

VITAL SIGNS



THE NEWSLETTER OF MCGILL UNIVERSITY DEPARTMENT OF MEDICINE

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Wishing you all a very Happy Holiday Season!



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WORD FROM THE CHAIR

David Eidelman, M.D.
Chair, Department of Medicine



TO TEACH OR NOT TO TEACH

As I write this, the *Fédération des médecins spécialistes du Québec* (FMSQ) is locked in a bitter dispute with the government of Québec. On June 12, 2006, Québec abrogated an agreement which committed to eventual parity between specialist incomes in Québec and those in the other provinces. The unwillingness of the Government to honor that commitment led to a breakdown in negotiations. Québec then passed a special law (Bill 37 "*Loi concernant la prestation des services de santé par les médecins spécialistes*"), which imposes a very unfavorable contract until 2010, backed up by severe measures aimed at preventing any work action by medical specialists. Remarkably, this law restricts freedom of speech and freedom of assembly, even going so far as to prevent specialists from changing their practice profile or withdrawing from RAMQ. Indeed, the law even prohibits apprehended actions by specialists, meaning that severe sanctions can be applied even in the case of the anticipation of work action.

Although the FMSQ has begun legal action to overturn this odious law¹, such challenges will take years. A more urgent method of changing government policy is essential. In this context, the FMSQ has recommended the suspension of teaching, hoping that the threat of delayed student graduation will bring the government back to the negotiating table. The rationale for this approach is that teaching has traditionally been at best under-remunerated and is not covered by special law. Moreover, the problems created by suspension of teaching are high profile and potentially embarrassing for government.

The decision to suspend teaching has been a difficult one. No one who has been involved in medical education can be happy about making students or residents suffer to win a better contract for specialists. Although compliance with the FMSQ recommendation to suspend teaching has been high, some faculty members have refused to participate on the grounds that this tactic is not ethically defensible. They hold that students and residents should not be made to pay for conflicts between ourselves and the government. Moreover, teaching is a fundamental duty of medical practice, enshrined in the Hippocratic Oath. This view seems to me both understandable and honorable.

Others have decided that however regrettable, it is necessary to withdraw from teaching. Several justifications have been put forward including that it is essential to show solidarity with other Quebec specialists. McGill should not stand alone, they say. Although this is true, it does not seem to me the best of arguments. We should not base our ethical

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http://www.fmsq.org/fmsq/documents/REQUETEINTRODUCTIVEINSTANCE_12-09-06_.pdf

choices on their endorsement by colleagues in other institutions. It is essential that we choose based on our own understanding of the situation. There are stronger reasons to act.

Medicine in Québec is at a crossroads. The government has used increasingly harsh and anti-democratic measures against physicians, with the obvious long-term strategy to degrade our independence and professional status. In the past number of years, Québec has imposed special laws on the emergency room physicians, on residents and now on medical specialists. General practitioners escaped a special law this year by accepting the government's offer without negotiation. It is clear that the civil servants responsible for implementing health policies have concluded that it is possible to solve contract disputes and establish working conditions through special laws or the threat of imposing them. They wish to see physicians converted into ordinary government employees, the better to control their income and professional activities. Should they succeed our ability to retain and recruit physicians, to develop academic medicine in Québec, would be even more threatened than it already is.

This is an untenable situation, which we must resist or face the inevitable progressive decline in medical practice in Québec. Our extraordinary circumstances demand that we do whatever we can to oppose the government's special law, up to and including the suspension of teaching. The short term harm and injustice to students and residents is more than outweighed by the potential long term benefit of an environment in which we will be able to practice medicine free from the arbitrary dictates of government. The future of our students, our residents and our patients is in the balance.

QUALITY INITIATIVES

As part of our continuing look at initiatives aimed at improving quality, this issue focuses on end-of-life care. Here, we look at the McGill Cancer Nutrition and Rehabilitation Program launched in 2003 and End-of-Life Care for Non-Cancer Patients.

THE MCGILL CANCER NUTRITION AND REHABILITATION PROGRAM

Martin Chasen, MBChB

With the evolving successes of cancer diagnosis and treatment during the past 70 plus years, the importance of optimizing patient outcomes in terms of quality of

rehabilitation and survivorship is increasingly appreciated. Cancer rehabilitation is a process that assists the individual with a cancer diagnosis to obtain optimal physical, social, psychological and vocational functioning within the limits created by the disease and its treatment. An imperative in accomplishing these goals is a coordinated multidisciplinary team approach that addresses the potential rehabilitation needs of the individual from time of the cancer diagnosis onward.

Members of the rehabilitation team may include physicians (e.g. oncologist, surgeon, physiatrist, internist), other health care professionals including the rehabilitation oncology nurse, relevant volunteers and others.

Historical Bases of Cancer Rehabilitation and Survivorship

The use of a rehabilitation approach to treatment of patients with cancer goes back to the United States National Cancer Act of 1971. This legislation declared cancer rehabilitation as an objective and directed funds toward development of training programs and research projects. In 1972, the NCI sponsored the National Cancer Rehabilitation Planning Conference. This conference identified the following 4 objectives in rehabilitation of cancer patients:

- Psychosocial support
- Optimization of physical functioning
- Vocational counseling
- Optimization of social functioning

The McGill Cancer Nutrition-Rehabilitation Program (CNRP)

At present, the program is part of the Division of Palliative Medicine and Department of Oncology (McGill University - Jewish General Hospital) as well as the Department of Medicine (McGill University and McGill University Health Centre (MUHC)). The program started in 2003, initially enrolling patients with lung and gastrointestinal cancers.

In January 2006, the Cancer Rehabilitation Program was started at the Royal Victoria Hospital. This program is designed for all patients with cancer who have a decreased appetite, are experiencing weight loss, fatigue and a loss of function due to their cancer and/or the anti cancer treatment. This Cancer Rehabilitation team includes an oncologist/palliative care physician, psychologist, nurse, physiotherapist, dietician and clinic manager, who together provide the patient with information, treatment and support.

This program is based on state of the art cancer research and addresses the patients' specific symptoms. The team also meets with patients weekly in a group learning setting for discussion. Each session focuses on a different health issue and group participation is encouraged.

The Program aims to improve treatment, research, and education in the following key areas:

1. Assessment of the patient for specific symptoms such as early satiety, nausea and vomiting which may contribute to the profound weight loss some patients experience;
2. Nutritional counselling and specific nutritional supplement interventions. The dietitian provides information and suggests ways to help optimize food intake and minimize the symptoms, which prevent a person from eating adequately;
3. Cancer-related fatigue, physical rehabilitation and exercise. After an assessment by the physiotherapist, a unique program is formulated for the patient. Patients learn which kinds of activities and exercises are most beneficial. The exercise program is designed to help prevent muscle wasting, maintain cardiovascular stamina and promote functional independence;
4. Psychosocial assessment and intervention. A clinical psychologist is available for consultation and treatment should patients require help adjusting to or coping with the cancer diagnosis and treatment, or should they be experiencing psychological distress;
5. Education and Support. A nurse introduces the goals of the Cancer Rehabilitation Program. The nurse coordinates program activities, integrates helpful information, provides support and answers questions over the program duration of eight weeks.

Specific Research projects

The future success of any well organized, well thought out program relies heavily on the performance of research with the specific goal aimed at:

1. Research into the causative factors of the Anorexia/Cachexia Syndrome and the relationship to markers of chronic inflammation such as C Reactive Protein (CRP)
2. The clinical application of the Electrogastrogram in determining abnormal gastric rhythms in patients with profound weight loss
3. Research into clinical measurement tools which allow for ongoing detection of functional impairments and disabilities
4. Investigation of Ghrelin-a stomach hormone which stimulates appetite in patients attending the clinic
5. Newer investigational treatments of other symptoms such as the use of Cannabinoids to improve taste in these patients

We have had over 100 patient referrals since January 2006 and are presently preparing a patient satisfaction document which we will introduce to help us assess the service. There

is now no doubt that what we are offering is an essential component of the treatment of patients with cancer and their families.

As the Cancer the Cancer Nutrition and Rehabilitation program formalizes its knowledge and expertise in this area we hope to be able to present some formal proposal to government to request governmental funding which will then allow this “whole patient care” to be promulgated into the community. It is envisaged and believed that this will translate into better symptom control, better lifestyle behavior and better use of available medical resources.

INTEREST GROUP IN END-OF-LIFE CARE FOR NON-CANCER PATIENTS

Sandra Richardson, MD & Anna Towers, MD

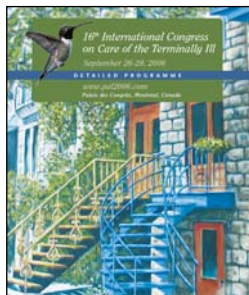
Until very recently, Palliative Care Services throughout the world have focused almost exclusively, on cancer patients. Since only 25% of the population die from cancer, and another 10-15% die with a short illness of a few weeks or less, this leaves the majority of patients dying from such chronic illnesses as COPD, CHF, CRF or neurological disease. Many have multiple hospital admissions in their final months.

Last September, a small group of subspecialty physicians as well as an ethicist began to meet to address the issue of End-of-Life Care for non-cancer patients in our hospital sites. We started by asking each subspecialty to discuss the care given and the challenges faced in their patient population. Through this process, we discovered that there are already in place some multidisciplinary programs to address end-of-life issues which can provide useful models for others; e.g. the CHF outpatient program and the MNI program for ALS.

Last year we also had three outstanding visiting professors with expertise in Non-cancer End-of-Life Care. Joan Teno from Brown School of Medicine was the Jane Poulson lecturer in April, Diane Meier from Mount Sinai School of Medicine in New York was Geriatric Grand Rounds speaker in May and Gian Borasio from the University of Munich spoke at Palliative Care rounds in June.

The new academic year in September started off with a full-day symposium with international leaders in the field of End-of-Life Care for Non-Cancer Patients on September 26th, 2006. The symposium is part of the McGill-sponsored International Palliative Care Congress that took place in Montreal from September 26-29, 2006. (For further information contact Bernard Joannette at local 43933 or see website www.pal2006.com)

Following the symposium, we intend to broaden our Interest Group to include representatives from other disciplines who have expressed an interest. The plan is to:



- a) finish the presentations of the subspecialty services and identify common issues and concerns;
- b) become aware of models of care and programs in other countries;
- c) advocate for quality improvement at all our sites and initiate pilot projects.

Our goal is to raise the level of awareness of the needs of this patient population and advocate for programs of quality improvement in collaboration with colleagues within our institutions as well as with our community partners. The result will hopefully be a new culture of enhanced end-of-life care for patients on all our medical services.

We owe thanks to the other members of the MUHC Non-Cancer End-of-Life Care Group for their participation: Marcel Arcand, Jean Bourbeau, Manuel Borod, Jane Chambers-Evans, Catherine Ferrier, Laurence Green, David Lussier, Nadia Giannetti, Paul Lysy, Dev Jayaraman, Murray Vasilevsky and Lucy Viera.

ERNESTO L. SCHIFFRIN ELECTED TO THE RSC



We are proud to announce that **Dr. Ernesto Schiffrin**, Physician-in-Chief of the JGH and Vice-Chair of the Department of Medicine, was among the 82 new Fellows recently elected to the Royal Society of Canada (RSC). Elected to the Academy of Sciences, Division of Life Sciences, he is one of the seven McGill faculty members elected to the Society. The induction ceremony was held Sunday, November 19, 2006.

The Royal Society of Canada

The RSC is Canada's oldest and most prestigious scholarly organization. Election to RSC is the highest honour that can be attained by scholars, artists and scientists in Canada.

Founded in 1882 by the Governor General, the Marquess of Lorne, the Royal Society of Canada was incorporated by an act of Parliament and granted its Royal Charter in 1883. The Society followed the model of the Royal Society of

London but with the addition of literature and other elements found in the Institut de France.

The founding Fellows, who included Sir Sanford Fleming, the originator of the world system of Standard Time, and Sir William Osler, one of the greatest physicians of his day, were nominated by a committee headed by Sir John William Dawson, Principal of McGill University and the former Premier of Quebec, Pierre J.O. Chauveau, respectively the first and second Presidents of the Society.

The Society as a whole was reorganized into the present three Academies in 1974. The Life Sciences Division of the Academy of Sciences was created in 1990.

This is a signal honor for Dr. Schiffrin who is one of our most distinguished faculty members. It is well deserved as is clear from the following citation by the Royal Society highlighting Dr. Schiffrin's achievement.

Royal Society Citation for Dr. Schiffrin:

Dr. Schiffrin is one of the great clinical scientists in Canada, and a world leader in the field of the mechanisms and management of arterial hypertension. Amongst many contributions, he demonstrated that anti-hypertensive drugs interfering with the renin-angiotensin-aldosterone system correct blood pressure and the structural remodeling of resistance arterioles. He also showed the role of endothelin in this vascular remodeling.

Congratulations Ernesto!

APPOINTMENTS

It gives us great pleasure to announce that **Dr. Michael Libman** has assumed the dual role of Director of the MUHC and McGill Divisions of Infectious Disease effective November 1, 2006. Dr. Libman is a distinguished clinician, teacher and administrator who is widely respected in the Division and the Department.

We are pleased to announce the appointment of **Dr. Christina Wolfson** as Director of the Clinical Epidemiology Division of the MUHC Department of Medicine effective January 1, 2007. Dr. Wolfson, a distinguished senior faculty member within the McGill Departments of Epidemiology and Biostatistics and Medicine is currently the Director of the Centre for Clinical Epidemiology and Community Studies at the Lady Davis Institute for Medical Research at the Jewish General Hospital.

RECRUITMENTS

Five new faculty members have joined the department. Please join us in welcoming them.

Devi Banerjee, M.D., has been appointed as an Assistant Professor in the Division of Clinical Immunology/Allergy based at the MUHC. Dr. Banerjee completed two years of postdoctoral training at the Rockefeller Institute. Based at the M.G.H. site, she will establish a unique food allergy clinic in addition to duties at the Asthma Centre.

Robert Scott Kiss, Ph.D., has been appointed as an Assistant Professor in the Division of Cardiology at the MUHC. Dr. Kiss obtained his PhD at the University of Alberta in Biochemistry and did post-doctoral work at the University of Ottawa since 1999.

Viviane Nguyen, M.D., has been appointed as an Assistant Professor in the Division of Cardiology at the MUHC. Dr. Nguyen's cardiology training at McGill was followed by additional training in echocardiography at the Montreal Heart Institute and in heart failure and transplant at the Brigham and Women's Hospital at Harvard University.

Manu Prabhakar, M.D., has been appointed as an Assistant Professor in the division of Cardiology at the MUHC. Dr Prabhakar did his medical degree and his cardiology residency training at the University of Western Ontario. He then completed a fellowship in Interventional Cardiology at Sunnybrook Health Sciences Centre at the University of Toronto.

Robert Sladek, M.D., has been appointed as an Assistant Professor in the Division of Endocrinology and Metabolism, based at the Genome and McGill Innovation Centre. Dr. Sladek completed medical school studies and training in internal medicine and in endocrinology and metabolism at the University of Toronto. He then undertook research fellowships characterizing the estrogen related receptors and in the area of genomics of complex trait diseases.

GRANTS AND AWARDS

Robert Scott Kiss has received the Young Investigator Award from the Canadian Lipoprotein Conference.

Erwin Schurr has been selected as an International Research Scholar of the Howard Hughes Medical Institute

and will be awarded a research grant of U.S. \$487,000 over five years.

HONOURS

Suhad Ali is the winner of the 2006 Young Investigator Award from the *Canadian Society of Endocrinology and Metabolism*. Dr. Ali has made novel insights into the mechanisms of prolactin receptor signaling.

Yves Bacher was recently named the new president of the *Association internationale francophone de gériatrie et gérontologie* 2006-2010.

Howard Bergman has been renominated as Chair of the Institute Advisory Board of the *CIHR Institute of Aging* for another three-year term.

Allen Huang and **Robyn Tamblyn** were awarded the prestigious J.-Armand-Bombardier Award by the *Acfas*, which is the *Association francophone pour le savoir*. Dr. Huang and Dr. Tamblyn received this award for their work on the MOXXI, the Medical Office of the XXIst Century.

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