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CRAJ SCR

The Journal of the Canadian Rheumatology Association

Focus on: The Business of Rheumatology

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EDITORIAL

With a Little Help...

By Philip A. Baer, MDCM, FRCPC, FACR

"Oh, I get by with a little help from my friends / Mmm, going to try with a little help from my friends / Yes, I get by with a little help from my friends."

– The Beatles, "With A Little Help (From My Friends)" (lyrics, Lennon/McCartney), *Sgt. Pepper's Lonely Hearts Club Band*, 1967.

Every patient is different, but while catering to those differences, a rheumatology office has to employ a system for getting through the workday efficiently and in a timely fashion. I like to think some of this stems from rules I have established and honed over the years.

However, the greatest efficiencies come from learning from colleagues, and implementing their best practices in my own office. Many of my peers have shared ideas generously over the years, and I thank all of them. Three in particular stand out because of the sheer ubiquity and utility of their contributions to Canadian rheumatology practice.

Prescribing medications is a daily—if not hourly—task when seeing patients. Education about therapies is crucial to reduce patient non-adherence, and to enable patients to take complex antirheumatic medication regimens properly. With medication frequencies ranging from QID to Q6 months, and multiple routes of administration even for the same medication, this is no simple task. Chronic versus acute management can be entirely different (*e.g.*, gout), resulting in avoidable poor treatment outcomes even in a well-understood disease with multiple effective therapies. Relying on handouts delivered by pharmacists with the dispensed prescription is unsatisfactory, as balance is often lacking and meaningless drug interactions are too often highlighted. Prescription information from industry is limited to drugs currently "on patent", and has its own issues. Thankfully, our own Dr. Andy Thompson has created and continuously improved the *rheuminfo.com* website. I hand out these medication sheets with every prescription, and personalize them by scribbling notes in the margins.

Biologic and targeted therapies are a key component of every rheumatologist's practice. Access to the right medicine at the right time has been problematic from the outset, given the costs of these therapies and the limited dollars available to pay for them in public and private formularies. However, again at least in Ontario, access has improved dramatically. I now have a frequently updated, one-page form for each of the three major rheumatic diseases which asks only for enough pertinent data to allow a rational decision about whether the patient qualifies for biologics. None of this would have happened without the leadership of Dr. Carter Thorne, and his ORA Exceptional Access Program (EAP) Committee that expended years on building a trust relationship with the provincial public formulary body. Rheumatologists are now the envy of other specialties which use the same targeted therapies. Work continues, led by Dr. Thorne and Dr. Jane Purvis, to extend these simplified forms and criteria in a pan-Canadian fashion to all private payers.

Finally, the EMR system has become the lifeblood of the office. While I knew the move was inevitable, I saw limited benefits until rheumatology-enhanced EMRs with clickable homunculi, automatic calculators of composite disease activity measures, and other rheumatology templates were developed. Compared to the thousands of GPs who were more readily adopting EMRs, the limited number of practicing rheumatologists made persuading vendors to create enhanced rheumatology modules a tough proposition. Fortunately, our own Dr. Vandana Ahluwalia spearheaded this work through the ORA EMR committee, and I silently thank her every day for enabling me to work using a viable rheumatology EMR system with all its long-term advantages.

In my capacity as Rheumatology Section Chair at the Ontario Medical Association (OMA), I meet regularly with other medical specialist leaders to discuss practice issues. I never leave without a sense of great satisfaction at what rheumatologists have been able to accomplish in these areas compared to other medical subspecialists. But, these benefits did not come spontaneously—they are the product of hard work. Use these creations daily, perhaps be inspired to create other tools to share with your Canadian rheumatology peers, and do not forget how the efforts of a few dedicated colleagues has made such a difference to how each work day proceeds and succeeds.

Philip A. Baer, MDCM, FRCPC, FACR
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Scarborough, Ontario

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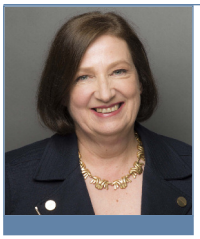
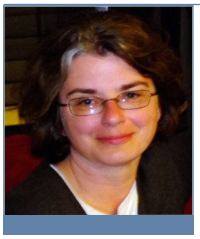
AWARDS, APPOINTMENTS, ACCOLADES



Dr. Joan Wither was the winner of a European League Against Rheumatism (EULAR) Abstract Award in June 2015 for her work entitled "Presence Of An Interferon Signature In Anti-Nuclear Antibody Positive Individuals Prior To The Onset Of Systemic Autoimmune Rheumatic Disease." This abstract stemmed from a prospective, multicentre, observational study, in which the researchers examined antinuclear antibody (ANA) positive patients with no clinical symptoms of systemic autoimmune rheumatic diseases (SARD); those who were ANA positive and had at least one SARD symptom; and those who had been recently diagnosed with a SARD. Central to this investigation was whether progress from asymptomatic autoimmunity to clinical disease can result in patients developing immunologic changes that might help predict disease onset.

Dr. Wither is a senior scientist at Toronto Western Research Institute, part of the University of Toronto's Health Network. Her research focus is the immune mechanisms that lead to the development of systemic autoimmune rheumatic diseases (*e.g.,* systemic lupus erythematosus [SLE]).



Dr. Regina Taylor-Gjevre received the University of Saskatchewan's Provost's Award for Outstanding Teaching in the College of Medicine for 2015. The University of Saskatchewan Provost's Awards are presented to an individual faculty member in each College annually. These Awards recognize evidence of outstanding teaching and educational leadership.

The award was based on Dr. Taylor-Gjevre's contributions to both undergraduate and postgraduate education. These contributions included the postgraduate rheumatology program directorship from 2007 to 2014, and ongoing undergraduate education and educational administration. She is the course director for rheumatology/MSK within the undergraduate curriculum and, since 2014, she has also been Co-Chair for the Foundations of Clinical Medicine I-III courses within the first two years of the undergraduate medical program. She had previously received the 2011 Faculty of Medicine Excellence in Teaching Award. Dr. Taylor-Gjevre is a Professor of Medicine and Head of the Division of Rheumatology at the University of Saskatchewan.

AWARDS, APPOINTMENTS, AND ACCOLADES

The Journal of the Canadian Rheumatology Association (CRAJ) would like to recognize the contributions of its readers to the medical field and their local communities.

To have any such awards, appointments, or accolades announced in an upcoming issue, please send recipient names, pertinent details, and a brief account of these honours to *katiao@sta.ca*. Picture submissions are greatly encouraged.

WELCOME TO THE RHEUM

The CRA would like to welcome the following new members:

Myriam Allen, Quebec, QC
Ibrahim Almaghlouth, Toronto, ON
Elvira Bangert, Hamilton, ON
Mollie Carruthers, Vancouver, BC
Amieleena Chhabra, Vancouver, BC
Carson Chin, Vancouver, BC
Isabelle Ferdinand, Sainte Julie, QC
Shannon Galway, Vancouver, BC
Maeve Gamble, London, ON
Amit Ghelani, London, ON
Noémie Gionet-Landry, Sherbrooke, QC
Liane Heale, Toronto, ON
Meriem Kerbachi, Quebec, QC
Evelyn Kwok, Edmonton, AB
Karim Ladak, Brampton, ON
Madison Leitch, London, ON
Lillian Lim, Toronto, ON
Greg Marcotte, Vancouver, BC
Mehveen Merchant, Halifax, NS
Nazanin Montazeri, Hamilton, ON
Vanessa Ocampo, Hamilton, ON
Geneviève Oligny Longpré, Montreal, QC
Paolo Pace, Hamilton, ON
Maria Parfenova, Sherbrooke, QC
Natalia Pittman, Ancaster, ON
Nicolas Richard, Montreal, QC
Raphael Rush, Toronto, ON
Jenny Shu, Toronto, ON
Janet Wilson, London, ON
Stephanie Yang, Toronto, ON

App*air*ently, We Are Doing Well!

Key Takeaways From the CRA Mentorship Programs

Working with Dr. Silverman through the CRA Summer Scholarship has been a great experience. His guidance and support throughout my project allowed me to develop essential skills for conducting clinical research, as well as encouraged me to pursue my great interest in rheumatology. I would definitely support medical students in the same way as my mentor once I become a clinician-scientist.
- Erika Lee, mentee

Never again will I have the opportunity to hone my history-taking and clinical skills with such individualized, one-on-one attention from a skilled rheumatologist as during this mentoring program. My key takeaway was that rheumatology allows a clinician to practice systemic medicine—from lupus nephritis to CNS vasculitis—and a wide scope of knowledge is required.
- Megan Himmel, mentee

What I like best about mentoring is seeing trainees get excited about rheumatology and seeing their growth and development from the beginning to the end of the experience.
- Dr. Shirley Chow, mentor

The mentorship program at the CRA annual meeting was a valuable experience for me as I attended my first CRA meeting. Being partnered with a mentor allowed me to become acquainted with the meeting itself, key talks and debates, as well as fun social activities. Importantly, through discussions with my mentor, I was able to gain a better, more informed view on the amazing training and career opportunities that exist in rheumatology! I strongly feel that the mentorship program contributed to a highly enjoyable meeting experience, and hope the mentorship program continues for future trainees!
- Mark Warwas, mentee

CRA Summer Studentship Programs

There is a high demand for new rheumatologists in Canada. The Summer Studentship programs are an excellent way for medical students to garner experience and interest in our important subspecialty.

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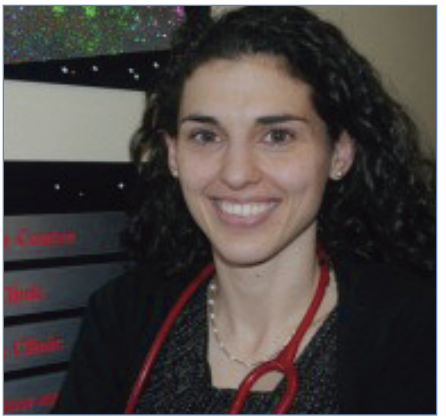
- Mentors are always encouraged to sign up! The CRA welcomes **community and academic** rheumatologists to contribute their expertise to the programs.
- For more information, please visit **www.rheum.ca/en/students/summer_studentship** or contact Christine Charnock at **christine@rheum.ca.**

Reality Bites! The Transition From Medical Training to Professional Employment

By Karoon C. Danayan, MD, FRCPC, FAAP

As medical trainees, our lives revolve around treating patients with complex medical issues, intensely studying medical literature, and attempting to balance our lives outside of medicine in the meantime. Generally, one's thoughts are not focused on future professional employment.



Dr. Karoon Danayan leads Rouge Valley Health System's first pediatric rheumatology clinic.

My decision to study pediatrics and later, pediatric rheumatology, at The University of Toronto was based on pure passion for this area of medicine. Honestly, I did not consider the potential of no job at the end of my training in the equation. However, within a year of my fellowship training, reality quickly set in – I had acquired significant student debt, a first home, and a second child. My pragmatic mind thus took control and I began to research future employment opportunities upon graduation.

I began aggressively networking within the rheumatology community, considering both academic and community-based positions, as well as a blend of pediatrics and pediatric rheumatology. I focused on areas where both my husband and I could find fruitful employment and live close to our extended families. I set up electives in academic centres with good infrastructure, a sufficiently large population base to benefit from my subspecialty, and a paucity of pediatric rheumatologists. The adult rheumatologists in these centers were tremendously supportive; moreover, senior rheumatologists at The Hospital for Sick Children involved me in the triage process, studying where referrals were being generated in the Greater Toronto Area, thus helping me identify underserviced areas close to home. Thereafter, I connected with the directors of pediatrics in specific community-based academic hospitals needing my subspecialty services, and delivered grand rounds on a topic of interest to their pediatric hospitals. In the end, I attempted to create not one, but several potential future employment options for myself. The reality is that many of these opportunities did not flourish due to financial, practical, or political reasons.

Within two years of graduation, I was able to secure a part-time staff position at Rouge Valley Centenary Hospital as a pediatric rheumatologist, serving an underserviced area in my subspeciality, relieving part of the patient workload from our tertiary medical centre, all while receiving excellent support from the staff, especially the pediatric rheumatology team at The Hospital for Sick Children. However, a weekly rheumatology clinic would not be financially sustainable alone. I was fortunate to join a busy, private pediatric practice in downtown Toronto where I receive the majority of my income; I am involved in medical research and teaching core pediatrics to family medicine residents from The University of Toronto.

My success stems from perseverance, focus, adaptability, and mentorship from critical individuals who helped shape my career. I understood well what I wanted to achieve and created my own opportunities.

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Toronto, Ontario

Change is Such Hard Work

By Jane Purvis, MD, FRCPC

Billy Crystal would certainly agree. After working in the same building for 20 years, and being on the same Electronic Medical Record (EMR) since 2005, I decided to move my office and simultaneously switch EMR providers. The EMR landscape has changed vastly since I first started using one. The building I was previously located in was an early adopter of the Ontario Family Health Team model of care and half of the physicians were family physicians. We all shared the EMR, such that we could see each other's notes, labs, and the like. This had pluses for patients being referred to me from within the building, but unfortunately offered no advantage for the majority of my patients who were referred from elsewhere. The old EMR was useful to store my patient data, but was frequently buggy. Often, when there were updates, it would respond by becoming non-operational. It had no rheumatology-friendly add-ins. I was hearing better and better things about some of the other programs, so I decided to make the switch. Given that this also involved leaving my building for a new office, I signed a contract and made a plan to "go live" in six months with my new EMR on the first day in our new location. We had no patients booked and had arranged a trainer to be on site for our first three days. This trainer was brought on as a transition implementation facilitator, primarily (I thought) to deal with the logistics of the move (*e.g.*, telephones, construction), but she was also very well versed in EMR and computer issues should need arise.

Not all transitions are smooth...

As our moving day grew closer, the new EMR vendor let me know that they wanted to get started with the data extraction process, which was going to involve my old vendor sharing data with the new. This was the start of our problems. I had to fork over an extra $2,000 to my old vendor for them to slowly give my data to the new company, yet, on the day of my move, there was no data in my new EMR. For the next eight weeks I had to use my old EMR to look back at what was in the patient charts, and use the new EMR at the same time going forwards. The training that we had arranged on our "go-live" date had to be cancelled, while the training we had after that was fragmented and frustrating. Luckily my implementation person had the hours to spend on the phone working through all our issues, and she also negotiated some extra training hours for myself and my staff. I would say we were fully functional on the new EMR by the end of February, eight weeks after our "start date".

Lessons learned? Change is such hard work! Hire people who know what they are doing. If I had to do all the phone calls to the EMR people myself, we would have been lost. I did not know what I needed or how to get it. If I was ever to change EMRs again, I would insist on a signed schedule with firm milestones each week, and fallback plans if targets could not be met. If my transfer had started eight weeks earlier, it would have been much better. My new EMR is certainly better than the previous one for my uses, but the transition process could have been so much better. Remember, patience is a virtue!

Jane Purvis, MD, FRCPC
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Rheumatologist,
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The Business of Rheumatology

By James Henderson, MD, FRCPC

This article is primarily for individuals setting up a fee-for-service practice. If you are joining an academic group, many of the decisions we will be talking about will be handled for you.

When one commences a full-time practice after residency, there is usually a noticeable increase in income. The obvious temptation is to immediately upgrade everything (*e.g.,* house, car, clothes, etc.). My first advice is to temper the temptation! Most residents I speak to are carrying significant debt after their residency. They would be far better off to pay down their debt, starting with any credit card debt, followed by lines of credit and student loans. Being able to avoid interest payments will ultimately put more money in your pockets. I would prolong the "residency lifestyle" a year or two to get the debt paid off.

Some may not be ready to start a practice of their own just yet; a good alternative would be to offer your services as locums. This provides new practitioners an opportunity to see various practice patterns, as well as to see more of the country to get a sense of what locale and type of practice you would ultimately like to set up.

When one is ready to start a practice, you will need to assemble a team: I would ask colleagues to recommend a lawyer, an accountant, and a financial adviser who are familiar with medical practices. They will provide you with an overall financial plan, assist with leases, set up accounting procedures for the office, and help set up long-term financial goals for the business.

I feel the most important decision you will make early on is the selection of office staff. I recommend you advertise and collect résumés. Pick the top five résumés and interview each candidate, giving them a typing test with a short rheumatologic letter. These individuals are crucial to the success of your practice as they are the face and voice of your office! In my personal experience, I have usually shared a secretary with another rheumatologist. Over the years I have been fortunate, only having train two secretaries. My clinic now has an office manual with all businesss-related facts set down, to ease the transition to a new secretary if that ever becomes necessary.

The location of an office is important. Ideally, it would be near your affiliated hospital and close to home, provide adequate parking for patients, and have a good layout. The lease can be negotiated regarding rent, leasehold improvements, cleaning services, duration of lease, and other issues. I would have your lawyer assist you with these discussions. Optimally, the office would be accessible by public transit, and be accessible to patients with disabilities and mobility impairments. Over the 30 years I have been in practice, I have practised out of four different offices, each one suited to my needs at that time. Be aware of your needs, and adapt accordingly.

Make sure you have all the necessary insurance, including general liability, disability, Canadian Medical Protective Association (CMPA), office overhead, and a health plan for your family. Your family may even play a role in your practice: your spouse can take on a role in the office to allow for income-splitting. Many spouses of rheumatologists assist with billing and the scheduling of travel clinics. Moreover, if your spouse is trained to do patient counseling, so much the better.

There is a book from the Medical Post called *Succeed at Everything in Your Practice* available on Kobo, Amazon, and i-books: I would strongly recommend this reading to any practitioner looking to open their own practice!

Good luck and enjoy the ride!

James Henderson, MD, FRCPC
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Internal Medicine,
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Preparing for Transitioning Into Practice

By Thanu Ruban, MD, FRCPC

With only two years of rheumatology training ahead, senior rheumatology residents need to be as proactive about career planning as they are about learning the ropes in their chosen field. Career planning requires dedicating time and resources to ensure you are set following graduation. In this article, I highlight my own personal journey into practice as well as impart helpful advice for current trainees.

The first thing one needs to decide upon when choosing the type of rheumatology practice to pursue is whether academic or community practitioner is the correct direction for oneself. This is a conversation that may start with mentors while in medical school and internal medicine training; this will take more concrete form during subspecialty training. For myself, I was drawn to both spheres of practice: the pull of academia would allow one to explore research questions as well as teach and inspire junior trainees, while community practice would allow for more independence and focus on clinical practice. I found the following most helpful in deciding on my career plans: networking with other rheumatologists and taking part in community practice electives during my training. I was fortunate enough to work with community practitioners, who showed me that there was plenty of opportunity to work with trainees with the increase in distributed medical education, as well as to take part in clinical research and advocacy work while in private practice.

Networking is a critical step in the process of deciding your career plan. During my first year of rheumatology training at the University of Toronto, I had the opportunity to attend the Ontario Rheumatology Association (ORA) Annual General Meeting (AGM), where I spoke with multiple practitioners about the job market and perceived underserviced areas. Following this meeting, I contacted several rheumatologists in areas where I was interested in working, and discussed clinical opportunities as well as hospital affiliations. During my second year of rheumatology training, I was able to do community rotations at several of these sites that gave me a chance to see how private practice was conducted, the role of allied health professionals in rheumatology practice, and the available research opportunities for the community rheumatologist. Learning about office technology and staffing issues was also very helpful. These opportunities gave me a brief glimpse into what my future practice might entail.

With the support of the local rheumatologists, I decided on setting up practice in Markham, Ontario, a rapidly expanding city within the greater Toronto area. I contacted the hospital Chief of Medicine to discuss terms of a hospital affiliation. It was helpful to have some perspective from the current rheumatologists in the area when it came to negotiating clinic opportunities in the hospital and call duties; I also started doing internal medicine call coverage following my internal medicine certification and found this was a great way to get to know the hospital and its medical and support staff. Being exposed to this welcoming environment while doing internal medicine call was another positive factor that influenced my decision-making at that juncture in my career.

Following my rheumatology training and while studying for the rheumatology Royal College exam, I had the opportunity to do a clinical locum to cover a maternity leave. This was a great way to be immersed into practice without the worry of starting up one's own clinic right away. I worked with a group of supportive rheumatologists, which made transitioning from training to practice all the easier. I would highly recommend exploring locum opportunities as well as working with seasoned rheumatologists when starting out in the field.

For those currently in rheumatology training and those who are planning to pursue a career in rheumatology, here are some helpful pointers for the post-fellowship job search:

1. **Be engaged:** Become a member of your regional professional rheumatology association and attend their annual meetings. This is a great networking opportunity, allowing you to get up-to-date job market information. You may find that there are specific programs directed to help you with career planning; for example, the ORA has a great initiative (*www.rheumcareers.ca*) that assists current rheumatology trainees in exploring job opportunities in underserviced areas in Ontario. This program allows trainees to visit an area that they might not be familiar with and learn more about what the community has to offer.
2. **Take part in community electives:** Contact a local rheumatologist in the region where you are interested in working. Doing community rotations during fellowship allows you to get a feel of the type of practice you would like, including solo vs. group practice, Electronic Medical Record (EMR) use, and involvement of allied health professionals within the practice.
3. **Know your business:** There are many resources available to graduating residents who are setting up their practice. The Canadian Medical Association (CMA) administers all-day practice management seminars,[1] with discussions around contract negotiations, financial wellness and evaluating practice options. Be sure to also check out the CMA's document *Setting Up Your Medical or Clinical Office*.[2] For those in Ontario, the Ontario Medical Association (OMA) has a similar document,[3] which is a great resource for transition to practice.

Setting up practice following subspecialty training may seem like a daunting task, especially with clinical duties, research endeavours, and the looming Royal College exam; however, there is plenty of support available to help you build the ideal practice. The key is get out there, explore resources, and make the best of your opportunities.

Suggested Readings

1. Canadian Medical Association. Seminars for Medical Residents. Complete listing available at: *www.cma.ca/En/Pages/seminars-family.aspx.*
2. Canadian Medical Association. Module 14: Setting Up Your Medical or Clinical Office. Available at: *www.cma.ca/Assets/assets-library/document/en/practice-management-and-wellness/MEDED-12-00307_PMC_Module_14_e.pdf.*
3. Ontario Medical Association. Starting a Practice: A Guide for New Physicians. Available at: *www.oma.org/Resources/Documents/1_StartingPractice.pdf.*

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Academic Alternative Relationship Plan at the University of Calgary

By Liam Martin, MB, MRCPI, FRCPC

The Academic Alternative Relationship Plan (AARP) in the Department of Medicine at the University of Calgary began in 2004. The leaders in the department recognized a need to change the way we practiced medicine, and the AARP was developed to address these needs. Amongst all the subspecialties, rheumatology was identified as having increasing numbers of patients with complex medical profiles who would benefit from a team-based approach to the management of their illnesses. It was felt that an innovative approach was needed through which such care would be delivered. The department also recognized that we needed to recruit more consultants to address the changing demographic of our members and the community we served. Our neighbours to the North had an alternative funding plan; we felt that such a plan would enable us to make the necessary changes to our practices. An organizing committee consisting of the division heads of all the subspecialties in the department was struck, and further refined into four sub-committees which addressed manpower, assessment and evaluation, innovation, and compensation. There were numerous meetings with government and local health authorities as well as with the members of the department over the next 18 months, culminating with the final plan launched in April 2004.

All department members, both clinical and academic, were invited to participate in the AARP. Those who joined are paid a monthly stipend dependent on their subspecialty and their years of service. The stipends are generated through funds from the provincial health plan Physician Services budget, a conditional grant from the provincial Department of Higher Education and, where applicable, the members' university salary. Clinical members whose offices are not on a hospital site are given a yearly stipend to help offset their office costs. Non-university members are also given a yearly stipend equivalent to the cost of the benefits package that the university members receive.

Provincial Academic Alternate Relationship Plan

P-AARP

The plan is overseen by the AARP management committee, which includes a member from each subspecialty within the Department of Medicine and a chair who is voted in by the committee. The department head sits on the committee as an *ex-officio* non-voting member. We also have a business manager and a budget manager who are employees of the AARP. Each member has an Independent Service Agreement (ISA) that addresses their responsibilities at the clinical, research, administration, and teaching levels. Each member decides on the proportion of their time that they will devote to each area; they are evaluated each year by their division head using their respective ISA as the framework for the assessment of their activities. All clinical activities are monitored through shadow billing. This process is mandatory as it allows the plan to demonstrate to government that members are actually working. It is a relatively tedious process, unfortunately, especially for members who have never worked in a fee-for-service environment.

The AARP has been very successful to date across all subspecialties. We in rheumatology have been able to develop a number of initiatives to improve patient care, including our Central Triage program, and clinics focusing on early inflammatory arthritis (EIA), young adults with rheumatic diseases (YARD), spondyloarthropathy, and biologics. We have been able to hire a number of rheumatologists to address the shortage of specialists in the community and in academic areas. We have also hired extra staff to help deliver the above programs and clinics. These new staff members include a nurse practitioner, four clinic nurses who work in our general clinics, and two nurses who work in the

biologic clinic. We have also hired a part-time pharmacist, social worker, and a physiotherapist.

The Central Triage program has allowed us to prioritize patient appointments and initially reduced wait-times by 30%. Although our wait-times have increased since the initiation of Central Triage, we are still able to address urgent referrals in a more efficient manner than before. We have developed educational programs for newly diagnosed rheumatoid arthritis (RA) which are delivered bi-weekly in an interactive class environment at the clinic by our pharmacist and physiotherapist. These classes have helped patients and their significant others gain a better understanding of the disease and its treatment.

The development of the EIA clinic has allowed us to evaluate our care of patients with early disease and given our trainees an opportunity to undertake quality improvement and other clinical studies in these patients, which has subsequently led to a number of publications. The biologic clinic has allowed us to monitor patients very closely. The nurses who manage the clinics are a tremendous resource for patients taking biologic treatments. The EIA clinic has also provided us with significant research opportunities; the data that we collect have been instrumental in allowing us to publish outcomes results, in collaboration with our University of Alberta colleagues, on biologic therapies in patients with severe RA.

Education has always been an important part of our activities at the University of Calgary and the AARP has increased the opportunities for clinical members to contribute to the education of undergraduate and postgraduate physicians. In the past, clinical members were not compensated for their important contribution to teaching; however, through the AARP this issue has been addressed, making it much easier to include our clinical members in our education activities.

In summary, the AARP has provided us in the Division of Rheumatology, and in the Department of Medicine in general, with significant opportunities to improve the way we manage patients with complex medical conditions. It has also allowed us to recruit rheumatologists and allied health providers to address the needs of our community.

Suggested Reading
For further information on the AARP, please visit: *www.ucalgary.ca/albertapaarp/faqs.*

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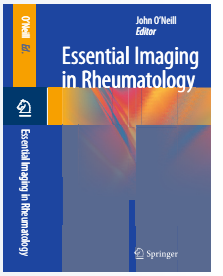
Book Review



Essential Imaging in Rheumatology

Editor: John O'Neil
Publisher: Springer
Date: 2015

Imaging is an essential component in both the diagnosis and management of rheumatic disease, and imaging interpretation is a skill every rheumatologist strives to master. As a rheumatology fellow, imaging was one of the most daunting and challenging areas of the specialty. Useful comprehensive resources were and are both welcome and appreciated.

A new rheumatology title, *Essential Imaging in Rheumatology*, is a valuable resource in our field. The book's editor is Dr. John O'Neill, an Associate Professor of Radiology at McMaster University, Hamilton, Ontario. The other contributions are all rheumatologists from McMaster, making this a decidedly Canadian publication!

Essential Imaging in Rheumatology explores all current methods of imaging and imaging techniques related to common rheumatic symptoms and specific rheumatic diseases. This is a well-written and comprehensive resource in its coverage of the rheumatic diseases as well as its description of multiple imaging modalities, including radiographs, ultrasound, bone scan, CT, and MRI. Each section starts with an overview of the clinical aspects of the disease followed by an in-depth discussion of the imaging modalities, including examples of high-resolution images, used in diagnosis and management.

The authors have done an excellent job tying the clinical aspects of rheumatic diseases to the radiographic findings. This is an important feature for new learners as they appreciate the relationship between clinical and radiographic findings. The more experienced learner will appreciate exploring some of the more rare diseases or more esoteric radiographic findings.

This book should be recommended to all PGY-4 and -5 rheumatology trainees as essential reading. It is a concise reference source for radiologists and rheumatologists delivering up-to-date and complete information on the imaging of rheumatic disease.

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The Rheumatology AARP at the University of Alberta

By Stephen Aaron, MD, ABIM, FRCPC

The Academic Alternate Relationship Plan (AARP) of the Department of Medicine was the first such arrangement made in Alberta, following by several years the establishment of the practice plan in the 1990s by then-Chair, Dr. Garner King. It was negotiated with the Alberta Government to provide predictable and sustainable funding for academic activities, as well as the more complex clinical care taking place in a university setting.

To date, it remains very much an academic plan, particularly within our division, where all members are on the tenure track in the Faculty. With the recent retirement of Dr. Paul Davis from the University, our division has only seven members, although we are actively recruiting for several positions, including a new Divisional director.

The plan has been very successful in its goal of providing flexibility in the pursuit of education and research.

The AARP is funded by the Alberta government through two budgets: one that provides base funding for clinical activities, the other a "conditional grant" that provides for academic activities and overhead. Our plan in Edmonton is administered through the University of Alberta. A salary component is channeled through the University, which provides us the benefits and pension of an academic position. The clinical component is administered by a committee of the department and has been designed to provide us with independent professional income allowing for favourable taxation and incorporation.

Each member of the AARP is given a job description, but their total annual income, divided into university salary and a clinical component, depends only upon seniority and university merit increment. This income, which includes university benefits, is highly competitive. We are provided with clinical facilities, office space, and staff. The stability of our individual incomes makes it very easy for us to make decisions about our career pathways and scholarship based only upon our areas of interest and success. For example, an educator can move from a position as program director to a position as undergraduate clinical skills coordinator without any concern about how these positions will be funded.

Percentages of time to be spent by each member on clinical care, teaching, research, and administration are negotiated with the chair of the Department of Medicine, and may change only by agreement. This may take place, for example, when a major position such as Program Directorship changes. However, according to our contract with Alberta Health, the total amount of clinical time committed by our Division must not fall below the negotiated amount. This is tracked by a comprehensive system of "shadow billing;" it is the responsibility of the Divisional Director to ensure accountability.

The "shadow billing" system has created some challenges to delivering care in more innovative ways, although allowances have been made, for example, for telehealth. In addition, although we strive to provide integrated, team-based care, there has to date been no dedicated program in Alberta Health Services (AHS) to fund alternate providers.

We are fortunate to have a team of nurses, physiotherapists, occupational therapists, and a pharmacist working with us, and are optimistic that with this nucleus we shall be able to expand our integrated programs to encompass more of northern Alberta.

In summary, the AARP of our Department of Medicine has been very attractive to rheumatology, giving us a great deal of flexibility as individuals to pursue our clinical and academic career pathways. Our primary issue with the plan has been its reliance on traditional, service-based metrics rather than upon clinical outcomes. Tracking these outcomes on a wide, regional basis is a major strategic goal of our unit.

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Tangri's Ten Tips on Starting a Rheumatology Practice

By Vikram Tangri, MD, FRCPC

1. **Get a lawyer and incorporate.** Early on, it may seem like an onerous undertaking, but incorporation is a must and it is always best to start out early. You will save plenty in the longer term. Your lawyer can help you navigate incorporation and also help with signing of leasehold agreements later. The Ontario Medical Association (OMA) has resources which may be helpful, and other provincial medical associations may also be helpful in this regard.

2. **Get an accountant.** They will become your new best friend. Remember that the more you have your accountant take care of, the more your expenses will climb. Accountants, along with lawyers, work on billable hours so it is probably best to have them help you early on during incorporation, and then yearly to do your corporate taxes and year-end statements.

3. **Choose a location.** This is one of the most difficult choices of all—deciding on where to begin your practice. Lifestyle and family considerations are obviously important, but also think about the size of your community and catchment area for referrals. These factors will play a role on how quickly your practice becomes a "full-time" practice.

4. **Decide on whether you wish to locum or not.** Locums can be a key way to start bringing in income. Consider whether you are prepared to do internal medicine (IM) locums or rheumatology locum work. IM work may be easier to find and many hospitals will require some degree of IM work to maintain privileges; however, IM work requires at times tedious night shifts at times! Rheumatology locums can provide a taste of what is to come.

5. **Academic vs. community.** This is a big question mark hanging over the heads of many residents during their training years. Staying in a large academic centre typically involves additional education/training, but also provides for an easier transition to practice, with hospitals/departments often helping set up your practice. An academic centre allows more education and research opportunities, but a community practice can offer a significant role for teaching (you may get affiliation with a University as an Adjunct Professor) and community-based research.

6. **Partnership.** Do you want a partner? The answer is generally yes! Sharing an office with another physician will split costs in half, and also provide some much-needed social interaction during your work days. On the other hand, you need to have an effective understanding with a partner, since decisions will have to be made collaboratively.

7. **Take inventory.** Wherever you work now, go into the office and mentally follow patients' steps from when they register for an appointment to the physician assessment. Note all equipment, supplies, and staffing needed along the way. The initial costs to set up an office are not minimal. Remember to get business cards/appointment cards!

8. **Record keeping.** If you have the chance, try to use and understand various electronic medical record systems (EMRs). Get comfortable before choosing one; weigh your options carefully. Remember that templates are great—creating a sheet that easily records important patient information in a single page format will save you time!

9. **Develop policies.** Most rheumatologists (for good reason) post a sign indicating there are mandatory fees to be paid (*e.g.*, for missed/skipped appointments). Decide on these early, and have it posted in your waiting room.

10. **Enjoy!** With all the headaches of starting up a practice behind you, it is time to reap the rewards.

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- Reduction of signs and symptoms, induction and maintenance of clinical remission and induction of mucosal healing in pediatric patients with moderately to severely active UC who have had an inadequate response to conventional therapy (i.e., aminosalicylate and/or corticosteroid and/or an immunosuppressant)
- Reduction of signs and symptoms, induction of major clinical response, inhibition of the progression of structural damage of active arthritis and improvement in physical function in patients with psoriatic arthritis (PsA)
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References: 1. Data on file, Janssen Inc. **2.** REMICADE® Product Monograph, Janssen Inc., September 26, 2014.

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Pain, Compassion, and Motivational Communication

By Monique Camerlain, MD, FRCPC; May Shawi, PhD; and Denis Faucher, MSc

"We speak more to each other with our features and bodies than we do with our mouths…Only if someone was in an extreme state, such as fear and anxiety, would you understand what they were feeling, whereas if you have a face and a body, you pick up on a whole range of subtleties…You can tell the difference between someone who is lying or exaggerating, someone who is bored, and someone who wants to go to bed with you."

– Robert Wilson, *The Hidden Assassins*, 2006.

On February 6th, 2015, at the CRA meeting in Quebec City, Dr. Monique Camerlain and Dr. Kim Lavoie presented a symposium on Motivational Communication to illustrate how these competencies can improve patient adherence satisfaction and treatment outcomes.[1]

The experience of pain is an overwhelming whole-person experience;[2] motivational communication based on compassion (from the Latin *com* and *pati*, meaning "to suffer with,") is at the foundation of finding solutions in a win-win approach to better patient care.[3] The literature also demonstrates that between 50% to 80% of the information transmitted by a health-care professional in a medical visit is immediately forgotten by the patient, and half of the retained information is incorrectly remembered. The problem is more important for the elderly population, those who are anxious, and those concerned about receiving bad news. Between 30% to 80% of patients' expectations are not met in primary-care visits while differences in agendas and expectations often are not reconciled.[4]

As noted by Doheny at a 2014 conference on compassion in healthcare, various studies suggest that compassion helps patients feel less pain and anxiety,[5] yet, only 12% of patients say that physicians have given them reason to hope.[6] There is an important need to improve doctor-patient communication to identify and eradicate the problems which hinder communication in order to bridge this gap and to establish an I-Thou relationship as described by Buber.[7]

Physicians, as communicators, tend to have a high education and learning culture, use regulatory and abstract language, thereby placing high importance on the hypothetico-deductive model of reasoning and on the use of print and technology. Less literate persons have low education and learn through life experiences. They seek evidence of caring and prefer practical, simple, concrete language as well as verbal and visual information. This information-frame mismatch can be the cause of a breakdown in doctor-patient communication and should be of concern to all who value a humanistic approach to health care. Our goal and challenge is to achieve a balance between the art of compassionate communication and evidence-based deduction. The aim of motivational communication is to elicit "change conversation" with the goal of resolving a patient's ambivalence about change. It is not a way of tricking people nor is it just one technique.

Compassionate Communication: How It Helps

According to a 1996 survey, 90 million Americans have significant literacy problems;[8] this figure is approximately 48% of Canadians. The failure to detect low health literacy is costing the health care system $93 billion annually in the US, putting one in three people at risk of poor health outcomes.[8] Health literacy refers to the ability to read, understand, and act on healthcare information.[9]

People with low literacy cannot properly read consent forms, medicine labels, inserts, or appointment slips. They have difficulty understanding health information for a variety of reasons including literacy, age, disability, language, and emotion.

Low literacy is difficult to detect because patients struggling to understand written and verbal information are often ashamed of this problem and hide it from everyone including their physician. Low health literacy affects people from all backgrounds but senior citizens, minorities and low income individuals are at higher risk. They are more likely to have chronic diseases and less likely to get the care they need. Numerous studies have demonstrated that they are more likely to be hospitalized and need emergency care. They have poorer health habits and are less likely to use preventive strategies to ward off disease.[10]

To improve communication and to motivate patients in the management of chronic diseases, the importance of compassion must be stressed.[7] Communication role enactment must respect motivational patterns and stages of change. It must be flexible and consider the total patient, his expectations and his level of health literacy for there is no single right way to approach patients.

Motivation is a force that energizes, maintains and controls human behavior. To initiate a change in attitude and behavior, one must take into account the existence of a continuum between the internal motivators which create a force behind human behavior based on an internal locus of control and the external motivators based on an external locus of control.[11] Deci and Ryan suggest that the internal process of motivation would be more likely to produce a lasting effect when compared with the one coming from the external. According to them, the feeling of being able to perform tasks to achieve a goal and the ability to self-regulate one's own behaviour are the foundation of autonomy and self-determination. This sense of self-determination would drive an individual to make the necessary efforts to achieve a goal, even in situations where external interventions are minimal, even nonexistent.[12]

Prochaska et al have also described various stages which may influence the conditions of change in their trans-theoretical model. According to their vision, people go through: pre-contemplation, contemplation, preparation, action, and maintenance.[13] This has been documented in 103 patients with rheumatoid arthritis (RA) and 74 with osteoarthritis (OA): 44% were in pre-contemplation, 11% in contemplation, 22% in preparation, 6% in action, and 17% in maintenance.[14]

We must remember however, that our patients are of the talk show and self-actualization books generation. They "want the microphone" and they consider that what they have to say is very important.[9] A previous study from a tertiary referral centre, characterized by a selection of difficult patients with complex histories, has shown that, if patients are asked to talk spontaneously about their complaints and to indicate when they are finished, the spontaneous talking time is 92 seconds on average. However, doctors tend to jump in and begin asking directed questions after only 22 seconds. Some recommend the 80/20 rule: listen 80% and talk 20% of the time.[9] It is also worth being aware of body language, which represents 55% of communication.[4]

Giving the patient a comfort zone to mention all complaints is a sign of compassion and respect. It may take less than two minutes, but it increases information gathering and both doctor and patient satisfaction. Since satisfaction influences outcomes it is a worthwhile investment.[14]

As Maya Angelou once said: "I've learned that people will forget what you said. People will forget what you did, but people will never forget how you made them feel." Farley also considers that "meeting a person in pain and staying with her becomes a spiritual experience."[10]

We contend, in conclusion, that the traditional review of systems and the standard patient history should be used as a safety net. An encounter should have three or four functions: gathering information, developing a relationship, communicating information, negotiating plans, and facilitation of the patient becoming active in his or her own care. This having been achieved, in the newer frameworks of total-care, emphasis should be put on improving doctor-patient communication to ensure patient empowerment and on creating an I-Thou relationship based on compassion as described by Martin Buber.[7]

Motivational communication is becoming a popular topic in medical education at all levels from undergraduate to continuing professional development, and in many different spheres of medical practice. If you get a chance to participate in motivational communication training, I would highly recommend it: your patients will thank you.

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References

1. Thompson A. Use of Motivational Communication to Better Patient Outcomes. 6 February 2015. Available at : *www.rheumreports.com/?report=163&title=Using_Motivational_Communication_to_Better_Patient_Outcomes.&c=2015_CRA_AHPA&r=%2F%3Fc%3D2015_CRA_AHPA.*
2. Ferrell B. Ethical perspective in pain and suffering. Pain Manag Nurs 2005; 6(3):83-90.
3. Covey SR, Merrill AR, Merrill RR. Priorité aux priorités. New York, New York: Simon and Shuster. 1995.
4. Camerlain M, Richard N, Trasler T. L'art de la Science: communiquer aux patients. Perspectives du College Royal 2005; 2(3):12-4.
5. Doheny K. Rx for Better Health Care: Kindness and Compassion. Health Day: News for Healthier Living. 24 November 2014. Available at: *www.consumer.healthday.com/mental-health-information-25/emotional-disorder-news-228/rx-for-better-health-care-kindness-and-compassion-693888.html.*
6. Camerlain M. Communique l'espoir. L'Actualité Médicale 2006; 24:25-7.
7. Buber M. I and Thou. New York, New York: Free Press. 1971.
8. Camerlain M, Myhal G. Health Literacy: Bridging the Gap. The Canadian Journal of CME 2004; 68-73.
9. Kirby MJL. The Health of Canadians: The Federal Role. Final Report. Volume Six: Recommendations for Reform. October 2002. Available at: *www.parl.gc.ca/content/sen/committee/372/soci/rep/repoct02vol6-e.htm.*
10. Farley M. Compassionate Respect. A feminist Approach to Medical Ethics and Other Questions. 2002 Madeleva Lecture on Spirituality. Mahwah, New Jersey: Paulist Press. 2002.
11. Long LW. Communication and Motivation. Normal, Illinois: Illinois State University. 2000.
12. Deci EL, Ryan RM. Intrinsic Motivation and Self-Determination in Human Behavior. New York, New York: Plenum Press. 1985.
13. Prochaska JO, Norcross JC, DiClemente CC. Changing for Good: The Revolutionary Program That Explains the Six Stages...Six Stages of Change and Teaches You How to Free Yourself from Bad Habits. New York, New York: William Morrow. 1994.
14. Keele FJ, Lefevre JC, Kerns RD, et al. Understanding the adoption of arthritis self-management: stages of change profiles among arthritis patients. Pain 2000; 87(3):303-13.

2015 CIORA Awards

The grant recipient for the 2015-2016 CRA(CIORA) TAS Clinician Investigator Salary Award is Dr. Bindee Kuriya, for her research into whether rheumatoid arthritis (RA) is associated with an increased risk of depression compared to diabetes and to the general population. The research will be borne out in a large-scale study using electronic medical records (EMRs) from across Ontario.

Dr. Kuriya's research will also seek to identify risk factors for the development of depression after RA is diagnosed. Supplementary analyses will assess the use of mental health care services for depression such as counselling or psychiatric care, along with deepening understanding of any serious mental health consequences of depression such as emergency room visits, hospitalizations or self-harm attempts among individuals with RA.

CIORA ICORA

CANADIAN INITIATIVE FOR OUTCOMES IN RHEUMATOLOGY CARE | INITIATIVE CANADIENNE POUR DES RESULTATS EN SOINS RHUMATOLOGIQUES

The Clinician Investigator Salary Award is intended to provide a young investigator with the opportunity to demonstrate their ability to initiate and pursue independent research of clear relevance to arthritis, before becoming involved in carrying out the full clinical, teaching and research duties expected of a regular member of the university staff. This two-year grant is awarded to an individual upon completion of post graduate training, within four years of a full-time clinical faculty appointment.

Awardees are expected to complete a research project during the term of this salary award. The proposed project must be of clear relevance to rheumatic diseases and be aligned with one or more of the research pillars under the Canadian Initiative for Outcomes in Rheumatology Care (CIORA) grant program:

- Awareness/Advocacy/Education
- Early Access for Rheumatic Disease Patients
- Multi-disciplinary Care Teams

For more information on this award and how to apply, please visit: *www.rheum.ca/en/ciora/cra_ciora_tas_clinician_investigator_award.*

CIORA 2015 Grant Awards

Supporting Patient Care with Electronic Resource (SuPER): Efficacy of an Online Decision Aid for Patients Considering Biologic Therapy for Rheumatoid Arthritis
Principal Investigators: Linda Li and Diane Lacaille
Grant Amount: $51,130

Testing of System-Level Performance Measures for Inflammatory Arthritis
Principal Investigator: Claire Barber
Grant Amount: $110,000

Do Persons with Rheumatic Diseases Have Timely Access to Chronic Pain Services?
Principal Investigator: Kadija Perreault
Grant Amount: $68,540

Understanding the Effects of Creating and Viewing Art and Digital Stories with Pediatric Rheumatology Patients, Healthcare Teams and in Educating the Community
Principal Investigator: Paivi Miettunen
Grant Amount: $52,841

The Economic Challenges of SLE: Measuring and Mitigating the Impact
Principal Investigator: Ann Clarke
Grant Amount: $111,800

Preventing Rheumatoid Arthritis (Pre-RA): Perspectives of People at Risk and of Rheumatologists on Selected Interventions
Principal Investigators: Mark Harrison and Marie Hudson
Grant Amount: $82,933

Translating Research into Practice: Identifying Factors that Influence the Uptake of Canadian Research Findings into the Clinical Care of Children with Arthritis
Principal Investigator: Elizabeth Stringer
Grant Amount: $74,990

Pharmacist-led CVD Intervention for Inflammatory Arthritis Patients
Principal Investigator: Carlo Marra
Grant Amount: $99,627

Improving the Care of Patients with Systemic Vasculitis Through the Development of Management Recommendations and Educational Materials: A Canadian Vasculitis
Principal Investigator: Christian Pagnoux
Grant Amount: $89,170

The Arthritis Society: Walk This Way...

Addressing the looming shortfall of rheumatologists across the country is a priority for the CRA and its Ontario affiliate, the Ontario Rheumatology Association (ORA).

For the past five years, ORA members have been coming together to support this important cause by participating in The Arthritis Society's **Walk to Fight Arthritis**, the single largest day of arthritis fundraising and awareness building in Canada.

Three weeks before the national Walk, the ORA host heir own Walk as part of their Annual General Meeting (AGM), providing their members and their families with a fun and positive way to engage in the cause together.

This year's ORA Walk, held in Muskoka, saw more than 125 rheumatologists and family members raise over $17,000 in a show of solidarity with the patients they care for throughout the year.

"I think it's important that we recognize the important role that The Arthritis Society plays in our profession", says ORA President Dr. Arthur Karasik. "From providing the therapists and social workers that many of us depend on to help our patients adjust to life with a chronic disease, working with us to develop a new Models of Care strategy, supporting many of us in our early development as clinicians and researchers in this field, The Arthritis Society is a vital ally and partner for the ORA and our members. We're proud to partner with them in working to bring along the next generation of rheumatologists who will support our patient communities."

Joanne Simons, Chief Mission Officer of The Arthritis Society, told the *CRAJ* she sees the role of rheumatologists as critical: "The support of the ORA, the CRA, and their members is vital to the advancement of arthritis care. Above and beyond the work you do in your day-to-day practice to improve quality of life for Canadians with arthritis, you are stepping forward to support improved access to care for patients now and in the future. Whether through the Walk, or through your support for the Every Member campaign, your contributions are helping us attract more bright young medical minds to the rheumatology profession, and helping build the foundation for future care. We can't thank you enough."

ORA President Art Karasik (centre) is flanked by Ed Ziesmann (left), The Arthritis Society Vice-President of Education, Programs, and Services and Joanne Simons, Chief Mission Officer (right) at this year's ORA Walk in Muskoka.

This year's national **Walk to Fight Arthritis** was held on June 7, and raised $1.1 million (including a further $28,000 raised by rheumatologists), which brought the Walk's six-year total to $8 million in funds raised for arthritis programming, professional development, and research.

The next national Walk will be held on Sunday, June 5, 2016, and once again the ORA's members will be in the starting blocks three weeks earlier to kick-start another successful Walk year.

For information about supporting the Walk or the **Every Member** campaign, please contact Sandra Dow at *sdow@arthritis.ca*, or by phone at 416-979-7228 ext. 3343.

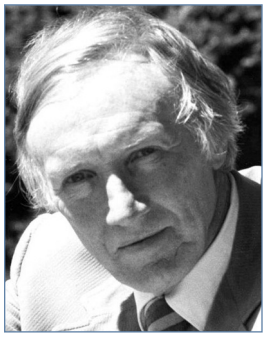
The Arthritis Society

Legacy in Rheumatology

By Claire Bombardier, MD, FRCPC

In 2012 and 2014, two rheumatology icons were lost and a lectureship in the name of each was created to pay homage to their memory.

Hugh Smythe Visiting Professor in Fibromyalgia



- Dr. Mary-Ann Fitzcharles, Associate Professor of Medicine, McGill University Health Centre, Division of Rheumatology, and Alan Edwards Pain Management Unit, Montreal, Quebec was selected as the inaugural recipient of the Hugh Smythe Visiting Professorship in Fibromyalgia in March 2014.

This visiting professorship was created in 2013 to honour Dr. Hugh Arthur Smythe's area of research.

Dr. Smythe graduated with a medical degree from the University of Toronto in 1950 after which time he specialized in rheumatic disease, caring for patients with rheumatologic diseases for almost a half-century. In clinical investigation, Dr. Smythe was a leader in the description of fibromyalgia as a valid clinical entity, studying its associated pain and sleep-associated mechanisms to become a leading expert in fibromyalgia. He was a major contributor to arthritis education and awareness as a long-standing director at The Arthritis Society (TAS), as well as to the development of arthritis self-management programs throughout Canada. Dr. Smythe assisted hundreds of doctors to establish a foundation of rheumatology knowledge. He was Chief of the Rheumatology Unit at Wellesley Hospital, then later at Toronto Western Hospital. He was a founder and served as a co-editor of the *Journal of Rheumatology*. Dr. Smythe passed away in October 2012.

Claire Bombardier, MD, FRCPC
Professor of Medicine, University of Toronto
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University of Toronto

Peter Lee Visiting Professorship in Scleroderma

- Dr. Daniel Furst, Professor of Rheumatology, Director of Clinical Research, David Geffen School of Medicine at UCLA, Los Angeles, California, was named the inaugural Peter Lee Visiting Professorship in Scleroderma in June 2013.
- Dr. Thomas Medsger from the University of Pittsburgh will serve as the Peter Lee Visiting Professorship in Scleroderma beginning in June 2015.

In June 2014, Dr. Peter Lee passed away after a lengthy illness. Dr. Lee had been practicing since the 1970s; he spent over three decades researching scleroderma and helping patients through his clinic. Much of Dr. Lee's career was spent as Director of the Scleroderma Clinic at Mount Sinai Hospital. He was a former member of the Medical Advisory Board, Scleroderma Research Foundation (USA), and advisor to the Scleroderma Society of Ontario. He was acknowledged as an international expert on the subject and played a prominent role in the Canadian rheumatology field. Prior to his passing, a Visiting Professorship was created in his honour.

Both of these respective Visiting Professorships in Fibromyalgia and Scleroderma are awarded every one or two years. These events are well attended and enjoy a growing reputation as a prestigious part of the University of Toronto citywide rheumatology rounds.

Senior Scientist, Toronto General Research Institute,
University Health Network Canada Research Chair in
Knowledge Transfer for Musculoskeletal Care
Past Co-scientific Director, Canadian Arthritis Network
Toronto, Ontario

Teach the Teachers Course: Ultrasound-guided Joint Injections

By Maria Bagovich, MD, FRCPC, RhMSUS

Greetings, CRA members. We would like to update you about a recent Canadian Rheumatology Ultrasound Society (CRUS) advanced learning opportunity undertaken at the University of Florida's College of Medicine on March 13-14, 2015. This two-day interventional musculoskeletal (MSK) ultrasound (US) course was led by local expert Dr. Gurjit Kaeley at the Jacksonville Simulation Centre. Funding was graciously provided by an educational grant from Janssen Canada. The course was exclusive to CRUS members, and included Dr. Diane Wilson, Dr. Abe Chaiton, Dr. Maggie Larché, and myself.

The CRUS team practicing US-guided injections.

Despite facing airline drama and flight cancellations, our CRUS group persevered and arrived in time to a wet but warm Jacksonville, Florida. Our purpose was to learn US-guided injection techniques from the injection master, Dr. Kaeley. After a brief didactic session on the principles of visualizing key anatomic landmarks and injection techniques, we went to the simulation centre, a converted operating suite equipped with injection materials, portable Sonosite US machines and cadaver specimens. Specimens were set up for shoulder, hand and wrist, and elbow injections throughout the day. In a 2:1 ratio of attendee to specimen, we were able to practice US-guided injections in real-time on sections of cadaver until the anatomy and technique was mastered. I have a newfound appreciation for the concept of the "stand-off gel pad" and needle visualization through the various tissue planes. It is remarkable the detail that can be seen with US, even on cadaveric specimens! On the second day, we covered the hip, knee, ankle, foot and a few other special regions including the sacroiliac (SI) joint and, thanks to Dr. Wilson, the suprascapular nerve block.

Dr. Kaeley provided a fantastic learning environment enriched with classical music and masterful feedback. Our trips to and from the hotel in the Honda Pilot "fun wagon" was memorable. We also experienced Jacksonville hospitality at the Crowne Plaza Steakhouse, receiving a personal escort from a local motivational speaker for our evening stroll across the riverfront walkway. All in all, it was a successful trip with a great opportunity for small-group learning and hands-on experience with US-guided injections.

Furthermore, we are excited about the growth of MSK US in rheumatology practice and would love to have you join our CRUS family! Luckily, you have many training opportunities in Canada. The next CRUS Basic Course will be September 19-20, 2015 in Hamilton, Ontario. Details regarding registration can be found at *www.crus-surc.ca*. Sign up early to ensure your spot! The next Intermediate Course will be held in association with the CRA conference in Lake Louise, Alberta, in February 2016. In 2017, the Intermediate Level CRUS course will be in Montreal in association with the annual CRA meeting. The course will be dedicated to US-guided procedures. Enrollment will be limited so please register early! Stay tuned for more details. If you still have questions, please direct them to *info@ecrus.ca*.

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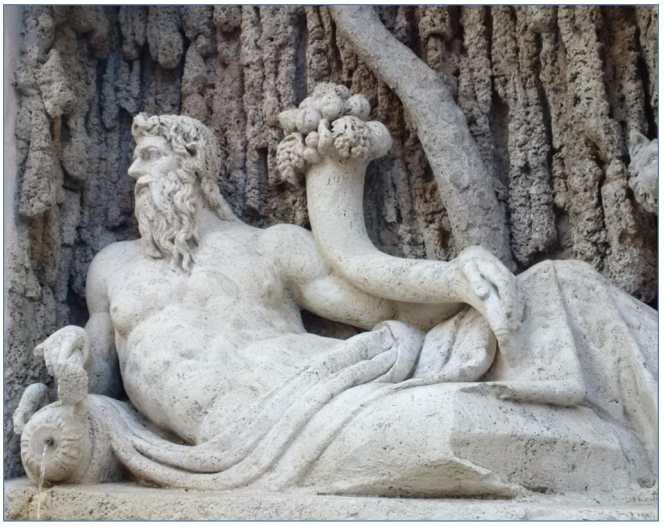
Roaming in Rome: EULAR 2015

By Philip A. Baer, MDCM, FRCPC, FACR

The 16th European League Against Rheumatism (EULAR) Congress took place in Rome in 2015; Rome was the site in 2010 as well. With the growth of the conference to over 14,000 participants, the choice of venues for EULAR is restricted. Trepidations at the time concerned the conference centre being close to the airport but quite far from downtown Rome, with limited transportation links. There were even rumours that the conference might be moved elsewhere, perhaps to Milan. Despite such concerns, I enjoyed attending EULAR 2010. I stayed with a group in downtown Rome near the Vatican. On the first day, I recall following the conference instructions and taking the Metro to the outskirts, where I was supposed to be able to find a EULAR shuttle to the conference centre. Emerging to the surface, I circled the entire Metro station without finding the appropriate bus or any EULAR signage. After 10 minutes, I worked out that I had to cross the street and descend to a parking lot at a lower level, where the shuttle buses were waiting. The transfer by this route took over an hour each way. While the conference runs about 10 hours a day, I really don't like to be stranded there the entire day with no other options, particularly so when I am in a wonderful tourist city like Rome. Eventually, our group organized a private shuttle bus to convey us daily from the hotel to the conference centre, which reduced the one-way transit to a manageable 45 minutes in air-conditioned comfort.

For 2015, the organizers decided to take a different approach. The same conference centre, Fiera di Roma—which resembles a series of 10 airplane hangars—was used. Shuttle buses were to be provided to and from the official hotels, similar to what is usually done for the American College of Rheumatology (ACR). However, this meant that there were even fewer official conference hotels than usual. EULAR opens for hotel bookings as of September for the next June. I have never been prepared to book a hotel in September; usually by the time I get around to it in December or January, all the hotels are booked. This time I did not even try. I also noted that the usual EULAR transit pass included in the conference registration fee was no longer offered, given that the shuttle buses were being provided. My leading criterion for picking a hotel was to find one that provided easy transportation to and from the conference centre. With the help of my son, who seems to be somewhat of an expert in this matter despite his never having visited most of the conference cities, I selected the Hotel IQ Roma. It was both central to all the major attractions, as well as being very close to both Metro lines and a suburban rail link to the conference. My only other requirements were a quiet room, good hotel Wi-Fi, and on-site breakfast. All of these were met, providing the underpinnings for a successful conference. The hotel featured IQ-test-type puzzles on the walls and breakfast placemats. I could solve most of those; the most puzzling thing I could not understand was why the cleaning staff felt they had to replace my towels daily, despite my willingness to reuse them as a "green" consumer.

Some pre-congress siteseeing at the Roman Colosseum.



No evidence of osteoarthritis in this classic picture of repose.

Only two coins in the fountain, still hoping for a possible future return to Rome.

Air Canada only has one direct flight per day to Rome so I took the precaution of reserving that as well, six months in advance. Arriving two days before the start of EULAR provided some time for adjustment to the time zone change, and to see some of the sites, including the Pantheon and Colosseum.

The conference occupied most of the rest of my time. Pre-planning is of the essence; I used the EULAR online application to customize my itinerary, deciding to focus on osteoporosis and rheumatoid arthritis (RA), as these were topics I had been asked to review in post-EULAR presentations for my colleagues. Osteoporosis is a manageable topic at this conference; RA, not so much. Restricting my search to podium presentations and those selected for poster tours winnowed down the field to a manageable number. At the last minute, I ended up presenting a poster on which I was author number seven, but otherwise I had time to wander randomly among the thousands of posters on display.

There were many Canadian attendees, including a cadre of excellent RheumReporters providing real-time updates in digestible chunks. Once again, kudos to Marlene and Dr. Andy Thompson and their team for doing such a great job. Check out Dr. Shahin Jamal's article on the history of gelato in particular: *www.rheumreports.com/?report=203&title=The_Gelaterias_of_Rome&c=EULAR_2015&r=%2F%3Fc%3DEULAR_2015*.

Canadian content was also strong in every facet of the scientific meeting, from podium presentations to posters. Three of six basic science abstract award winners were Canadians. EULAR President Mauricio Cutolo pointed out that EULAR 2015 received over 4,300 abstracts, which were also the most highly rated ever, and accepted 3,500 (82%) for presentation. The program included 150 different sessions, 300 oral presentations, 350 invited speakers, 400 lectures, 40 poster tours, and 2,000 posters.

This year's edition also featured a Joint Congress between EULAR and the Pediatric Rheumatology European Society (PReS)—as is the case every three years—with an extended programme for pediatric rheumatology and various activities initiated by the PReS.

Themes that dominated the scientific presentations included new JAK inhibitors and IL-6 inhibitors for RA, de-escalation of therapy in RA, IL-17 inhibitors in spondyloarthritis (SpA), comorbidities in rheumatic diseases (smoking, obesity, cardiovascular risk factors) and the emerging field of biosimilars.

New EULAR recommendations and "points to consider" were highlighted, covering cardiovascular disease in RA, management of comorbidities in rheumatic diseases, and management of psoriatic arthritis (PsA).

Regarding steroid therapy in early RA, high-dose induction using the COBRA regimen has reported excellent results but never gained wide acceptance. This led to COBRA Light in 2013, and now in 2015 at EULAR we saw the results of the CareRA study comparing COBRA Classic, COBRA Slim (formerly COBRA

Light), and the new COBRA Avant-Garde. You cannot tell the regimens apart without a program, it seems. COBRA Slim appeared to be the winner (Abstract OP0180).

Other noteworthy initiatives included a new open-access rheumatology journal, *RMD Open*, launched by EULAR and the *British Medical Journal*; a platform for young rheumatologists called Emerging EULAR Network (EMEUNET); and one for young patients called YOUNG PARE.

Takeaways from Rome: A good talk/text/data plan is essential for "roaming in Rome", and the competition amongst Canadian wireless carriers has certainly helped in that regard, as has the new Canadian wireless code of conduct, which prevents charges in the thousands of dollars for data use on GPS and apps.

An agent with an apt name, romo (romosozumab), looks like a future winning therapy in osteoporosis (Abstract OP0251).

Rome's new conference centre, the "Nuvola" ("Cloud"), will be closer to the centre of Rome in the EUR district. Nuvola was started in 2007 and scheduled to open in 2013, but now is only rumoured to open in 2017, already years late and over budget. Nothing to do with Italy, as Toronto subway expansions suffer from the same problems. I remember as well planning to arrive at EULAR 2012 in Berlin at their new Brandenburg airport, which as of now is projected to open perhaps in 2018.

Fantasy: The Nuvola, the proposed new Roman conference centre.


Reality: An aerial view of the Fiera di Roma, current home of the EULAR conference.

The EULAR hotel and subway shuttles worked much better, with good signage and lots of people wearing "Ask Me" shirts around. EULAR even scrambled and provided some excellent shuttles from multiple locations around Rome during the four-hour transit strike on the opening day of the congress.

I will not be at EULAR 2016 in London as my son is getting married that weekend. Applications for someone to write a review of EULAR 2016 for the *CRAJ* can be sent to my attention.

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Editor-in-chief, CRAJ
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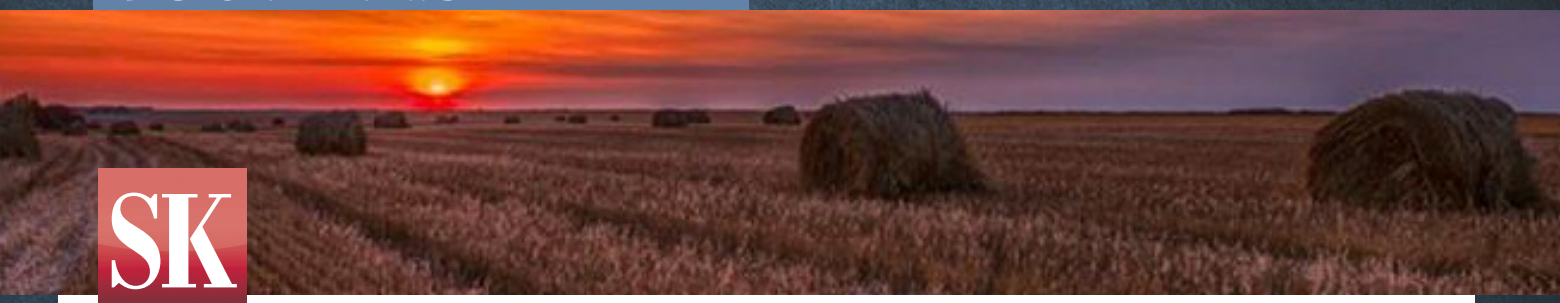

SK

Regan Arendse @drreganarendse
Saskatoon is left with seven adult rheumatologists following the unexpected passing of our dear colleague, the late Dr. Janet Markland, in 2013. Our group is collaborating with the Saskatchewan Ministry of Health to create a pooled referral system and triage system to reduce the lengthy waiting times for most of the rheumatologists. We eagerly welcomed the arrival of two new rheumatologists, Dr. Keltie Anderson and Dr. Jodie Reis, in July 2015 when they completed their fellowships in rheumatology.

W.P. Olszynski @drwpolszynski
#drwpolszynski #drkeltieanderson #drjodiereis

W.P. Olszynski @drwpolszynski
What's new in Saskatoon? Well, first of all, two of our rheumatology fellows have successfully completed their program, and now they are "facing" the pleasure of a rheumatology exam this fall. As a Program Director, I know that both of them are well prepared but pre-exam tension is always there.

W.P. Olszynski @drwpolszynski
#rheumatologyassociatesofsaskatoon

Keltie Anderson @drkeltieanderson
Saskatoon is enjoying a much-needed infusion of new rheumatologists. With two recently locally trained graduates, Dr. Jodie Reis and I, joining Dr. Wojciech Olszynski in his long-standing practice downtown, we are proud to announce the opening of Rheumatology Associates of Saskatoon! The new space has room for even more doctors in the future, and we have our eyes on a few up and coming residents. Let us hope that patient waittimes enjoy a precipitous drop!

W.P. Olszynski @drwpolszynski
#rheumatologyassociatesofsaskatoon

W.P. Olszynski @drwpolszynski
With the extension of our clinic on the main floor, we have also expanded our facilities to the second floor. In addition to seven beds in the Infusion Centre, the Osteoporosis Centre has two bone densitometry (DXA) machines and one bone ultrasound machine. We have also created a new space for our Osteoporosis Research Centre.

W.P. Olszynski @drwpolszynski
Enjoying our success story in Saskatoon, we promise to continue delivering outstanding service to our patients, and we should remember to "judge our success by the degree that we are enjoying peace, health, and love."

Top Ten Things Rheumatologists Should (And Might Not) Know About Inflammation and CV Disease

By Michael C. Hartleib, MSc, MD, FRCPC; and Melinda Gooderham, MSc, MD, FRCPC

Recent data have demonstrated an increasingly strong link between chronic inflammatory conditions such as rheumatoid arthritis (RA), systemic lupus erythematosus (SLE), psoriatic arthritis (PsA)/psoriasis, ankylosing spondylitis (AS), and vascular events.[1,2] In addition, atherosclerosis is no longer thought to be a passive disease of lipid sequestration in arteries, but rather an active inflammatory process that appears to share inflammatory and immune pathways with other chronic inflammatory conditions. This article outlines some relevant data regarding the association of chronic inflammatory disease with atherosclerosis and cardiovascular (CV) outcomes.

1. **CV disease is a leading cause of morbidity and mortality in patients with inflammatory arthritis such as RA and PsA.**[1-5] The European League Against Rheumatism (EULAR) guidelines suggest that RA, AS, and PsA should be considered as conditions with a higher risk for CV disease due the presence not only of traditional risk factors but also the burden of inflammatory disease.[2]

2. **The risk of CV events** in patients with inflammatory disease (*e.g.*, RA) is not fully explained by traditional CV risk factors alone.[6,7]

3. **Patients with inflammatory arthritis have a greater burden of abnormalities in surrogate markers of atherosclerosis,** including carotid intimal medial thickness, coronary artery calcium content, and ankle-brachial index as well as abnormalities of endothelial function such as flow mediated dilation, pulse wave analysis, and coronary flow reserve.[8-10]

4. **The pathogenesis of inflammatory arthritis and atherosclerosis share many similarities;** these include T-cell and mast cell activation, production of pro-inflammatory cytokines such as tumour necrosis factor (TNF)-alpha and IL-6, increased expression of leukocyte adhesion molecules, and increased expression of downstream inflammatory markers such as C-reactive protein (CRP).[11,12]

5. **Further linking inflammation and vascular risk,** patients with a higher burden of disease activity appear to be at higher risk for adverse cardiac events compared with patients who have moderate or no disease activity.[13,14]

6. **The lipid paradox seen in inflammatory arthritis**—in which cholesterol appears to be inversely related to CV risk—may be related to the influence of chronic inflammation on lipid values similar to what is seen in a variety of chronic inflammatory diseases as well as in more acute states such as sepsis, cancer, and post myocardial infarction (MI). Notably, suppression of inflammation in RA has been associated with a rise in lipid values but a decrease in vascular risk.[15,16]

7. **Traditional risk factor assessment** (*e.g.*, Framingham Risk Score) may underestimate overall vascular risk as the impact of systemic inflammation is not properly accounted for in traditional algorithms. For example in RA, risk scores should be multiplied by a factor of 1.5 when patients have two of the following:
   - disease longer than 10 years;
   - rheumatoid factor (RF) or anti-cyclic citrullinated peptide (CCP) positivity; or
   - the presence of certain extra-articular manifestations.

   Even with this modification it is recognized that risk may be underestimated. Non-invasive imaging techniques such as carotid ultrasound may be a valuable tool in this setting; having an association with a good cardiac or vascular risk reduction clinic may be valuable.[17-19]

8. **Successful treatment of inflammation with biologic agents has been consistently associated with a decreased risk of CV morbidity.** The EULAR recommendations for CV risk management in inflammatory arthritis[2] suggest that adequate disease control is necessary to lower vascular risk.[20-22]

9. **Atherosclerosis is no longer thought of as a disease of passive sequestration of lipids in the endothelium,** but as an active inflammatory process that involves both the innate and adaptive immune systems and shares many similarities with a variety of chronic inflammatory states such as RA and PsA. Downstream markers of inflammation (*e.g.,* CRP) can give information about an individual's inflammatory state, and are as good as or better than traditional CV risk factors in predicting disease as well as those patients who might benefit from treatment.[23,24]

10. **There are currently two large multicentre trials** testing the hypothesis that suppression of inflammation (utilizing either an IL-1 specific monoclonal antibody[25] or low-dose methotrexate[26]) in patients at high vascular risk may decrease CV outcomes in patients already on optimal medical therapy.

References:

1. Meune C, Touze E, Trinquart L, et al., High risk of clinical cardiovascular events in rheumatoid arthritis: levels of associations of myocardial infarction and stroke through a systematic review and meta-analysis. Arch Cardiovasc Dis 2010; 103(4):253-61.
2. Peters MJ, Symmons DP, McCarey D, et al. EULAR evidence-based recommendations for cardiovascular risk management in patients with rheumatoid arthritis and other forms of inflammatory arthritis. Ann Rheum Dis 2010; 69(2):325-31.
3. Wong D, Gladman DD, Husted J, et al. Mortality studies in psoriatic arthritis: results from a single outpatient clinic. I. Causes and risk of death. Arthritis Rheum 1997; 40(10):1868-72.
4. Ogdie A, Yu Y, Haynes K, et al. Risk of major cardiovascular events in patients with psoriatic arthritis, psoriasis and rheumatoid arthritis: a population-based cohort study. Ann Rheum Dis 2015; 74(2):326-32.
5. Horreau C, Pouplard C, Brenaut E, et al. Cardiovascular morbidity and mortality in psoriasis and psoriatic arthritis: a systematic literature review. J Eur Acad Dermatol Venereol 2013; 27(Suppl 3):12-29.
6. Dessein PH, Joffe BI, Veller MG, et al. Traditional and nontraditional cardiovascular risk factors are associated with atherosclerosis in rheumatoid arthritis. J Rheumatol 2005; 32(3):435-42.
7. Boyer JF, Gourraud PA, Cantagrel A, et al. Traditional cardiovascular risk factors in rheumatoid arthritis: a meta-analysis. Joint Bone Spine 2011; 78(2):179-83.
8. Scarno A, Perrotta FM, Cardini F, et al. Beyond the joint: Subclinical atherosclerosis in rheumatoid arthritis. World J Orthoped 2014; 5(3):328-35.
9. Tam LS, Shang Q, Li EK, et al. Subclinical Carotid Atherosclerosis in Patients with Psoriatic Arthritis. Arthritis Rheum 2008; 59(9):1322-31.
10. Beinsberger J, Heemskerk J, Cosemans J. Chronic arthritis and cardiovascular disease: altered blood parameters give rise to a prothrombotic propensity. Semin Arthritis Rheum 2014; 44(3):345-52.
11. Pasceri V, Yeh ET. A tale of two diseases: atherosclerosis and rheumatoid arthritis. Circulation 1999; 100(21):2124-6.
12. Skeoch S, Bruce IN. Atherosclerosis in rheumatoid arthritis: is it all about inflammation? Nat Rev Rheumatol 2015; 11(7):390-400.
13. Libby P. Role of inflammation in atherosclerosis associated with rheumatoid arthritis. Am J Med 2008; 121(10 Suppl 1):S21-31.
14. Solomon DH, Reed GW, Kremer JM, et al. Disease activity in rheumatoid arthritis and the risk of cardiovascular events. Arthritis Rheum 2015; 67(6):1449-55.
15. Myasoedova E, Crowson CS, Kremers HM, et al. Lipid paradox in rheumatoid arthritis: the impact of serum lipid measures and systemic inflammation on the risk of car- diovascular disease. Ann Rheum Dis 2011; 70(3):482-7.
16. Schimmel EK, Yazici Y. Increased lipid levels but un- changed atherogenic index in rheumatoid arthritis patients treated with biologic disease modifying antirheumatic drugs: published experience. Clin Exp Rheumatol 2009; 27(3):446-51.
17. Arts EE, Popa C, Den Broeder AA, et al. Performance of four current risk algorithms in predicting cardiovascular events in patients with early rheumatoid arthritis. Ann Rheum Dis 2015; 74(4):668-74.
18. Dessein PH, Semb AG. Could cardiovascular disease risk stratification and management in rheumatoid arthritis be enhanced? Ann Rheum Dis 2013; 72(11):1743-6.
19. Gomez-Vaquero C, Robustillo M, Narvaez J, et al. Assessment of cardiovascular risk in rheumatoid arthritis: impact of the new EULAR recommendations on the score cardiovascular risk index. Clin Rheumatol 2012; 31(1):35-9.
20. Westlake SL, Colebatch AN, Baird J, et al. Tumour necrosis factor antagonists and the risk of cardiovascular disease in patients with rheumatoid arthritis: a systematic literature review. Rheumatology 2011; 50(3):518-31.
21. Barnabe C, Martin BJ, Ghali WA. Systematic review and meta-analysis: anti-tumor necrosis factor alpha therapy and cardiovascular events in rheumatoid arthritis. Arthritis Care Res 2011; 63(4):522-9.
22. Roubille C, Richer V, Starnino T, et al. The effects of tumour necrosis factor inhibitors, methotrexate, non-steroidal anti-inflammatory drugs and corticosteroids on cardiovascular events in rheumatoid arthritis, psoriasis and psoriatic arthritis: a systematic review and meta-analysis. Ann Rheum Dis 2015; 74(3):480-9.
23. Libby P, Okamoto Y, Rocha VZ, et al. Inflammation and atherosclerosis: transition from theory to practice. Circ J 2010; 74(2):213-20.
24. Ridker PM, Danielson E, Fonseca FA, et al, for the JUPITER Study Group. Rosuvastatin to prevent vascular events in men and women with elevated C-reactive protein. N Engl J Med 2008; 359(21):2195-207.
25. Cardiovascular Risk Reduction Study (Reduction in Recurrent Major CV Disease Events) (CANTOS). A Randomized, Double-blind, Placebo-controlled, Event Driven Trial of Quarterly Subcutaneous Canakinumab in the Prevention of Recurrent Cardiovascular Events Among Stable Post-Myocardial Infarction Patients With Elevated hsCRP Including Substudies to Evaluate the Effect of Canakinumab on Carotid Atherosclerosis, and on Glucose Control Following OGTT in T2DM. Clinicaltrials.gov; NCT01594333. Available at: *www.clinicaltrials.gov.* Accessed on July 6, 2015.
26. Cardiovascular Inflammation Reduction Trial (CIRT). A Randomized, Double-blind, Placebo-controlled, Event-driven Trial of Weekly Low-dose Methotrexate (LDM) in the Prevention of Cardiovascular Events Among Stable Coronary Artery Disease Patients With Type 2 Diabetes or Metabolic Syndrome. Clinicaltrials.gov; NCT01594333. Available at: *www.clinicaltrials.gov.* Accessed on July 6, 2015.

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What Lies Ahead?

By Christine Charnock, CEO

This issue, the CRA surveyed members on their thoughts about retirement: what plans lie ahead for the future, and what roles they may take on once active practice or research winds down.

Of the 162 members surveyed, 54 shared their thoughts. Three-quarters (74%) of respondents reported that they have given thought to their retirement, with an additional 17% noting they have given a bit, but not much, thought to life post-rheumatology.

The patient community in Canada would no doubt be pleased to know that phasing out of practice gradually was the most likely plan for many rheumatologists (64%), and remaining in part-time practice (42%) is also a common sentiment. A quarter of respondents see themselves staying active in many other ways, including continued medical involvement in some capacity or another (Table 1). The diversity of post-practice plans was impressive to note; the future of Canadian rheumatology looks bright if this is the direction we are headed!

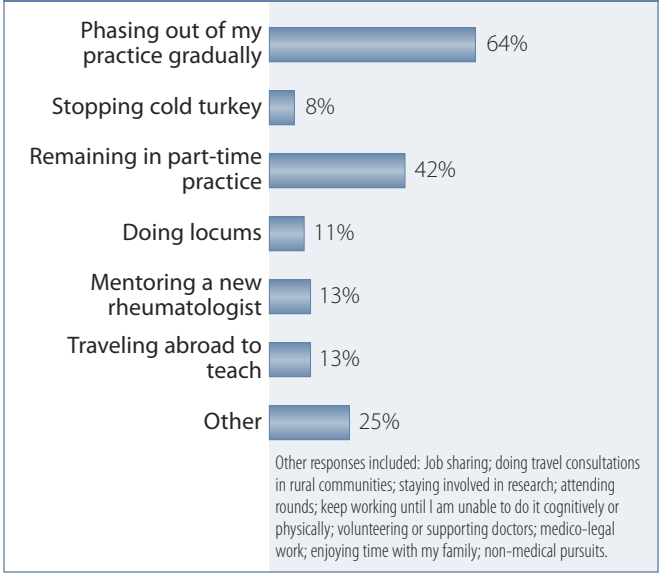
Whether a little (27%), moderately (40%), or a lot (25%), respondents will miss rheumatology practice as it winds down. Numerous aspects of practice will be missed (Table 2), highlighting the devotion to the field that our members share. The sense of accomplishment associated with the medical needs and challenges you face ranked highly (69%) among what will be missed, along with patients (79%), colleagues (66%), and collaboration opportunities (47%).

The CRA is always open to your feedback on what it can offer to help support the transition to retirement; common topics of interest cited included employment opportunities (locums, part-time teaching, shared practice), shutting down a practice, and legal/logistical issues of record storage.

To those worried this survey is a call to "put you out to pasture;" not at all! The aim of the CRA is to support your transitions when and as they occur. If you have questions or suggestions on how better we can support you, please contact Claire McGowan at *claire@rheum.ca*.

Christine Charnock, CEO

Table 1. **What do you envision yourself doing post-retirement? Please select all that apply.**



Other responses included: Job sharing; doing travel consultations in rural communities; staying involved in research; attending rounds; keep working until I am unable to do it cognitively or physically; volunteering or supporting doctors; medico-legal work; enjoying time with my family; non-medical pursuits.

Table 2. **What will you miss most about practicing rheumatology? Please select all that apply.**

Other responses included: Getting up and doing what I love to do every day; my team; teaching and mentoring; carrying on family legacy in rheumatology.

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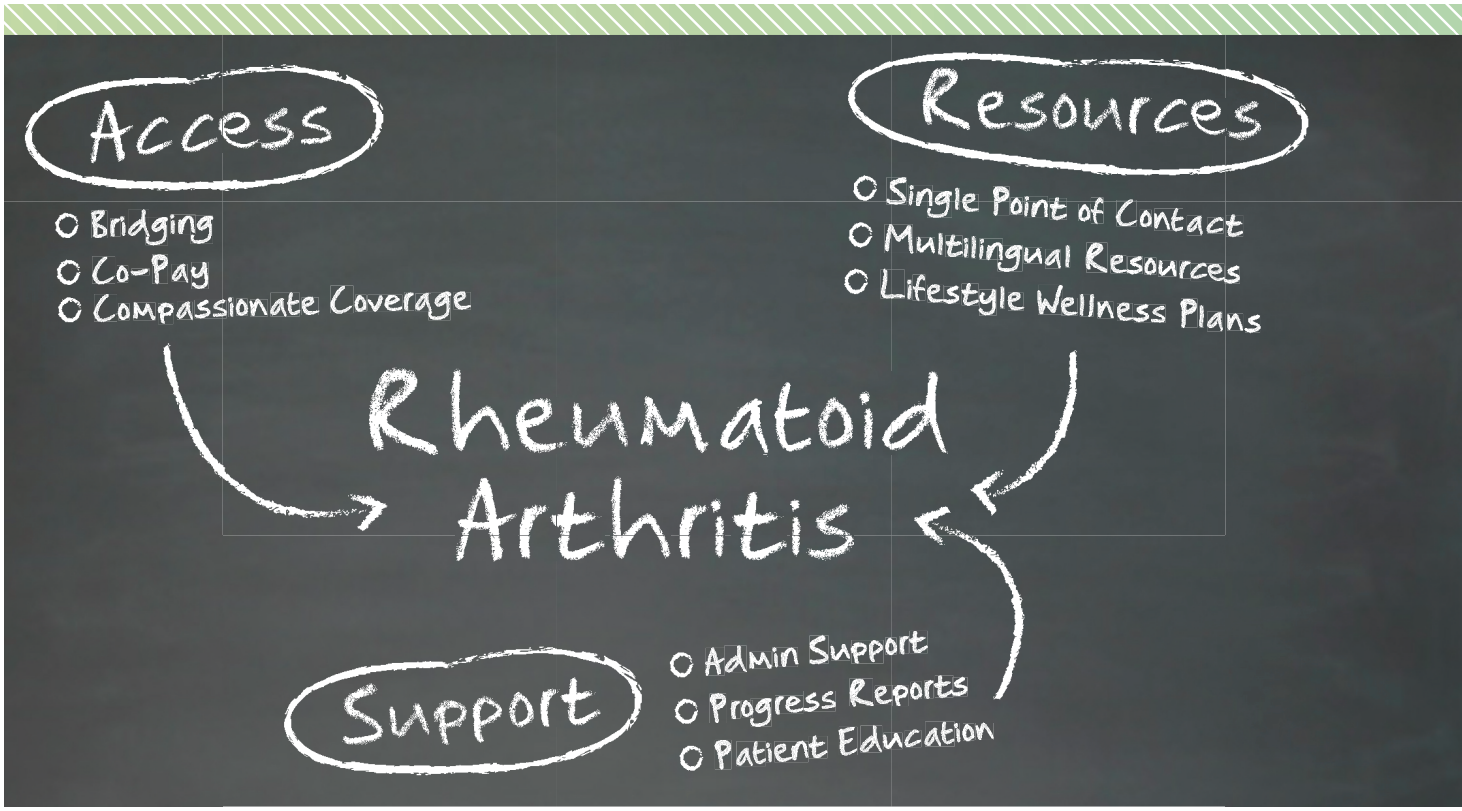

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I have rheumatoid arthritis. But I didn't want that to stop me from having a busy life.

When it comes to choosing an RA treatment, it's true that everyone's different. Some prefer a subcutaneous treatment, while others may find an I.V. medication a suitable choice.

As a shift worker, I looked at my schedule and discussed it with my doctor before choosing a treatment option. It was good to know that I had options – and to talk about them – before choosing a therapy.

– **Jim, Fork Lift Operator***
Has had RA for 5 years; currently on I.V. medication.

* Based on a real patient. May not be representative of all patients.

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