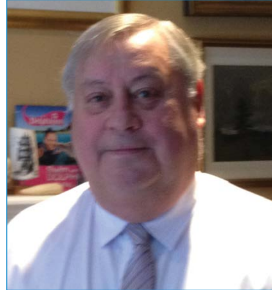
Canadian Heroes in Rheumatology: An Interview with Dr. Paul Davis



Why did you become a rheumatologist? What or who influenced you along the way to do so?

My interest in rheumatology started even before I went to medical school. I worked as a lab technician at the Canadian Red Cross Memorial Hospital in Taplow, England. This was Britain's premier clinical and research institute in arthritis, under the direction of Professor Eric Bywaters and Dr. Barbara Ansell at the time.

One of the jobs that I had as a lab technician was to set up the erythrocyte sedimentation rates (ESR) and the rheumatoid factor (RF) and LE (lupus erythematosus) cell test preparations for patients with rheumatic diseases. I became fascinated by the conditions that these tests were being used for, and that piqued my interest in rheumatology, which lasted obviously for the rest of my career.

From where did your passion and interest in rheumatology stem?

I was lucky enough throughout my training to have exposure to other subspecialties. At one stage, I was even being persuaded to become an orthopedic surgeon, which fortunately I didn't do. But, throughout my career, I found so many of the specialties fascinating. But each time I gravitated back to rheumatology. I think one of the reasons was that clinical immunology and its application in disease processes was rapidly evolving at that stage. So, this was a unique opportunity to combine my interest in clinical immunology with clinical disease as we see it in rheumatology.

Can you tell us about your journey from being a medical student in England to establishing yourself as a rheumatologist in Edmonton, Alberta?

Well, when I left Taplow as a lab technician, I went to the University of Bristol where I obtained my medical degree; but through my undergraduate training, I maintained my relationship with the Research Institute in Taplow, working there during the longer vacations. Subsequently, when I graduated, I spent a short period of time working there as a medical resident. After that, I spent 3 years of training in general internal medicine and then landed a position at the Royal Postgraduate Medical School in the Hammersmith Hospital in London, England, again under the directorship of Professor Eric Bywaters and Dr. Graham Hughes. This was an opportunity for me to reinvigorate, if you like, my interest in rheumatology.

Subsequently, I became a Fellow at the University of Bristol and Bath where I worked in the Bath Mineral Hospital for rheumatic diseases, and throughout that period of time, my enthusiasm for rheumatology persisted and indeed increased.

In 1974, I had the opportunity of attending the Pan American Congress of Rheumatology which was held in Toronto. There I met Dr. Tony Russell who I had worked with previously in Taplow, and he told me that they were recruiting for a rheumatologist at the University of Alberta in Edmonton. So, in 1975 I took a year's sabbatical from my position at the University of Bristol. I went to Edmonton for a year and never looked back. Fortunately, I wanted to stay. Fortunately, they were prepared to offer me a permanent position. So that's how I got to Edmonton. And that's where I stayed for the rest of my professional career.

How did rheumatology in Canada evolve over the course of your career and where do you see it heading now?

I think the changes over the years have related to, firstly, a greater understanding of the pathogenesis and the clinical manifestations of rheumatic diseases, and, secondly, our understanding of the pathophysiology has allowed us to become more focused on specific therapies. As an example, when I first went into rheumatology, the treatment for rheumatoid arthritis used high doses of aspirin, other anti-inflammatory medications, occasionally antimalarials, and if you were really bad, gold injectables. If you ask the trainees now, they would laugh at you with this antiquated treatment regime. I think the definition of the different subsets of rheumatic diseases, our understanding of the pathophysiology, and our ability to develop targeted therapies, particularly biologics, have significantly changed the treatment for patients with rheumatic diseases.

You were President of the Canadian Rheumatology Association from 1990-1992 and led the successful process of making the CRA independent of the Royal College. Can you tell us more about why you became involved with the CRA and why making the CRA independent of the Royal College was so important?

I think there were a number of factors that came into play around about the same time. Certainly, the CRA was important, but it wasn't relevant to many practicing rheumatologists, particularly those in the community. When I first joined the CRA, it was really more like an elite club for those people who were working in the academic rheumatic disease units. So, its relevance to community rheumatologists was lacking.

What happened was that the Royal College, mainly due to external pressure, decided that it was important that physicians should be able to demonstrate their continuing commitment to professional development beyond just obtaining their medical degree or some specialty diplomas.

The CRA was one of the first subspecialties to actually participate in the Royal College of Physicians and Surgeons of Canada's Maintenance of Competence program. This program, as you probably know, has developed into the Maintenance of Certification program which is now part of everyday physicians' lives. I think the CRA can have a pat on the back for actually taking the initiative to be part of the development of that program, which was, I must say, a little stressful and was actually at times quite controversial.

So, the spin-off from that was that it was inherent on the CRA to try and develop educational programs that were relevant to rheumatologists to allow them to fulfill the requirements of the Maintenance of Competence/Maintenance of Certification program. We couldn't do that in the existing structure; therefore, it became important for the CRA to take the initiative to develop educational programming that was relevant to all rheumatologists

(academic or community-based) so that they could fulfill these requirements. And again, it was something of a bold step; it wasn't universally accepted originally. But we've continued with it, and of course, it's now continued for many years. But in fact, we established a program, and the basic structure we established then is still being used in the programming today.

What do you foresee as challenges to Canadian rheumatologists in the future and what can individual rheumatologists and the CRA do to meet these challenges?

I think there are a number of issues which face rheumatologists. But they're not unique to rheumatology. I think they probably are relevant to all practicing physicians, whether they're specialists or family doctors. I think the first thing in rheumatology is making sure that we maintain a good lifestyle balance between work and the home. There has been a massive change in terms of manpower. We have a large number, in fact, probably even now a majority of practicing rheumatologists who are women. And we need to respect their needs to balance clinical practice with their home life. I think to some extent that applies also to males in clinical practice. We need to ensure that this balance is maintained because I think maintenance of that balance is reflected in the quality of care that we give to our patients.

I think the second thing is that we need to ensure that we make maximum use of the time that we spend in the office. It's become increasingly apparent to me that physicians are spending huge amounts of time dealing with paperwork, bureaucracy, and this is unremunerated time, but more importantly, this is time that is being taken away from devoting ourselves to patient care. We need to ensure that when we're in the office, we're actually doing what we're specifically trained for, not bogged down by bureaucracy.

And finally, I think it's important to ensure that when we're in the office we are seeing the patients that we are specifically trained to diagnose and treat. There is increasing evidence now that an early diagnosis and early treatment leads to very positive outcomes. We must ensure through whatever mechanism, whether it be through screening processes or some other mechanism, that we get to give priority to those patients that we are particularly trained to treat, which would be patients with inflammatory arthritis and connective tissue diseases. Those are the patients that we can do the most for, and those are the people that we must give priority to; they should not be sitting on a waiting list for 6 months, 9 months, or a year.

What are your proudest accomplishments to date?

It's a difficult question because one doesn't like to blow one's own trumpet. But I actually in reflection, do think I've accomplished something, certainly in my time on the CRA Executive and as CRA President. I think I did significantly influence the development of the CRA, changed its focus, and helped to develop it into what it has become today.

I'm particularly proud of the fact that I, along with Bonnie Thorne of the Arthritis Society (now known as Arthrits Society Canada), co-organized Arthritis 2000. This was a one-off free-standing meeting involving all stakeholders in the rheumatology community. It was held in Ottawa. We had a huge attendance. It was very well received, and as a result of that, there are many other initiatives that evolved from that initial start, which persist today.

I must say I'm also quite proud of the fact that along with John Esdaile, we started the Western Alliance for Rheumatology. This was started off as a one-off meeting. We didn't expect it to go beyond just one meeting. In a couple of weeks, we'll be celebrating our 21st anniversary, and that is a local, regional meeting that has become hugely popular and has been quite a good focus for local rheumatologists, but also for supporting local trainees who subsequently go into rheumatology as a long-time career.

What do you enjoy most about being retired? What have been some of your other passions outside of rheumatology?

Well, although I don't have the chance to do it as much as I used to, travel has always been a passion, and I've been very, very lucky in that over the years, I've had the opportunity to travel both professionally and for personal reasons. I had the opportunity to practice in Zimbabwe and in Kenya, and, I've always had and continue to have a huge love of Africa. I'm not quite sure if I will ever get back there, but certainly that would be on my bucket list. I'm a huge fan of rugby, so I played rugby until I was I think, 40, and I continue to follow International rugby with a passion. And I guess, finally, I'm a collector. I collect toy soldiers, toy trains, English stamps, and I'm very proud of my Canadian art collection, which I enjoy every day.

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Arthritis Society Canada Invests to Stop Osteoarthritis in Its Infancy

Arthritis Society Canada is partnering with the University of Alberta to scale a revolutionary project to quickly and affordably diagnose and treat developmental dysplasia of the hip (DDH) in infancy.

The Newborn Arthritis Prevention Screening (NAPS) project is led by Dr. Jacob Jaremko, a pediatric musculoskeletal radiologist at the University of Alberta. This digital health innovation uses artificial intelligence (AI) and 3D imaging to capture images of babies' hips, comparing them to thousands of previously-recorded scans to determine — within seconds — if an abnormality exists. These portable devices, currently piloted in places like rural Alberta, can be operated by trained professionals already in communities.

Up to 40 percent of hip osteoarthritis is associated with DDH. Yet DDH that is diagnosed early in infancy can be successfully treated by wearing a soft brace — sparing newborns a lifetime of pain and discomfort.

Arthritis Society Canada is supporting the project's expansion, fundraising with an organizational goal of $5 million and seeking an additional $5 million in funding opportunities from government. This collaborative approach has the potential to save the healthcare system millions of dollars while reducing future cases of osteoarthritis due to undiagnosed and untreated DDH.