



## The Journal of the Canadian Rheumatology Association

Spring 2011, Volume 21, Number 1



PHOTO CONTEST WINNER  
Best Candid by Marlene Thompson



PHOTO CONTEST WINNER  
Best Scenic by Dr. Jacqueline Stewart

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In the boardroom, not on the beach.

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**Announcement:** Dr. Sindhu Johnson has recently stepped down from the editorial board. The Editor and Board of the *CRAJ* would like to thank her for her many contributions and enthusiasm as a member of the *CRAJ* Board.

The editorial board has complete independence in reviewing the articles appearing in this publication and is responsible for their accuracy. The advertisers exert no influence on the selection or the content of material published.

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# Footprints

By Glen Thomson, MD, FRCPC

What do we really want to know? And about what? Some things are important to know, while others may be less interesting or perhaps even disturbing. Is ignorance bliss or just a way of coping with a threatening reality? In this issue, Dr. Edward Johnson explores what patients want to know—from us. Accordingly, “Consenting to be Informed” is this issue’s Joint Count survey.

Those of us who attended the 2<sup>nd</sup> Mexican-Canadian Congress of Rheumatology (the Cancun Congress) were exposed to a lot of information over the four days of meetings. This issue highlights the scientific meeting, the organizational challenges, and the more social aspects of the Congress. Our hosts from the Mexican College of Rheumatology (MCR) were, as always, most gracious and the setting could not have been more beautiful, at least after the tropical storm passed. The front cover celebrates the winners of the *Journal of the Canadian Rheumatology Association’s (CRAJ)* photo contest and the back cover depicts great photos from the meeting. Thank you to all who submitted their photos! It was a great pleasure and difficult task to select our winners this year.

The Canadian Rheumatology Association (CRA) meetings are always convivial affairs much like a family reunion; this year included some distant cousins. Our colleagues from the MCR face most of the same issues as we do in the practice of rheumatology. They are keenly aware of their extra challenges at this time in Mexico. Many, who live mere miles from where we were conversing about the cutting edge of science, exist centuries away from modern education and healthcare. I was personally struck by the great gulf between the opulence of our hotel and convention centre and the dilapidated Mexican homes beside the highways.

With this in mind, I have made the suggestion to the CRA Executive that we donate a portion of the profit made by the CRA at this meeting to local Cancun educational or health-related charities. It has been stated that this would be an insignificant drop in the bucket and that charity begins at home. After all, Canada still faces challenges even with the billions that we spend on our persistently porous social safety net. I have worked in the inner city and have been a northern primary-care physician. But I was still moved by the absolute penury of so many. We may wish to ignore this reality, but in the end, poverty is poverty. I would like to think that the members of the CRA want to leave something more tangible behind than footprints in the sand.

Two members of the CRA recently departed and left behind far more than mere imprints of their journeys. I did not know Antoine Helewa, but I wish I had. Those who knew him remember a kind and generous man who was a leader in both clinical and research physiotherapy. I did know Dr. David Hawkins, and remember he always took pleasure in maligning Manitoba’s magnificent weather—this coming by way of a man from the clement climate of Newfoundland. Good-natured jibing aside, David was as much of a champion of medical education as Antoine was for the place of allied health professionals in the care of arthritis patients.

This issue also features interviews with our 2011 CRA Awardees who were celebrated in Cancun. There are recipes for success and a smile or two. Is there a reason why Gunnar Kraag is loathe to be seen in Winnipeg from late spring until after the third week of November? Read on.

*Glen Thomson, MD, FRCPC  
Editor-in-chief, CRAJ*



CRA Scientific Chair Dr. Glen Thomson and MCR President Dr. Olga Vera-Lastra



Hall of Presidents

# Reformed Consent

## A psychologist's perspective on what patients want to know and how physicians can meet these needs when making informed consent decisions

By Edward Johnson, PhD, C. Psych

Consider the following scenario: you have recommended a new treatment for your patient, Mr. Rodriguez, and sent him home armed with material (DVDs, pamphlets, etc.) from the pharmaceutical company that carefully and extensively presents the risks and benefits of the treatment. During his follow-up visit, Mr. Rodriguez mentions that he is afraid to take the medication and points to the pamphlet where two or three particularly serious, but rare, potential adverse events are circled in red ink. You proceed to explain that these events are very unlikely to occur and that this treatment has helped many patients. Mr. Rodriguez looks again at the adverse events, shakes his head and explains that he just is not willing to take that risk. Alternatively, perhaps Mr. Rodriguez initially agrees to treatment, but subsequently discontinues his medication for the same reasons.

Does this sound familiar? Do you ever wonder if there is a better way to approach the whole business of providing information and obtaining consent for treatment?

In this article, my goal is to offer new ways of thinking about informed consent that consider the psychological underpinnings of the process. Of particular importance in this approach is to identify emotional and cognitive factors that affect understanding of medical information and willingness to consent to treatment. Suggestions will be provided throughout the article to help you address these factors and improve your patient care.

### Informed Consent: One-time Event vs. Ongoing Process

Usually, obtaining informed consent for treatment is conceptualized as a one-time event that occurs prior to the initiation of treatment. Although, since many patients exercise their right to discontinue treatment along the way, it is more helpful to think of informed

consent as an ongoing issue; like so many other things in life, it needs attention and periodic maintenance, just like changing the oil in your car's engine. From this perspective, both you and your patient may have good reasons to revisit the treatment plan. On the physician side, this may have to do with new information about the patient's medication, or the availability of better or less costly medication. On the client side, there may be concerns about the efficacy of the treatment, side effects, cost or treatment options.

### Developing Understanding: Is Consent Informed?

The initial focus in informed consent is ensuring the patient is adequately informed about the risks and benefits of the various treatment options that are available, including the "no treatment" option. An important question is whether the methods used to present information to patients affect their comprehension and retention of the material. Principles of good pedagogy would suggest that this type of difficult material be simplified as much as possible; be presented in clear, jargon-free language; and be accompanied by a variety of visual aids (e.g., charts, graphs, pictures) to facilitate learning. Certainly, this would be important to ensure a clear understanding of the nature and consequences of various possible adverse events. Research on this topic, however, has not yet demonstrated a compelling or consistent advantage, or disadvantage, for using audio-visual materials in informing patients about treatments.<sup>1</sup>

*Information-processing considerations.* In general, patients' understanding of treatment and disease-related information depends on the adequacy of the information-processing resources they apply to the task. Briefly, what patients need to do is to attend to and encode the relevant information (risks and benefits), holding this information in short-term memory while processing it (com-

paring risk:benefit profiles). Subsequently, after treatment is initiated, they need to be able to recall this information whenever re-evaluating whether they wish to continue taking the medication. As I will discuss, a variety of factors can interfere with the operation of these information-processing mechanisms, and thereby prevent a full understanding of the essential components needed for informed consent.

*Understanding probabilities.* A major part of the challenge of understanding the risks and benefits of a given treatment is that these are inescapably probabilistic. Not all patients will benefit from treatment or encounter adverse events. Consequently, the standard rational utilitarian decision-making model that underlies our informed consent procedures assumes that patients will assign, for each possible outcome, some quantitative value for how good or bad it would be were it to occur, and multiply this value by the probability of its occurrence. Summing these products yields a numeric measure of the net benefit of a given course of action, including no treatment, and allows the patient to make a rational choice by selecting the course of action with the highest value. At least, so the model would have us believe. Before we go on, however, ask yourself whether your patients—or you, for that matter—ever explicitly perform the full set of calculations needed to evaluate all possible outcomes for all relevant courses of action in the fashion just described. Ordinarily, few people actually do this.

*Heuristics.* In fact, considerable psychological research has demonstrated that people typically deal with probabilistic information informally, relying upon a variety of mental shortcuts known as heuristics.<sup>2</sup> Although heuristics allow for rapid decision-making in the face of uncertainty, they also can result in distorted understandings that significantly diverge from actual probabilities. In order to minimize these distortions, it is helpful to present probability information in both numerical (*e.g.*, proportions: a 1 in 1,000 chance) and verbal (*e.g.*, a very low probability) formats. It can also help to cite more familiar types of events to illustrate the rate of occurrence concretely (*e.g.*, about as often as you could expect to be struck by lightning in a given year). This kind of information allows patients to use their heuristic-based system with less distortion.

*Emotional obstacles to understanding.* Emotional and cognitive factors can seriously limit or distort patients' understanding of the risks and benefits of treatment alternatives. Fear and anxiety can cause people to attend



Meeting those needs: Dr. Johnson and his wife relaxing with a good book at one of their favorite spots near the Winnipeg river.

primarily to threat-related information, to the exclusion of benefit-related information. Moreover, fear can magnify or exaggerate the negative consequences of potential threats like adverse events while minimizing and underestimating the individual's ability to cope with

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such events. Depression and hopelessness, however, may cause individuals to underestimate the potential benefits of treatment and focus their attention on past treatment failures. Conversely, a sense of desperation can have the opposite effect of unrealistically magnifying potential benefits, while underweighting potential risks. As discussed below, identifying and addressing emotional influences is important for enhancing informed consent decisions.

*Cognitive obstacles to understanding.* Cognitive obstacles to understanding arise when there is a mismatch between the cognitive demands of the problem and the cognitive resources of the individual who needs to

understand the problem. As noted earlier, information presented in a way that is clear, simplified and readily understood can lower the cognitive demand. However, variability in the cognitive capacities of individuals will make even such accessible information challenging for some. Individuals who have limited education may not possess some of the basic knowledge and vocabulary needed to understand disease processes or the effects of medication. When limited education is compounded by limited intelligence, it may be difficult to successfully explain these concepts, though with patience and concrete analogies, much can be done even in these situations. Another challenge arises when English is not the native language; with individuals who have poor English skills, a good translator and/or translation of written material is essential for good understanding. Whenever doubts exist about patients' comprehension of consent-

*Whenever doubts exist about patients' comprehension of consent-related information, having them share their own understandings can be very helpful for clarifying their level of comprehension and permitting you to correct any misunderstandings.*

related information, having them share their own understandings can be very helpful for clarifying their level of comprehension and permitting you to correct any misunderstandings. It is encouraging to see a large majority of those surveyed in this issue's Joint Count indicated they at least "sometimes" utilize this practice.

### Factors that May Affect Consent

Emotional and cognitive factors can also affect the process of making or altering consent decisions. Assuming that information and understanding precedes decision-making—an assumption that is not always tenable—any unchecked misunderstandings or distortions about consent-relevant information will affect the consent decision. It is worth noting that patients will encounter new information after consenting to treatment (e.g., from Internet sites, blogs, chat-groups, news

media, etc.) or may re-appraise the information they already have; this can result in patients altering their consent decision. If new understandings are distorted or inaccurate, this may lead to decisions to discontinue treatment. Accordingly, patients should be advised at the time of initial consent that they are likely to encounter further information about their disease and medication over time from a variety of sources. They should be advised to seek consultation with you or their family doctor whenever they have concerns about whether the treatment is working or whether there are likely to be serious side effects.

*Culture and consent.* In our increasingly multicultural society, we are more likely to encounter individuals for whom the concepts of individual rights and responsibilities underlying the practice of informed consent are less familiar; these concepts may even be at odds with their past experiences and expectations. For instance, individuals who have recently come from authoritarian societies may expect their physician to simply tell them which medication to take. They may become confused or anxious when presented with this as a health-related decision they need to make for themselves. Some explanation of Western norms of patient autonomy and socialization into the role of becoming an active, informed medical consumer, might be necessary. Even thoroughly Western patients may be surprised, and a little alarmed, when presented with a range of treatment options and told that there is no one "best" choice. In these instances, it may be helpful to remind patients that they are not necessarily choosing forever, and that some experimentation may be necessary to identify what works best for each person.

*Emotional and interpersonal influences.* Research on patients' concerns about medication shows that fears and worries about serious adverse consequences of medication use bother a great many patients.<sup>3,4</sup> Some wonder if the medications they are taking to combat their disease will do as much or more damage than the disease itself, or if their medications may even kill them. With these worries, it may not take much for patients to begin panicking about worst-case scenarios, no matter how unlikely. This may cause patients to discontinue their medication or refuse to consent to it in the first place. Indeed, research on patient perceptions of adverse outcomes shows that there are a substantial number of patients who essentially ignore probability information when considering their willingness to take medication.



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## Summary of Recommended Practices

1. Disease and medication information is presented in a simplified, clear, and accessible manner and includes visuals (charts, pictures, graphs).
2. Probabilistic information is presented using equivalent words (*e.g.*, unlikely), numeric proportions (*e.g.*, 1 in 1,000 chance), and familiar, concrete illustrations (*e.g.*, as likely as...).
3. Factors that may interfere with understanding, such as limited education or intelligence, or poor English skills, are identified and accommodated appropriately.
4. Cultural-based differences in understanding and expectation are monitored and explored as necessary.
5. Emotional responses to disease- and medication-related information is monitored and explored. Patients should know that fears of adverse events are normal and that they can count on their doctor and healthcare team to work through any problems with them—they will not be abandoned.
6. Patients who exhibit signs of medical phobia should be referred for treatment to a psychologist or other behavior specialist.

The authors concluded that such patients consider certain adverse outcomes to be “protected values” they are unwilling to subject to considerations of trade-offs and probabilities.<sup>5</sup> Although these authors have suggested that doing so results in suboptimal decisions, others have suggested that these decisions reflect patients’ desire to avoid future regret, and hence may be considered as having a rational foundation.<sup>6</sup>

### Catastrophic Thinking

Although research has not yet identified what patients fear they will regret, I speculate that this fear has to do not only with incurring an irreversible adverse outcome, but that doing so would be catastrophic. In particular, I suspect their mental image is of their being not only physically disabled or disfigured in some way (as if that weren’t bad enough), but that they will be completely alone in having to cope with this circumstance. Consequently, they may fear their lives would be inevitably miserable as a result. This fear of social isolation is important for two reasons. First, chronic illnesses tend to increase social isolation, in that they impair mobility and can damage one’s sense of being worthy of social contact. Thus, it is natural for patients to fear that further physical damage or dysfunction may ensue from medication side effects, further increasing their isolation. Second, social isolation tends to be associated with a reduced sense of one’s ability to cope with problems. This sets up a vicious cycle in which fear of declining social support drives greater anxiety, which creates

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greater doubt about coping ability, which generates pessimism about outcomes, which increases worries about isolation, and so on. If this picture is correct, then no amount of reassurance that the feared outcome is very unlikely will assuage patients’ fears, since in their minds, any chance of this disaster occurring is unacceptable. Accordingly, what patients need in this context is to understand that, when worries or actual issues of adverse effects related to medication use occur, they will not be alone in dealing with them, for they will have the support of their physician and healthcare team. Moreover, it may be useful for patients to know at some point that even when individuals have experienced adverse events related to medication usage, it is typically much less troubling

than they feared. In sum, when fear of a particular adverse event appears to be weighing heavily on a patient's willingness to consent to treatment and they are not reassured by considerations of low probability, an alternative tactic to consider is addressing the worry head-on. By having the patient clearly describe what they fear, the physician will have an opportunity to open a dialogue about their worry of facing the problem alone. If done compassionately, I suspect that most patients will feel reassured by having their fears understood and having a greater appreciation of how their medical team can support them in avoiding or dealing with adverse events.

This approach will likely be helpful for many patients. However, there will be a subset of patients for whom you may find that any discussion about adverse events triggers panic, no matter how supportive and reassuring

*... there are two, blood-injection-injury and situational phobias, which include fears of stimuli involving medical settings or procedures and which have the potential to interfere with obtaining necessary medical information or the use of certain treatments.*

your manner. These individuals may have a medical phobia and may benefit from specialized psychological treatment designed to address these problems.

### Medical Phobias

The results of this issue's Joint Count survey suggests that about half of the respondents believe 10% to 50% of their patients have a true phobia related to taking medication. The Diagnostic and Statistical Manual of Mental Disorders – IV (DSM-IV) indicates that a specific phobia has three central features: fear is directed at a limited set of stimuli; encountering these stimuli elicits intense fear and avoidance behavior; and the fear is unreasonable and excessive to a degree that it interferes with daily life. Recent population-health surveys in the U.S. and Netherlands indicate that specific phobias are among the most prevalent mental disorders, with 10%

to 12% of the population meeting criteria for a lifetime diagnosis of specific phobia.<sup>7</sup> Age of onset is typically young, usually between 7 and 9 years, although claustrophobia begins later, around age 20.<sup>8</sup> Of the five recognized subtypes of specific phobia, there are two, blood-injection-injury and situational phobias, which include fears of stimuli involving medical settings or procedures and which have the potential to interfere with obtaining necessary medical information or the use of certain treatments. As these two types of phobias have quite different physiologic responses involved, I will discuss them separately.

*Situational phobias.* The phobias in this category commonly involve claustrophobic fears associated with being inside an enclosed environment (e.g., airplane, movie theatre, elevator). In the medical context, these fears may include having to remain in an imaging device for an extended period of time without moving or leaving, such as a magnetic resonance imaging (MRI) scanner. If the environment is completely enclosed, there may be a fear of suffocation; otherwise the fear may be of "going crazy" or fainting as a result of being overwhelmed by panic without being able to escape the situation. Although persons with situational phobia may fear fainting, they do not actually faint because they experience an increase in blood pressure and heart rate.

Another situational phobia relevant to medication has to do with the fear many children and some adults have associated with swallowing pills (they fear they will choke or gag while struggling to swallow). A variant of this is found among patients who cannot bring themselves to consume medication for fear of experiencing an adverse event.

*Blood-injury-injection phobias.* In contrast, persons who fear blood, injuries or needles tend to experience an initial rise in heart rate, followed by a drop in heart rate and blood pressure, which could lead to fainting. Moreover, unlike other phobics who experience intense anxiety in the face of the feared object, those who avoid the sight of blood may be more likely to be disgusted or repulsed by an encounter with it and may be more likely to fear fainting.<sup>9</sup> This type of phobia is more strongly heritable than other types of phobias, perhaps due to an inherited strong vasovagal response to bleeding, injury or the possibility of an injection.

*Natural course.* Left untreated, the natural course of most phobias is chronic, albeit with mild, rather than severe, symptoms of anxiety. In one study, only 16%



of cases remitted over a seven-year period.<sup>10</sup> Many individuals with specific phobia simply avoid situations where they are likely to encounter what they fear; escape it quickly; or endure it with distress when they do encounter it. Depending on the nature of the phobia, the restriction on activities for the individual and the impact on family and friends can be significant (e.g., no air travel for flight phobics, no medical scans for claustrophobics).

*Treatment of situational phobias.* The treatment of choice for specific phobias is some form of cognitive behavioral therapy in which prolonged or repeated exposure to the feared stimulus is a central feature. Medications, including benzodiazepines and selective serotonin reuptake inhibitors (SSRIs), have generally not been found to be effective in the treatment of specific phobias. Technological developments in recent years now allow for many types of phobias to be treated using virtual-reality devices that simulate the experience of being in the feared environment. These are particularly useful when it is difficult to access the feared real situation (e.g., airplane, MRI). Unfortunately, equipment costs have limited the uptake of this procedure by therapists. Ideally, these in-office sessions are followed by in vivo sessions in which the patient encounters the feared situation directly and, with the therapist's support, remains in the situation for up to two or three hours. During the exposure, the therapist guides the patient to engage continually with the feared object (e.g., petting the dog, going up and down the elevator); these activities enhance the patients' sense of mastery or self-efficacy. Therapist-guided exposure has been found to be significantly more effective than simply encouraging patients to do exposure exercises on their own. Substantial reductions in fear and anxiety can be obtained in as few as one or two sessions. By using extended exposure sessions, patients get to experience their anxiety decreasing in the face of the feared object. This helps reduce patients' belief that their fear is a good indicator of objective danger in these situations.

*Treatment of blood-injury-injection phobia.* Applied tension, involving sustained tensing and releasing the muscles of the legs and arms, is the generally recommended treatment for this form of phobia.<sup>11</sup> This procedure allows patients to engage in exposure to the feared stimuli and avoid sudden drops in blood pressure associated with the sight of blood or venipuncture. This approach has been found to be quite successful.

## Summary

Situational and blood-injury-injection phobias about medical equipment, procedures, or treatments can significantly interfere with medical investigations and patient adherence to treatment recommendations. Cognitive behavioral treatments that involve prolonged, guided exposure to feared stimuli, accompanied by applied tension for blood-injury phobics, has been found to be highly effective in treating these forms of phobia. Insofar as these phobias do not tend to remit spontaneously, patients with medical phobias should be encouraged to pursue treatment with a psychologist or a behavioral specialist, or with the aid of a credible self-help manual<sup>12</sup> in order to reduce avoidance and unnecessary suffering, thereby enhancing their ability to follow assessment and treatment recommendations.

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# An Interview with the CRA's 2011 Distinguished Rheumatologist: Dr. Gunnar R. Kraag

What do you believe are the qualities of a distinguished rheumatologist?

There is no guidebook or list of qualities for this award. The prime requirement is a contribution to our specialty which can occur through a wide number of avenues and activities. In the end, it is the respect and affection of colleagues that determines who has left a mark on rheumatology and deserves recognition as "Distinguished Rheumatologist."

John Esdaile once wrote in the *CRAJ* that answering this question was tricky since "one could not be distinguished until one was dead and the whole page could be written." Fortunately, the CRA does not wait that long or both John and I would be out of an award.

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

As an intern at Queen's, I was assigned to a rotation on the arthritis ward. I tried desperately to trade with someone as this was not a popular rotation. No one traded! I then met the irrepressible Garfield 'Gub' Kelly and the very cool Doug Kinsella (taught me what a T-cell was), loved the patients and had an outstanding experience.

While at the Toronto Western Hospital, I decided on cardiology as a career, but then met Jack Crawford (Rehab) and Jack Reynolds during a rotation and was reintroduced to rheumatology, which rekindled my interest in the field. I was also exposed to terrific lectures by Dunc Gordon, Hugh Smythe, Metro Ogryzlo and Murray Urowitz. I was sold. I withdrew from cardiology and switched to rheumatology.

When did you become certain that you wished to pursue a career in medicine and not become a professional athlete?

You might recall several years ago at the Canada Night Dinner during the ACR meeting in Washington, D.C., Rubin "Hurricane" Carter, the professional middleweight boxer, was the guest speaker. During his speech, he mentioned that many people had asked him what his toughest



fight was. He replied that there was no doubt in his mind that it was a narrow victory over Gunnar Kraag. People bought me many drinks that night wanting to hear all the details. So the legend began.

There are many other stories concerning the NFL, NHL, CFL, golf and tennis. Even a story about a career in figure skating shortened by injury was hot for a while.

True? Total fabrication? Urban legend? BS?

Let's talk about it some time.

Was it always inevitable that you would practice in a university setting?

Absolutely not! I considered community practice very seriously and Peterborough was a strong option. I also looked at several other opportunities but decided to stay at McMaster. Thirty-six years later, I am still in a university setting so I guess it was the right choice.

You have been promoted to a number of university administrative positions in your career. What have

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been the frustrations and rewards of working as a section and department head?

There are rewards?

I was known to carp a great deal about hospital and university administrations. Therefore, when the opportunity to get involved presented itself, I couldn't turn it down. My major administrative roles were Chief of Staff, Chief of Medicine, Vice-president Medicine Portfolio, Deputy Chair of the University Department of Medicine, and Hospital and University Chief of Rheumatology. I enjoyed these responsibilities thoroughly and came to appreciate the other side of the fence. I was delighted to see more and more doctors having input into hospital affairs with many physicians developing management skills often through executive MBA courses and assuming major administrative positions. The frustrations inherent in a bureaucracy remain, but I found out the administrators do a much, much better job when they listen to physicians. By the way, I also found out that dealing with physicians is not like herding cats, as has been suggested, but more like trying to herd squirrels.

You have held a number of portfolios in the CRA including that of President. What are the greatest challenges and achievements of the CRA on your watch?

I think the most exciting and daring venture during my presidency was the purchase of the *Journal of Rheumatology*. The CRA had real financial concerns, but I am delighted to see that two years later things are very sound. We did the right thing!

Our annual meeting remained a jewel and continued to improve. Our sponsorship support remained strong and continued to grow. The CRA remains financially sound and, believe me, that allows the CRA executive to sleep nights without the 10 mg of lorazepam.

Otherwise, I would say that my greatest achievement was to have the good sense to let the committees and members do their thing and stay out of the way.

I would be remiss in not mentioning that my role as the chief captioneer for the CRAJ is personally one of my proudest roles. Where else could I say the things I do without risking physical harm?

What does the CRA mean to you personally?

Should the theme to "Love Story" be playing now? We rheumatologists are a small, tight-knit, proud, and very collegial group and I have said it often and will say it again: I have never met a rheumatologist I didn't like. It has given me immense pleasure to be a CRA member and eventually President. It has been incredibly satisfying to work with fellow members who never cease to amaze me by their willingness to work on behalf of their colleagues despite other pressing responsibilities including jobs that are not exactly 9 to 5. This organization has come a long way and continues to grow. My involvement has been rewarding and a lot of fun!

What should the CRA aspire to be in the future?

Excellent!

Is it true that you have never met a rheumatologist you didn't like?

Absolutely.

P.S. I still feel I won that fight with Hurricane.

*Gunnar R. Kraag, MD, FRCPC*

*Professor of Medicine,*

*University of Ottawa*

*Ottawa, Ontario*

## Student Awardees at the 2011 CRA Annual Meeting

### Best Overall Presentation

Roberta Berard,  
University of Toronto (supervisor: Dr. Claire Bombardier)

### Philip Rosen Award, Best Clinical Presentation

Marie Clements Baker,  
McMaster University (supervisor: Dr. Nader Khalidi)

### Ian Watson Award

Brandusa Florica,  
University of Toronto (supervisor: Dr. Paul Fortin)

### Best Basic Science Presentation

Nigel Haroon,  
University of Toronto (supervisor: Dr. Robert Inman)

### Medical Student Poster Award

Jennifer Lee,  
Queen's University (supervisor: Dr. Paul Fortin,  
University of Toronto)



# An Interview with the CRA's 2011 Distinguished Investigator: Dr. Gillian Hawker

**Why did you become a rheumatologist?**

I liked the fact that it was a medical subspecialty that had a “whole patient” perspective—rheumatologic conditions can affect virtually all the organ systems—and that diagnosis relied on sharp history taking and clinical examination, somewhat like sleuthing, rather than simply on a blood test or x-ray.

Also, my husband had just started a practice in neonatology/pediatrics and I envisioned rheumatology would afford more flexibility of time to raise a family than hematology/oncology, the field where I was initially headed (which theoretically is true, but not the way I've done it!).

**How did you become interested in the research aspects of rheumatology?**

I have no idea really. I always knew I wanted to stay in academia and early on was exposed to clinical research in rheumatology by all the faculty at the University of Toronto, including my subsequent supervisor, Claire Bombardier, who at that time was deep into establishing the clinical epidemiology program there. So...probably osmosis!

**What are your current areas of investigation and what are the reasons you have focused on these areas?**

I have always focused my research in the area of access to and outcomes of care for people living with osteoarthritis (OA). I chose OA because no one else was paying any attention to this condition, which is by far the most common arthritis and which is becoming even more of an issue with the aging population. Although, as a rheumatologist, I believe most people with OA should be and could be effectively cared for by primary-care physicians, the reality is that this is not happening.

There are really two main areas of interest that we have had in OA: first, a long-standing interest in disparities in rates of use of total joint replacement surgery for OA by gender/socioeconomic status/geography and why these disparities exist, and what we can do to reduce them; and second, understanding the determinants and consequences of pain in OA, including the downstream effects of OA pain on fatigue, disability, sleep and mood.



Our research participants have helped to inform our research. We have been following a cohort of people living with hip and knee OA for more than 15 years and we frequently hold information sessions to ask about their main concerns. In this way, our study participants helped to influence the development of the NET grant.

Currently, we are also exploring the impact of OA on management of other common conditions like diabetes and heart disease and vice versa, hoping to get some attention to OA as an important chronic condition that cannot be ignored.

**You established a CIHR NET in OA pain and fatigue. Why did you begin this team? What was the team's goal/purpose for patients with OA?**

This is actually finished (2004 to 2009) and was focused on the causes and consequences of pain and fatigue in OA. This grant evolved from the 2002 OA consensus conference at which people living with OA said pain and fatigue were their primary concerns, yet little research was being done in these areas in Canada and beyond. We learned a ton from this research and I think

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it has changed the way OA is considered, evaluated and understood.

**Are there other areas of interest you would like to investigate in the future? What projects will you be undertaking in the new year?**

In my capacity as Chief of Medicine at my hospital, I am spending a lot of time developing programs to address and prevent hospitalization in people with complex chronic conditions. Currently, approximately 1% of the population of Ontario accounts for about half of the hospital and home care costs to the province. Most of these people have multiple medical conditions, notably heart disease, diabetes, depression and musculoskeletal (MSK) conditions (mainly OA). Despite this, we continue to plan healthcare by disease. We rarely think about and deliver healthcare that considers the whole patient. Further, our treatment guidelines rarely take into consideration other comorbid conditions that make ideal care impossible (like giving an anti-inflammatory pain medication to a patient with painful OA who also has high blood pressure). My next focus of research will be clarifying the gaps and needs for care for these folks, to inform how best to address these needs.

Research to date in the area of joint replacement has laid the foundation for many ongoing studies evaluating the use of patient-decision aids and other interventions to improve access to surgery for the right patients at the right time.

Our research on pain in OA has led to new studies examining the role of neuropathic type pain in OA, which we hope will improve the targeting of pain medications to the right pain mechanism in OA.

**How does your research influence the clinical care of arthritis patients? Are there differences that you see in the way that MD researchers approach epidemiologic studies and health services research compared to PhD researchers?**

There are many ways our research can influence clinical care. Understanding gaps in care is important for advocacy and policy; we've developed new measures and patient-decision tools and physician tools for referral, etc.

In my personal practice, the fundamental difference between MD clinical researchers and PhD researchers is that the former interact with patients and the best research questions are generally those that come from

patient interactions. Further, the MD clinical researcher has the opportunity to integrate their research findings into their subsequent clinical care in an ongoing iterative manner—it's the best!

I also enjoy presenting our research to the public (I give lots of lay talks), answering questions and listening to people who may not be getting the help they need. I feel I am providing people with some knowledge and (hopefully) the confidence to ask the necessary questions, and to find the care and treatment that is right for them within a complex healthcare system which can be intimidating.

**What advice would you give to aspiring young rheumatologists interested in a career of epidemiologic research?**

I would tell them to look around themselves and figure out where they can make a unique/important contribution to the care of arthritis patients—where is there a need for research—and focus there.

I would also advise them to get excellent research training, and not to hurry to finish but instead take the time to get the skills they need to be successful. They should find good (great) mentors who are willing to spend real time with them to guide them along the way, including giving constructive—albeit sometimes tough to take—criticism (a mentor who always tells you that your work is great is leading you down the garden path).

If possible, I would recommend they work in a well established team with resources that they can capitalize on; it is much harder to start from scratch to build a research program. Start with some simple projects and work up to the big one! Success is critical to landing that first big grant.

**What was your first thought when you learned that you would receive this award?**

Utter joy. The ultimate honor is that bestowed by one's colleagues.

*Gillian Hawker, MD, MSc, FRCPC  
Physician-in-chief, Department of Medicine,  
E.M. Hill Chair in Academic Women's Medicine,  
Women's College Hospital  
Professor of Medicine, Division of Rheumatology,  
University of Toronto  
Toronto, Ontario*

# An Interview with the CRA's 2011 Teacher-Educator: Dr. Nader A. Khalidi

What do you believe are the qualities of a good Teacher-Educator?

A good Teacher-Educator needs to challenge trainees to achieve the highest standards and be open to all methods of teaching, as not all trainees are created equal.

What do you enjoy about teaching medical students and rheumatology trainees?

There are many things I enjoy about teaching, but the most important is that trainees and patients keep me humble with a variety of daily challenges.

What are the current challenges for those teaching in the university environment?

At McMaster [University], we have created a great learning atmosphere and have attracted many who want to learn more about rheumatology to enrich their education or even to pursue further training. The greatest challenge is our resources—in terms of space and manpower—as we have become very popular and have a difficult time trying to accommodate all those who apply. Furthermore, while we have created great interest, we have a limited number of training positions because of provincial funding; this has improved, but we still need more to add to the rheumatology workforce that remains an underserved profession in Canada.

Is there educational value in having students and trainees exposed to community-based physicians and their patients?

Absolutely. Many of us specialize in caring for patients with specific diseases, but we still need trainees to be as wide-eyed as possible to all aspects of the multitude of diseases we encounter in rheumatology, and community-based physicians help keep us rounded. In particular at McMaster, community-based rheumatologists, including Drs. Brian Hanna and Saeed Shaikh, are key and integral players in our training program. Several of our trainees have started community-based rheumatology practices and will continue to be involved in teaching.



Over the past few generations, there has been a change in the classic models of education with less didactic expert lectures and more student-led seminars. Novel methods of education and teaching have also been introduced. Are students and trainees better educated today and more prepared to be practicing physicians than a generation ago?

I am not sure that one should compare education to a generation ago, but certainly as our world becomes more complex, new ways

of education have had to emerge to adapt to this to allow for more engagement and ways to handle intricate problems and help tackle the huge and ever-expanding knowledge base in rheumatology.

What would your advice be to some of your younger colleagues who are interested in enhancing their teaching skills in rheumatology?

I would suggest that they remain flexible in their thinking, adapt to new technologies and continue to listen to and be taught by their trainees. Furthermore, formal training and mentorships are available through the Royal College as well as through various academic institutions that meet regularly through The Arthritis Society (to whom I owe great gratitude for their generous five-year support with the Clinician Teacher Award) and the Canadian Council of Academic Rheumatologists, such as the innovative Future Leaders in Rheumatology Training (FLIRT) program pioneered by Dr. Janet Pope.

*Nader A. Khalidi, MD, FRCPC  
Associate Professor, Head of Service,  
Rheumatology, St. Joseph's Health Care System  
Program Director, Rheumatology, McMaster University  
Hamilton, Ontario*



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# An Interview with the CRA's 2011 Young Investigator: Dr. Marie Hudson

What has been your proudest

accomplishment in your research to date?

When I look back over the past few years, I am proud of the scleroderma network that I helped develop, the students that I coached and the papers that I published. But I think that when I meet study patients who tell me that the research we are doing is so important to them, that is when I am most proud. In fact, it always impresses me to see how much insight patients have. They understand very clearly that their problems are often chronic, that there are no quick and easy treatments and that their condition is often very serious. But it is important to them that someone somewhere is interested in their problem, is working on it and may find a solution that, even if it is not found in time to help them, might help others in the future. That knowledge in itself is, if not therapeutic, at least very beneficial for the person who suffers from a serious, chronic disease. The respect that patients have for you as a researcher is very rewarding.



What direction would you like to see for your future projects?

I am currently very interested in the outcomes of scleroderma lung disease. I am trying to develop an international group to pursue research in this area. In addition, I am also very interested in cross-disease research, such as lung disease in various systemic autoimmune rheumatic diseases.

What are the hurdles that you have faced as a young MD researcher?

Time...I never have enough time. There is so much to do, in addition to being a clinician, a teacher, a mother, a daughter, etc. There are certainly many other hurdles, but most of those are in some way or other under your control. Time is not.

For those wanting to pursue rheumatology and a career in research, what is your advice?

First, I used to think that you were either a clinician or a researcher. But I now realize that it is because I like to be a clinician that I have good research questions. My

clinic patients provide me with all the questions I will ever need. So, embrace the role of clinician.

Second, I often tell trainees that the training opportunities in research are endless. There are so many good training programs around the world and reasonable opportunities to be funded for these programs. I think that going away to pursue additional training for a few years is one of the most enriching career experiences.

Finally, there are many fields of research in rheumatology, such as rheumatoid arthritis, osteoarthritis, autoimmune diseases, etc. A lot of the research in these fields is cutting-edge and it has and will continue to have a huge impact on patient care. Find the subject that interests you and go for it. On the other hand, research is not easy. There is a constant pressure to publish and receive funding for your latest endeavor. The best key to success is, first, to be committed. If it does not work at first, try and try again. Second, surround yourself with the best team—your team is the single most important key to your success. The team members encourage you, challenge you, help you and really make you enjoy your work. They keep you coming back the next day.

What was your first thought when you learned that you would receive this award?

My first thought was certainly the delight that accompanies being rewarded. I spend a lot of time alone behind a computer. It is nice to think that someone is actually paying attention to what I do. However, this first moment of gratification was quickly replaced by another thought: the responsibility that accompanies getting an award. Now that I realize people are paying attention, the bar is set even higher to perform even better. I have to live up to the expectations this award has created.

*Marie Hudson, MD, MPH, FRCPC  
Jewish General Hospital and Lady Davis Research Institute  
Assistant Professor, McGill University  
Montreal, Quebec*

# Tropical Thunder

By Glen Thomson, MD, FRCPC

The 2<sup>nd</sup> Mexican-Canadian Congress of Rheumatology began amidst tropical thunder in the splendor of Cancun, located in upbeat Quintana Roo, Mexico. Some Canadians attended the musculoskeletal pre-course, including Dr. Johannes Roth from Ottawa. The Arthritis Health Professions Association (AHPA) pre-course, organized by Marlene Thompson and Terri Lupton, featured notable rheumatologists Drs. Janet Pope, Ken Blocka, Doug Smith, Marvin Fritzler and Paul Fortin. The resident's pre-course was the first official Canadian Rheumatology Association (CRA) event. This was also known as the "miracle of Cancun" as Dr. Eric Rich's amazing conjuring act included taking an empty room and filling it with chairs, audiovisual equipment, and breakfast for the residents and faculty within 26 minutes.

Pomp and circumstance surrounded the opening gala, where Canadians were officially welcomed by president of the Mexican College of Rheumatology (MCR) Dr. Olga Vera-Lastra. This year marked the 50<sup>th</sup> anniversary of the MCR. Photographs of MCR past presidents were on a giant wall poster; a giant canvas portrayed past Canadian presidents with photographs from their prime years. The MCR Masters certificates were presented with intimate biographies, followed by the introduction of MCR past presidents. CRA past presidents on the stage included Drs. Tony Russell, Paul Davis, Jean-Luc Senécal, Simon Carette, Glen Thomson, Dianne Mosher, Michel Zimmer, Arthur Bookman, Gunnar Kraag and John Thomson, along with current chief Jamie Henderson, who made a



The Dunlop-Dottridge lecturer Dr. Sherine Gabriel with Dr. Jamie Henderson, CRA President



Drs. John Thomson and Michel Zimmer, and CRA Manager Christine Charnock

trilingual address to the audience. In the midst of the presentations, someone fainted, and all of the Canadian past presidents wondered which of our number had hit the deck. One of the young female attendants on the stage had passed out, but was successfully on her feet within a few minutes. Certificates were presented to each of the CRA past presidents and Dr. Russell led the procession off the stage. There followed a well-populated cocktail reception kept indoors by the blustery weather. At that point, some CRA members made side tours to other locations of historical interest, like that of local hero Jimmy Buffet.

The plenary sessions began early Friday morning with "point chair" Dr. Carter Thorne. A few technical glitches did not detract from the strong scientific component. The pre-eminent Mayo Clinic rheumatologist and former president of the American College of Rheumatology (ACR), Dr. Sherine Gabriel, presented the Dunlop-Dottridge lecture "Heart Disease and Rheumatoid Arthritis." The response of the audience was overwhelmingly positive, as was the personal welcome to Dr. Gabriel, whose pedigree includes University of Saskatchewan, an internship in Winnipeg, and epidemiology training under Dr. Claire Bombardier in the University of Toronto/McMaster program.

The Saturday program also featured three simultaneous symposia. The session on Basic Science Immunology of Rheumatic Diseases, chaired by Dr. Joanne Homik, featured cutting-edge science by Dr. Gilles Boire and Dr. Fritzler. There were no pregnant pauses as Dr. Mosher kept Drs. Earl Silverman and Stephanie Keeling on time in

the Pregnancy and Rheumatic Diseases symposium. Dr. Steve Edworthy will renew his subscription to *National Geographic* after the excellent talks by Drs. Carol Hitchon and Christine Peschken on geo-epidemiology.

The first Pearls session, chaired bilingually by Dr. Ricardo Cartagena, was a great success thanks to Dr. Robert Offer and Dr. Kraag's Ottawa protégé, Dr. Nataliya Milman, with their audience-stumping cases.

Later that night, the CRA's version of the Oscars annual awards dinner began with the AHPA awards presented by Marlene Thompson. Dr. Murray Baron made an impassioned plea for stable research funds for academics in his introduction of former lawyer and the CRA's 2011 Young Investigator awardee Dr. Marie Hudson. Dr. Alf Cividino, the 2010 Teacher Educator awardee, introduced the 2011 awardee Dr. Nader Khalidi, who cited as one of his influences Dr. Jane Purvis, who encouraged his rheumatologic aspirations while he was a family practitioner. Accompanied by Dr. Mosher, Dr. Bombardier introduced the CRA's 2011 Distinguished Investigator, Dr. Gillian Hawker, who shared her secrets of professional success in a succinct slide show. The CRA's highest award—that of Distinguished Rheumatologist—was presented at the end of the evening, as Dr. John Thomson introduced Canada's leading rheumatologist, Dr. Kraag. Gunnar gave a fast-moving set of vignettes on the turning points in his career and those who have influenced his course. He stated that the only thing that has never been overrated is being a grandfather. Gunnar still has a number of professional goals, including attaining the Young Investigator Award, but traveling to Texas is no longer on his agenda. He received a CRA commemorative plaque, as well as a Kraag 2011 football jersey “on behalf of grateful fans every-



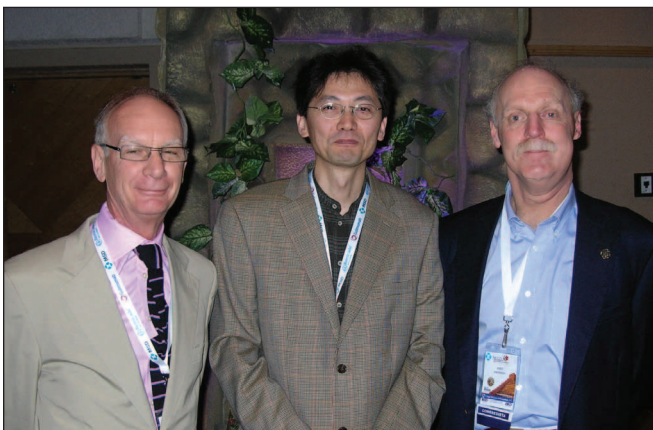
2011 Draft Pick

where” in recognition of his decision to pursue a career in medicine and not professional football. Celebratory dancing proceeded shortly after.

Though it was hard to get up on Sunday morning, Dr. Zummer chaired the plenary session on spondyloarthropathies (SpA), which also included MCR presentations on systemic sclerosis. The MCR's keynote speaker, Dr. Luis Javier Jara Quezada, led a talk on antiphospholipid syndrome. The simultaneous sessions were highlighted by Dr. Russell, who introduced the spondyloarthritis version of the dynamic duo, Drs. Robert Inman and Walter Maksymowych. Not to be outdone, Dr. Peter Docherty chaired the session with two scleroderma wonder women: Drs. Pope and Hudson. The juvenile idiopathic arthritis (JIA) tour de force, featuring Drs. Rae Yeung and Ciaren Duffy, was led by Dr. Lori Tucker. Dr. Bookman organized the poster session tours and, with able assistance from Dr. John Esdaile and Dr. Duffy, a number of Canadian and Mexican posters were presented in a more intimate setting.

The Xcaret bus tour that afternoon and evening gave us a sobering view of Mexican living conditions off the hotel strip. The stage production at Xcaret can only be described by a series of superlatives. All who took this trip enjoyed Mayan culture, replete with a ball-hockey game with an incendiary device, flying acrobats, and a spectrum of Mexican music.

Monday morning began with the CRA symposium on challenges and advances in lupus, hosted by Dr. Esdaile and featuring Drs. Dafna Gladman, Christian Pineau and Dr. Fritzler. Dr. Cory Baillie chaired the plenary session on systemic lupus erythematosus (SLE). Introduced by past president Dr. John Thomson, the CRA keynote speaker,



Keynote Speaker Dr. Hyon Choi with Dr. John Esdaile (left) and Dr. John Thomson (right)



Dr. Hyon Choi, rekindled interest in the subject of gout. Three solid simultaneous symposia followed, making the decision of what to see extremely difficult. It was a Montreal morning, with Dr. Denis Choquette chairing the Rheumatoid Arthritis Management pair Drs. Paul Haraoui and Sasha Bernatsky. Dr. Cividino led the Montreal Canadiens, Dr. Yves Troyanov and Dr. Sénécal, who scored with their presentations on Inflammatory Myopathies. On the sports medicine theme, Dr. Kraag introduced Saskatchewan Roughriders physician and rheumatologist Dr. Robert McDougall. Dr. Leblanc demonstrated sports medicine injuries with her crutches and cast from her tibia-fibula fracture. If there were an award for most courageous rheumatologist attending the meeting, it would be awarded to her. The final Pearls session featured fascinating cases by Dr. Umjeet Jolly and Dr. Docherty from the University of Western Ontario. Dr. Cartagena kept the session moving well despite some minor audio-visual challenges.

Our gracious hosts from the MCR organized the closing gala Sunday night at the Convention Centre. There was opportunity again to thank the MCR for their work in collaborating on this Congress. People had the chance for some pleasant informal discussions; I even learned that there was a beach in Cancun.

The final day started with the CRA Annual General Meeting. There was a surprisingly good turnout, given the previous night's festivities. The session ran a little late but Dr. Diane Lacaille made a good recovery, getting the plenary session on Epidemiology and Health Services Research up and running quickly. The keynote speaker on SpA was the well known and respected Dr. Rubén Burgos-Vargas. With Dr. Andy Thompson at the helm, the early rheumatoid arthritis session navigated through basic science to epidemiology, helped by Drs. Hani El-Gabalawy and Vivian Bykerk. Dr. Suzanne Ramsey introduced the topic pediatric vasculitis and lupus, in conjunction with the effervescent Dr. Susanne Benseler and enthusiastic Dr. David Cabral. The morning's solid performances were anchored by insightful talks on biologic therapies for orphan diseases by Drs. Esdaile and Khalidi under the watchful eye of Dr. Carette. Dr. Bookman reprised his role as the tour guide, with colleagues Dr. Kam Shojania and Dr. Maksymowych, discussing the best posters. Unfortunately, the turnout was less than expected as many were already packing and heading to the airport.

This year, the trainees' and students' abstract presentations were spread throughout the Residents Day, as well as

the plenary sessions. Since the last plenary session was on the Tuesday morning, there was no official event at which the winners of the various prizes could be recognized. The University of Toronto claimed 4 of the 5 awards. Congratulations are in order for all of the students and trainees for their excellent work!

The meeting adjourned with the final analysis demonstrating equal parts of the exotic, educational, and fun. Dr. Zummer and Christine Charnock worked ceaselessly for three years, planning the logistics with a very successful outcome. Drs. Thomson and Henderson provided the CRA's political guidance to initiate and complete this task with our colleagues from the MCR. I am personally indebted to the CRA scientific program committee, Drs. Lacaille, Cartagena, Edworthy, Homik, Zummer, Bookman, Rich, Tucker and Cividino, for their inspiration and perspiration.

I have received 1,643 incoming e-mails about the meeting (and counting)—was it worth it all? Personally, I am grateful for the opportunity to experience the difference in customs, language and organizational cultures between the two associations. There were certainly challenges at times, but ultimately, I think we were all rewarded with exemplary presentations from MCR and CRA speakers and the warmth and hospitality of our MCR hosts. Each CRA meeting provides the camaraderie of our Canadian colleagues from coast to coast, no matter where it is held. It was an honor to serve as the CRA's scientific program director for this special Congress.

*Glen Thomson, MD, FRCPC  
Editor-in-chief, CRAJ  
Winnipeg, Manitoba*



Dr. Diane Lacaille, Abstract Chair

# CRA Annual Meeting: Back for a Second Mexican Experience in Cancun

By Michel Gagné, MD, FRCPC

First, it was Acapulco in 2006. This year, Cancun provided the backdrop for the second meeting between Canadian and Mexican rheumatologists, as this year's Canadian Rheumatology Association (CRA)/Mexican College of Rheumatology (MCR) Joint Congress was held from February 11 to 15 at the Cancun Convention Centre in Mexico.

The Convention Centre is conveniently located in the hotel district and easily accessible from most hotels. The building is well designed, with the various conference rooms on the same floor. The approximately 950 attendees meant, however, that our Mexican colleagues had to travel down two floors to access refreshments and the booths of pharmaceutical representatives. For Canadian rheumatologists, making the rounds was well worth the effort: we were warmly greeted by smiling representatives, most of whom spoke English this time, and offered an array of tablets (*e.g.*, cyclobenzaprine and analgesics, meloxicam and glucosamine)! Coffee breaks were conveniently arranged for the Canadian group in a room close to the meeting rooms, a gesture that was much appreciated.

From a scientific standpoint, I appreciated the variety of topics presented. Our colleagues from the Organizing Committee and Scientific Committee succeeded in attracting excellent speakers. The talks by Dr. Hyon Choi on the progress of gout, Dr. Sherine Gabriel on heart disease in rheumatoid arthritis, and Dr. Rubén Burgos-Vargas on spondyloarthropathies, were very well received. Several Canadian rheumatologists, too numerous to mention here, also gave excellent presentations on the status of their work.

The clinical "Pearls" presented over two days were also interesting. Dr. Ricardo Cartagena, who presided over the sessions, was truly in his element. Dr. Robert Offer from Penticton, B.C., even received an award! This is an activity worth pursuing in coming years.

But not everything went smoothly. In my opinion, the opening ceremony on Friday was too long, but I understand that our Mexican hosts were keen on celebrating the 50<sup>th</sup> anniversary of the founding of their association. There were also gremlins on the first day of the congress: an audio-visual system was out of synch, which left speakers regularly searching for their pointers or trying to keep pace with unpredictable



Dr. Michel Gagné

slide presentations. Finally, few physicians attended the last poster sessions—did the others head to the beach, perhaps?

The high point of the Congress was the CRA banquet and awards presentation. The 2011 Distinguished Rheumatologist, Dr. Gunnar Kraag, entertained attendees with his lively sense of humor. Congratulations to all the recipients.

Obviously, the temperature was much hotter than in Canada, but it is the human warmth of this Congress that we should remember, especially the welcome extended by our Mexican hosts who lived up to their reputation as a warm people.

Is the experience worth repeating? Most probably, especially if the Congress is held every five years. The intervening four years are time enough for us to appreciate the snow in Canada! Incidentally, it seems that the promise of warm southern climates is not a major draw for our rheumatologist colleagues: the Cancun congress attracted about the same number (100 to 120) of attendees as our annual meetings at home. So, next year, don't plan on a beach down south or for -4°C weather and snow. The next annual meeting of your association will be in Victoria, B.C., in March 2012.

See you next year!

*Michel Gagné, MD, FRCPC  
Polyclinique St-Eustache  
St-Eustache, Quebec*

# AHPA in Cancun: Report

By Marlene Thompson, BScPT, BSc

The Arthritis Health Professions Association (AHPA) was once again pleased to join the Canadian Rheumatology Association (CRA) in our Annual Scientific Conference and meeting. Sunny Cancun was a beautiful destination to host our Annual General Meeting, as well as our 3<sup>rd</sup> annual pre-course for arthritis health professionals. This year's pre-course was on lupus and once again we "sold out" of space and bursaries for the course. It was well-attended, with an excellent lineup of speakers including Drs. Janet Pope, Ken Blocka, Paul Fortin, Marvin Fritzlter; registered nurses Carolyn Neville and Anne Cymet; and Tammy Rice (an occupational therapist) and Donna Tierney (a physiotherapist).

Awards for the best allied health abstracts submitted to the conference were presented during the CRA's award banquet. The Carolyn Thomas Award, given to the first author of the best scientific abstract, was established in honor of Carolyn Thomas, a founding member of the AHPA. This year, it was awarded to Kelly Warmington for her research entitled "Development, evaluation and implementation of a successful interprofessional education program for adults with inflammatory arthritis."

The Special Interest Abstract Award was established by AHPA to recognize an individual whose work contributes to the knowledge for arthritis treatment and enhances patient care, but does not fit traditional models of research. This year's recipient was Mary Ellen Marcon for her project "Telemedicine as a tool assisting therapists to deliver arthritis care in remote/rural communities."

Through the generous support of The Arthritis Society (TAS), AHPA also awarded a \$5,000 grant for arthritis

health professional research. Michael Hunt received this grant for his research on "The immediate and short-term biomechanical and symptomatic effects of shock absorbing shoe insoles in individuals with varus gonarthrosis."

In addition to our research awards, we also presented a clinical award to recognize AHPA members who have designed and implemented an innovative clinical project or related initiative that benefits the lives of Canadians living with arthritis. This year's winners were Tammy Rice and Donna Tierney for the Beryl and Richard Ivey Rheumatology Scleroderma Day Program at St. Joseph's Hospital in London, Ontario.

The Extraordinary Service Award recognizes contributions an AHPA board member has made in advancing the mission, vision and goals of our organization. Terri Lupton has been instrumental in creating a national presence for AHPA; she has worked hard to create a diverse organization and, as such, has recruited many nurses to join AHPA. Terri has also helped to attain sponsorship for the running of our pre-course, bursary program and scholarship programs. She remains the AHPA Sponsorship and Marketing Chair.

The Lifetime Achievement Award was given to Sydney (Lineker) Brooks. As a physiotherapist, Sydney has devoted her entire career to the management of clients with arthritis—through direct clinical treatment, management and mentoring of other staff—and ultimately to research activities related to the management of clients with arthritis. Her 29-year employment with TAS has seen an evolution from a staff employee to her present role as Director of Research.

Sydney's research interests led to her involvement with the Arthritis Community Research and Evaluation Unit



Kelly Warmington, Carolyn Thomas Award



Mary Ellen Marcon, Special Interest Abstract Award



Terri Lupton, Extraordinary Service Award





Donna Tierney and Tammy Rice, Clinical Innovation Award



Sydney (Lineker) Brooks, Lifetime Achievement Award

(ACREU). As her research abilities grew, so did her opportunities to provide her peers with valuable educational information. She has had several opportunities to deliver poster presentations and present podium sessions at numerous conferences; with her Masters project, Sydney developed an outcome measure (Knowledge Questionnaire), which is used in the management of clients with rheumatoid arthritis. Most recently, Sydney earned her PhD, with her reviewers agreeing that she has contributed valuable new knowledge to the field of rheumatology. Sydney's work has also produced the landmark program Getting a Grip on Arthritis (GRIP). To date, more than 900 Canadian primary-care providers have graduated from GRIP, helping TAS forward a valuable strategy to improve care for people with arthritis, and addressing the need to improve diagnosis and care. Sydney's own PhD research has produced two published papers, with another submitted, but the total number of papers arising from the GRIP project is far greater. Sydney has been the nexus and the coordinator for all of this work.

One of a group of clinicians with a vision to create a platform for people interested in advancing shared knowledge related to arthritis management, Sydney became one of the original members of AHPA. She volunteered to actively participate in the development of the association, holding numerous positions within the organization and partici-

pating in its evolution to become the national organization that it is today.

Congratulations to all of our AHPA award winners! I would also like to say a special thank you to the members of the board who made this meeting possible: Kathy Drouin (Education Chair), Karen Gordon (Communications Chair), Leslie Soever (Professional and Career Development Chair), Terri Lupton (Sponsorship and Marketing Chair), Lorna Bain (Member Services Chair), Janet Jeffrey (Research Chair), Yvonne Tobin (Executive Provincial Representative), Jane Cottrell (Treasurer) and Jennifer Burt (President Elect).

I would like to give a warm welcome to our incoming president Jennifer Burt. Jennifer is a physiotherapist from Newfoundland working at St. Clare's Hospital in St. John's on the Rheumatology Outpatients Service; she has been with AHPA since 2005.

*Marlene Thompson, BScPT, BSc  
Outgoing President, AHPA (2008-2011)  
Associate Clinical Professor,  
University of Western Ontario  
Advanced Physiotherapist Practitioner (trainee),  
St. Joseph's Hospital  
London, Ontario*

## In Brief

Congratulations to Dr. Robert Inman, who has accepted the position of Deputy Physician-in-Chief for Research in the Department of Medicine at the University Health Network (UHN) at the University of Toronto.

Dr. Inman is currently Director of the Arthritis Center of Excellence at UHN and Director of the

Spondylitis Program at Toronto Western Hospital. He is Chair of the Research Committee of the UHN Arthritis Program. He has previously served as Departmental Division Director of Rheumatology at the University of Toronto, and was Chief of Rheumatology at UHN from 1991 to 1998.



# Pearls in Rheumatology: A Review

By Ricardo A. Cartagena, MD, FRCPC

“Viva Mejico!” was the repeated roar of the Mexican public at the peak of their excitement while watching the exquisitely choreographed spectacle describing their history and costumes, region by region, at the Xcaret theme park. My accompanying family thought that the place was beautiful and that Mexico had many good things to offer visitors. The state-of-the-art presentations included in the scientific program provided a similar impression at the 2<sup>nd</sup> Mexican-Canadian Congress of Rheumatology, held from February 11 to 15, 2011. I was also quite happy with the four cases which were very well “dissected” during the two days of the “Pearls in Rheumatology” sessions. I had the opportunity to co-chair these sessions with my Mexican colleague, Dr. Leonor Adriana Barile Fabris.

The Canadian participation had begun one year earlier when the Scientific Committee of the Canadian Rheumatology Association (CRA) decided to navigate relatively uncharted waters; proposed was an educational tool allowing the Canadian community of rheumatologists the opportunity to participate to the fullest extent. We suggested a format of a clinical case presentation that included the name of the topic, learning objectives, relevant history, and physical exam and laboratory results. The presenter would ask three multiple-choice questions and attendees would answer with the audience response system (ARS; attendees select their answers with a keypad). After briefly discussing the results from the quick survey, the presenters would then explain the reason for the correct answer and state the key message(s) taken from the clinical case in discussion.

After launching a few announcements, we got several clinical cases from our Canadian colleagues. This was followed by a period of intense and, at times, tough competition, but eventually a jury of adjudicators from the CRA selected the winners who represented us in Cancun. Criteria used for selection were originality, clarity and clinical value. The winners were two senior rheumatologists from eastern and western Canada, respectively, and two very bright trainees, one a rheumatology fellow from the University of Ottawa and the other a chief medical resident from the University of Western Ontario. The winning cases were “Pulmonary Arterial Hypertension with Adult Still’s Disease” by Dr. Peter Docherty; “Lumps in

Scars” by Dr. Robert Offer; “Lupus Profundus with Macrophage Activating Syndrome” by Dr. Nataliya Milman; and “H1N1 with Microscopic Polyangiitis” by Dr. Umjeet Jolly. Their performances were first-class! In addition to complying with the above format, they also presented a relevant literature review, crystallizing the goals the organizers had intended in the first place.

Our Mexican colleagues did a similarly excellent job presenting cases of intestinal vasculitis as the initial manifestation of systemic lupus erythematosus (SLE), contraceptive prescription in SLE, autoimmune/inflammatory syndrome induced by adjuvants (ASIA) and neuropsychiatric lupus.

Of course, nothing like this could ever happen without countless hours of masterful work put in behind the scenes by real people doing their very best. Thank you to Dr. Glen Thomson, the Scientific Committee of the CRA, Dr. Michel Zummer and the CRA Executive, Christine Charnock, and all those who contributed in such a special way.

*Ricardo A. Cartagena, MD, FRCPC  
Staff Rheumatologist, Department of Medicine,  
Brandon Clinic Medical Corporation and  
Brandon Regional Health Centre  
Brandon, Manitoba*



Drs. Umjeet Jolly, Ricardo Cartagena and Peter Docherty

# David Hawkins

By Johannes Roth, MD

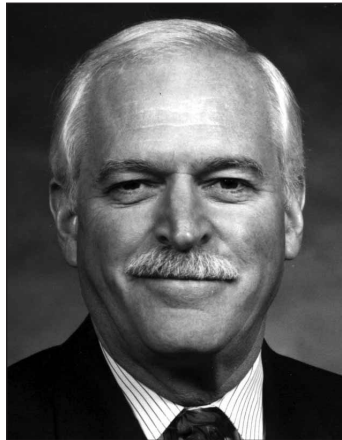
David Hawkins was born in St. John's, Newfoundland, and was always proud of his Newfoundland heritage. He got his early medical education at Dalhousie University in Halifax, Nova Scotia; he then had the opportunity to pursue post-graduate training in medicine and biomedical research at McGill University in Montreal, Quebec, as well as the prestigious Scripps Research Institute in La Jolla, California. From the late 1960s until 1980, he worked at McGill, and then returned to his native St. John's as the third dean of medicine at Memorial University of Newfoundland.

He is author of more than 100 scientific publications. Among them are publications as first or last author in the highest-ranking journals including *Proceedings of the National Academy of Sciences (PNAS)*, *Nature*, *Science* and *The New England Journal of Medicine*.

From 1995 to 2005, he served as director of the Ottawa-based association that provides the national voice for Canada's 17 Faculties of Medicine. He had been the chair of the Board of the Canadian Medical Hall of Fame since 2007. The Royal College of Physicians and Surgeons of Canada appointed him Director of Education in 2008/2009.

Dr. Hawkins had extensive experience in the accreditation of programs of medical education in Canada, the United States and the Caribbean. His international accreditation activities had also taken him to Europe, the Middle East and South America. He had been president of several Canadian medical organizations, governor of the American College of Physicians, and Senior Editor of *The Canadian Medical Association Journal*.

In 1993, Memorial University and the Medical Research Council jointly endowed the Annual David Hawkins Lectureship in Health Sciences Research, and in 1995, the Dalhousie Medical Alumni Association named him Alumnus of the Year. The Canadian Rheumatology Association (CRA) recognized him as Distinguished Rheumatologist of the Year in 2005. He was later elected to fellowship in the Canadian Academy of Health Sciences.



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Dr. Hawkins contributed to patient care, science, medical education and administration in a unique and impressive way on a national and international level.

Behind all these achievements was an extraordinary, but also very approachable, person with a very kind nature. Nothing can illustrate this more than the fact that Dr. Hawkins, who had been trained as an adult rheumatologist, joined the Children's Hospital of Eastern Ontario (CHEO) as a pediatric rheumatologist during the last phase of

his career because there was an urgent need for pediatric rheumatology care in Eastern Ontario. He remained in this function for 13 years, making him by far the longest serving pediatric rheumatologist that CHEO has had to date. Beyond patient care, he also contributed as an advisor on many levels.

Thinking of David Hawkins, it is hard to imagine that he would ever retire and indeed, he never did. Only when the pediatric rheumatology division at CHEO had grown to a size that would not absolutely require his presence did he ask to end his contract at CHEO. He immediately went on to work in Saudi Arabia, where he helped to establish an impressive new medical school.

He was in the midst of planning his next career steps when he became ill and died from complications of his disease on February 12, 2011.

*For the Pediatric Rheumatology Group at CHEO.*

*Johannes Roth, MD  
Associate Professor of Pediatrics,  
University of Ottawa  
Head, Pediatric Rheumatology,  
Children's Hospital of Eastern Ontario (CHEO)  
Ottawa, Ontario*

# Antoine Helewa

By Barbara Stokes, PT, with contributions from Joan M. Walker, PhD

Antoine Helewa passed away on January 30, 2011, after a distinguished career spanning over 50 years dedicated to improving the lives of those with arthritis. He was an educator, researcher, a leader of his profession, and mentor to many.

Born in Haifa, Israel, he received his diploma in physiotherapy before coming to Canada where, as a Fellow of The Arthritis Society (TAS), he obtained a Teacher's Certificate in 1964. He taught at the University of Toronto and the University of Manitoba before joining TAS' Ontario Division as Director of Professional Services, a post he held for 16 years. There, he fostered collaborative, multidisciplinary and evidence-based practices while providing therapists with opportunities for learning and professional growth. He was instrumental in expanding the program from one based solely in southern Ontario into northern Ontario, while adding occupational therapy and social-work services. Many therapists hired in the 70s and 80s remain employed by TAS because Antoine instilled in them his passion, challenging them to think critically and to take leading roles in the provision of evidence-based care.

A Research Associate at the Wellesley Hospital for 10 years, he collaborated with the University of Toronto Rheumatic Diseases Unit to develop and implement the annual training program "The total assessment of inflammatory polyarthritis by physiotherapists and occupational therapists." Thirty-five years later, it has trained nearly 1,000 therapists in Canada, Australia and New Zealand.

In 1977, he received a Master's Degree in Epidemiology from McMaster University and continued to build collaborative relationships as a researcher. He was the chairperson of the Multicenter Trial Group. Over several decades, he made important contributions to research, often in collaboration with Charles Goldsmith and Dr. Hugh Smythe. He was an investigator on 23 research grants (14 as the primary investigator), and an author on 31 publications and 53 peer-reviewed presentations.

In 1985, he became Chairman of the School of Physical Therapy at the University of Western Ontario (UWO). There, he was influential in UWO's decision to offer a Master's degree program and professional education for individuals



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with doctoral degrees in other subjects. Antoine was made an Emeritus Professor in 2002.

In 1996, he was the co-editor of *Physical Therapy in Arthritis*, the first comprehensive textbook for therapists focusing on arthritis. He was co-editor of the second edition (2004) and, until his death, was seeking support for a third edition. In 2000, he and Joan M. Walker published *Critical Evaluation of Research in Physical Rehabilitation*, a milestone in clinical decision-making for rehabilitation specialists. Believing that

individuals with arthritis should have access to evidence-based approaches to care, we published *How to Stay Active and Relieve Your Pain* as a self-help manual in 2007.

Antoine was active in the Ontario and Canadian Physiotherapy Associations, serving terms as president for both associations. He was on the Board of Physiotherapy Canada, and a reviewer for 10 journals and research/grant funding agencies. An early patron of the Physiotherapy Foundation of Canada, he served on its scientific awards committee as chairman. He was also actively involved with the College of Physiotherapists of Ontario.

In spite of commitments to his work, time with family was sacrosanct. Weekends and holidays were spent at the cottage in northern Ontario, where he enjoyed cross-country skiing, sailing and golf, and visits from children and grandchildren. When he retired in 2002, the "cottage" became a beautiful home on the shores of Grass Lake. Antoine and Gesine lived there until 2005, when a move to Parksville, B.C., meant a gentler climate and proximity to their children. He remained connected with former colleagues and friends, consulted and continued to write. Antoine's contributions to his profession and to the rheumatology community will long be remembered.

*Barbara Stokes, PT*  
*Former Director, Client Services, Eastern Region*  
*The Arthritis Society, Ontario Division*

*Joan M. Walker, PhD*  
*Emeritus Professor, Dalhousie University*

Congratulations to  
this issue's Joint Count  
survey winner  
Dr. Steven Katz  
from Edmonton, AB

# Consenting to be Informed

by Glen Thomson, MD, FRCPC

We all make decisions every day, and some of the consequences of those decisions are larger than others. It probably doesn't matter that much whether we choose brand name or store brand when we purchase our bread. It is difficult to know where to find information about what differentiates the products, and which—if any—of the differences are significant. We could ask somebody at the bakery department in hopes they would give us an honest appraisal. In the end, the risks and benefits of one loaf vs. the other are likely very comparable. It really isn't worth much of our time or mental capacity to fret over the decision.

On the other hand, when it comes to health, the stakes are raised. There are significant benefits for the patient to get the right therapy at the right time for the right disease process. Unfortunately, there is always the potential, no matter how small, for unexpected untoward events. Gone are the days of "trust me, I'm a doctor"; here is the era of "class-action lawsuits."

As shown by Question 1, more than 95% of physicians responding to this issue's Joint Count survey will verbally discuss the pros and cons of a new therapy with their patient. Almost half of us will provide our own written information to the patient, and 15% who are technologically more capable will refer patients to their own website. The

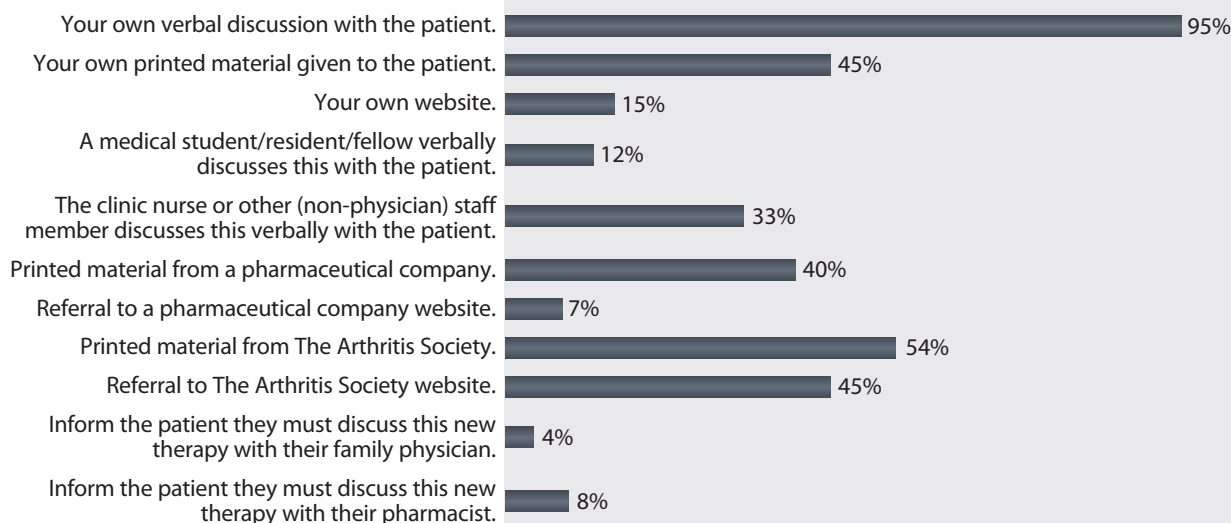
job of informing the patient of risks and benefits is shared with clinical nurses and staff by one third of our respondents, with medical trainees by 12%, with pharmacists by 8%, and with family physicians by 4%.

Printed material from a pharmaceutical company (40%) is used less frequently than printed material from The Arthritis Society (54%; TAS). There is a large difference between referral to pharmaceutical company websites (7%) and the TAS website (45%).

Most, but not all, patients will look up information about their medications on the Internet, according to our respondents (Question 2). But, also according to our respondents and as shown by Question 3, this does not make patients more confident about the risks and benefits of the therapy, which may in part stem from their basic lack of understanding of how to evaluate and weigh risks and benefits. Physicians tend to emphasize the benefits of a new therapy slightly more than the risks. It is thought that a minority of patients simply do not wish to take on the burden of knowledge of the potential risks, and just want the physician to prescribe what is best for them. A comparable number of patients are thought to have true phobias about medications.

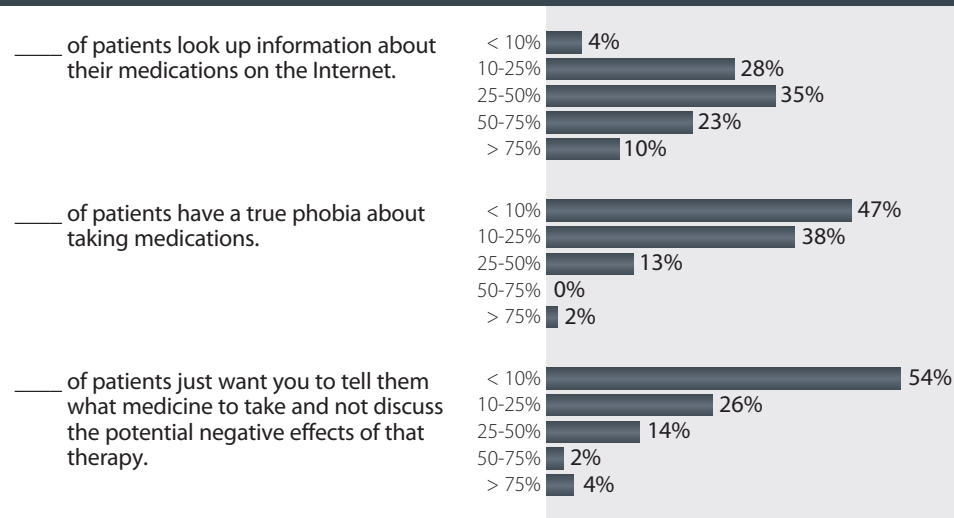
The majority of the survey's respondents feel that the multi-page, legally correct consent forms used often in pharmaceutical trials do not really inform ordinary

## Question 1. When you are prescribing a new medication, what information sources do you use (check all that apply)?





**Question 2. In your experience ...**



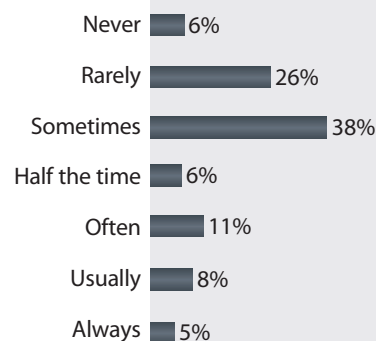
**Question 3. On a scale from 1 (strongly disagree) to 5 (strongly agree), please rate the following:**

	1 (strongly disagree)	2	3	4	5 (strongly agree)
Information that patients glean from the Internet makes them feel more confident about the benefits and safety of your newly-suggested therapies.	18%	35%	29%	16%	2%
Patients understand the concept of risk and benefit.	11%	34%	35%	17%	3%
When explaining a new drug to a patient, the emphasis should be on potential benefits.	0%	11%	33%	39%	17%
When explaining a new drug to a patient, the emphasis should be on safety aspects.	3%	11%	42%	34%	10%
Multi-page "consent forms" are commonly used in pharmaceutical studies and provide information in a way that ordinary people can understand, thus providing "informed consent."	20%	40%	20%	15%	5%

patients. It is a pity that, in this era of "risk management" and fear of litigation, this complicated format is increasingly adopted by hospitals and health authorities. Soon, the only patients who can be ethically enrolled in some patient programs will have to be lawyers. One way around this information overload is for the physician to have a discussion with the individual to get feedback and ensure that the patient really understands what has been presented and to what they are agreeing. Only a minority of respondents do not engage in these conversations (Question 4).

*Glen Thomson, MD, FRCPC  
Editor-in-chief, CRAJ  
Winnipeg, Manitoba*

**Question 4. In your practice, do you ever ask patients to restate their understanding of the consent, in their own words, to ascertain whether they are adequately informed?**



# Photo Contest

## Scenic Photo



2<sup>nd</sup> Place

2nd-place photo by Dr. Frédéric Massicotte

## Candid Photo



2<sup>nd</sup> Place

2nd-place photo by Dr. Carter Thorne

3<sup>rd</sup> Place



3rd-place photo by Dr. Claire Leblanc

3<sup>rd</sup> Place



3rd-place photo by Dr. Michel Zummer

\*The "Best Scenic" and "Best Candid" winners are located on the front cover.

For the complete set of pictures from the 2011 CRA annual meeting, click on the following links:

[Winners](#) [Candid: Series 1](#) [Series 2](#) [Series 3](#) [Scenic](#)

Publication of *The Journal of the Canadian Rheumatology Association* is made possible through an educational grant from Pfizer Canada.



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