WORD FROM THE CHAIR
David Eidelman, M.D.
Chair, Department of Medicine

CURARE, SCIRE, DOCERE

In this issue of the newsletter, I am pleased to present our new logo, which was chosen by the department leadership to underscore the importance of the university department of medicine which brings together three hospital departments, and to help reinforce the sense of belonging of the department’s members. To develop the logo we needed to find symbols that represented well the nature of the department. After reflection, it was clear that the department’s emblem had to represent its three core missions: clinical care, research and teaching.

Curare

Patient care is the primary mission of any clinical department, and is the basis for all our research and teaching activities. To represent this aspect of the department, we chose the caduceus of Asclepius, a short staff with a snake wrapped around it. Originally, in Greek mythology, this symbol was an attribute of the god Apollo who offered it to Asclepius, his son and the god of medicine. It is interesting to note that snake has been part of symbols of the medical profession for 5,000 years, as it is associated with regeneration because of its capacity to shed its skin. The caduceus of Asclepius has been known as a symbol of medicine since at least 1200 BCE, at least in the western world, and its use has been widespread since the 17th century.

Scire

Research is also an essential aspect of the department’s activities, particularly a department such as ours which has such a rich tradition of research excellence. We had some difficulty finding a symbol for research because of the diversity of this activity in the department. How does one find a representation that encompasses the broad range of research programs underway in the department? Finally, after long reflection, we decided on the double helix of DNA which, given the centrality of the genetic code in biology and medicine, is the ideal emblem to represent all of our research activities: basic, clinical and population based.

Docere

Finally, as a university clinical department, the diffusion of our knowledge and the training of the next generation are central responsibilities. The classical symbol for teaching and knowledge is the book. We therefore chose a book both as a symbol of teaching, and also as the background for the other icons, symbolizing at once the importance of the links to the two other pillars of the department.

To complete the logo, a motto in Latin summarizes the three symbols “scire, curare, docere”, in other words “research, healing, teaching”.

Web site

The announcement of a new departmental logo coincides with the launch of a new web site for the department, supervised by Andrea Gitton. The site is not yet in its definitive form and we plan many improvements over the
coming year. In addition, it is only available in English for now. Nevertheless, it’s worth a visit, if only for a peek: www.medicine.mcgill.ca/deptmedicine. We hope that the site will become the main source for information about the McGill Department of Medicine.

QUALITY INITIATIVES

As part of the focus on quality, in this issue we highlight quality initiatives at the JGH and the “O2 Ticket to Ride” initiative at the RVH.

QUALITY OF CARE ISSUES ADDRESSED AT THE SMBD JEWISH GENERAL HOSPITAL

Ernesto L. Schiffrin, M.D.

The issue of quality of care and the development of Care Quality Indeces (CQI) has attracted increasing attention within the healthcare system and other stakeholders and interested parties across North America, and in Canada with different goals than in the USA. In the USA some of the issues have been related to reimbursement, and are not a concern within our system. However, the issue of cost has been a common thread both in the USA and in the different Canadian provinces, and CQI has become a way of ensuring a certain degree of cost control of the healthcare system through approval of standards of care that have been formalized in guidelines and that are cost-efficient.

However, for an academic Department of Medicine, and in fact for any department of medicine, the issue is one of excellence of care, which requires that CQI be used to ensure the application of available guidelines and evidence based medicine, as well as improved outcomes and adequate patient satisfaction. However, the tension between cost and quality will also come into consideration when considering cost-benefit analysis even in a university hospital, particularly in a single payer system.

At the JGH the administration and the Department of Medicine have both initiated moves to develop criteria and data that will ensure safety and quality of care. In response to a recommendation of the Council of Physicians, Dentists and Pharmacists (CMDP, also known as MEC), the administration of the Hospital has created a CQI activity. The quality and risk management committee co-chaired by the Director of Professional Services and the director of nursing (or delegates) and a hospital CQI steering committee will be involved. The latter committee includes the co-chairs of the Quality and Risk Management Committee, the chair of Committee for Assessment of Medical Acts, the three members of the CQI office, the chief of Pharmacy, a CQI Program coordinator, a Quality Assurance Risk Management clinical coordinator and a representative of the Board. This committee is co-chaired by representatives of the CMDP (or MEC) and Nursing Executive Committee (NEC) and should report to the CMDP and NEC. This committee should invite on an ad hoc basis different CQI experts and leaders from within and from outside the hospital. For an initial evaluation of quality, the following CQI have been identified: percentage of occupied stretchers in the Emergency with admitted patients; the rejection rate by the CCU, and the waiting time for CT-scans and MRIs. These are evidently gross indicators of quality of service offered by the Hospital, and not really indicators of quality of the full range of care that we offer as a teaching general hospital.

In the JGH Department of Medicine there are the usual Morbidity & Mortality meetings and evaluation that is carried out regularly in each division. However, in addition and as mentioned already, with Mark Lipman, the Associate Chief of Medicine at the JGH we are also starting a quality of care evaluation in the CTUs. This is currently being developed as an online program that will among other allow us for example to detect the degree to which there is increased length of stay in the CTU and delayed discharge due to waiting time for remaining tests such as MRIs or scans. Again, this may not necessarily measure adherence to guidelines and evidence-based medicine, improvement in care and better outcomes, reduced complications, greater patient safety and ultimately patient satisfaction, but these should all eventually become goals of a quality of care improvement program.

Ultimately, the objective is to adhere to best practice, which is what we want to teach and at which we are supposed to excel. This will require setting up quality improvement projects as done in other centers, and evaluating objectively whether indeed there is compliance with these goals. Research into tools to determine which CQIs are useful indicators, how to use information technology in the field of quality of care, and other subjects should be developed at the level of the University Department of Medicine and applied in all teaching sites of the McGill system. Indeed, at the University Department level we are already looking into means to develop this field as a common area of interest across our different campuses. So we can look forward to quality of care issues becoming a major area of research as well as teaching and patient care in the McGill Department of Medicine. Stay tuned.
TICKET TO RIDE: LEARNING FROM AN ADVERSE EVENT
Mark Daly, RRT, MA (Ed.) & Molly Warner, M.D.

Promoting a culture of safety within organizations must include learning from adverse events and translating the lessons learned into concrete changes that will improve patient safety. In May 2005 the McGill University Health Centre Policy on Sentinel Events¹ was implemented to provide a standardized framework to manage these events and help promote the culture of safety within the organization. This framework has helped us realize a number of changes to improve patient safety including the O₂ Ticket to Ride.

The O₂ Ticket to Ride project is a direct outcome of an adverse event and is a good example of a patient safety initiative resulting from a collaborative effort between the Department of Medicine, Quality Management, Nursing, Transport, and Radiology. The project is being piloted at the Royal Victoria Hospital and will include all oxygen dependent patients being transported between 6/10 Medical and Radiology. The goal of the project is to ensure that appropriate verification and documentation occurs at each transition point to guarantee an adequate supply of oxygen during the patient’s transport.

The O₂ Ticket to Ride form is a two-sided form. One side includes the information that must be completed prior to the patient’s departure by either the Radiology Technologist or Nurse. This includes the date the patient goes to radiology, departure time from the Unit, name of the departure unit (6M, 10M, or Radiology), destination, type of oxygen device, litres per minute of oxygen, amount of pressure remaining in the cylinder, the time the cylinder must be changed, and the initials of the Nurse or Radiology Technologist. The opposite side includes a chart that describes how long the oxygen will last based on the flow administered to the patient and the amount of pressure remaining in the cylinder.

Evaluation of the project will be focussed in two areas: process and outcome. The former will measure compliance with using the tool. The Assistant Head Nurse will keep a master list of the oxygen-dependent patients. This list will be reviewed against the completed O₂ Ticket to Ride forms to evaluate if the tool was used each time a patient was transported to radiology. In addition, risk management will be asked to review the incident reports received from 6/10 medical to identify any possible incidents involving patients running out of O₂ in-transit during the pilot phase.

The O₂ Ticket to Ride is an excellent example of what can happen when a standardized framework, including multidisciplinary participation, is used to review an adverse event. In this case the various stakeholders identified their challenges, worked together to address them, and implemented a change in practice that will improve patient safety.

DIVISIONAL UPDATE
ENDOCRINOLOGY
Simon Wing, M.D. – Division Chief

Clinical Activities

The Division continues to see its clinical activities grow. With the epidemic of obesity and Type2 diabetes, the Division is contemplating how to best provide consultation services for this ever growing demand. In a project supported by Glaxo Smith Kline’s Prism programme, Dr. Jean-Francois Yale has been exploring the effect of sending a nurse and dietician into community clinics to do teaching to patients and of offering telephone consultations to the physicians in these clinics. As part of our Quality Assurance Program, we are reviewing the profile of patients that we see in this disease area to see whether our resources are being optimally used. Under Dr. David Goltzman’s leadership, a clinical MUHC Centre for Metabolic Bone Disease has been established at the RVH site on E1. This Centre offers consultation services for the full range of calcium and metabolic bone disorders and helps support a large clinical research program. At the MGH site, an Endocrine Neoplasia Centre has been set up under the leadership of Drs. Jacques How and Roger Tabah in which nodular thyroid disease can be assessed by both an endocrinologist and surgeon in one visit. At the JGH site, the search will be underway soon to appoint a new director of endocrinology to replace Dr. Enrique Silva who moved to Massachusetts last fall. Also at the JGH, Dr. Stravroula Christopolous has returned from a year of formation complémentaire under the supervision of Dr. André Lacroix and will provide additional expertise in the management of adrenal disorders.

Research Activities

Awards from the Canadian Foundation for Innovation have led to the formation of two research centres involving investigators from McGill University and Université de Montréal. The Bone Centre, directed by Dr. Goltzman,
offers core services to researchers in bone and mineral research in Montreal. The Montreal Diabetes Research Centre (MDRC), led by Drs. Marc Prentki and Lawrence Rosenberg, also provides core services to the diabetes research community. In addition, Drs. Barry Posner and Marc Prentki led a group of researchers from the MDRC in a successful application for a large Genome Quebec/Genome Canada award on the proteomics and genomics of Type 2 diabetes. The core of the Divisional Research is delivered by 17 medical scientists and 14 clinician investigators. The basic research is carried out in six main groups at the MUHC – Calcium Research Laboratory, McGill Nutrition Centre, Hormones and Cancer Research Unit, Endocrine Laboratories, Fraser Laboratories and the Polypeptide Laboratory as well as a very active group at the Lady Davis Institute. Last year, Dr. Christian Rocheleau joined the Hormones and Cancer Research Unit and brought new expertise in the area of MAPkinase signaling using \textit{C. elegans} as a model system. Clinical research is actively carried out in the areas of diabetes, lipids, and bone research.

**Educational Activities**

Together with the Nephrology Division and the Pediatric Endocrinology Division in the MUHC Research Institute Endocrinology/Diabetes/Nutrition/Renal Diseases Axis, a monthly research seminar with mostly guest speakers from outside of McGill has been successfully established. McGill Combined Rounds are held four times a year rotating around each of the four sites – MGH, RVH, JGH, and Montreal Children’s Hospital. The highlight of the year in the McGill Endocrine Community is the McGill Endocrine Retreat. This is an afternoon event consisting of short oral presentations from the researchers, case presentations at Endocrine Grand Rounds, followed by the keynote Yogesh Patel Memorial Lecture delivered by an eminent investigator. The day concludes with cocktails and dinner.

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**WORD FROM THE VICE-CHAIR, RESEARCH**

Ernesto L. Schiffrin, M.D.

**RECRUITING NEW INVESTIGATORS INTO OUR RESEARCH ENTERPRISE**

In my previous communication I discussed some of the challenges ahead that we have to find answers for to make sure that our research enterprise moves forward as efficiently as possible. These included among others the recruitment of young clinician-scientists. This remains in my view the most difficult and challenging task.

A critical aspect for us to recruit more clinician-scientists is to start early. For this, it is imperative that medical students be exposed to role models and that mentoring should be encouraged and stimulated to impress on young minds the challenge and fun of discovery, to light up the sacred fire that makes individuals pursue a difficult but highly gratifying career whatever the obstacles, conscious of the rewards at the end of the road. But there has to be action on the part of the research community and granting agencies to nurture any nascent enthusiasm for research in medical students. For this reason we have in the past proposed at a CIHR committee that a program whereby med students are exposed to clinical research for 6 months to a year during their medical studies be created. During this time students would carry out a research project in a clinical research center where translational research takes place. This would be their opportunity for exposure to role models such as experienced clinician-scientists, and the chance to see them in action and hear about their experience. At the same time, structured training programs in cutting edge techniques and approaches in biomedical science and the rigour of research would start to prepare them for future successful scientific competition.

This attempt to make medical students interested in and enthusiastic about biomedical science and providing them the opportunity to acquire the basic tools to eventually be able to compete successfully should be accompanied by a similar, parallel effort with PhD students to get them interested in clinical science, if we are to develop efficient multidisciplinary translational research teams. Exposing PhD students to the clinic is imperative to successfully achieve the goal of having PhDs who understand the clinical needs that will generate projects with translational significance that will be carried to clinical application. This is what we need to develop, particularly those of us who are part of a research intensive University Department of Medicine.

The question now is how to finance these activities, and who will create these programs that are only superficially touched upon in this short article. If we have this vision, we must create blueprints for such programs and obtain the agreement of granting agencies such as FRSQ and CIHR to establish such activities urgently. We cannot wait. The health of our population and our own wish to discover and
gather new knowledge that we can apply to improve the quality of life of our fellow Canadians should spur us forward, and the granting agencies, to become pro-active and create these paths that will provide us with a corps of new clinician-investigators, MDs and PhDs, who will carry forward our research enterprise into the future.

DONATION TO THE INTERNAL MEDICINE RESIDENCY TRAINING PROGRAM

Thomas Maniatis, M.D. – Director, Internal Medicine Residency Training Program

I am happy to announce that the McGill Internal Medicine Residency Training Program has received a $10,000 per year donation for a total of 3 years from Dr. Amy Hendricks: a past trainee, past Chief Medical Resident, and current alumna who is practicing General Internal Medicine in Yellowknife, Northwest Territories. She has made this donation to support the McGill Internal Medicine Training Program at the RVH site with respect to the provision of food at rounds. The use of these funds is conditional upon the absence of industry sponsorship from RVH site program educational activities. This donation has been made in honour of her father, W. James Hendricks, whose brief biography is below:

W. James Hendricks, born in Pennsylvania in 1935, received a degree in geology and worked briefly in the Northwest Territories as a geologist. He later received a PhD in mathematics and went on to teach mathematics at Case Western Reserve University, the University of Virginia, and the University of London, England. Throughout his career, he was respected for maintaining his integrity even in difficult circumstances, and for his generous commitment to his students. Both of his daughters eventually graduated from McGill, although his premature death prevented him from seeing his younger daughter become a practicing physician. His high ethical standards, compassion, and commitment to education continue to inspire his students, friends and family.

This donation comes at a time when the Internal Medicine Residency Training Program has been critically examining the role that industry support plays in its Training Program activities. During the last year or so, the McGill Internal Medicine Residency Training Program has elected to stop soliciting and organizing for industry support for the provision of food at teaching rounds. Thus, the donation from Dr. Amy Hendricks has arrived at a most fortuitous time, and the Training Program certainly welcomes any similar such gestures of generosity in support of resident well-being.

I would like to take this opportunity to wholeheartedly thank Dr. Amy Hendricks for her generosity and support of Residency Training at McGill.

RECRUITMENTS

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

David Colantonio, PhD, has been appointed as a part-time Assistant Professor joining the division of Clinical Biochemistry. Dr. Colantonio completed a fellowship in Clinical Chemistry at Johns Hopkins University, School of Medicine.

Carmela Pepe, M.D., has been appointed as an Assistant Professor in the division of Respiratory Medicine at the JGH, with a cross-appointment to the MUHC. Dr. Pepe just completed a clinical research fellowship in lung oncology at the Princess Margaret Hospital.

Please join us in welcoming back Dr. Phil Wong to the Gastroenterology Division after a 2-year leave of absence for family reasons at the University of Toronto. He has rejoined both the Hepatology and Liver Transplant groups and is clinically based at the RVH site.

DEPARTMENT OF MEDICINE AWARDS

The JGH Department of Medicine Staff and Residents Awards Year-End Party took place on June 15, 2006. Congratulations to this year’s recipients!

Dave Feder Award: Presented to the resident who most practices medicine with compassion and sensitivity. Displays kindness, respect and camaraderie towards colleagues and educators. Carries a positive outlook enabling him/her to enjoy a meaningful balanced life beyond his/her profession. Awarded to: Dr. Beth-Anne Cummings
Sheldon Zemelman Memorial Award: For academic excellence and outstanding contribution to patient care. Awarded to: **Dr. Tal Kopel**

Dr. Allen Spanier Internal Medicine Award: To the resident who exhibits an enduring passion for the practice of medicine. Through the enjoyment of solving the challenges of patient care and sharing the solutions with others, while maintaining a high level of professionalism, he has been chosen as the individual who best embodies the unique legacy of Dr. Allen Spanier. Awarded to: **Dr. Majid Al-Madi**

**Teacher of the Year** voted by the residents: **Dr. Andrew Hirsch**

### GRANTS AND AWARDS

**CIHR OPERATING GRANTS**

Congratulations to the following faculty members who have been awarded CIHR operating grants in the March 2006 competition:

- Chantal Autexier
- James Brophy
- Mark J. Eisenberg
- Jacques Jr. Genest
- Vincent Giguere
- Michael T Greenwood
- Andrew Karaplis
- Lawrence Kleiman
- Rongtuan Lin
- Danielle Malo
- José A. Morais
- William J Muller
- Salman T. Qureshi
- David Rosenblatt
- Donald Sheppard
- Patricia N. Tonin
- Mary M. Stevenson
- Mark A. Wainberg
- Brian J. Ward

### ADDITIONAL GRANTS

**Patricia Tonin** has been awarded an operating grant from the Canadian Cancer Society.

### HONOURS

**Ernesto L. Schiffrin** has been elected as a New Fellow to the Royal Society of Canada, Academy of Sciences, Division of Life Sciences.

**Maida Sewitch** has been awarded the 2006 NCIC’s Dorothy J. Lamont Scientist Award for her research contribution in cancer control.

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