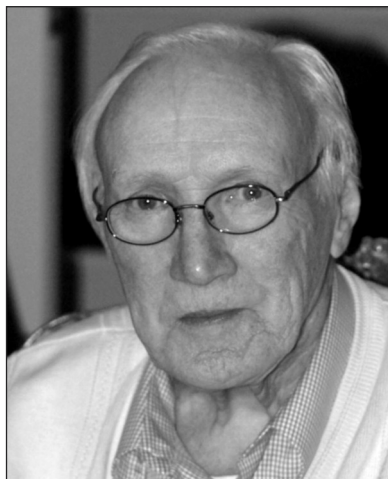
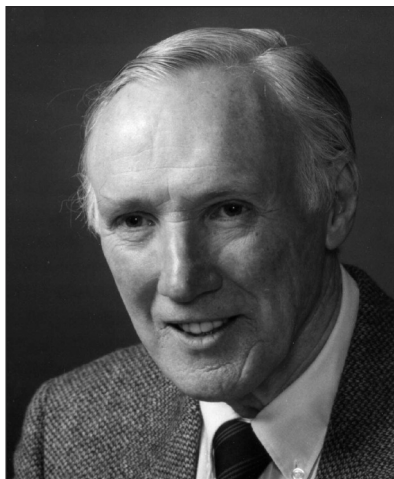


Hugh Smythe

By Robert Inman, MD



1927 - 2012

There are few rheumatologists in Canada who will have their name engraved on the Stanley Cup, or serve as team physician for an NHL team, as Hugh Smythe did. But it is with respect to rheumatology in Canada that Hugh set innovative precedents, which bear directly on the challenges that face our specialty today.

First, Hugh prioritized the centrality of the patient in research, as well as in education and care. Long before patient-related outcomes (PROs) became fashionable, Hugh emphasized that precision in the history and physical examination was the cornerstone of clinical research. His description of cervical spine syndromes and the importance of referred pain reflect this meticulous attention to detail. The following is his direction for locating one of the cardinal tender points of fibromyalgia: "Palpate along the second costal cartilage to the costochondral junction. Here, a very distinct region of deep tenderness is found, not localized precisely at this junction, but extending 1 cm laterally, and often more marked on the superior surface than elsewhere on the rib."¹ In an age when ultrasound and magnetic resonance imagery (MRI) are proposed by some

investigators as the new standards of clinical measurement, Hugh's attention to detail in the physical examination is a reminder that careful attention to detail in patient assessment is one of the pivotal strengths of rheumatology.

Secondly, at a time when the young specialty of rheumatology was defining its place in the curricula of Canadian medical schools, Hugh ensured that rheumatology was firmly embedded in internal medicine. One of his earliest publications described the aortitis associated with ankylosing spondylitis,² anticipating that the spectrum of rheumatology would extend beyond bone and joint disease, and that over time rheumatologists would become quintessential internists involved in the management of multi-organ diseases. While defining the Division of Rheumatology as an integral member of the Department of Medicine, there were two distinctive aspects to this young specialty; these were embodied in the concept of the Rheumatic Disease Unit (RDU). The RDU was a distinct geographic entity, with its own outpatient clinics and inpatient wards. This allowed a concentrated focus on medical education and clinical research that set the standard for

rheumatology programs in Canada and abroad, and established the RDU as a distinct entity in the academic health science scene. The RDU concept also set the stage for integrated, multidisciplinary care of patients with rheumatic diseases, involving not just rheumatologists, but also orthopedic surgeons, physiotherapists, occupational therapists, and nurses. Hugh's time as team physician with the Toronto Maple Leafs left him with a deep appreciation of the importance of allied health professionals in the management of arthritis and allied conditions. Commenting on his learning curve as team physician, Hugh stated, "It meant I was in the dressing room, and learned to respect the trainers and the physiotherapists, with a relationship that evolved over my years as team doctor, from 1950 to 1969."³

Thirdly, Hugh's career highlights the importance of strategic partnerships with patient organizations, which for Hugh was The Arthritis Society (TAS). Hugh served on the TAS Board of Directors from 1961 to 1999. Working closely with Edward Dunlop (Managing Director of TAS from 1949-1981), a strategic plan was developed which envisioned an RDU within each medical school in the country.⁴ In 1959, Hugh joined the Medical Advisory Committee (MAC) of TAS; in 1961 he co-authored the Society's submission to the Royal Commission on Health Services. This submission spelled out the need for an RDU within each teaching hospital, operating as an integral part of the Department of Medicine. This submission had a profound effect, ensuring that rheumatology had a viable presence in the academic health science centers of each Canadian university, and that subspecialty training in rheumatology had visibility and profile in the respective Departments of Medicine. TAS played a critical role in this initiative, providing fellowship funding which matched the respective provincial postgraduate residency funding. Not only did this lay the groundwork for training a generation of Canadian rheumatologists,

it positioned TAS at the forefront of research funding and manpower development in rheumatology. It highlighted the potential impact of strategic partnerships between physicians and patient advocates. An effective partnership achieves more than each party alone can accomplish, and this synergy was embodied in the collaboration of rheumatology and TAS, in which Hugh took a vital leadership role.

Hugh brought to rheumatology the same intensity and focus which he brought to sports. His enthusiasm for new knowledge and his impatience with uncritical thinking set a high standard for performance in rheumatology. The strength of the rheumatology program at the University of Toronto reflects that high standard to this day. Hugh would not suffer sloppy methodology ("Post hoc ergo poppycock" being one of his critical commentaries) any more than he would tolerate a sloppy defence by the Leafs. He had a scientific scepticism which made him a superb editor, a critical reviewer, and a creative investigator. This scientific scepticism co-existed with a sustained encouraging and supportive approach to trainees and junior faculty.

It was his unwavering commitment to his patients, faculty colleagues, and friends which will be remembered by so many.

References:

1. Smythe HA, Moldofsky H. Two contributions to understanding of the "fibrositis" syndrome. *Bull Rheum Dis* 1977-1978; 28(1):928-31.
2. Graham DC, Smythe HA. The carditis and aortitis of ankylosing spondylitis. *Bull Rheum Dis* 1958; 9(3):171-4.
3. Smythe HA. A long career with the Leafs. *CRAJ* 2007; 17(3):10-1.
4. Smythe HA. Editorial. *J Rheumatol* 1981; 8:1.

Robert Inman, MD

Read more of Dr. Smythe's contributions to the CRAJ:

<http://bit.ly/S2DAcK>

<http://bit.ly/VaQ06u>

<http://bit.ly/PHI23H>