

The Canadian Rheumatology Research Consortium (CRRC)

The past decade may be considered the “Golden Years” of clinical research in arthritis. Developments based on the painstaking, basic scientific discoveries of the past 20 years were finally developed into practical, safe and effective therapies for patients with rheumatic diseases. A massive amount of work for clinical trialists became available at a time when support for peer-reviewed, basic and epidemiologic work reached its nadir. Not surprisingly, many individuals and universities who publicly eschewed funding from the pharmaceutical industry became overnight enthusiasts as other sources of funding evaporated.

Today, there continues to be a boom in the development of new therapies for arthritis. Industry Canada recognized this opportunity and has funded the inception of the Canadian Arthritis Network (CAN) to form a link between basic research and practical outcomes. But even CAN cannot exist forever on government largesse. Dr. Edward Keystone, known to virtually all Canadian rheumatologists as the major figure in novel therapeutics and Canadian clinical trials research, conceived the idea of a network of clinical researchers supported by the infrastructure of CAN. After months and years of negotiation and effort, the Canadian Rheumatology Research Consortium (CRRC) will finally become the clearing house for clinical trial work in Canada.

The concept is simple: the individual rheumatologists who sign onto the CRRC will work exclusively for the CRRC. The CRRC, through the infrastructure at CAN, will market Canadian clinical trialists and attract more work, extract a premium from pharmaceutical companies using this service, and fund the ongoing activities and infrastructure of both CAN and CRRC from the profit of this nonprofit company. Some rheumatologists, who are members of both CAN and the CRRC, may find their future peer-reviewed funds deriving from funds raised through CRRC activities.

Over the past few weeks, the CRAJ approached many of the individuals who have worked diligently to create the CRRC and asked them for their thoughts about present and future expectations for this unique

Canadian institution. Their comments are presented below. (Dr. Keystone is somewhere in an airport or at a meeting promoting Canadian arthritis research and was unavailable for his comments.)

Carter Thorne, MD, FRCPC
Toronto, Ontario

You are the new Secretary-treasurer for the CRRC. How is the CRRC, as an organization, set up? How was the initial group created to begin the formation of the CRRC? How were the first Board and officers chosen?

The CRRC is the culmination of two years of discussion with rheumatologists who identified themselves as being involved in clinical research, and the work of an appointed Steering Committee. I was elected to the CRRC Executive at its inaugural meeting held during the Canadian Rheumatology Association (CRA) Annual General Meeting, 2003, at Mont-Tremblant, Quebec.


At the CRRC inaugural meeting, 45 out of approximately 65 clinical trialists in Canadian rheumatology had indicated their interest in joining and they elected the following Board members: Ed Keystone, (Chair), Vivian Bykerk, Majed Khraishi, Janet Pope, Earl Silverman, Glen Thomson, Carter Thorne (Secretary-treasurer), Chris Nelson (nonvoting representative of CAN), Boulos Haraoui (Vice-chair) Kam Shojania and Hy Tannenbaum.

Dr. Tannenbaum is Chair of the Membership Committee, and I am Chair of the Trials Review Committee and have also been appointed as the CRRC observer of the Board of CAN.

Frequent meetings are held by teleconference and members are contacted via email. The following website: <http://www.pipi.com/crrc/english.htm> is available to members.

The CRRC is a nonprofit organization, yet works for profit-making companies. Why is the CRRC's nonprofit status important?

The members considered a number of different models for incorporation, including “for profit” and “not for



profit.” After discussion with other parties, including other consortia and industry, the not-for-profit model was determined as the most effective according to the mission of this organization.

The mission of the CRRC is to facilitate the conduct of rheumatology clinical research in Canada. Our commitment to improving the quality and efficiency of clinical research will enhance Canada’s competitiveness in the global marketplace and ensure that arthritis patients have early access to novel and effective treatments.

As a nonprofit organization, will the Board and Executive receive stipends?

At this time, neither the Board nor the Executive will receive stipends. However, when any member of the CRRC is requested to provide service on behalf of the membership (*i.e.*, reviewing protocols, etc.) an honorarium will be paid by the organization, with funds arising from the surcharge paid by Industry to the CRRC for each trial.

How are issues of liability for the CRRC and individual participants handled? Does CRRC liability insurance cover individual participants in CRRC-sponsored trials?

The Board has purchased liability insurance for the directors, as related to their administrative role with the CRRC. All members, including the directors, are responsible for ensuring that they have adequate liability insurance for conducting trials at their individual site.

Is the organization of the CRRC similar to other Canadian or American research consortia?

The CRRC is unique for having attracted such a large number of first-class investigators in its initial recruitment. The CRRC’s objectives are: 1) to ensure that all trialists in Canada benefit from increased access to trials and economically favourable terms, and 2) to lead the development of investigator-driven Canadian trials.

Boulos Haraoui, MD, FRCPC
Montreal, Quebec

Why is the CRRC necessary and why now?

Background: Canadian investigators are well regarded around the world for high-quality, clinical research in rheumatology—being independent clinical research or industry-sponsored research. The problem with


Canadian clinical research is that it has been “sandwiched” between the United States (US) and Europe, and Canada is a small country in comparison. When industry wants to do clinical research they have certain scientific questions they want answered, but they also have marketing issues to address, so they go to the big markets: Europe and the US. Canada is regarded as a secondary site. Therefore, Canadian investigators felt the need, because they are internationally renowned in all rheumatologic fields (rheumatoid arthritis, osteoarthritis and other inflammatory diseases), to pull their acts together in terms of trying to impact and influence the decisions of the big pharmaceutical companies with respect to recognizing Canada as a major player in the international scene.

The CRRC started with several Canadian clinical investigators getting together and discussing how to organize themselves to address the issues mentioned above. Therefore, invitations were addressed to several people across Canada with the result being a representative group of about 12 people— half being university-based and half being community-based (Initially, it was felt that large trials should be based within a university setting. However, there are also large trials within the community setting.) The CRRC had its first meeting a couple of years ago.

The CRRC is necessary, especially now, as it is important for Canada to play a major role and promote Canadian investigators as leaders in rheumatology around the world.

The CRRC has been set up in close consultation with CAN. What is the role of CAN in the creation of the CRRC and what will be its ongoing role?

Rheumatologists in Canada are small in number and have an even smaller number of clinical investigators, plus, we are scattered all across the country. So, we needed an administrative base to help start the CRRC. The natural thing to do was approach CAN since it is part of one of the centers of excellence promoted by the federal government for rheumatology research in Canada. We felt that the CRRC and CAN would be a natural mix and the expertise and experience of CAN would help to set the CRRC in motion. CAN also had funds that could be used to help the CRRC pull its act together and start working. Also, since one of the main initiators of the CRRC—Dr. Ed Keystone—is based in



Toronto, it was easier for him to have access to the CAN infrastructure, which is based in the hospital where he practices. This access would facilitate the work of the CRRC.

Working with CAN has been a great experience. Over the past couple of years, the administrative infrastructure of CAN has helped bring together all these investigators at different meetings and exchanges and has helped set up the bylaws, logistics, etc. that are required to keep the CRRC “up and running.”

In summary, CAN helped the CRRC to set forth its interim leadership, to have meetings, and to address the different logistic issues. The CRRC had its first annual meeting at the annual meeting of the CRA, in February 2003, where its first executive committee was elected. We are hoping to launch our activities this Fall.

Rheumatology members of the CRRC are not shareholders, employees or members of a cooperative. Is there a specific consortium or model after which the CRRC is created? When profit from the CRRC is realized, how will it be distributed? Will the CRRC become a funder of arthritis research grants outside of clinical trials?

In terms of influences or a “model” for creating the CRRC, we debated whether it should be a “for-profit” organization, where a group of investigators put together their expertise in order to gain more clinical trials and at the same time, run a productive business which earns profit. But we felt that for the sake of science and for promoting Canadian excellence in rheumatology, it should be a nonprofit organization.

We are hoping to generate some income for the CRRC, in order to be independent, self-sufficient and improve the quality of our activities. In particular, we would like to set up a national rheumatology database which would help to manage clinical trials more efficiently with respect to recruitment, industry requests regarding appropriate population numbers for certain trials, etc. A database is critical for this and requires funding. We also need to improve the quality of each trial site and to attract more clinical investigators by providing training for both the investigators and the coordinators. Also, organization activity is becoming more and more regulated; the FDA and Health Canada may require accredited investigators and coordinators to do the clinical research. Funding would be

required for training those involved and, ultimately, for improving the quality of clinical research in Canada.


What advantages will the CRRC be able to offer the pharmaceutical research industry? Will the CRRC be able to satisfy the desired research activity of the many new rheumatology members of the consortium? How?

The advantages are two-fold:

- 1) It is critical now for the pharmaceutical industry to bring new products to the market as quickly as possible. Therefore, they want high-quality trials, but they want to complete their trials as quickly and as efficiently as possible. By having a more efficient and productive clinical-trial program, they could recruit patients more rapidly, maintain high-quality clinical data and submit their results in a timely fashion. The CRRC could help in this regard by providing the critical investigators and by having a database of patients that can be quickly screened to easily determine those who fit the clinical-trial protocol. This makes for more efficient recruitment and faster completion of the trial.
- 2) The national subsidiaries of different countries usually compete when it comes to attracting more investment in clinical research or other investment. If the Canadian subsidiaries of international pharmaceutical companies gain more prominence within the global interest of their companies and if they can prove to their head offices that we do very efficient and high-quality clinical research in Canada, this could attract more funding to Canada and promote the Canadian subsidiaries.

How else can the CRRC make Canada more competitive internationally for clinical trials?

We want Canadian investigators to become lead investigators in international clinical trials. Right now whenever the pharmaceutical industry wants lead investigators, it generally goes to the bigger European or American markets. So by proving that Canada is a major player in the international scene in clinical rheumatology trials, we can promote our key opinion leaders to become the lead investigators internationally. When Canada starts having its key players in the international scene, we will have more input with respect to the design of trials and, at the same time, address some specific Canadian issues in terms of



healthcare and rheumatology. Addressing Canadian issues will not only benefit Canadian concerns but will profit the international scene, as Canada has an efficient healthcare system that could prove beneficial to other countries and physicians in the way they treat/manage certain diseases.

Where would you like to see the CRRC in five years time: strategically; intellectually; fiscally?

Strategically we would like to see the CRRC as the gateway to all clinical trials, starting with rheumatoid arthritis and osteoarthritis and expanding to other areas in rheumatology (i.e., the pharmaceutical industry would approach the CRRC and the CRRC would find/manage the investigators).

Intellectually speaking, our goals are to have more lead Canadian investigators and have more Canadian input into clinical research. At the same time, some of the funds generated by the CRRC could be put towards designing specifically Canadian trials addressing specific Canadian issues.

Majed Khraishi, MD, FRCPC
St. John's, Newfoundland

Why is the CRRC necessary and why now?

The landscape of rheumatology has been changing rapidly in the last decade. Rheumatologists now have a better understanding of the pathogenesis of many arthritic diseases (e.g., rheumatoid arthritis) and this knowledge has led to the discovery of many novel therapeutic modalities. In a competitive international market, we believe that as a group, rheumatologists can contribute to new discoveries, and we want to be able to attract new research projects to Canada. The CRRC enables us to consolidate our resources as a group of experienced researchers who have individually proven their credentials, which gives us a better chance of being granted these new studies. We also can draw upon our individual strengths to improve our capabilities in providing high-quality research (for our patients first and for the sponsors of the studies).


The CRRC has been set up in close consultation with CAN. What is the role of CAN in the creation of the CRRC and what will be their ongoing role?
The majority of the CRRC members were members of

CAN and the idea of the CRRC came from CAN (Dr. Keystone was the leader of this initiative). CAN provided initial financing and logistic support, however, we expect to be financially independent within the near future. As two organizations interested in advancing arthritis research in Canada, I am sure we will maintain contact in the future, however we expect to be totally independent of CAN within two to three years.

What advantages will the CRRC be able to offer the pharmaceutical research industry? Will the CRRC be able to satisfy the desired research activity of the many new rheumatology members of the consortium? How?

The advantages of the CRRC include easy and quick access to many researchers with information about the availability and number of certain types of patients. The CRRC can provide review of protocols, consultation to the pharmaceutical industry and other funding groups in a timely and efficient manner. By helping to iron out many of the initiation and site-selection issues, we can shorten the time necessary to start the actual recruitment and research. We do hope that we can attract more research to Canada and introduce our new members to the sponsors. A database (confidential, of course) will enable the CRRC to couple specific study populations with the researchers who have the patients. The CRRC will make sure that researchers have equal opportunity to be involved in studies. Selection of sites will eventually be made by the sponsors.

Rheumatology members of the CRRC are not shareholders, employees or members of a cooperative. How would you define their relationship to the CRRC? When profit from the CRRC is realized, how will it be distributed? Will the CRRC become a funder of arthritis research grants outside of clinical trials?
Although we (the members) are not shareholders in the stock-market sense, we are the owners of the enterprise. (However, the CRRC will be open for future membership.) The members of the CRRC collectively established the consortium and its bylaws. The profits can be invested in arthritis research initiated by the membership and/or used to fund other initiatives. These initiatives will be directed towards advancing the capabilities of the consortium and its



members to conduct their research (e.g., education and training, technical support).

Where would you like to see the CRRC in five years time: strategically; fiscally; intellectually?

In five years, I envisage the CRRC as the premiere arthritis research consortium in Canada, involving the majority of researchers in the country. We would have physical (and virtual facilities) in all the major centers across the country. The CRRC would be recognized internationally as a group providing support and infrastructure to develop, maintain and conduct clinical research in arthritis. In addition to being involved in industry-financed studies, we will be able to fund and oversee nonprofit, high-quality clinical research. We will be building databases and researching all types of arthritic disease (in addition to rheumatoid arthritis). I also believe that, by then, we will be in a position to build collaborations with similar groups in other parts of the world.

It is an exciting time for me and, I am sure, for the rest of my colleagues.

Janet Pope, MD, FRCPC
London, Ontario

Why is the CRRC necessary and why now?

The CRRC should enhance the number of research trials in Canada, improve our relations with industry and expedite the process from contract to study close out. With solidarity there is more of an opportunity to add investigator-initiated ideas into certain trials at little or no extra cost.

The CRRC has been set up in close consultation with CAN. What is the role of CAN in the creation of the CRRC and what will be their ongoing role? Could a research consortium be set up independently of an organization like CAN, as has been the case in the US with their various consortia?

CAN represents arthritis in some capacity nationally and internationally, and is a credible and exciting partner in this initiative. CAN and the CRRC can benefit each other. CAN's desire is to have more arthritis research in Canada and become self-sustaining with respect to creating more money for grants and research. The CRRC's mandate is to

increase the visibility of rheumatology clinical research (initially focusing on rheumatoid arthritis) in Canada and, in particular, to have Canadians do a larger share of clinical-trial work.

Is there a specific consortium or model after which the CRRC is created? What other Canadian clinical research consortia are there and how do they differ from the CRRC?

I believe there are other successful consortia in the US with similar goals and there are other Canadian groups such as urology and stroke consortia.

What advantages will the CRRC be able to offer the pharmaceutical industry? Will the CRRC be able to satisfy the desired research activity of the many new rheumatology members of the consortium? How?

In terms of advantages for the pharmaceutical industry, the CRRC can help identify the sites qualified to do trials, be the one point of entry, and be the one contract negotiation. With a consortia we can agree to deliver subject enrolment in a timely fashion.

Rheumatology members of the CRRC are not shareholders, employees or members of a cooperative. How would you define their relationship to the CRRC? When profit from the CRRC is realized, how will it be distributed? Will the CRRC become a funder of arthritis research grants outside of clinical trials?

The CRRC is a nonprofit organization, but the money gained in the clinical trials can be used to upgrade sites with respect to software, training of staff and certifying the principle investigator (PI) and coordinator. The CRRC also has the advantage of conducting investigator-initiated projects which ask questions of relevance and interest to both researchers and patients—questions that may not necessarily be on the agenda of pharmaceutical research.

Where would you like to see the CRRC in five years time: strategically; fiscally; intellectually?

Hard to say... The first few years will indicate whether the situation is better and more feasible than what we have experienced in the past.