VITAL SIGNS

THE NEWSLETTER OF MCGILL UNIVERSITY DEPARTMENT OF MEDICINE

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WORD FROM THE CHAIR

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

IN THIS ISSUE

Welcome to another issue of the Newsletter. Highlights of this issue include an update on some exciting quality projects in the Department, a brief profile of our incoming Dean and a summary of a February division leaders retreat on the future of the Department.

RECOGNITION OF CLINICIANS

A reality of the academic life of our department is the distinction between those with tenure or on tenure-track, GFT-Us, and the majority of the faculty, GFT-Hs, a group which is paradoxically classified by the University as “part time” professors. This is despite the fact that many of such “part-timers” are working more than 60 hours per week. Obviously, the distinction does not reflect the number of hours of work but rather the mode of remuneration. GFT-Us, who are salaried by McGill University, are eligible for the privileges that come with a university appointment such as pension plan and other fringe benefits, not to mention the possibility of a permanent position. In contrast, GFT-Hs, who do not receive a regular university salary, live with an ambiguous university status. Despite their official rank as part-time employees (usually unpaid), they are the backbone of the Department and of the Faculty of Medicine. In addition to their clinical contributions, they are responsible for most of the teaching of medical students and residents. Their administrative contributions are also very important. For example, GFT-Hs are well represented among the Associate Deans, course coordinators and the planners of the medical curriculum. Moreover, GFT-Hs are critical to clinical research, a very important scientific contribution that, in addition to publications and profile, brings in significant sums of money to the University and the research institutes.

Despite the importance of the work they accomplish, GFT-Hs have never benefited from the appropriate type of recognition. The problem is well illustrated by deficiencies in our promotion system. It is true that the University grants the same titles to all members of the faculty such as Assistant Professor, Associate Professor or full Professor. It is also true that in principle the criteria for promotion are the same for a full time researcher, a medical educator or an outstanding clinician. Nonetheless, the promotion system is difficult to apply to clinicians because there is no recognition of the specific types of contributions made by them. In practice, this problem is solved within the promotion committee by interpreting the University’s promotion rules with a sufficient flexibility to accommodate clinicians. Instead of evaluating a master clinical teacher in comparison to his peers, accomplishments are evaluated in such a way as to make them comparable to those of a researcher. This gets the job done but does not properly recognize the work of clinicians per se.

We must do better. The University should recognize GFT-Hs as full time faculty members, eligible for fringe benefits and pension plan, even if the University is not called upon to contribute financially. Furthermore, the university should specifically recognize the university-based clinician in its promotion system as has already been done in other institutions. For example, the University of Toronto, an institution with an academic culture comparable to our own, has for several years recognized multiple ways to make scholarly contributions to the university. By including “creative professional activity” as a promotion criterion,

Toronto recognizes work by clinicians within the university promotion system[1].

We now find ourselves in a period of change. The nomination of a new Dean should be an opportunity to reevaluate our policies and procedures including those surrounding promotion. It is my hope that this renewal will serve as a catalyst for the changes needed in the promotions system to recognize the essential contribution of the academic clinician.

QUALITY INITIATIVES

In his last editorial, Dr. Eidelman spoke of the importance of clinical quality as a priority for the department. As part of the focus on quality, in each issue of the Newsletter we will highlight quality improvement projects at each of our sites. In this issue, we look at projects at the MGH and the Montreal Chest Institute.

FINDING THE ERROR IN OUR WAYS?

Laurence Green, M.D.

Medical error remains an important cause of morbidity and mortality in hospitalized patients as recently documented by the Canadian Adverse Events Study. In departments of medicine, medication and fluid error was responsible for the highest percentage of medical error (43%). Medication error is a frequently exposed problem on our CTUs during our Morbidity and Mortality monthly reviews. The CCHSA accreditation report pointed to medication error as a significant problem that needs to be addressed, particularly at the MGH site where there is no computerized order-entry system. Such a system is coming, but we felt that we couldn't wait for its implementation. Furthermore, it is clear that medication errors will continue even after implementation of a computerized pharmacy ordering system, and indeed new errors may be created.

With this in mind, the 15th floor CTU assembled a working group to examine the medication process and recommend and implement improvements. Our first step was to review the physician order and the nurse transcription process. We then undertook a chart review and found several areas for improvement, such as including the time of prescription. Following education sessions led by our pharmacy team, we repeated the chart audit and found significant improvements in all areas. For example, the time was written on 75.6% of prescriptions compared with 44.2% before the education sessions.

We then turned our attention to periods of transfer of care, well-known to be high-risk times for patients. Such times are the arrival from home to Emergency, the transfer from Emergency to the CTU, the transfer from an intensive care area to the CTU and finally the discharge to home or to a rehabilitation facility. Our pharmacists, led by Nadine Tadros and Genevieve Cyr, adapted a tool, which reconciles the admission meds with the discharge meds. In brief, the pharmacist interviews the patient or family and then calls the community pharmacist to establish the medications the patient was taking on arrival. These are then written on a reconciliation discharge form, which acts as the exit prescription. On this reconciled exit prescription, the doctor indicates whether the medications on arrival are to be continued, modified or discontinued. All modifications are written on the form, with reasons for change. This form then goes with the patient to be given to their pharmacist with a copy to their treating physician and a copy for the hospital chart.

We next tackled the transition from ER to CTU. Our pharmacists now go to the Emergency Department (ED) prior to admission and complete the reconciliation prescription before the admitting staff sees the patient. This has been a great help for the admitting team and has undoubtedly diminished medication prescription error. Our pharmacists are gathering data as to the number of important discrepancies that have been discovered between the meds as listed in the ED and the actual med list.

Despite these efforts, medication errors persisted. We then tackled the problem of transcription error, both on the ward and after transfer. With the help of our Department of Pharmacy, we have hired a pharmacy technician (Sylvie Brunet) to compare the orders as registered on the pharmacy computer with the orders written on the medication cardex. She has been documenting and classifying pharmacy "errors" as well as intervening in these discrepancies. Her energy, diligence and enthusiasm are appreciated by all.

Our work is certainly not done. We still await a modern computerized order-entry system. In the meantime, we hope to computerize the work that we have already accomplished and to have a computerized medication cardex. We hope, in the near future, to have our exit reconciled prescription on computer and accessible to

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[1] I invite you to read more about this on their web site (http://www.deptmedicine.utoronto.ca/English/Understanding-Promotional-Criteria-and-Process.html) where one can also find an interesting article by Dr Eliot Phillipson on the subject of creative professional activity (http://www.deptmedicine.utoronto.ca/userfiles/page_attachments/library/1/1656601_Feb1998_140_1949692.pdf).

physicians in the medical clinic as well as the Emergency Department along with an electronic discharge summary.

We owe a great deal of thanks to our pharmacy department, led by Patricia Lefebvre as well as to our pharmacists, Nadine Tadros, Lucie Gaudreault and Co Pham. Further accolades to our nursing staff headed by Joan Legair and to Maria Dias, our clinical-nurse specialist and co-leader of our quality team.

QUALITY OF CARE IMROVEMENT INITIATIVE IN COPD[2] PATIENTS AT THE MUHC

Jean Bourbeau, M.D.

As part of a MUHC project "RECAP (Rehabilitation, Education for COPD and Added-value to the Medical Practice)" we implemented a quality management process specific to COPD patient care. The aim of this project is to evaluate COPD management, support teams and health professionals in specific action to improve quality of care and services.

We carried out a chart review between January and March of 2003, 2004 and 2005 at three sites of the MUHC: the Royal Victoria Hospital, the Montreal General Hospital and the Montreal Chest Institute, for a representative sample of COPD patients that were either hospitalized or visited the Emergency department for acute exacerbations of COPD. Data extraction was done by the same professional in medical records using a standardized form. A respirologist determined whether appropriate management (pharmacological and non pharmacological) was administered based on the recommendations of the Canadian Thoracic Society for COPD management. A COPD nurse decided on the need to offer CLSC and/or Soins respiratoires spécialisés à domicile (SRSAD) support based on priority criteria put forward in the current policies of the Agence de la santé et des services sociaux (ASSS) of Montreal for COPD patients.

We defined management and care delivery gaps as the percentage of patients *not* receiving a specific treatment (pharmacological and non pharmacological) consistent with the 2003 Canadian Thoracic Society COPD Guidelines and *not* referred to services on the Montreal territory.

We identified clinically significant care gaps in a majority of patients at all sites. Notably, spirometry was underutilized, smoking cessation counseling was either not done or not reported, pharmacological treatment for severe COPD patients on hospital discharge was far from optimal and very few patients were referred to a pulmonary rehabilitation program.

We are now entering an important phase of our project in which we call for actions to reduce care gaps. We are planning the following initiatives in the coming year:
1. Forum discussion (nurses, medical residents and attending staff) to highlight care gaps, to review recommendations to optimize COPD management;
2. Implementation of a discharge planning tool to assist the medical teams and better serve the needs of patients returning to their own environment;
3. Weekly visits of the COPD nurse (COPD/ Pulmonary rehabilitation of the MCI) to medical units to support the unit teams and health professionals in their actions.

Success in these initiatives will require support from across the MUHC. We are confident that we can work together to reach the high standards of practice recommended by recent national and international guidelines.

[2] Chronic Obstructive Pulmonary Disease

INCOMING DEAN
DR. RICHARD I. LEVIN

In case you missed the University announcements or the spread in the Globe and Mail, we are about to welcome a new Dean to the Faculty of Medicine. Dr. Richard Levin comes to McGill from New York University School of Medicine, where he serves as Vice-Dean for Education. A graduate of Yale and NYU, Dr. Levin is a cardiologist with broad experience in basic and clinical research. In addition, he has extensive experience in curricular development and medical school administration. After a post-doctoral fellow at Cornell, Dr. Levin joined the NYU Faculty, where he served in several capacities including Director of the Laboratory for Cardiovascular Research, Associate Dean and currently Vice-Dean.

Dr. Levin's full title will be Vice-Principal (Health Affairs) and Dean, Faculty of Medicine. This title underscores the changes in the job that took place under the outgoing Dean, Dr. Abraham Fuks, who has served with great distinction for the last 11 years.

As the University has put it, "Dr. Levin will lead McGill's Faculty of Medicine, already among the world's best, to the highest tier of excellence in medical education, research in the health sciences, the delivery of quality clinical services

to patients, the development of health-care policy, and in designing stronger relationships to the community, including the private sector."

As a cardiologist, Dr. Levin's formal academic appointment will be in the Cardiology Division of our Department. We are delighted to welcome him and wish him every success in his new position.

DIVISION LEADERS RETREAT

On Monday February 13, 2006 an event of world-historical significance took place. Okay, maybe not quite that important but still very unusual. All the Division Chiefs of the Department at the McGill and hospital levels (St. Mary's, JGH and MUHC) came together for an evening retreat to discuss issues of interest to the Department as a whole. The division leaders were asked a series of questions about how the McGill Department of Medicine should develop in the face of the challenges from complementarity, the RUIS and the changing nature of our profession. What follows is a summary of our findings organized around the three major themes of the department.

CLINICAL SUMMARY

David Eidelman, M.D. & Todd McConnell, M.D.

There were two tables that looked at the issues from the point of view of clinical care. A number of issues arose at both tables. Firstly, there was an understanding of the benefit of working together across sites, as this would strengthen McGill's competitiveness in a number of ways. In addition to focusing competitive energies on "outside" competitors, increasing collaboration would help us to develop critical mass and to more effectively establish priorities within the Department of Medicine. If we are successful, we will be able to take a leadership position in the Quebec health care system and internationally.

There was however concern that for this to make sense for clinical care, a number of preconditions needed to be satisfied. Firstly, any development process should have a strong "bottoms-up" orientation. There is little to be gained from the imposition of solutions by administrators or clinical leaders who are often remote from the bedside. The process needs to be an iterative one, with constant interaction between leaders and clinicians.

Another concern was to avoid compromising basic clinical care in the rush to move certain activities to single sites. It is clear that basic services need to be maintained at all sites and than any change in where a clinical service may or may not be given, should take place by consensus and in a transparent manner. The quality of clinical care must be a overarching criterion in any decision about where to carry out particular activities. In addition, such decisions need to take into account our training programs and should be developed so as to enhance learning opportunities.

Both groups also commented on the issue of infrastructure support. If we are being asked to take on new responsibilities for the RUIS, it is essential that we be provided with the tools to do so. Consideration must be given to increasing the PREM, to expanding the use of physician extenders, and to the provision of informatics infrastructure and telehealth.

EDUCATION SUMMARY

Linda Snell, M.D.

Two tables addressed education issues and their relationship with the proposed new department structure and the upcoming demands of the RUIS.

We agreed that the educational mission of the department is broad both in terms of target group and content. Our "target" for education includes medical students (preclinical and clinical), residents, fellows, post-graduate students, colleagues in academic and community settings, other members of the health care team, as well as patients. The education content includes clinical skills and reasoning, medical science, ethics, leadership and other core medical competencies both at a basic and advanced level. In all cases our goal should be excellence in education with a systematic approach. It was agreed that education must be recognized as a valued activity which is rewarded appropriately by the Department and University.

With realignment of clinical services it is likely that not all services will be offered at all sites. Therefore not all sites will necessarily have trainees. This will lead to a need for "physician extenders" and separating 'service' from education. We will also have to look at different models of teaching, attending and learning at the MUHC and JGH sites, as well as including St. Mary's Hospital and community hospitals throughout the RUIS in the educational framework.

We foresee a number of challenges. We must look at how to move education away from the in-patient ward at a tertiary hospital to ambulatory settings and community sites. It is clear that the learners will have to follow the 'best patients for education': after all, how can you teach students and residents to give primary and secondary care when they learn in a tertiary care institution? As well, we need to find out the characteristics of each teaching site and match these

to our own learner needs. A second challenge is training, recognizing and rewarding teachers, both at our university hospitals and in the community sites. A third challenge will be to maintain contact with trainees when they are outside our university sites. This will be facilitated by well thought-out use of information systems that will be integrated throughout the RUIS. Fourth, we must look at a way of supporting the learning of our colleagues throughout the RUIS, who will look to us for education. We must match our expertise with their learning needs. Finally, although it is clear that the responsibility for core undergraduate and post graduate training and continuing education will be at the division level, there must be a clear and free communication across the academic sites and between Divisions to provide a cohesive whole.

RESEARCH SUMMARY

Ernesto L. Schiffrin, M.D.

As in the two other areas, "Research" was discussed by two groups who came to very similar conclusions.

A University Department of Medicine should be a translational research center, which advances knowledge that will result in improvement of care and health of the population, applying progress in biomedical sciences to benefit patients. Thus, research in the department should manage to translate basic science discoveries into clinically applicable diagnostic, preventive or therapeutic strategies. Research activities should be aligned with clinical activities, striving for excellence but serving the needs of the population. The McGill RUIS represents an opportunity to open new areas of research including population and multicenter studies that relate to the health of the RUIS population.

To achieve the goal of developing a research intensive department, division heads with strong research interests should be appointed, who would be leaders in identifying the areas of strength to be expanded and supported to ensure that a critical mass in the field is available and that teams capable of multidisciplinary approaches to the questions to be answered are built. Teams should go across disciplines and cover the recognized pillars of basic and clinical research, health services and outcomes research as well as population science. Areas in need of development to achieve the mission of the department should also be identified. An active effort of mentorship/nurturing of students and faculty should be undertaken to increase the attraction of research careers and contribute to increase the pool of clinician scientists. Use of information technology should be maximized to make sure that the research is not limited to urban centers but also addresses needs of isolated communities.

Efforts should be directed toward creating virtual centers for research that include the different sites where the department is based.

RECRUITMENTS

Four new faculty members have joined the Department. Please join us in welcoming them.

Andrea Benedetti, PhD, has been appointed as an Assistant Professor in the Division of Respiratory Medicine. Dr. Benedetti received her PhD in Epidemiology and Biostatistics from McGill University and then went on to do a post-doctoral fellowship at the Institut national de la recherche scientifique – Institut Armand-Frappier.

Jeffrey Jirsch, MD, has been appointed as an Assistant Professor in the Division of Neurology. Dr. Jirsch is a graduate of the Faculty of Medicine at the University of Toronto and did his neurology training at McGill. This was followed by fellowship training in clinical neurophysiology at the Montreal Neurological Hospital and at Columbia University in New York.

Tiina Podymow, M.D., has been appointed as an Assistant Professor and has joined the Nephrology Division at the MUHC. She completed residency training in Internal Medicine and a Nephrology Fellowship at the University of Ottawa. Dr. Podymow also completed a clinical fellowship in Hypertension and Obstetric Nephrology at the Cornell Medical Center.

Michael Reed, PhD, has been appointed as an Assistant Professor in the Division of Infectious Diseases. Dr. Reed received his PhD in Microbiology from the University of Melbourne and then completed his post-doctoral studies in the Turberculosis Research Section of the National Institute of Allergy and Infectious Diseases in Rockville, Maryland.

PROMOTIONS

ASSOCIATE PROFESSOR WITH TENURE

Marcel Behr
Yong Rao
Tomoko Takano

TENURED

Martin Olivier, Associate Professor
Konstantinos Pantopoulos, Associate Professor

DEPARTMENT OF MEDICINE AWARDS

Congratulations to this year's recipients who were recognized at the MUHC Departmental Annual Dinner on Thursday, May 25, 2006.

Physician-in-Chief Award
For Outstanding Service to the MUHC Department
- **Dr. Harry Goldsmith**

Department of Medicine & Merck Frosst Award
For Research by a McGill Core Internal Medicine Resident
- **Dr. François Mercier**

Department of Medicine Award
For Research by a Subspecialty Resident
- **Dr. George Thanassoulis**

MUHC Department of Medicine Staff Research Award
- **Dr. Louise Pilote**
- **Dr. Ann Clarke**

The Louis G. Johnson Award
For Excellence in Teaching by a Medical Resident – selected by RVH residents
- **Dr. Chantal Cassis**

The Lorne E. Cassidy Award
For Excellence in Teaching by a Medical Resident – selected by MGH residents
- **Dr. Ted Clark**

The Douglas G. Kinnear Award
Outstanding Clinician-Teacher at the MUHC
- **Dr. Suzanne Morin**
- **Dr. Peter Ghali**

The W.H. Philip Hill Award
Outstanding Clinician-Teacher at the MUHC
- **Dr. Lucie Opatrny**

MUHC Department of Medicine Award for Innovation in Clinical Care or Quality
- **Dr. Ash Gursahaney**

The JGH Department of Medicine Staff and Residents Awards Year-End Party will take place on June 15, 2006. The winners of the awards will be announced in the next issue of the newsletter.

GRANTS AND AWARDS

Congratulations to our faculty members for these grants and awards :

OPERATING GRANTS

CIHR
- **Samuel David**
- **John Hoffer**
- **José A. Morais**
- **Ernesto L. Schiffrin**

FRSQ
- **Christian Pineau**

Kidney Foundation of Canda
- **Andrey Cybulsky**

Multiple Sclerosis Society of Canada
- **Stephane Richard**

National Cancer Institute of Canada
- **Antonis Koromilas**
- **Stephane Richard**
- **Mark Trifiro**

NSERC
- **Kostas Pantopoulos**

The Susan G. Komen Breast Cancer Foundation
- **Wilson Miller**

SALARY AWARDS

CIHR New Investigator
- **Maya Saleh**

HONOURS

Orval Mamer has been elected to the Board of Directors of the American Society for Mass Spectrometry, to take office in June 2006. Dr. Mamer is also President of the Canadian Society for Mass Spectrometry.

April Shamy has been named to the Faculty Honour List for Educational Excellence by the Faculty of Medicine.

Chaim Shustik has been appointed to the Scientific Advisory Board of the International Myeloma Foundation.

Emil Skamene was awarded the title of Master of the American College of Physicians (MACP) by the Board of Regents of the American College of Physicians.

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