6. Establish Heart Team in Critical Care Heart Team in collaboration with Cardiac Anesthesia
   and Cardiac Surgery.

7. RCPS Accreditation Residency and 3 AFCs.

8. Implementation of Harvey to teach cardiac physical exam to IM residents during
   ambulatory care block.

9. Creation of a library of high media quality ECGs for use in training IM residents

10. Implement the Ottawa protocol for imaging for, and management
    of, chemotherapy-related toxicity in breast cancer patients.
Key Publications & Grants

Publications


**Grants**

**Liu P** (PI)—“IGFBP7—A Novel Biomarker, and a Clue to the Pathophysiology of Heart Failure with Preserved Ejection Fraction?” ($595,099 over 5 years)

**Derek So** (PI)—“Reassessment of Anti-Platelet therapy using InDividualized Strategies—Ticagrelor in Patients with Acute Coronary Syndromes Treated by Coronary Artery Bypass Graft Surgery—A Pharmacodynamic and Clinical Study to Decrease Bleeding Risks and Ischemic Complications - The RAPID-TITRATE CABG study” ($512,179 over 4 years)

**Liu P** (PI)—“Developing Novel Therapeutic Targets for Heart Failure” ($925,000 for 5 years including $400,000 from Servier)

**Tulloch H** (PI)—“Neurocognitive outcomes after out-of-hospital cardiac arrest” ($149,644 over 3 years)

**Coutinho T**—Investigating the pathogenesis and clinical applications of arterial health in cardiovascular diseases ($148,927 over 3 years)

**Birnie D** (PI)—Cardiac Sarcoidosis in Multi-centre Prospective Cohort ($259,897 over three years, Ranked 85.45% in Committee 1b)

**Coutinho T** (PI)—Predictors of Disease Progression in Thoracic Aorta Aneurysms: Role of Arterial Stiffness and Hemodynamics ($220,938 over three years, Ranked 96.49% in Committee 1a)

**Stewart A** (PI)—Mechanisms of coronary artery calcification risk conferred by 9p21.3 genetic variants ($217,740 over 3 years, Ranked 98.04% in Committee Iva)

**Hibbert B** (Project Leader)—Platelet Biology to Improve Patient Outcomes—from Bedside to Bench and Back ($537,500)

Honours and Awards

- **Dr. Rob Beanlands**—Canadian Cardiovascular Society Research Achievement Award, Department of Medicine Vision Award
- **Dr. David Birnie**—University of Ottawa Clinical Research Chair Award (Tier 1)
- **Dr. Thais Coutinho**—Canadian Cardiovascular Society Young Investigator Award, HSF Ontario Clinician Scientist Award
- **Dr. Ross Davies**—The Ottawa Hospital’s Physician Clinician Recognition Award
- **Dr. Darryl Davis**—University of Ottawa Clinical Research Chair Award (Tier 2)
- **Dr. Rob deKemp**—European Union Patent for Rubidium PET technology
- **Dr. Lloyd Duchesne**—Exemplary Care Recognition from UOHI Nursing
- **Dr. Girish Dwivedi**—Canadian Society of Echocardiography Top Abstract Award, CIHR New Investigator Award, CIHR Institute of Musculoskeletal Health and Arthritis (IMHA) Research Ambassadors Knowledge Translation Award, Junior Clinical Research Chair Award from uOttawa
- **Dr. Nadine Gauthier**—Master’s in Education, University of Cincinnati
- **Dr. Lisa Mielniczuk**—University of Ottawa Clinical Research Chair Award (Tier 2)
- **Dr. Derek So**—HSF Mid-Career Investigator Award
- **Dr. Steven Promislow**—2016 PARO Resident Teaching Award

Leadership

- **Duncan Stewart**, CEO and Scientific Director, OHRI
- **Ruth McPherson**, Chair, the Ruddy Canadian Cardiovascular Genetics Centre
- **Marino Labinaz**, Director Cardiac Care Unit (CCU)
- **Michael Froeschl**, Education Director for Cardiology (and Residency Training and Fellowship Director)
- **Michele Turek**, Site Director of Cardiology, TOH General Campus
- **Nadine Gauthier**, Director English and French Cardiovascular Block Program
Clinical Epidemiology

Prior Year’s Divisional Goals

In 2015–16 both Dean Fergusson and Jeremy Grimshaw:

- enhanced and enabled research in the Department of Medicine
- assisted with Department of Medicine recruitment
- assisted with academic promotions
- promoted Department of Medicine’s research visions and activities within the Ottawa Hospital Research

Most Significant Divisional Accomplishments in Last Academic Year

The Clinical Epidemiology Program accomplished a variety of initiatives in the 2015–16 academic year. Two that we would like to highlight are:

The Ottawa Methods Centre’s Strategy for Patient-Oriented Research (SPOR) program has grown significantly, in both capacity and impact, this past year. SPOR inherently aims to positively impact patient care by engaging patients as partners on the traditional research team. This ensures that research aligns with patient-reported priorities and outcomes. The knowledge generated is used to improve healthcare systems and practices. Further, OMC-SPOR’s role in providing training has impacted education within the hospital and the community. Such training includes planning the hospital’s Clinical Research Training week last year. The week took on a patient engagement focus and key patient engagement experts led many sessions. It resulted in an educational opportunity for researchers interested in conducting patient-oriented research.

In terms of advancing research, OMC-SPOR is actively involved with researchers who wish to engage patients in their work and are applying to provincial or national funding calls. Our group consults with applicant teams and offers scientific leadership in reviewing research proposals. Internally, the methods centre has been focused on conducting methods projects in order to build its knowledge base. A Horizon Scan and POR Literature Search are in their final stages and the intent is to send them for publication soon.
**Improving Quality at The Ottawa Hospital (IQ@TOH)** The Ottawa Hospital (TOH) has a goal to be among the top 10% in North America for quality and patient safety. TOH’s leadership team recognizes that in order to achieve top performer status, it is important to use scientific methods and rigour to guide priority setting, implement change, and evaluate impact. The OHRI-Clinical Epidemiology Program (CEP) has several world class scientists who have dedicated their careers to these goals. Traditionally, there has not been sufficient collaboration between hospital leaders, care providers and scientists.

To facilitate the creation of a meaningful collaboration between these stakeholders, a centre for excellence in health-care quality has been created called IQ@TOH. In its preliminary stages, IQ@TOH has achieved several important milestones, including: Senior Management Team support, receipt of external funding, and initiation of the first collaborative project with TOH’s Human Resources Department.

**Plans for the Coming Year**

For the coming year, Dean Fergusson and Jeremy Grimshaw will continue to enhance and enable research in the Department of Medicine, assist the Department of Medicine’s recruitment activities and academic promotions, and promote the Department’s research vision within the Ottawa Hospital Research Institute.

**Key Publications & Grants**

**Publications**


**Grants**

2015–2018. CIHR ($394,050). Tranexamic acid during cystectomy trial (TACT). Co-PI: **Dean Fergusson**

2015–2018. OSSU ($1,456,990). A Pragmatic Strategy Empowering Paramedics to Assess Low-Risk Trauma Patients with the Canadian C-Spine Rule and Selectively Transport them Without Immobilization. Co-PI: **Dean Fergusson**

2016–2021. CIHR ($1,490,000). Transfusion in Traumatic Brain Injury Trial (TSiTBI Trial) Co-PI: **Dean Fergusson**


2009–2015. CIHR ($1,400,000). Canadian Research Chair of Health Knowledge Transfer and Uptake (Tier 1 chair) renewal. PI: **Jeremy Grimshaw**


**Honours & Awards**

- **Jeremy Grimshaw** was elected co-chair of the Campbell Collaboration, an international research network that produces systematic reviews on the effects of social interventions in crime and justice, education, international development and social welfare. Dr. Grimshaw is a long standing contributor to The Cochrane Collaboration, which focuses on health-related systematic reviews, and he has led Cochrane Canada since 2005. He has completed 35 systematic reviews (including 10 Cochrane reviews) on a wide range of topics.
• Jeremy Grimshaw and David Moher recently made the list of the world’s top 3,000 researchers. This puts them in the top 0.03 percent, as it is estimated that there are more than 9 million researchers worldwide. The list of the “world’s most influential scientific minds” is compiled by Thompson Reuters, a major international multimedia company. Researchers are included based on the number of times their scientific publications are referenced by other researchers. Drs Grimshaw and Moher are both world-renowned experts in the field of systematic reviews—combining the results of many different studies to solve medical controversies.

**Critical Care**

Critical Care delivered clinical care to over 3,000 critically ill patients at both the Civic and General Campus Intensive Care Units (ICU) in 2015. Critical Care also maintained a strong presence in managing acute in-patient emergencies with the Rapid Assessment of Critical Events (RACE) team, present at both the General and Civic sites. The RACE team provided assistance for over 800 patients at both sites combined, and follow-up for over 3,200 in-patients. Critical Care continued its expansion of care for acutely ill patients in the Neuroscience Acute Care Unit, in direct collaboration with the Division of Neurology and Division of Neurosurgery. The NACU provided care for over 1200 patients.

**Most Significant Divisional Accomplishments in Last Academic Year**

Dr. Erin Rosenberg has led a multidisciplinary knowledge translation initiative to implement a fully integrated care bundle for management of Pain, Early mobilization, Delirium, Sedation and Sleep (PEDSS) for critically ill patients. This project formed the foundation of her Master’s Degree in Health Administration (MHA) as part of her completion of her Clinical Scholarship. This care bundle integrates the recommendations made by the Society of Critical Care Medicine, and represents a key tool in improving functional outcome for ICU survivors, and integrates the first multidisciplinary approach to knowledge translation for Critical Care guideline implementation. This bundle was implemented in November 2015 and is currently in the evaluation phase.

Drs Aimee Sarti and Pierre Cardinal have led initiatives in systems needs analysis on multiple fronts in 2015–16, including but not limited to the REACHout initiative in Cornwall Community Hospital (evaluation phase completed and published), Ebola Virus Disease (EVD) preparedness at The Ottawa Hospital (whose needs assessment methodology was
published in *CMAJ Open* in November 2015), and palliative care needs for community care settings (published 2015). Dr. Sarti and Dr. Cardinal’s work has received grant and financial support from the Royal College of Physicians and Surgeons of Canada (RCPSC), The Ottawa Hospital Academic Medical Organization (TOHAMO), the Department of Medicine and the Critical Care Medicine. They are currently collaborating with Dr. Michael Hartwick on national curriculum development in physician communication skills with organ and tissue donation.

**Dr. Lauralyn McIntyre** has led the Cellular Immunotherapy for Septic Shock (CISS) program, which examines the use of mesenchymal stem cells in the management of septic shock for critically ill patients. This program has received grant and financial support from Canadian Institutes of Health Research (CIHR), the Ontario Institute for Regenerative Medicine, and Critical Care Medicine, and has received media attention from print and television media for its innovation in clinical research for critically ill patients. She also continues her work in fluid resuscitation and blood product use (and their alternatives) in septic shock.

**Dr. Shane English** continues his research program examining red blood cell (RBC) transfusion and resuscitation during subarachnoid hemorrhage (SAH). He is now leading the SAHaRA group, who are conducting a multi-center phase 1 randomized control trial (RCT) examining the effect of different RBC transfusion strategies on neurologic outcome following SAH. Dr. English’s work has received grant and financial support from CIHR, Canadian Blood Services (CBS), The Department of Medicine and Critical Care Medicine. Dr. English also continues his research in traumatic brain injury as a member of the Canadian Traumatic Brain Injury Research Consortium (CTRC). This work offers the clear potential to improve outcome after both SAH and traumatic brain injury.

**Plans for the Coming Year**

Critical Care has successfully transitioned to a self-sustaining funding model for academic support, which obtains equal support from all subspecialty members within Critical Care. Critical Care will next seek to review its strategic plans in 2016–17 to ensure its ongoing growth in success in clinical care, national leader status for Critical Care in medical education and system change management, and its ongoing innovations in clinical research.

Critical Care is also implementing quality of care and patient safety (QuSa) initiatives to establish physician and nurse scorecards for clinical performance. The design phase is underway, with implementation expected for late-2016/early-2017.

Critical Care also seeks to consolidate its status as a leader in medical education and system change management through its collaboration with the Trillium Gift of Life, in the establishment of a national curriculum of physician communication for organ and tissue donation, led by **Drs Sarti** and **Cardinal** in collaboration with **Dr. Hartwick**; as well as ongoing national curriculum development for the ACES program book revision led by Dr. Pierre Cardinal; and in bedside point-of-care ultrasound (POCUS), led locally by **Dr. Scott Millington**.
Critical Care will continue to expand on its innovations in clinical research with support for the CISS, SAHaRa, variability in critically patients, that are respectively led by Dr. McIntyre, Dr. English and Dr. Andrew Seely.

Critical Care will expand on its excellence in quality of care and patient safety (QuSa) with the creation of a new self-funded QuSa section, planned for implementation in 2016. Dr. Rosenberg (Knowledge translation), Dr. Gianni D’Egidio (complex systems analysis), Dr. Kwadwo Kyeremanteng (strategic modeling), Dr. Sherissa Microys (Anesthesiology) and Dr. Dalibor Kubelik (Surgery/Vascular Surgery) bring multi-specialty QuSa expertise that Critical Care believes will ensure ongoing success in both clinical QuSa initiatives and in QuSa scholarship.

**Key Publications & Grants**

**Publications**


**Grants**


Honours, Awards & Leadership

- **Drs Shane English, Gianni D’Egidio, Scott Millington, Aimee Sarti, Giuseppe Pagliarello** and **Dalibor Kubelik** received the TOH Angel awards for 2015–16, in recognition of their exemplary roles as advocates for patient care at The Ottawa Hospital.

- **Dr. Rakesh Patel** received the Department of Medicine’s “Going The Extra Mile Award” in 2015–16. Dr. Patel’s tireless efforts at improving residency education, clinical bedside care and pharmacotherapeutics as Chair of the Pharmacy and Therapeutics (P&T) Committee for TOH are just but a fraction of the contributions Dr. Patel has given TOH and the University of Ottawa, in addition to his 10 years of service as Residency Program Director for Critical Care. His award is well-deserved—congratulations!

- **Dr. Michael Hartwick** serves as the Regional Medical Lead for Organ Donation for Trillium Gift of Life. Drs Hartwick, Cardinal and Sarti are currently collaborating on national curriculum development for physician communication with organ and tissue donation.

- **Dr. Erin Rosenberg** successfully completed her Master’s Degree as part of her Clinical Scholarship with the University of Cincinnati in Health Administration (MHA) in the summer of 2015.

- **Dr. Aimee Sarti** successfully completed her Master’s Degree as part of her Clinical Scholarship with the University of Dundee (Scotland) in Medical Education (MMEd) in the fall of 2016.

- **Dr. Aimee Sarti** received the University of Ottawa Medical Associates (UOMA) Scholarship in July 2015, whose funding for 2016 was provided by Critical Care Medicine.

- **Dr. Gianni D’Egidio** was appointed as Program Director for the Residency Training Program in January 2016.
Dermatology

Prior Year’s Divisional Goals

Our major goals for the past year included: building our Dermatology Centre of Excellence, recruiting academic/research dermatologists, rejuvenating our aging workforce and improving efficiencies and functions in our clinics. Our successes in achieving these goals are delineated below.

Most Significant Divisional Accomplishments in Last Academic Year

The Division managed approximately 10,000 outpatient visits at The Ottawa Hospital (TOH) this past year and provided over 400 in-patient consultations, approximately 380 at TOH and a further 11 at the Children’s Hospital of Eastern Ontario (CHEO). In addition, over 3,800 outpatients were cared for at CHEO and additional patients at Elizabeth Bruyère.

The Charlie Logue Dermatology Centre of Excellence is now under construction on the fourth floor of the Civic Parkdale Clinic. Phase 1 is due for completion by January 2017, with full completion due by September 2017. The Division, in cooperation with key community members and the Ottawa Hospital Foundation, have raised over $3.5 million to fund this project.

Dr. Carly Kirshen was recruited back to Ottawa and opened a specialized vulvar clinic. This clinic will be a great specialized service to our community and an opportunity for clinical research.

Dr. Ivan Litvinov was recruited from McGill as a clinician-investigator with 70% of his time dedicated to research, particularly within his field of expertise, cutaneous lymphoma. We have already seen evidence of Ivan’s success in his recent presentation at Grand Rounds, in the research awards he has won, and the publications he has completed.

Dr. Rob Prokopetz stepped down in June as our prime community dermatopathologist and teacher of pathology to our residents. Rob has provided exemplary service in Ottawa to our Division for 25 years. I want to extend our sincere thanks to Rob for keeping us on-track. There are countless patients who were well managed because of Rob’s interpretation of their pathology.

Dr. Scott Bradshaw has moved to Ottawa from Kingston to take over as the lead community dermatopathologist at Dynacare, and as the lead teacher of our residents.

Dr. John Goodall retired after almost 40 years of exemplary service to the Ottawa community.

Our residency training program continues to be the single most important activity in our division.
Our Program Director, **Dr. Steven Glassman** is a stellar leader in this regard. We are very proud that his contributions have been recognized with his recent award, the only PARO Excellence in Clinical Teaching Award for the University of Ottawa.

Our Division provides a full spectrum of clinical and academic opportunities for our trainees. Our clinics include general adult and paediatric dermatology, as well as specialty clinics for cancer, contact dermatitis, psoriasis, Mohs micrographic surgery, melanoma-pigmented lesions, leg ulcers and systemic therapy of skin diseases. We provide strong one-on-one mentorship for all our residents. In addition we provide classroom and clinical teaching for medical students and residents from other specialties. Some successes of our recent graduates include:

- **Dr. Julie Lacroix**—Provides community care at Elizabeth Bruyere and Montfort hospitals.
- **Dr. Shanna Spring**—Completed her Paediatric Dermatology fellowship in San Francisco and Toronto and is now based at CHEO providing pediatric dermatological care and will have a cross appointment at TOH.
- **Dr. Maxwell Sauder**—Successfully completed our residency program and Royal College exams and is currently doing a fellowship in cutaneous oncology in Boston.
- **Dr. Jeffrey Cowger**—Successfully completed our residency program and Royal College exam and has entered private practice in London, ON.

**Plans for the Coming Year**

Dermatology has been a Division within the Department of Medicine at both the Civic and General Hospitals since 1967, and will be celebrating its 50th Anniversary in 2017!

Moving forward we will continue the search for a new Division Head as Dr. Ken Kobayashi departed for a job in the USA with Novartis. In the interim, **Dr. Jim Walker** has returned as Acting Division Head while the search continues. We will complete the Dermatology Centre and continue to recruit more clinicians and academics. We will continue our pursuit to obtain operational funding from TOH and strive to improve our financial health and update our Divisional Practice Plan.

**Key Publications & Grants**

**Publications**


Grants

John R. Evans Leader’s Fund for project entitled Practice changing research: Improving diagnosis and management for Cutaneous T-Cell. Funding in the amount of $153,000 approved on November 27, 2015. Role in the project—Ivan Litvinov, Principal Investigator.

Department of Medicine Developmental Research Award. Amount: $42,000. Project Title: “The use of transcriptional profiling to improve personalized diagnosis and management of Cutaneous T-cell Lymphoma (CTCL).” Role in the project—Ivan Litvinov, Principal Investigator.

Joan Sealy Trust in the competition (Ottawa Hospital Research Institute—Awarded funding on January 20, 2016 in the amount of $40,000 for the project entitled, “Assessing the efficacy of Maraba MG1 oncolytic virus against Non-Melanoma Skin Cancers (NMSCs). Role in the project—Ivan Litvinov, Principal Investigator

Honours & Awards

- Guardian Angel honour roll for 2014–15 included Dr. Jillian Macdonald who was named a Guardian Angel for the fifth time.

- Dr. Jennifer Beecker, was awarded the prestigious 2016 President’s Cup an award given at the discretion of the Canadian Dermatology Association President to a member who has been of particular assistance to the president and/or the association over the past year and who the president feels made a significant contribution to the Association.
Endocrinology & Metabolism

Prior Year’s Divisional Goals

Transition of bariatric medicine patients to community office without disruption of clinical care and education mandate: A new model of care was developed and established in the community to complement care available through The Ottawa Hospital (TOH) Bariatric Centre of Excellence. The bariatric fellowship program continues to grow with increased academic activity.

Improve diabetes care for patients using CGM (continuous glucose monitoring) and insulin pumps by ensuring readiness of glucose management data through information management: A working group was established. Processes and materials were developed, and then implemented successfully in clinic. Evaluation of the project is ongoing.

Monitor and reduce wait times: Ongoing discussions with our clinic manager and community endocrinologists are occurring. Triage criteria for new referrals have been modified. There is now a communication tool with referring providers to encourage distribution of consults to community endocrinologist when appropriate. Wait times are being monitored and additional clinics for urgent referrals are scheduled when needed. We continue to promote eConsultation as alternative to face to face visits.

Consolidate clinical research activities to enhance efficiency and collaboration: Our clinical research centre renovation is now completed. Our research personnel are now better integrated, and we have optimized the use of our research space. There are ongoing opportunities for collaboration with Riverside-based investigators.

Most Significant Divisional Accomplishments in Last Academic Year

Multiple peer-reviewed publications involving Internal Medicine and Endocrinology and Metabolism residents supervised by Endocrinology and Metabolism faculty.

The Champlain BASE eConsult service, co-founded by Dr. Erin Keely, has provided over 16,000 patients with faster access to specialist advice. Multiple peer-reviewed publications and leadership at the provincial and national level has resulted in expansion of the service in Ontario, Newfoundland, and Nunavut.

Dr. Janine Malcolm was accepted into the IDEAS Advanced Learning Program, a program that is designed to assist health care professionals leading quality improvement projects. IDEAS is a collaborative Ontario based program involving provincial institutes and universities. Her TOH-based project is “Optimizing perioperative glucose control to improve surgical site infections”.

The Fruits of Our Labour
Two division members have been appointed to key leadership roles.

- **Dr. Heather Lochnan** is the Assistant Dean Continuing Professional Development (CPD), Education Programming within the University of Ottawa, Faculty of Medicine. Her role includes overseeing the faculty development program, the faculty teacher recognition initiatives and promotion of a comprehensive CPD program.

- **Dr. Alexander Sorisky** is the Director of Mentorship, a newly created position by the Department of Medicine. This program is formally matching new department members or those otherwise seeking career advice (mentees) with more senior members (mentors) to provide support and guidance. The goal is to nurture career success and satisfaction through these collegial interactions.

**Plans for the Coming Year**

1. Smooth change in leadership positions for Division Head and Director of the Endocrinology and Metabolism Residency Program.

2. Build clinical research activity, including collaborative translational projects related to vascular and metabolic health.

3. Leadership in patient-centered quality improvement activities, including a) identification of metrics relevant to our outpatient-focused clinical care, b) patient focus groups to improve quality of resources available for people with diabetes involved in high intensity physical activity, c) effective use of technology for self-management of diabetes including availability of continuous glucose monitoring devices, and d) participation as a pilot site in TOH MyChart initiative.

**Key Publications & Grants**

**Publications**


**Grants**


**Sorisky A.** Heart and Stroke Foundation of Canada. Adipose Progenitor Cell Responses to Nutrient Stress and Macrophages.

**Liddy C, Keely E.** Canadian Institutes of Health Research (CIHR). Building Access to Specialist Care through eConsultation

**Zha X** (PI). Canadian Institute of Health Research (CIHR). ABCA1 regulated Inflammatory Response and Cholesterol Efflux through Disrupting Lipid Rafts in Macrophages

**Scott F** (PI). Canadian Institute of Health Research (CIHR). Antimicrobial Peptides and M2 Macrophages as New Targets for Intervention in Type 1 Diabetes.

**Honours & Awards**

- **Drs Erin Keely** and **Clare Liddy** (Dept of Family Medicine) received several awards recognizing the impact of the Champlain BASE eConsult program. These include the Honor Roll of the Ontario Ministry of Health and Long Term Care, Minister’s Medal for Excellence in Health Quality and Safety, Honour Roll, and second prize in the Canada Health Infoway’s Imagine Nation e-Connect Impact Challenge.

- **Dr. Heather Lochnan** was awarded a Faculty of Medicine Educator Award in the Leadership/Manager Competency (Dec 2015)

- **Dr. Amel Arnaout** and **Kim Twyman** were nominated for the University of Ottawa Heart Institute’s Annual President’s Team Spirit Award on May 24, 2016 for their work on the Insulin Pen Project.


**Gastroenterology**

The division of gastroenterology at The Ottawa Hospital and the University of Ottawa provides excellent clinical gastroenterology, hepatology and therapeutic endoscopy services. The division maintains a strong, fully accredited gastroenterology residency training program, supports undergraduate and post graduate medical education, and conducts investigator initiated, industry funded research in the areas of colorectal cancer screening, endoscopy quality, inflammatory bowel disease and Therapeutic endoscopy. The division supports a growing number of medical student and resident research projects. GI divisional members hold key national, provincial and regional leadership roles including: the medical lead for the Ontario Colorectal cancer screening program (ColonCancerCheck), National endoscopy training co-lead (CAG-SEE Program); national GI quality affairs (CAG); regional endoscopy / QBP /QMP medical lead; and participation in National IBD research Networks.

**Most Significant Divisional Accomplishments in Last Academic Year**

**Clinical Care**

The division has now recruited to the required 4 hepatologists with the recruitment of **Dr. Cynthia Tsien**. Dr. Tsien will lead the end stage liver disease and the pre/post liver transplant program at TOH. This program will shortly be supported by an experienced transplant coordinator nurse funded 50-50 by the Division of GI and the LHIN/TOH.

Therapeutic endoscopy has become a major pillar of the specialty, more so now than ever with the resent explosion in microsurgery technology. ERCP is no longer synonymous with GI therapeutics. In fact with the upcoming change to the Ontario Colorectal Cancer screening program to use FIT rather than FOBT, there will be significant demand for endoscopic microsurgery. As such, **Dr. Ralph Lee** has gone on a six-month sabbatical to Sydney Australia to train in advanced endoscopic mucosal resection with the top EMR expert (Dr. Michael Bourke) so as to expand the TOH skill to 6 divisional Members. In addition, **Dr. Rostom** is training in another advanced technique called endoscopic submucosal dissection which allows en block resection of early invasive GI neoplasia (University of Florida with Dr. Peter Draganov). **Dr. Dhaliwal** has now completed well over 50 endoscopic Zenkers’ diverticulotomies with very good safety and efficacy results. To support these advanced techniques, the GI division has purchased animal scopes and developed an explant organ and live animal lab at the University of Ottawa/TOH simulation Centre. In addition, the division performed the first cases at TOH of direct endoscopy of the bile ducts with endoscopic stone lithotripsy (**Dr. Grégoire**). These cases
were performed using a new single use bile duct endoscope called Spy Glass and were funded by the Division for TOH patients.

**Improved Clinical Care Pathways**

The division identified several key clinical care pathways to work on in this reporting Year. These were: improved ER referral pathways; centralizing referrals for key GI areas; and improved outcomes in common GI procedures.

To this end, the Division worked with the Departments of Radiology, and ER to develop a new care path for cirrhotic patients presenting to ER for paracentesis. The new pathway allows ER Docs to discharge these patients home with following day outpatient large volume paracentesis in Radiology followed by recovery in the medical care unit under the GI on call physician. The division has also worked with ER to streamline outpatient urgent referral requests. In collaboration with Corporate endoscopy, we are in the process of implementing an ER central referral intake clerk and process. A similar process currently exists for all colorectal cancer screening colonoscopy requests and requests for the registered flex sig colon screening program. Additionally, all endoscopic ultrasound and ERCP referrals are handled centrally, and hepatology referrals for 3 of 4 hepatologists (all at general) are handled centrally in a shared office environment.

Furthermore, the division has taken a leadership role in implementing new corporate PEG tube insertion and management guidelines as well as enteral feeding guidelines.

**Research infrastructure**

The division continues to see important improvements in research productivity. To further assist with research success, the Division has hired a full time PhD-level research coordinator with coordination, research and writing skills. This adds to industry funded an IBD research coordinator. The division continues strong research ties with the GI group in Calgary.

**Education**

The division planned to continue to build on its educational mandate, both locally as well as nationally. The Division now supports a CAG accredited and supported national Skills Enhancement in Endoscopy (SEE) Centre. The Centre ran three live endoscopy courses in the past year for GI residents, practicing GI docs, surgeons, and GI pediatricians (CHEO). The Centre is expected to run a minimum of four courses per year with two already filled for 2016–17.
Plans for the Coming Year

The Division’s Goals for the upcoming year continue to follow our 5-year strategic plan. The hallmark of this plan is to: a) fill the critical clinical care gaps that have been identified through strategic recruitment; b) improve the quality and efficiency of care for TOH patients with GI disorders through hospital and LHIN wide collaboration; and c) continue to build and support academic infrastructure in support of research and education as well as to develop the next generation GI leaders.

For the next year, the division will concentrate on centralization of GI resources and clinics to enable cost and efficiency realizations while improving access and quality of care. This will be coupled with a trial of a new endoscopy scheduling model that frees clinicians from outpatient clinical and endoscopy work while on service in hospital.

Regional Coordination continues to be a key priority for the Division. Significant strides have been made in the last year. The next year will see continued work and in particular regional resource planning for the implementation of FIT colorectal cancer screening in the Champlain LHIN and more relevant here, its impact on TOH.

Key Publications & Grants

Publications


Grants

Murthy S. University of Alberta—Future Leaders in IBD. Development of Diagnostic Algorithms for Predicting Disease Phenotypes in Adult Onset Ulcerative Colitis Patients Using Ontario Health Administrative Data. ($25,000) 2014–16.


Honours & Awards

- Alaa Rostom has been selected as the recipient for the Canadian Association of Gastroenterology (CAG) Education Excellence award for 2016. The CAG Education Excellence Award is awarded to a member of the CAG who has made an outstanding contribution to education on a national or international basis. The contribution may be in the areas of direct teaching, research in education or development of educational programs.

- Multiple Division members have received guardian angel awards and hospital recognition for excellent Care: Harry Dhaliwal, Linda Scully, Nav Saloojee, Tom Shaw-Stiffel, Avi Chatterjee.

National Provincial & Regional Leadership Roles

- Catherine Dubé was selected by Cancer Care Ontario (CCO) to be the Clinical/Medical Lead for the Ontario colorectal cancer screening program (coloncancercheck).

- Alaa Rostom was appointed by CCO and the regional VP for cancer care to take on the role of Colorectal cancer screening and endoscopy lead for the Champlain region. More details are provided under patient advocacy.
• **Alaa Rostom** is the Canadian Association of Gastroenterology national endoscopy training co-lead. The CAG skills enhancement in endoscopy program (SEE) was modeled after a similar program supporting endoscopy quality in the UK.

• **Sanjay Murthy** belongs to two inflammatory bowel disease research consortiums: CINERGI (Consortium of IBD-focused iNvEstigatoRs and Gastroenterollgists) and Canadian Gastro-Intestinal Epidemiology Consortium.

• **Sanjay Murthy** is the Medical Director for the TOH home TPN program.

• **Sylvie Grégoire** is the Medical Director of the TOH corporate endoscopy Committee.

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**General Internal Medicine**

The Division of General Internal Medicine remains active academically and clinically. The division is committed to excellence in clinical care with a focus on patient quality and safety, medical education and health care system performance. General Internal Medicine continues to be at the forefront of systems innovations and patient care initiatives at The Ottawa Hospital (TOH).

**Most Significant Divisional Accomplishments in Last Academic Year**

1. Established a Rapid Referral Clinic Quality Improvement Project with the help of Dr. Heather Clark. This process has allowed us to streamline referrals to RRC from ED and our wards while expanding our clinic footprint. Preliminary data suggests this may help our discharge process, shorten length of stay while also decreasing re-admission rates.

2. Establishing non-teaching service to protect and enhance CTU experience for learners

3. Established POCUS training and curriculum for our trainees

4. Established a Vascular Risk Reduction Clinic
Plans for the Coming Year

1. Successful Accreditation of our GIM training program
2. Expand our training and education of POCUS
3. Continue to develop our RRC process and consider expanding it to include complex disease management
4. Explore alternate models of care for our complex patients who are admitted to hospital
5. Continue to focus on our successes in research, medical education and leadership roles at TOH, UO and associated organizations.

Clinical Activities

In-Patients—The Division of General Internal Medicine cares for a large volume and proportion of TOH in-patients, mostly in the setting of the Clinical Teaching Units. There are six units, three at each of the Civic and General campuses. These include fourteen monitored (Civic eight and General six) beds and four telemetered beds (Civic). Almost eight thousand patients were admitted to General Internal Medicine over the past twelve months, representing an increase of 30% over 3 years, most of which were referred from the Emergency Department of The Ottawa Hospital. It’s worth noting that approximately 35% of all patients admitted to The Ottawa Hospital via the emergency department are cared for by the General Internal Medicine team.

There is also a non-teaching unit, supervised by attending physicians from the Division and staffed by 3 Physician Assistants. At both sites, a fourth non-teaching team has been developed. This team accepts patients with acute medical conditions and is staffed solely by an attending physician.

In addition, to the in-patient units, General Internal Medicine provides an inpatient consultation service to other departments and divisions, staffed by GIM faculty and senior medical residents. A second consult service for ward-based referrals exists. This allows one team to provide peri-operative care and other services on the wards and one team to dedicate its efforts on patient care and flow in the Emergency Room and Intensive Care Unit.

Out-Patients—General Medicine out-patient clinics are conducted at the General and the Riverside. The clinics include a specialized preoperative evaluation assessment unit for patients with known medical illnesses. The clinic works closely with the PAU and liaises with our ward based peri-operative consult service. Our Rapid Referral Clinics operate five days a week and decant patients from the CTU’s and the Emergency Room. It also serves as our GIM fellows/longitudinal clinic.

As well as General Medicine clinics, our GIM staff participate in special interest clinics: Medical Complications of Pregnancy, HIV, Diabetes, Rheumatology, Pulmonary Hypertension, Thrombosis and Weight Management. More recently our division has established a vascular risk reduction clinic in conjunction with the vascular surgery team at the Civic Campus.
**Educational Activities**

Our GIM training program will be undergoing our first Royal College Accreditation this fall. Under the guidance of Dr. Heather Clark and Dr. Samantha Halman we are looking forward to a successful evaluation.

Under the guidance of Dr. Hassan Mustafa and others we have successfully established a curriculum in Point of Care Ultrasound (POCUS). This has been implemented for the Core IM residents and will be rolled out to our GIM residents shortly.

Our staff are active at the Simulation Centre, including ACLS training, ACES courses, Cardiac exam simulation, line insertion courses etc.

We have established dedicated bedside teaching rounds for both junior and senior medical residents. We have recently started “Difficult Diagnosis Rounds” which are led by our GIM trainees.

Our staff continue to care for many patients directly in order to enhance the teaching and learning environment on the CTUs.

**Research Activities**

The division has an internationally recognized research program. Areas of interest include patient safety, resource utilization and public policy. This work is facilitated by both The Ottawa Hospital comprehensive Data Warehouse and the ICES satellite unit. The physicians primarily involved are well funded by peer-reviewed agencies and have a very impressive publication record. The division is also active in medical education research. Areas of focus include student and resident assessments, procedure skills and feedback processes.

**Quality and Collaboration**

- General Internal Medicine has been actively involved in many Ottawa Hospital quality projects. Our Patient Safety and Quality committee is led by Dr. Delvina Hasimja.

- Dr. Delvina Hasimja and Dr. Krista Wooller have created a Foundation of Quality Improvement curriculum for the core IM and GIM programs.

- We have expanded our M and M rounds with dissemination of information.

- We are establishing resident led M and M rounds are part of their core education.

- We have hired two clinical scholars who are doing focussed training and education in Patient Safety/Quality and Medical Informatics.
• Under the leadership of **Dr. James Chan** we have expanded our peri-operative clinic. Particularly we are part of the Peri-op Glucose Initiative. This is an active dysglycemia case finding initiative with the goal of decreasing LOS for surgical patients.

• We participate in a variety of discharge projects at TOH including the COPD Outreach Program and the CHF Gap Tool initiative.

• We have a variety of ongoing PSQ projects. These include a Code Blue Simulation project, End of Life Communication project and expansion of our Catheter Associated UTI prevention project.

• We have established ADT (Admit, Discharge, Transfer) criteria for our Advanced Monitoring Areas (AMA). The AMA ADT criteria we established as part of a wider IHO project examining patient flow at TOH.

**Leadership Roles at The Ottawa Hospital, uOttawa & Other**

General Internal Medicine members occupy a variety of key leadership roles.

**The Ottawa Hospital**

• **Dr. James Chan**—Co-chair of the Physician Wellness Committee at The Ottawa Hospital. He is also the eHealth lead for the Faculty of Medicine

• **Dr. Alan Forster**—Chief Quality and Performance Officer at The Ottawa Hospital

• **Dr. Glen Geiger**—Chief Medical Information Officer at The Ottawa Hospital.

• **Dr. Alan Karovitch**—TOHAMO Board of Directors, Medical Staff Association Secretary/Treasurer

• **Dr. Jeff Turnbull**—Chief of Staff at The Ottawa Hospital

• **Dr. Heather Clark**—Medical Director Ambulatory Care

• **Dr. Delvina Hasimja**—Chair, Dept. of Medicine Patient Quality Assurance Committee

• **Dr. Alison Dugan**—Administrative lead between The Ottawa Hospital and the Nunavut Specialist Physician Group.
University of Ottawa

- **Dr. Loree Boyle**—Associate Program Director Core Internal Medicine, University of Ottawa
- **Dr. James Chan**—International Medical Graduate (IMG) Director at the University of Ottawa
- **Dr. Justine Chan & Dr. Isabelle Desjardins**—Associate Directors Medicine Clerkship University of Ottawa
- **Dr. Cathy Code**—Core Internal Medicine Program Director and Director UGME, Department of Medicine, University of Ottawa
- **Dr. Vladimir Contreras-Dominguez**—Internal Medicine Clerkship Director, University of Ottawa
- **Dr. Catherine Gray**—Director of Link Block, University of Ottawa
- **Dr. Samantha Halman**—OSCE Chief Examiner, Francophone Stream, UGME, University of Ottawa. Lead Simulation Educator, Internal Medicine, University of Ottawa Skills and Simulation Centre (uOSSC).
- **Dr. Steve Kravcik**—Chair of Faculty Appeals Committee, University of Ottawa.
- **Dr. Debra Pugh**—Director of the Ottawa Exam Centre
- **Dr. Carl van Walraven**—Site Director ICES@uOttawa

Other

- **Dr. Craig Campbell**—Director, Continuing Professional Development, Offices of Specialty Education, Royal College of Physicians and Surgeons of Canada
- **Dr. Debra Pugh**—Vice Chair of Central Examination Committee, Medical Council of Canada
- **Dr. Claire Touchie**—Chief Medical Education Advisor, Medical Council of Canada, Senior Research
Key Publications & Grants

Publications


Grants

Dr. Alan Forster—Canadian Institutes of Health Research (CIHR). Improving care for emergency department and Pre-hospital patients with acute and life-threatening conditions

Dr. Samantha Halman—Royal College of Physicians and Surgeons of Canada. Bridging the surgical/medical divide: implementation of the Ottawa Clinic Assessment Tool (OCAT) in Internal Medicine.

Dr. Claire Touchie, Dr. Debra Pugh, Dr. James Chan—Royal College of Physicians and Surgeons of Canada. The influence of first impressions on OSCEs: Does scoring format and type of assessment matter.
Dr. Carl van Walraven—National Centre for Excellence, Tech Value Net. Pilot study of an automated one-year mortality prediction tool to trigger Advanced Care Planning


Dr. K. Wilson—PHAC—Innovation Strategy Program. Development of a mobile enhanced immunization information system.

**Honours & Awards**

- Dr. Cathy Code—TOH Clinical Recognition Award
- Dr. Vladimir Contreras-Dominquez—CAME Certificate of Merit Award
- Dr. Vladimir Contreras-Dominquez—DoM Professionalism and Collegiality Award
- Dr. Claire Touchie—Dr. Meridith Marks Educator Award for Innovation and Scholarship in Medical Education
- Dr. Jim Nishikawa—CSIM-Royal College Olser Lecturer 2015
- Dr. Samantha Halman—CAME Foundation Wooster Family Grant in Medical Education
Geriatric Medicine

Prior Years’ Divisional Goals

In 2015–16, the Division of Geriatric Medicine focused on three priority areas:

1. Communication and early implementation of our Strategic Plan. There were presentations to The Ottawa Hospital (TOH) senior management, divisions of Cardiology and General Internal Medicine and the Ottawa Heart Conferences describing our areas of expertise as the programmatic themes of MIND, MOBILITY, MEDICATIONS and MULTI-COMPLEXITY. The Geriatric Medicine Unit on A1 at the Civic campus and the Geriatric Medicine Consult teams continue to rapidly evolve to see more hospitalized high risk older patients, assist in developing durable discharge plans and improve patient flows. The Geriatric Medicine Ambulatory Services and Day Hospital continues to meet or exceed its patient volume targets.

2. Partnership with General Internal Medicine is ongoing. Early identification of high risk older patients being admitted is starting to lead to more timely referrals, assessments, transfers and discharges.

3. The Champlain LHIN falls prevention and management program has now been implemented as a new clinic at TOH.

Most significant Divisional Accomplishments in Last Academic Year

The Fall Assessment and Streamlined Treatment (FAST) clinic was inaugurated as a pilot project in 2015 and quickly attained mainstream operational status in 2016. Drs Shirley Huang, Frank Molnar, Bill Dalziel and Lara Khoury, along with Advanced Practice Nurse Taryn Mackenzie and physiotherapist Mary Haller have expertly designed, developed and implemented this clinic. This clinic, the first of its kind in Ottawa, will anchor the development of similar clinics across the region. These emerging falls clinics are an essential missing service to manage people who have fallen and have been identified in the Emergency Rooms, primary care offices and community outreach services.

An innovative medical education research project looking into teaching medical residents about working with interprofessional teams is underway. Teamwork is essential for best hospital care, which is frequently complex. Patients on the Geriatric Medicine Unit all have interacting medical and psychological conditions and social situations. If this research project shows that short training videos are successful in improving residents’ knowledge, skills and attitudes concerning team-based hospital care, then tools could be developed to be used in other clinical programs where team-based care is important.
A new book was published (see below) which features several Divisional members as authors, including our Geriatric Medicine Unit clinical pharmacist, Derek Dyks.

Another five primary care-based dementia clinics were launched in the Champlain LHIN with our members supporting as clinician experts. These clinics are modeled after those developed by Drs Linda Lee & George Hechtman (Kitchener, ON) and represents a new model of dementia care which more efficiently uses limited Geriatrician resources.

**Plans for the Coming Year**

Our Division will continue to work with General Internal Medicine on optimizing the processes for detection of admitted high risk older patients. We will continue to transfer appropriate admitted patients who are waiting in the Emergency Room for a bed, directly to the Geriatric Medicine Unit.

We anticipate a doubling of the capacity of the FAST clinic activities in the coming year. We will also work on models for its possible replication into other hospitals in the Ottawa area.

**Dr. Frank Molnar** will continue his work on promoting and advocating for dementia care programs and policies for Ontario and Canada. As the Canadian Geriatrics Society Vice-President and designated member to the Canadian Medical Association for Geriatric Medicine issues, especially in the implementation of a National Seniors’ strategy, he will ensure that the voice of Geriatrics is loud and clear.

**Dr. Allen Huang** will be actively participating in the MedStopper pan-Canadian multi-centre trial (Halifax, Montreal, Ottawa, Toronto, Calgary, Vancouver) looking at reducing post-discharge potentially inappropriate medications in older patients who had been admitted to the General Medicine Clinical Teaching Units.

**Key Publications & Grants**

**Publications**


a. Huang, A.R., Mallet, L. Chapter 1. Introduction
c. Huang, S.C.C., Forster, A. Chapter 7. Adverse Events and Falls
e. Huang, A.R. Chapter 19. The Role of Information and Communication Technologies.

Grants


Honours & Awards

Our division is extremely proud to have the following members in Departmental, University and National leadership positions. These include:

• Dr. Anna Byszewski—Anglophone Director of Professionalism in the Faculty of Medicine; assistant Anglophone Co-Chair of the “e-Portfolio” Program and the Geriatrics rotation coordinator for all medical students and residents.

• Dr. Lara Khoury—Geriatric Medicine residency training Program Director, University of Ottawa.

• Dr. Frank Molnar—Vice-President of the Canadian Geriatrics Society; the Editor-in-Chief of the Canadian Geriatrics Society CME journal.
• **Dr. Barb Power**—Anglophone Director of the Clinical Skills Program and the Physical Skills Development in the Faculty of Medicine, University of Ottawa; Department of Medicine Vice-Chair for Education.

• **Dr. Ed Spilg**—Department of Medicine Vice-Chair for Physician Health and Wellness.

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**Hematology**

**Prior Year’s Divisional Goals**

**Implement our Divisional Strategic Plan**

Our Hematology 2020 plan continues to guide our focus and efforts. Concrete projects and tools have been designed and implemented within the domains of Finance, Training and Workplace, including a staff satisfaction survey that will launch this fall. Measures of success have been identified and regular reporting on these measures will commence in 2016–17. As many of our strategic goals span multiple years for implementation, the plan will continue to be an area of focus in 2016–17.

**Raise $1 Million for our Research Chair in Advanced Stem Cell Therapy**

In 2015–16 we pursued several fundraising initiatives to make our goal a reality. Our division’s physicians contributed $40,000 to the Research Chair and we intend to repeat this annually over the next four years for a total donation of $200,000. We enthusiastically participated in the Department of Medicine’s Dancing with the Docs event, with **Dr. Mitch Sabloff** dancing and many of our physicians and staff purchasing tickets for the event. Again in 2015–16 many of us participated in Run for a Reason, raising funds for the Research Chair, and we also worked with a local public figure to raise funds for our cause. To date our efforts have resulted in approximately half a million dollars raised for our Chair.

**Achieve our wait time targets for new consults**

With growing numbers of referrals and patient visits, maintaining low wait times for new consults continues to pose a challenge for some of our programs. In our Thrombosis program, urgent consults are seen within 24 hours at one of our clinics offered 7 days per week, and peri-operative consults are consistently seen within the required time frame, reducing procedure cancellations.
Within our malignant hematology and benign hematology programs, wait times have not yet met targets. Referral volumes continue to grow: we had over 3,000 new consults received in 2015–16, representing a 6% growth from referrals in 2014–15. While urgent consults continue to be seen immediately (<24 hours), reducing the median wait time for patients from referral to consult.

With several new physicians joining our division and physical capacity enhancements in 2016–17, our expanded clinical capacity will enable us to reduce patient wait times.

**Most Significant Divisional Accomplishments in Last Academic Year**

In 2015–16, our division embarked on several improvement initiatives.

**Here we GROW again!**

In order to accommodate our growing physician and staff complement, we undertook a major physical reconfiguration of our office space in the Ottawa Blood Disease Center (OBDC), resulting in 17 net new workspaces. After months of exhaustive planning, the physical work took place over the course of 12 days with close to zero downtime for our staff. This reconfiguration allowed us to maximize our capacity within our existing footprint. With Dr. Natasha Kekre and Dr. Andrea Kew hired in 2015–16 and several more physicians recruited for 2016–17, finding space for our growing teams will continue to pose a challenge.

**Improving the Trainee Experience**

In response to feedback regarding our medical trainees’ experience in Hematology, and in line with our top education strategic goal of making Hematology “the rotation of choice”, we planned and implemented a comprehensive project to improve the trainee experience. Changes to our existing program are far-reaching, including eliminating malignant hematology ward call for PGY1s (perceived as overwhelming at PGY1 level) and creating a new Hematology Selective with clinics and consult service for benign hematology and thrombosis for PGY 1s to 3s. We are confident that these changes, along with continuing our formal teaching work (morning report, sub-specialty rounds) and handover rounds, will elevate our training program to the next level. An analysis of the impact of these changes is planned for the coming year.

**Establishing National and International Research Networks**

In 2015–16, our division was successful in obtaining a CIHR grant of $5.2 million over 5 years to establish CanVECTOR—the Canadian Venous Thromboembolism Clinical Trials and Outcomes Research Network. This new network is a pan-Canadian, patient-oriented network centred on venous thromboembolism (VTE) relate research, training and knowledge translation.
This first year of growth included the establishment of three platforms being led in Ottawa: Patient Partners, Clinical Trials, and Training and Mentoring. Pan-Canadian projects are now underway within each of these platforms.

We also launched INVENT—the International Network of Venous Thromboembolism Clinical Research Networks. This independent, not for profit network of academic VTE clinical research networks seeks to promote international collaboration for the conduct of VTE related research, and to enhance the profile, science and impact of investigator-led VTE clinical research. INVENT is hosted by our Division. With current member networks spanning 9 countries internationally, INVENT is poised to be a global leader in driving and accelerating academic VTE related clinical research.

**Plans for the Coming Year**

In the coming year, our Division will be focussed on several key initiatives: growth and integration of the Bone Marrow Transplant (BMT) program, driving investigator initiated research within the Malignant Hematology program, and expanding the scope and impact of our new national and international networks.

The BMT program at TOH is currently expanding at a rapid pace. With our new role as provincial leaders for assessing and triaging BMT patients for Ontario, the Ministry of Health is supporting a massive expansion of both our clinical human resources and physical capacity for providing care. Over the coming year, we will be working toward a doubling of capacity in our inpatient beds, clinics and medical day care as well as expanding our outpatient capacity. We anticipate that 3 physicians will join our team in 2016–17 and we will be working to expand and integrate the BMT program to keep pace with demand. With [Dr. Lothar Huebsch](#) co-chairing a Ministry of Health committee focussed on provincial access to transplants, the Ottawa Blood Disease Centre will continue to be a leader for transplants in Ontario.

In addition to expanding our clinical capacity, we will work to drive investigator-initiated research within the Malignant Hematology program. Major grant applications are underway for investigating innovative treatments for debilitating hematologic malignancies, and a new study examining infected cell vaccines in leukemia will be launching this year. With the recent addition of new clinician-scientists to our team and heightened interest in our ground-breaking trials, our research is poised to quickly escalate in 2016–17.

In the world of Thrombosis care and research, we will focus on the growth and expansion of our new networks, CanVECTOR and INVENT. As the CanVECTOR network enters its second year, we will be focused on providing support to trainees and early career investigators through grants and awards, as well as the launch of a new academic mentorship program and educational initiatives that will be informed by a recently completed needs assessment. We will continue to build infrastructure and explore opportunities to facilitate national research collaborations,
including a new member portal on www.canvector.ca for communicating and sharing research resources, and development of standardized data management tools. We will build a foundation for international research collaborations through the newly formed INVENT network which links established and emerging national venous thromboembolism networks from around the world to accelerate patient-oriented, investigator-initiated clinical research related to venous thrombosis.

**Key Publications & Grants**

**Publications**


Grants

**CIHR Operating Grant: $407,356.** Ito C, Perkins, TJ. **Sabloff M,** Stanford, WL. The role of PCL2/PRC2 in hematopoietic stem cells and leukemia.

**CIHR Community Development Program Grant: >$5,000,000.** Kahn SR, **Rodger MA** et al. CanVECTOR (Canadian Venous Thromboembolism Clinical Trials and Outcomes Research) Network.

**CIHR Operating Grant: $187,878.** Sheppard D, Tay J, Tinmouth A, Allan DS, Beattie SM, **Bredeson C,** Fergusson DA, **Sabloff M,** Thavorn K. Platelet Transfusions in Hematopoietic Stem Cell Transplantation—The PATH Study.

**CIHR Project Grant: $424,298.** **Rodger MA,** Fergusson DA, **Gandara E,** Kahn SR, Kearon C, Kovacs M.J, **Le Gal G,** Ramsay TO, Shivakumar SP, Tagalakis V, Thavorn K. StAtins for Venous Even Reduction in Patients with Venous Thromboembolism (SAVER). Top ranking in the 2016 CIHR project competition!

**Heart & Stroke Foundation Grant-in-Aid: $255,538.** **Le Gal G,** Anderson D, de Wit K, Kahn S, Kearon C, Ramsay T, **Rodger MA,** Righini M, Shivakumar S, **Wells P.** Age-adjusted D-dimer cutoff levels to rule out deep vein thrombosis (The ADJUST-DVT Study).

Honours & Awards (including leadership positions)

- **Dr. Marc Carrier** received the Dr. Michel Chrétien Researcher of the Year Award for leading a clinical trial, published in the New England Journal of Medicine, which will save countless thrombosis patients from unnecessary and potentially harmful tests. Rumours are we may soon be boasting about a Hematology 'three-peat' for this award!

- **Dr. Marc Carrier** has been recognized as one of two Ottawa research papers on New England Journal of Medicine's top 12 list in 2015. Dr. Carrier found that contrary to expectations, CT scanning does not improve cancer detection in people with unexplained blood clots. According to the journal’s editor, papers chosen for this list represent “the cream of the crop, the dozen studies from 2015 that we think will have the biggest influence on medicine.” His paper also won the Canadian Hematology Society’s Paper of the Year award.

- **Dr. Mitch Sabloff** was a fan fave performer at this year’s Dancing with the Docs event!

- **Dr. Melissa Forgie** was re-appointed Vice-Dean UGME.

- **Dr. Melissa Forgie** was the recipient of the Department of Medicine’s Jeff Turnbull Health Care Advocacy Award for her work establishing the Ottawa-Shanghai Joint School of Medicine in China.
Infectious Diseases

Prior Year’s Divisional Goals

Enhance Antibiotic Stewardship and Infection Control.

This goal has been met by the recruitment of Caroline Nott as an FTA in the Division of Infectious Diseases and into the position of Director, TOH Antibiotic Stewardship Program.

Enhance the academic activities in the Viral Hepatitis Program.

While the VHP continues to be a very successful program, attempts to meet this specific goal of recruiting a clinician investigator to this position are yet to be successful. Two potential candidates have committed to academic positions elsewhere. We have recently posted this position nationally and will begin to consider potential International candidates.

Increase the breadth of the Division of Infectious Diseases to involve community hospitals.

We have recently identified several individuals within the Division of ID with time available to provide ID consultations at the Montfort Hospital. Discussions with the Montfort Chief of Staff are ongoing and we are optimistic that we will be able to provide these services starting October 2016.

Most Significant Divisional Accomplishments in Last Academic Year

Recruitment of Caroline Nott as an FTA (see also above) with the enhancement of ASP activities in the Division and at TOH.

Recruitment of Juthaporn Cowan as an FTA allowing the growth of the clinical and academic activities of the Adult Primary Immunodeficiency/scIG program.
**Plans for the Coming Year**

1. Enhance the clinical and academic activities in the Viral Hepatitis Program
2. Continue to Enhance Antibiotic Stewardship and Infection Control
3. Formalize the role of ID at the Montfort Hospital
4. Recruit a FTA with clinical and research expertise in infections in the transplant population (candidate identified).

**Key Publications & Grants**

**Publications**


**Grants**


March 2016–March 2018. TOHAMO ($100,000). “Feasibility and Safety of Immunoglobulin (Ig) Treatment in COPD Patients with Frequent Exacerbations: A Pilot Study”. Principal Investigators: J. Cowan, B. Cameron


**Honours & Awards**

- **Dr. Bill Cameron**—Appointed Medical Director, Clinical Research, OHRI
- **Dr. Paul MacPherson**—Appointed Director, Clinician Investigator Program, University of Ottawa
- **Dr. Paul MacPherson**—OHTN Research Chair in Gay Men’s Health (2016–2021) $500,000 ($100,000/year)
Medical Oncology

Prior Year’s Divisional Goals

Excellence in Patient Care

1. Improve speed of lung cancer care through Lung Cancer Transformation: This initiative has been highly successful in speeding access to care for lung cancer patients. In September 2016, Ottawa received a recognition award from Cancer Care Ontario (CCO) for having the shortest wait time from referral to establishment of a lung cancer diagnosis, and has also had one of the shortest oncology referral-to-consult wait times in the province for lung cancer patients. This is in keeping with Ottawa having the highest ranking of any academic cancer program in the province on the Cancer Care Ontario Regional Performance Score Card, which looks at several performance indicators together.

2. Extend the lessons learned from the Lung Cancer Transformation Project to other malignancies: We have just launched a Hepato-Biliary Cancer Transformation Project to extend the successes in lung cancer to another important tumor type. Like lung cancer, hepatobiliary cancers can kill rapidly if patients do not access therapy, and rapid patient access to therapy is essential.

3. Reduce wait times from referral to consult: Rapid access to oncology services is extremely important for cancer patients. At a provincial level, the goal is to have 80% of referred patients seen within 14 days of referral. From 2014-15 to 2015-16 the Champlain LHIN experienced substantial improvement, with more than 86% of patients being seen by a medical oncologist within 14 days of referral (substantially better than the provincial average of 77%). This meant that we were among the best in the province.

4. Upgrade the cancer clinical molecular lab: The Molecular Lab now rapidly reports on molecular tests that can help guide cancer patient therapy. The Ottawa Hospital Foundation is raising funds to build a larger, permanent lab, and the lab continues to work towards the use of Next Generation Sequencing for molecular testing.

5. Inpatient service reform: To optimize efficiency of cancer patient care, we are in the process of reforming our inpatient care model. Interviews are underway to hire a new head of the Medical and Radiation Oncology Inpatient Services.

6. Enhance the survivorship program: Since 2012, a “Wellness Beyond Cancer” survivorship program has been in place to facilitate transfer of patients back to care by their family doctor or by a trained advanced practice nurse once they have completed therapies that have been administered with curative intent. This program provides specific guidance on how
these patients should best be followed to monitor for any evidence of recurrence of their malignancy. Since 2012, more than Ottawa 3,800 cancer patients have made the transition to the Wellness program. This program frees up space in oncologists’ clinics to permit them to more efficiently see new referrals.

7. **Monitor the impact of the change in the Cancer Care Ontario funding model to a Quality Based Procedure (QBP) model:** Over the past 2 years, CCO has moved from providing a fixed amount of life-time funding for each cancer patient we care for to providing specific amounts of funding for specific predefined tasks associated with the care of each patient. This change created several uncertainties and challenges, but Ottawa has adapted rapidly and has done well in this model.

8. **Work with TOH on the hiring of new oncologists:** We have been very successful in this, and continue to be fortunate in being able to attract and hire very high quality oncology faculty. Drs Stephanie Brulé and Sandeep Sehdev both joined us this year.

9. **Continue to assess models for administration of non-CCO-funded systemic therapy offsite:** Over the past few years, intravenous systemic anticancer therapies that are not funded by CCO have been administered through private providers such as Bayshore. Meetings have been held with them to explore other collaborative opportunities.

10. **Enhance capturing data on use of oral systemic anticancer therapies by using the OPIS computer system (previously used primarily for ordering intravenous chemotherapy) for generation of prescriptions for oral systemic anticancer therapies:** This has been highly successful. A high proportion of prescriptions for oral anticancer therapies are now ordered online (rather than by hand written prescription). This permits tracking of data, follow up of patients by trained pharmacists to advise patients and to monitor them for toxicity, and through the new QBP program, it enhances CCO funding that flows to TOH.

11. **Enhance availability of Triage/Stretcher Bay in the Cancer Centre to reduce cancer patient visits to the Emergency Department (ED):** The Division operates a drop-in service for medical oncology patients who require urgent assessment prior to their next scheduled appointment. This helps offload the ED and helps patients since they then avoid the long wait times often faced by patients in the ED. Over the past year we have been successful in increasing the availability of this service for our patients.

12. **Upgrade IT systems for patient care:** TOH is now in the process of upgrading its computer systems, and we have been active participants in discussions.

13. **Optimize us of GE OneView for access to scans done at other hospitals across the LHIN:** This now works well for rapidly accessing radiology reports, but the system remains too slow for efficient retrieval of scan images. Further work will be done on this with Diagnostic Imaging.
Recruitment

This has been very successful, and we have been fortunate in attracting very high quality candidates:

1. New AFP position funded by the government through the Ontario Oncology Associates: Dr. Stephanie Brulé was hired to fill this position and started July 1, 2016.

2. Replacement for vacant position: Dr. Sandeep Sehdev started August 22, 2016.

3. Clinician scientist: Dr. Guy Ungerechts, a clinician scientist in the oncolytic virus program, joined us in 2015.

Division of Labour

The Division’s Workload Assessment Committee has established criteria by which each Division member is assessed for their contributions to patient care, teaching, research and administration. Each individual is expected to meet WAC “gold” criteria in at least one of the areas and to meet at least “bronze” criteria in each of the other areas. This approach has proven very effective in ensuring that the required work gets done and that each Division member is recognized for his or her contributions.

Excellence in Research

1. Increased clinical research at the Irving Greenberg Family Cancer Centre (IGFCC) on the Queensway Carleton Hospital campus: Under the leadership of Dr. Glen Goss, we successfully competed for grant funds from the Canadian Cancer Clinical Trials Network (3CTN). Some of the funds from this $1,295,000 grant are being used to gradually increase clinical research at IGFCC. The Ottawa Regional Cancer Foundation has also contributed to the support of clinical research at the IGFCC.

2. Expanded of REaCT trials: There are too many barriers to the efficient performance of clinical trials. The Rethinking Clinical Trials (REaCT) program is a multidisciplinary initiative spear headed by Dr. Mark Clemons from the Division to perform practical, practice-changing research. The program has to date randomized more than 450 patients to a series of trials, and, under Dr. Clemons’ leadership, is expanding across the country.

3. Initiated the Clinical Research Transformation Project: This project (modeled on the highly successful Lung Cancer Transformation Project) will streamline cancer clinical research at TOH to make it more efficient, cost-efficient and productive. This Project is now underway, and is expected to have a positive impact on TOH clinical research in several other areas over and above oncology.
4. Rationalization of clinical research regulation: In collaboration with oncologists and patient advocates across North America, we have established the Life Saving Therapies Network (www.lifesavingtherapies.com) with the objective to achieve must faster, less expensive access to effective therapies for lethal diseases. Under the leadership of Ottawa patient advocate John-Peter Bradford, we have established collaborations with other patient advocacy groups and have obtained funding to hold an international roundtable discussion on the topic. Dr. David Stewart from the Division has also been invited to speak on this nationally and internationally.

5. Build research potential of molecular lab and interactions with StemCore: We have just received notification that a project led by Drs David Stewart (Medical Oncology), Pearl Campbell (StemCore), Bryan Lo (Molecular Lab and EORLA) and Craig Ivany (EORLA) has been successful in its application to Genome Canada for a highly competitive GAPP grant (to assess optimal methodologies for next generation sequencing for molecular characterization of very small tumor samples). This project evolved as a direct consequence of the Lung Cancer Transformation Project, and will translate into optimization of molecular testing of the very small samples that are often the reality in clinical medicine.

Excellence in Education

1. Refine model for funding of fellows: Funding has come from various pharmaceutical companies (through The Ottawa Hospital Foundation), and from contributions made by the members of the Division. Dr. Tim Asmis (head of the Division’s fellowship program) also participated in the recent Department of Medicine Fellowship initiative. We have again been successful in recruiting excellent fellows to train in our Division.

2. Inpatient service reform: As outlined above, we are in the process of reforming our inpatient service. As this evolves, the role of trainees on the inpatient service will also evolve.

Most Significant Divisional Accomplishments in Last Academic Year

Please see the discussion above re progress on meeting our goals for this past year. In addition:

- Drs Derek Jonker, Glen Goss and Scott Laurie continue to lead the cancer clinical research at a national level in GI cancers, lung cancer, and development of investigational new drugs as chairs of the committees for these at the Canada-wide NCIC Clinical Trials Group.

- Dr. Susan Dent continues to be an international leader in the evolving field of Cardio-oncology.

- Dr. Roanne Segal is playing an important role in helping build cancer services for Rwanda.
• Working with colleagues in other departments, **Drs Scott Laurie** and **Paul Wheatley-Price** have succeeded in having Ottawa designated as the site of an international conference on mesothelioma.

• **Dr. Paul Wheatley-Price** has assumed a leadership position in a national patient advocate group, Lung Cancer Canada.

• Despite having a clinical workload that is very heavy compared to other academic oncology centres in Ontario, members of the Division published 114 peer-reviewed and 11 non-peer reviewed papers last year, with an average of 7 peer-reviewed publications per Division member this past year.

**Plans for the Coming Year**

Our top goal is to continue to offer excellent care to cancer patients in our region through a wide range of initiatives that link patient care, clinical research and teaching. We will continue to build on the areas discussed under last year’s goals, including (among others) the following:

1. **We will push forward on co-leading transformation of cancer care and other initiatives, to prepare us for the future.**
   - We will continue our work in Lung Cancer Transformation.
   - With the dedicated hard work of **Dr. Tim Asmis** and other members of the GI Site Group in Medical Oncology, we will work with administration and with our colleagues from other departments to push forward on Hepatobiliary Cancer Transformation.
   - We will take the initial steps to expand this initiative to other tumor types.
   - **Dr. Susan Dent** will continue to play a major national and international role in the field of cardio-oncology.
   - Along with TOH Cancer VP Paula Doering, **Drs Tim Asmis** and **Garth Nicholas** from the Division will be visiting Nunavut to meet with government and health care officials there to explore ways to improve cancer patient care in Nunavut.
   - **Dr. Sandeep Sehdev** will be working with Suzanne Madore to expand Telemedicine services offered by the Division and to explore ways of optimizing use of Telemedicine to provide consults and other services across all TOH campuses and across the LHIN. Dr. Tim Asmis will also begin exploring the potential role of Telemedicine in permitting us to provide more effective, user-friendly cancer patient care in Nunavut.
2. We will continue our work to transform cancer clinical research so that patients with lethal diseases like cancer may have much faster access to effective new therapies.

- We will make clinical research here faster, more efficient and more productive, we will push forward with the TOH Clinical Research Transformation Project, with Drs Goss, Hilton, Jonker, Clemons and others working with our colleagues from the transformation team and from OHRI and other departments and divisions.

- Under the leadership of Dr. Mark Clemons, we will continue to push forward on the REaCT initiative to conduct pragmatic, rapid, efficient, randomized trials to optimize patient care.

- We will continue to work with partners at a national and international level to drive for major reforms of regulation of clinical research in lethal diseases so that progress can be much faster and more cost-effective.

- We will continue our work with collaborators from the Molecular Lab, StemCore and the basic researchers from the Cancer Program to move discoveries from bench to bedside and back to the bench.

3. With respect to education:

- Dr. Xinni Song is leading a review of our undergraduate teaching at the University of Ottawa to see how we might most effectively contribute.

- Dr. Tim Asmis will continue to work with the Department of Medicine Fellowship Committee and with members of the Division and with donors to further expand and strengthen the fellowship program.

- Dr. Neil Reaume will be working with Drs Xinni Song, Tina Hsu and other members of the Division and with the Royal College to introduce the Competency by Design (CBD) program to the Division.

- We will continue to work on inpatient service reform to optimize both patient care and the trainee experience.

**Key Publications & Grants**

**Publications**


**Grants**

Drs Roanne Segal and Xinni Song (co-investigators): The effects of an online mindfulness-based stress reduction program in cancer survivors with chronic neuropathic pain: A randomized controlled trial. Canadian Cancer Society; PI: Dr Patricia Poulin; 2016–19; Funding: 2016/2017: $112,728

Drs Derek Jonker (chair, GI Committee), Glen Goss (chair: Lung Committee), Scott Laurie (chair: IND Committee) (co-investigators): Canadian Cancer Society Clinical Trials Group: Canadian Cancer Society; PI: Dr. Janet Dancey; 2010–17; $25,586,666 ($5,117,333 each year)

Dr. Derek Jonker (co-investigator): Biotherapeutics for Cancer Treatment (BioCanRx)). Network of Centres of Excellence Canada; PI: Dr John Bell; $25,000,000

Dr. Glen Goss (PI): Canadian Cancer Clinical Trials Network (3CTN): $1,295,000

Dr. Mark Clemons (PI), John Hilton (co-investigator): A randomized trial of individualized care vs standard care for breast cancer patients at high risk for chemotherapy induced nausea and vomiting (the ILIAD study). Canadian Breast Cancer Foundation. $436,120 over 3 years

Dr. Guy Ungerechts: Terry Fox Young Investigator Award. $450,000
Honours & Awards

- **Dr. Rachel Goodwin** was winner of the Dr. Elizabeth Eisenhauer Early Drug Development Young Investigator Award at the NCIC CCTG annual meeting (for her contributions to the development and evaluation of new cancer treatments) and of the Conquer Cancer Foundation of ASCO Merit Award at the Gastrointestinal Cancers Symposium (2016).

- **Dr. Tim Asmis** has taken on a major provincial leadership role as the OMA Section Chief for Hematology/Medical Oncology.

- **Dr. Paul Wheatley-Price** has assumed the role of president of the national patient advocacy group Lung Cancer Canada.

- **Dr. Tina Hsu** obtained grant funding for and co-lead organization of the first Canadian Network for Cancer and Aging Meeting.

Nephrology

Prior Year’s Divisional Goals

The Division of Nephrology had two major goals identified last year. The first was to recruit a new Division Head by June 2016. This goal was achieved with the recruitment of **Dr. Greg Knoll** who began his term on July 1, 2016 after 10 years of exemplary leadership by **Dr. Peter Magner**.

The second Divisional goal was to deal with the growing outpatient workload, especially in the kidney transplant program and for patients in the Cornwall region. We have addressed this goal with a major expansion of our Telehealth program—we are now averaging 10 new consults and 68 patient follow-up visits per month via Telehealth. We have expanded the program to include our kidney transplant patients in addition to general Nephrology and advanced chronic kidney disease patients. We are now providing care to patients in Cornwall, Renfrew, Hawkesbury, Carleton Place, Trenton, Nunavut and Timmins. Telehealth clinics are being delivered by 19 different nephrologists. This expansion has made a direct impact on patients by allowing specialized care to take place closer to home and reduce burdensome travel for those with chronic conditions.
**Most Significant Divisional Accomplishments in Last Academic Year**

**Patient Care - Glomerulonephritis Clinic**

Patients with glomerulonephritis are amongst the most complex patients, often presenting with multi-system disease and requiring complicated treatment regimens. Historically, the care of such patients was fragmented and managed in private physician offices. Last September the Division of Nephrology established a specialized Glomerulonephritis Clinic to provide enhanced, coordinated care for patients with all types of glomerulonephritis. The clinic is now a local center of excellence directed by Dr. Todd Fairhead along with a dedicated pharmacist and clinic nurse. Early successes include implementation of standardized monitoring for adverse events and improved patient satisfaction.

**Education – Simulation Based Mastery Learning**

Drs Edward Clark and Cedric Edwards initiated a program by which all incoming nephrology residents and clinical fellows receive simulation-based mastery-learning (SBML) training in temporary hemodialysis catheter insertion. Such training has been shown to reduce the likelihood of life-threatening complications related to this emergency procedure. In the past year, this program has been disseminated nationally with Dr. Clark having been involved in the provision of SBML training in temporary hemodialysis catheter insertion for nephrology residents at McGill University and the University of Toronto. This important initiative will not only lead to better quality of care for our patients but enhances the learning experience for our trainees.

**Research - Can-SOLVE CKD grant**

Dr. Kevin Burns was a Principal Applicant on a multimillion-dollar grant entitled “Canadians Seeking Solutions and Innovations to Overcome Chronic Kidney Disease (Can-SOLVE CKD)”. The 5-year grant received a total $40 million, including $12.5 million from CIHR with the remainder from private donors, universities/research institutes, industry, provincial renal agencies, and charitable foundations such as the Kidney Foundation of Canada. The research network consists of projects and infrastructure that intends to transform CKD care in Canada over the next 5 years. Dr. Burns is leading a cell-therapy project to test the safety and efficacy of administration of autologous Sirtuin 1-enhanced endothelial progenitor cells to patients with advanced diabetic kidney disease. This is a “first-in-human” trial, based on evidence demonstrating that endothelial progenitor cells have potent anti-fibrotic effects in experimental kidney disease. The results, if positive, could transform the care of patients with advanced diabetic nephropathy, and could potentially be applied to patients with other causes of chronic kidney disease. Dr. Burns is also co-leading the development of a patient-oriented research
training curriculum for Can-SOLVE CKD. The curriculum will consist of research modules for patients, researchers, health care providers, and policy makers, to be delivered on-line, as well as at bi-annual face-to-face workshops.

**Plans for the Coming Year**

The Division of Nephrology has several initiatives under development but will highlight two that have been approved and are moving forward.

**Nephrology Palliative Care**

*Dr. Jan Davis* will be leading a divisional initiative to streamline and enhance the delivery of palliative care services to patients at all stages of chronic kidney disease. The provision of consistent and high quality palliative care to nephrology patients has been identified as a priority by the Ontario Renal Network.

**Regional Acute Kidney Injury Care**

Patients with critical illness and acute kidney injury (AKI) are treated with continuous renal replacement therapy (CRRT) by critical care specialists at the Montfort and Queensway Carleton Hospitals. *Dr. Brendan McCormick*, the regional medical lead for the Ontario Renal Network, and *Dr. Ted Clark* have embarked on an initiative to enhance collaboration and data sharing with these programs. The goal is to provide seamless nephrology care within the Champlain LHIN and to promote continuous quality improvement for AKI care and acute dialysis.

**Key Publications & Grants**

**Publications**


**Grants**

Dr. Dylan Burger was awarded a $521,859 grant from the Canadian Foundation for Innovation and the Ontario Research Fund.

Dr. Swapnil Hiremath, along with Drs Greg Knoll and Ayub Akbari from the Division of Nephrology; Dr. Ben Chow from Cardiology and Dr. Dean Fergusson from the Division of Clinical Epidemiology were awarded a $99,000 grant from CIHR to study contrast-induced acute kidney injury.

**Honours & Awards**

- Dr. Steven Nadler was selected for the University of Ottawa Distinguished Teacher Program based on his outstanding record of teaching in the undergraduate medical education program.

- Dr. Deb Zimmerman was recently voted in as the President-Elect of the Canadian Society of Nephrology (CSN). She is currently a member of the Board of Directors and will become the CSN President starting in 2018.

**Leadership Positions within the Division of Nephrology**

- Dr. Bob Bell—Leader Unit 1; English Undergraduate Curriculum
- Dr. Bob Bell—Director, Distinguished Teacher Program, Undergraduate Medical Education
- Dr. Bob Bell—Director of Curricular Delivery, Undergraduate Medical Education
- Dr. Ann Bugeja—Renal Content Expert Unit 1: English Undergraduate Curriculum
- Dr. Cedric Edwards—Director of Nephrology Subspecialty Program
• **Dr. Stephanie Hoar**—Chair of Post-Graduate Education Committee (term completed Spring 2016)

• **Dr. Jolanta Karpinski**—Associate Director, Specialties Unit, Royal College of Physicians & Surgeons

• **Dr. Greg Knoll**—Vice-Chair, Research, Department of Medicine

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**Neurology**

**Prior Year’s Divisional Goals**

**Build Epilepsy Program**

Our epilepsy program now has a fully operational 2-bed 24-hour continuous epilepsy monitoring unit (EMU) operating 5 days per week, 2 4-hour video monitoring units as well as routine EEG capabilities. Dr. Fantaneanu has been recruited as a full time epileptologist to joint Dr. Kale and Dr. Skinner in running the EMU.

**Create a Neuromuscular Clinic**

The hospital has approved the plans to move forward with the establishment of the Neuromuscular Clinical Research Centre (NCRC) with construction set to begin next year.

**Enhance our Stroke Program.**

Our Stroke program continues to grow and graduated 2 fellows this year. The creation of our neurovascular inpatient unit one year ago has been an immense success to enhance the care of stroke patients within our region.
Most Significant Divisional Accomplishments in Last Academic Year

Multiple Sclerosis

Dr. Freedman and Dr. Atkins in hematology demonstrated the long term benefit of treating early aggressive MS with stem cell therapy. This work attracted international attention because of the dramatic and sustained benefit of the treatment for the majority of the patients who underwent the procedure.

Stroke Care

Endovascular procedures for acute ischemic strokes improve mortality by 50% and last year 100 procedures were performed compared to 30 the year before at TOH. This is the most of any hospital in Ontario. Intravenous TpA is now being given in less than 30 minutes upon arrival to our emergency room three times more often which significantly improves patient outcomes.

Neurology End-of-life Communication Tool

Dr. Zwicker developed and evaluated a “Neurology End-of-life Communication Tool” template for documenting end-of-life care discussions and developed a handout for families regarding end-of-life care and stroke.

Plans for the Coming Year

Enhance the Neuromuscular program.

Finalize the plans for Neuromuscular Clinical Research Centre which will require the recruitment of a neuromuscular disease specialist with experience in clinical trials.

Stroke Program.

Continue to improve stroke care by creating designated “stroke beds” with enhanced allied health support. Recruitment of a full time stroke neurologist.

Clinician Teachers

Enhance the academic plan to improve the recognition and support of clinician teachers within the division.
**Key Publications & Grants**

**Publications**


**Grants**

**Schlossmacher MG** (PI), CIHR: Project Grant. A Role for LRRK2 and SNCA in Microbial Infections ($1,340,000)

**Schlossmacher MG** (PI), Michael J Fox Foundation: Tools for Parkin. To finance a partnership with BioLegend raising and commercializing immunoassays for Parkin. (US $200,000)

**Maclean H**. Educational Initiatives in Residency Education. “Electronic learning in clinical neuroscience: Does e-learning facilitate resident education? ($25,864.00)

**Schlossmacher MG** (PI) CIHR: To support MD/PhD students at the University of Ottawa ($138,000)

**Mestre, Tiago** (PI). Parkinson Research Consortium. A randomized, placebo-controlled, 2-arm parallel-group superiority phase II study of Glycopyrrolate for moderate-to-severe sialorrhea in Parkinson’s disease ($50,000.00)
Honours & Awards

- **Dowlatshahi D**—Ministry of Research and Innovation of Ontario, “Early Researcher Award”, $140,000.

- **Lelli D**—Greenblatt Award—top presentation, Medical Grand Rounds “My Dizzy patients are making me Dizzy!”

- **Warman Chardon J**—Faculty of Medicine, Junior Clinical Research Chair Award

- **Warman Chardon J**—2016 ‘Dr. George Karpati Award’ from Muscular Dystrophy Canada (MDC). This award is presented in recognition of exemplary contributions to neuromuscular research, the advancement of care of people with neuromuscular disorders, and public awareness, services and/or fundraising

- **Schlossmacher M**—Awarded a patent with his former employer (Brigham & Women’s Hospital) from the EU for the “Treatment of Synucleinopathies”.

Nuclear Medicine

Prior Year’s Divisional Goals

Funding and Completing the “Dinh Enhanced Educational Reading Room”.

Funds largely raised and equipment installed. Dedication ceremony in fall.

Increase Research Output

Recruitment of new staff including 2 clinical scholars and a physicist has resulted in a widespread increase in academic productivity in the Division.

Most Significant Divisional Accomplishments in Last Academic Year

1. Increased presence at multidisciplinary tumor boards leading to improved patient care and collaboration.

2. Installed SPECT SUV software allowing for more precise measurement of arting leading to multiple research publications.
3. Raised funds, planned, completed renovations of the Nuclear Medicine Reading Room at the General campus in memory of Dr. Laurent Dinh. Dedication pending.

4. Hiring of 2 Scholars to be involved in research and educational endeavours.

**Plans for the Coming Year**

1. Develop new Division plan including support for increased tumour boards.
2. Install dedicated software for teaching cases (MIRC server).
3. Expand involvement in The Ottawa Hospital tumour boards.

**Key Publications & Grants**

**Grants**

**Lionel S. Zuckier** (PI), Department of Medicine Patient Quality and Safety, “SPECT vs SPECT-CT in the evaluation of bone metastases” ($7,700.00)

**Lionel S. Zuckier** (PI), The Ottawa Hospital Academic Medical Organization (TOHAMO), “Dual time point FDG-PET to differentiate between recurrent brain tumour and radionecrosis” ($94,350.00)

**Ran Klein** (PI), Natural Sciences and Engineering Research Council (NSERC), “Improving the accuracy of cardiac PET with motion-free imaging” ($160,000)

**Publications**


**Honours & Awards**

- Dr. Bazarjani received award for Best Attendance at Department of Medicine Grand Rounds.
- Medical student Eric Nguyen (2016) received the American College of Nuclear Medicine Annual Meeting Best Abstract for his paper: Prior seed localization in breast cancer is associated with a reduced frequency of sentinel lymph node (SLN) visualization. American College of Nuclear Medicine Annual Meeting/Society of Nuclear Medicine Midwinter Meeting, January 28, Orlando, Florida. Co-authors Drs Mark Bryanton and Lionel Zuckier.
- Ran Klein awarded adjunct professor at Carleton University, Department of Physics
Palliative Care

Prior Year’s Divisional Goals

To establish a division of Palliative Care executive and develop committee oversight through the executive. This was established in the division after unanimous voting from the members of the division: Vice Chair of Research, Dr. Peter Lawlor; Vice Chair of Education Dr. Chris Barnes; Vice Chair of Finance, Dr. John Scott; Vice Chair of Clinical Services, Dr. Camille Munro and Member at Large (Dr. Mike Hartwick), now Dr. Jill Rice.

To develop a regional Palliative Care Lead. This was accomplished through Dr. Jill Rice who was interviewed and was the successful candidate as the Regional Palliative Care Lead. Jill now works closely with the Regional Co-Leads in Palliative Care: Paula Doering, Vice-President of Clinical Programs and Regional Cancer Program at the Ottawa Hospital and Chantale Leclerc, CEO of the LHIN.

To establish interest in the Department of Medicine for developing Palliative Care Leads. This has been established in several divisions. Several of these individuals are now taking training in Palliative Care and will become integrated within the program in the near future.

To consolidate our research program and change the focus as it was felt that the research focus was too broad.

To receive renewal of accreditation as an Integrated Centre of Oncology and Palliative Care.

Most Significant Divisional Accomplishments in Last Academic Year

The hiring of a divisional research coordinator Dr. Liesha Mayo-Bruinsma.

Completion of the Harvard Global Clinical Scholars Research Training (GCSRT) course with distinction in Epi and clinical trials (Dr. Lawlor).

Completion of the Melatonin Feasibility Randomized Control Trial (RCT) at Bruyère.

Completion of Dr. Chris Klinger’s postdoctoral contract with the division with multiple publications.

The division is now averaging over 50 admissions/month to the PCU at Bruyère. This is almost double the number from four years ago. Collectively we’ve still managed to provide care to the additional patients despite the elimination of resources at Bruyère.

Received renewal of accreditation as an Integrated Centre of Oncology and Palliative Care. We are one of only three centres so designated in Canada. This three-year designation acknowledges...
The Ottawa Hospital (TOH) as a centre of excellence for Oncology and Supportive and Palliative Care. In addition, European palliative care residents and fellows are supported by ESMO grants to come to Ottawa for training.

The ratings for integration week in training were remarkably high in the division of Palliative Care. The division trains trainees from almost all specialties, division and departments at The Ottawa Hospital and Bruyère. In terms of fact-to-face hours the University of Ottawa undergraduate curriculum in Palliative Care, to our knowledge, is the largest of its kind in Canada.

Despite a small outpatient program, 37% of our new consults are seen the same day. Overall we are exceeding our provincial target (80% of new consults to Supportive and Palliative Care seen within 14 calendar days). Indicators for the past 6 months show we are currently at 91.4% of new patients seen in that time frame. Our response time for patients admitted to any service at The Ottawa Hospital is close to 100% within 24 hours and most often the same day.

Plans for the Coming Year

A retreat is planned to develop our 5-year strategy.

**Dr. Shirley Bush** has published on delirium and the guideline paper in the CMAJ and is about to implement Phase I of the delirium guidelines and practice at Bruyère in November 2016.

**Dr. José Pereira** has moved on from his position as Head of the Division of Palliative Care. The division would like to thank him for his years of dedication and the transformative work that he performed in the division of Palliative Care. Jose has been a regional, provincial and national leader in Palliative Care and we wish him the best of luck in his future endeavours. The division will hire a new Division Head and refocus its future plans.

Key Publications & Grants

**Publications**


Coelho A, Delalibera M, Barbosa A, Lawlor P. Prolonged Grief in Palliative Family Caregivers:


**Grants**

**Pereira, José** (co-I). CIHR. Improving End-of-life Care in the Community. 2015–17 ($125,000)

**Kyeremanteng, Kwadwo** (PI). CIHR. Survey of Barriers to Critical Care and Palliative Care Integration. 2015–16
Physical Medicine & Rehabilitation

Prior Year’s Divisional Goals and Extent to Which They Were Met

The goals for the Division of Physical Medicine & Rehabilitation from 2015 are ongoing as we collaborate with the LHIN initiatives and future TOH plans that will take a few years to realize. These include:

1. Explore location and function of the stroke rehabilitation program, advocating for a one site integrated model: Dr. Dojeiji and Dr. Marshall each participated in the LHIN Sub-acute Capacity Planning Review Steering Committee. The final report from this committee recommended the integration of stroke rehabilitation services to one site.

2. Plan for one site regional rehabilitation program attached to new Civic site (part of the new Civic master plan)—supported by TOH Board. This would include stroke rehabilitation.


4. Growth in neuromuscular rehabilitation clinical program and scholarship (ALS and other neuromuscular disorders): Dr. Dojeiji has expanded the neuromuscular clinics at The Ottawa Hospital Rehabilitation Centre. The Division has also recruited Dr. Kelsey Crawford who will be starting her Pediatric fellowship with an emphasis on transition of care.

5. Growth of the post-concussion initiative: Dr. Quon and Dr. Marshall have worked to expand and coordinate the services for post concussion patients. Each are participating in provincial initiatives to improve care for patients.

Most Significant Divisional Accomplishments in Last Academic Year

The Division of Physical Medicine & Rehabilitation has over 100 inpatient beds located at Élisabeth Bruyère, The Ottawa Hospital General Campus and The Ottawa Hospital Rehabilitation Centre (TOHRC). The majority of the patients admitted to our inpatient programs gain the skills and confidence needed to return home.
The Ottawa Hospital Rehabilitation Center, the Bruyère Stroke Rehabilitation Program and the Division of Physical Medicine & Rehabilitation were:

- Nominated the #1 rehabilitation facility in Ontario based on patient experience and NRC survey
- Best performing stroke rehabilitation unit in Ontario
- Able to manage significant budget cuts of 10% in collaboration with TRC administration and the medical dyads of all TRC programs without significant impact to patient care or the elimination of any rehabilitation programs. This effort was recognized at the TOH Annual Awards.

In addition to the above accomplishments, the Physicians of PM&R sit on various committees and hold various positions which shape the medical environment in Canada. These positions include Dr. Jeff Blackmer who is Vice President of Medical Professionalism at the Canadian Medical Association. As well Dr. Sue Dojeiji and Dr. Nancy Dudek each hold positions with the Royal College of Physicians and Surgeons of Canada which are reshaping medical trainee assessment through the new Competency by Design faculty development and the CanMEDS roles. Dr. Gerald Wolff, in collaboration with Dr. Kirsty Boyd, is conducting research and rehabilitation regarding peripheral nerve transfer, an innovative method of “rewiring” nerves to restore function to extremities. Dr. Guy Trudel is leading a multi-year collaborative research project with NASA and the Canadian Space Agency regarding the effects of microgravity on the human body.

**Plans for the Coming Year**

In addition to the ongoing goals/plans from 2015, The Division of Physical Medicine & Rehabilitation will also:

1. Engage actively in the LHIN Sub-acute Capacity Implementation plan for rehabilitation resources across the Champlain LHIN following the release of the LHIN report.

2. Repatriate all of inpatient stroke rehabilitation back to Bruyère and confirm temporarily allocated stroke beds mandated by the Champlain LHIN as permanent.

3. Continue with the transition to a new Most Responsible Physician model with involvement of hospitalists providing inpatient care in conjunction with Physiatrists. MRP Hospitalists have been brought on to help decant inpatient care from Physiatrists thereby providing more consistent and continual care to inpatients and allowing Physiatrists more time to concentrate on rehabilitation programs, research, administrative responsibilities and scholarship activity.
**Key Publications & Grants**

**Publications**


**Grants**


**Campbell, Mark**. IRSC. The Posterior Capsule in Knee Osteoarthritis and Flexion Contracture: Examining Histologic Changes and the Role of Mesenchymal Stem Cells. $45,000. 2015.

Halman S, Rekman J, Wood T, Baird A, Gofton W, **Dudek N**. RCPSC. Bridging the surgical/medical divide: implementation of the Ottawa Clinic Assessment Tool (OCAT) in internal medicine. $10,500. 2015
Honours & Awards

- **Dr. Jeff Blackmer** received the University of Toronto Joint Centre for Bioethics 20th Anniversary Outstanding Alumnus Award, the first of its kind.

- **Dr. Shawn Marshall** was the recipient of the Health Care Provider of the Year as awarded by the Ontario Brain Injury Association.

- COPD outreach program was on the Honour Roll for the Minister's Medal for quality improvement in patient outcomes.

- TOH Guardian Angel awards were received by **Dr. Deanna Quon, Dr. Anthony Lentini** and Dr. Gerald Wolff.

- The Rehab Program was recognized at the Leadership Development Institute (LDI) for senior leaders for how we managed our budget crisis and achieved our requisite 10% reduction through collaboration between program physicians and administration

- **Dr. Hillel Finestone** celebrated 15 years of service at Bruyère Continuing Care.

- **Dr. Meena Acharyya** formally announced her retirement effective August 31, 2016 after over 30 years’ service.

- This year PM&R has tied the 1990 record for the number of residents who successfully passed their exams and graduated from the program in one year (four in total!).
**Respirology**

*Prior Year’s Divisional Goals*

**Develop a Divisional Practice Plan with new rewards for academic work**

This has been accomplished, and the new practice plan has been put into place which rewards research, teaching, and quality improvement initiatives within the Division.

**Further develop interventional pulmonology**

*Dr. Burkett* has trained in Interventional Pulmonology and has joined the Division as a Clinical Scholar. He is currently completing his Masters of Science degree in Epidemiology. He has opened a pleurex clinic at the Irving Greenberg Cancer Center. We are hoping to secure dedicated endoscopy time to expand Interventional Pulmonology services in Ottawa.

**Most Significant Divisional Accomplishments in Last Academic Year**

*Dr. Pakhale* successfully concluded the participant portion of the PROMPT (Participatory Research in Ottawa Understanding Drugs) study conducted at 216 Murray St. The study data shows admirable results of reduced cigarette use, reduced poly-substance use and improved social and economic standing for participants.

*Dr. Mulpuru* undertook several initiatives to improve quality of Ambulatory Clinic Service. Our Division formed a committee of physicians, administrative assistants, clerks, and clinical managers to review the service provided by our current ambulatory clinics. We developed goals for improved service and efficiency and we prospectively collected data to better understand wait times, acuity of consult requests, referral volumes, and clinic capacity. We instituted new triage systems, initiated urgent referral clinics, and trialed new methods of booking. Our urgent referral clinics now operate every 2 weeks, and ensure timely consultations for urgent and semi-urgent patients referred to us from within and from outside the hospital. Finally we have developed a system to track our wait times more accurately and monitor our referral volumes so that we can be more responsive to outpatient wait times for consultations.

We instituted a Hospital Based COPD Pathway for TOH. We worked with multiple stakeholders to develop a clinical pathway for COPD at TOH and Dr. Mulpuru reviewed clinical pathways from Champlain LHIN and other health care institutions. We used hospital data to identify factors driving increased costs for COPD admissions, and incorporated these into our pathway.
Our division, and Dr. Mulpuru, will begin implementation phase, testing, and data collection this year of the pathway.

**Dr. Alvarez concluded the Xpert TB study and published the study in CHEST.**
This study has had an important impact on the diagnostic capacity in Iqaluit, Nunavut. The study showed that we were able to reduce the wait time from next week/month to the next day with this new PCR technology. We supported this finding with a follow up publication in PLoS One on the cost effectiveness of this approach. Finally, Dr. Alvarez wrote health policy for the Territory for the use of Xpert. All of these pieces came together when the Territorial Minister of Health announced stable funding for the program with a view of expanding its use across the region. Our findings were broadcast in over 51 media vehicles including TV and newspapers. Dr. Alvarez was invited to be the key note speaker at the CIHR Awards Ceremony where he presented the above findings.

**Plans for the Coming Year**

The long-term goal is to continue to mentor young researchers within the division- to help them achieve research prominence. A short and medium term goal is to recruit new academic members to the division. We will work to fill clinical ‘gaps’ and academic ‘gaps’ in interventional pulmonology, cystic fibrosis, interstitial lung disease, sleep medicine, medical education, and quality improvement.

**Dr. Kaissa de Boer** joined our division in July 2016. She is completing a Master’s degree in Medical Education from the University of Chicago, and she has completed a two-year clinical fellowship in Interstitial Lung Disease at UCSF. Dr. de Boer will coordinate a tertiary care ILD clinic at TOH, she will assume the role of Program Director in our division in 2017.

**Dr. Andrew Burkett** will be responsible for clinical research in Interventional Pulmonology.

**Dr. Tetyana Kendzerska** is an MD/PhD population researcher who is currently completing a postdoctoral fellowship at ICES in Toronto. Dr. Kendzerska has been recruited to our division, and she will join our division in February 2017 as a clinician/researcher. Her clinical focus will be in sleep medicine. Her research will focus on administrative database/population health research in sleep medicine and obstructive lung diseases.

**Key Publications & Grants**

**Publications**


**Grants**


**Dr. Gonzalo Alvarez** (PI). Public Health Agency of Canada/First Nations Inuit Health Branch, Health Canada. The acceptability and completion rates of a new 12 dose treatment (3 month) compared to the standard treatment for latent TB infection (LTBI) treatment: a multisite observational study. $540,000.00 over 3 years

**Honours & Awards:**

- **Dr. Shawn Aaron** 2015–2020: University of Ottawa Faculty of Medicine Senior Clinical Research Chair in Obstructive Lung Diseases.

- **Dr. Shawn Aaron**: 2015 Ontario Lung Association’s Meritorious Service Award.

- **Dr. Gonzalo Alvarez** 2015–2020: University of Ottawa Faculty of Medicine Clinical Junior Research Chair in TB in Aboriginal Communities.

- **Dr. Sunita Mulpuru** 2015 Ontario Lung Association/Pfizer Canada Research Infectious Lung Diseases Award.
Rheumatology

Prior Year Divisional Goals

The Division of Rheumatology has seen significant challenges over the past several years. To face these challenges and to balance the clinical, education and research priorities in a way that inspires excellence, we held a Strategic Planning retreat on November 28, 2015. We identified a 5-year plan, generated a vision and a mission and identified four core values to achieve our vision: to be an internationally recognized center of excellence in Rheumatology. Three strategic goals were also identified:

**Balance the Division clinical workload to enhance productivity in the three priority areas: clinical, education and research.**

We are now able to appropriately triage referrals to specific clinics and prioritize acceptance based on clinical urgency. This has resulted in the creation of clinic slots for urgent consults that are now being seen in less than two weeks. The new triage system has also enabled us to decrease previous wait times for routine referrals of approximately 18 months down to 3–6 months. A record high of 12,421 patients received medical attention at the Arthritis Centre this year. The number of ambulatory consultation requests received was 2,549, 1,959 of which were accepted; this number represents a 32% increase from last year.

Six specialized clinics are now accepting patient referrals: lupus clinic (supervised by Dr. Doug Smith), the vasculitis clinic (supervised by Dr. Nataliya Milman), and the combined rheumatology/dermatology clinic (Dr. Milman and Dr. Fahim), ankylosing spondylitis and psoriatic arthritis (supervised by Dr. Aydin), anti-phospholipid syndrome (run by Dr. Antonio Cabral) and the newly created combined rheumatology/respirology clinic led by Dr. Milman and Dr. Voduc.

Denise Boone, a nurse specialist that joined the division last year, started a newly created nurse-led clinic in August 2016 four times a week as one of the implemented means to further reduce wait times for patients with inflammatory arthritis.

**Reinvigorate interest in Rheumatology as the medical specialty of choice.**

The Royal College of Physicians and Surgeons of Canada, Rheumatology Training Program continues to thrive under the leadership of Dr. John Thomson and Susan Duffield, program coordinator. The Division of Rheumatology faculty is highly committed to teaching. Our Rheumatology Program is a very attractive one to internal medicine residents from Ottawa and elsewhere in Canada. This year, for instance, we had a great demand for rheumatology residence
positions (n= 34, interviewed 10) for 2 available slots. Both of these were occupied by Ottawa U Internal Medicine residents. In addition, we had approximately 10 residents (mostly Internal Medicine) rotating in our clinics plus 5–6 Medical Students per month.

**Strengthen the infrastructure to produce and publish top-notch clinical research.**

Research in the Division continues to succeed and is taking on new directions, particularly into the area of musculoskeletal ultrasound in spondyloarthritis and other inflammatory arthritis.

- We acquired a highly specialized MSK imaging ultrasound equipment. This has helped Dr. Sibel Aydin launch her research and clinical program.
- We extended the work days of a research assistant.
- We designated new space for clinical research.
- A database (patient registry) to house data for research is now in progress.
- We strengthen the collaboration with Ontario Best Practices Research Initiative, a provincial patient Registry, to monitor use and safety of biologic agents in patients with rheumatoid arthritis.

**Most Significant Divisional Accomplishments in Last Academic Year**

1. **Dr. Antonio Cabral** joined the Division as Division Head (September 2015).
2. **Dr. Sibel Aydin** joined the Division as Associate Professor of Medicine (October 2015).
3. A retreat held in November 2015 identified a vision, a mission, four core values and three strategic goals and their corresponding priorities.
4. Creation of a central triage system that has permitted tracking of referral volume.
5. The Division acquired an MSK imaging ultrasound equipment with money from the Rheumatology Endowment Fund. This has supported Dr. Sibel Aydin to successfully launch her clinical and research program in spondyloarthritis and other inflammatory arthritis. Dr. Sibel Aydin published 16 papers last year in peer-reviewed journals, 7 of which appear after she joined our Division. She has two ongoing research projects: a) Screening for high risk axial spondyloarthritis in patients with psoriasis, iritis and colitis (SASPIC) study and b) The Evaluation of the Psychometric Properties of the 11 ASAS Proposals for the Definition of Flare in Axial Spondyloarthritis. As a result of her work, the Division of Rheumatology and Canada are represented in international leading research organizations such as ASAS (Assessment of spondyloarthritis), GRAPPA (Group for Research and Assessment of Psoriasis and Psoriatic Arthritis) and TUI (targeted ultrasound initiative).
Plans for the Coming Year

1. Recruit one academic Rheumatologist.
2. Generate funding to meet the needs of the projected expansion.

Key Publications & Grants

Publications


Grants


Pagnoux C (PI), Milman N (Co-Investigator). CIORA core members of the Canadian Vasculitis Network (CanVasc) Group Knowledge Dissemination Grant. Improving the Care of Patients with Systemic Vasculitis through the Development of Management Recommendations and Educational Materials: A Canadian Vasculitis Network (CanVasc) Initiative. $90,170
Department of Medicine Education Grants Program, University of Ottawa, Where are they now? A Ten Year Follow-Up of Medical Education Research Groups. **Susan Humphrey-Murto**, Bridget O’Brien, Steve Durning, Larry Gruppen, Stan Hamstra, Olle ten Cate, Cees van der Vleuten, Wendy Hu, David Irby, Lara Varpio. $22,500

**Honors & Awards**

- **Dr. C. Douglas Smith** received the Mentorship Lifetime Achievement by the Faculty of Medicine.

- **Dr. Jacob Karsh** is the Secretary-Treasurer of the Canadian Rheumatology Association, the Vice-President of the Board of the Journal of Rheumatology, the Chief Medical Officer of Red Maple Trials, and an external reviewer for the Canadian Agency for Drugs and Technology in Health (CADTH).

- **Dr. Peter Tugwell** continues in his role as Director for the Center for Global Health, Institute of Population Health, University of Ottawa. Peter also holds a Canada Research Chair for Health Equity.

- **Dr. John Thomson** is a Board Member of the CRA Executive and Chair of the Human Resources Committee. He also co-chairs the Eastern Ontario Rheumatology Association Annual Meeting with Dr. Brian Boate.

- **Dr. Susan Humphrey-Murto**: Co-Chair Education Research and Development Committee, Royal College of Physicians and Surgeons of Canada, founding faculty member of the Canadian Association for Medical Education National Assessment Course (CAME-PACCC); she is the Interim Director for the Research Support Unit, Department of Innovation in Medical Education, University of Ottawa and the DIME/University of Ottawa Skills and Simulation Center Medical Education Fellowship Director.

- **Dr. Humphrey-Murto** received the Faculty of Medicine Award of Distinction and Service University of Ottawa; a Nomination for the Meridith Marks Mentorship Award, Memorial University; and Department of Medicine Mentorship Award, University of Ottawa. The Division of Rheumatology greatly acknowledges the outstanding service Susan has championed in Medical Education in Canada over the years.