Transatlantic Transition: A Rheumatologist's Perspective on Practicing in Canada

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Why Canada?

That is a question I have been asked many times as a newly appointed staff rheumatologist and clinician investigator at The Ottawa Hospital (TOH) over the past two years. Writing this deeply personal reflection has given me an opportunity to look back on that decision from many perspectives.

When our family decided to move to Canada from the UK, our friends, relatives, and colleagues were intrigued. I am a clinical and academic rheumatologist trained in the UK, having completed my medical education at Cardiff Medical School, followed by 12 years of general internal medicine and rheumatology specialty training (including a PhD) at several teaching hospitals in England. I was fortunate to progress through training without breaks in employment. My husband, a UK-trained family physician, transitioned from surgical training to family medicine during the Modernising Medical Careers (MMC) upheaval—a period well remembered by my generation of doctors. We had both secured stable consultant and GP partner positions and had finally settled in the same city, bought our dream home, and envisioned long, fulfilling careers within the historically admired British National Health Service (NHS), supported by extended family and good schools for our two young children.

So why leave mid-career—uprooting our family, leaving loved ones, and giving up a thriving NHS and private practice? On paper, it may seem illogical. Yet lived experience rarely fits neatly on paper. We left the UK in search of a more fulfilling professional life—one where we felt valued, appreciated, and heard. We longed for autonomy to make decisions based on our patients' clinical needs, and for a work routine that allowed us to fulfill responsibilities beyond medicine. While the NHS was founded on the principle of equality — "to universalize the best"—its current state has left many clinicians and patients disillusioned. The challenges are not unique: an aging population and workforce shortages strain many healthcare systems. But the personal frustration of being managed by non-clinical administrators out of touch with clinical realities, coupled with inadequate infrastructure (limited office space, "hot desking," scarce administrative support, lack of efficient electronic medical record systems and minimal trainee assistance), made meaningful change feel impossible. Bureaucracy often hindered innovation—such as establishing multispecialty clinics, protecting research time, or centralizing care. These realities ultimately motivated us to take a leap of faith.

What began as a curious email to the Canadian Rheumatology Association became a life-changing journey—one I am profoundly grateful for. I was connected with a UK-trained rheumatologist who had previously relocated to Canada and guided me through the process of obtaining an academic registration to practice as a rheumatologist in Ottawa. My current Division of Rheumatology at TOH has been extraordinarily welcoming and supportive, making this professional and personal transition far smoother than I could have imagined.

Clinical medicine is remarkably similar in Canada and the UK, and the rheumatology practice guidelines are largely aligned—particularly regarding biologic therapies. However, there are notable differences. A dedicated biologic coordinator and patient support programs for accessing high-cost biologic drugs are unique

here, and allow patients to access these medications relatively quickly as well as additional services such as vaccinations, dietitian services and pre-biologic screening. I now work within a publicly funded fee-for-service model, which incentivizes clinical work, rewards efficiency, and, in my view, enhances patient access and care. The Ontario Health Insurance Plan (OHIP) covers core medical services for residents, but allied health services and many medications depend on private or age/income-based coverage. Navigating "limited use codes" and variable insurance formularies remains a work in progress. Despite these nuances, the advantages of practicing rheumatology at TOH far outweigh the inconveniences. I am grateful for a dedicated office, an efficient administrative assistant, and an inspiring, collaborative team of medical colleagues and trainees. Canadian rheumatology specialty training, though shorter than in the UK, is intensive and well-structured. While service provision dominates a large proportion of UK training time, Canadian programs emphasize focused clinical learning and decision-making.

The respect afforded to physicians in Canada is another notable difference. While multidisciplinary teamwork is the future of healthcare, strong medical leadership remains vital for quality and safety. In the NHS, that sense of medical leadership—and with it, professional morale—is eroding. In Canada, physicians are appreciated and appropriately recognized for their expertise and accountability. From an academic standpoint, although competitive, opportunities abound. There is consistent institutional encouragement to apply for internal and external research funding—from TOH's Department of Medicine, affiliated universities, academic medical organizations, and national grant bodies.

Ultimately, everything comes back to our patients—the reason we do what we do. Hearing comments such as "We're so glad you're here" or "We hope you will stay despite the harsh winters" truly warms my heart. It reflects a culture of gratitude and mutual respect that is refreshing and deeply motivating. As a family, we have embraced the relaxed, outdoors-oriented lifestyle Ottawa offers. My husband is content in his family medicine career, and our children proudly call Canada home. Not every leap of faith guarantees success—but this one has brought personal growth, professional satisfaction, and a renewed sense of purpose for which we will always be grateful.

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