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CRAJ Editorial Board

Mission Statement

The mission of the CRAJ is to encourage discourse among the Canadian Rheumatology community for the exchange of opinions and information.

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Not About Money

This issue is not about money—well, not directly. Money is too politically incorrect to discuss. However, brilliant ideas alone cannot build a research programme or pay for office overhead. Despite the intellectual challenges of a career in rheumatology, the poor economic remuneration of arthritis specialty care is consistently identified in surveys as a barrier to recruitment. The incongruity of remuneration in many faculties, with other internal medicine specialties receiving two or three times the salary of the rheumatologist, is not lost on the bright, young, potential trainee. Nor is this reality ignored by well-intentioned counsellors from national organizations that provide practice and career advice to trainees. The student loan will always be paid off faster if one has an interest in cataracts rather than lupus. Yet there are still those who seem to do exceedingly well from the modest practice of rheumatology, despite the constraints of a 24-hour day.

In the last Canadian Rheumatology Association (CRA) survey of the general membership, clinical trial research was an increasing source of income for many rheumatologists. The formation of the Canadian Rheumatology Research Consortium (CRRC) and its association with the Canadian Arthritis Network (CAN) will alter the clinical trial landscape for every Canadian rheumatologist. As discussed in this issue (page 4), the CRRC hopes to become the one-stop shopping centre for industry and rheumatologists in Canada.

Medical reports are taking up an increasing proportion of practice time (evenings and weekends) and income. In this issue, rheumatologists are provided feedback from a lawyer and an insurance company medical director on how well rheumatologists complete this segment of our professional work (page 10). Michel Zummer is interviewed on the new CRA fee schedule for noninsured services which, among other things, addresses remuneration for the seemingly endless numbers of medical reports (page 19).

Two thirds of Canadian rheumatologists practice outside a major teaching institution and take responsibility for some or all aspects of the business of their practice. Our medical school training is becoming more complex. Everything from molecular biology of rare diseases to ethics and cultural sensitivity, to statistical techniques for Canonical correlation, are part of the curriculum. Exposure to independent practice may take the form of a rare afternoon clinic. Nothing is taught on the business of running a practice the day after you graduate. Therefore, the *CRA Journal* approached a number of established, successful, leading rheumatologists to discuss how and where they learned to survive in the small-business jungle of an independent practice (page 14). We appreciate those who had the time to respond to the *CRA Journal*.

Finally, the CRA Annual Meeting at Lake Louise is fast approaching. The highlights of this upcoming meeting are announced in this issue (page 23). Begin waxing your skis for the ski race and don't forget your travel insurance. If you fall, at least someone else will have to write the medical report.

– Glen TD Thomson
Editor-in-Chief

CRAJ Editorial Board Meeting, Orlando, Oct. 26, 2003. Bottom row (left to right): Proton Rahman, Diane Lacaille, Michel Zummer, Arthur Bookman, Ron Laxer. Top row (left to right): Glen Thomson, Fred Little, Stephanie Costello, Paul Brand.

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 lead 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.

Report Card on Medical Reports

On any given evening, there are more rheumatologists writing some kind of medicolegal correspondence than enjoying a good Canadian novel. This is not because of the lack of worthwhile Canadian literature but, rather, because of the explosion in insurance claims and disability benefits being sought by patients with rheumatic diseases. While we became most proficient in medical school with the likes of the Krebs Cycle, did anyone ever take us aside to discuss the purpose, nature, obligations and style of the Medical Report? Does anyone know how much to charge for these, out of hours of overtime work that will contribute to our early mortality and earlier divorce?

While personal health information acts are reconfiguring the patient-physician interaction, legislation and local regulation already determine what can be shared with third parties, even with a patient's consent. In most jurisdictions in Canada, it is considered unethical to forward the written consultations or notes provided from referring physicians to third parties, without the express written consent of the original author of the information. With new federal legislation on its way from the much sullied office of the Privacy Commissioner, expect the rules and regulations to become more—not less—ponderous.

When responding to requests for medical information about our patients, how well do rheumatologists convey the information? In this article, the *CRAJ* asks a litigation expert (Stephen Hope) and an assistant medical director (Dr. Bruce Boyd) of a prominent Canadian insurance company to provide honest/constructive feedback on the medical reports they receive from rheumatologists, and from physicians in general.

STEPHEN M.K. HOPE
BARRISTER & SOLICITOR
CALGARY, ALBERTA

Generally speaking, there are three areas where medicolegal reports are required: 1) when patients apply for medical and/or disability insurance benefits, 2) when physicians treat patients involved in accident litigation cases, and 3) when a nontreating physician is involved in the defense aspect of a litigation case.

In general, do rheumatologists understand the difference between restrictions and disabilities? How would you define these two terms?

Lawyers definitely observe that physicians, in general, do not understand the difference between impairment and disability.

Functional impairment has distinct medical connotations and often does not define the disability, if any, of a patient.

Disability, on the other hand, has its own special legal meaning. For example, consider the case of a man who severs his finger. Losing a finger obviously results in some functional impairment. However, if the man is a heavy-equipment operator, the loss would not affect his ability to work, but if the man is a professional concert pianist, the loss would devastate his career. Therefore, an injury has different consequences in terms of disability. Disability is a concept that should be used to describe the impaired characteristics of a particular patient by applying the medically defined injuries of that patient.

Consequently, unless a physician is intimately aware of the demands of a patient's job requirements or has reviewed an assessment of a vocational expert, we ask that he/she describe the nature of the patient's functional impairment but refrain from providing opinions about the patient's ability to work (unless it is blatantly obvious).

What are the three most common problems or greatest failings with the medical reports that you receive?

Understanding the difference between impairment and disability and giving an accurate and unbiased diagnosis are two major problem areas. Physicians often use terms like "low back pain,"

"whiplash," and "muscle strain," which do not necessarily provide the etiology of the patient's pain. The purpose of a diagnosis is to provide insight into the mechanism of a pain problem. "Back pain" is merely a loose description and does not tell anyone whether the etiology of the pain is from facet joints, a nerve root impingement, a disc herniation, spondylosis, etc., each of which requires a different treatment.

A third problem area involves failure to consider further medical and psychological issues and factors beyond a physician's scope of expertise. This is especially the case with mild brain traumas or patients presenting with chronic pain—both of which are frequently misdiagnosed or not considered in accident cases.

What are three most critical pieces of information that you normally require in a medical report?
The most critical information would be: 1) an accurate diagnosis (the nature and extent of each injury); 2) the required predictable sequelae of the diagnosis in terms of pain, limitations of motion, restrictions of use and effects on function; and 3) a prognosis.

Do most physicians understand the concept of "balance of probabilities" as it relates to causation? How would you define this term?
Just as impairment and disability are misunderstood so is "medical causation" and "legal causation" (or "proximate cause"). Medical causation applies scientific deduction in determining whether a given event, injury or condition led to another particular condition. This can be further subdivided into types of medical causation, such as precipitating, predisposing, primary and secondary, to name a few. Legal causation is often defined as "that cause, which is the natural and continuous sequence (unbroken by intervening causes) that produces the injury or damage without which the result would not have occurred." The limitations of "legal/proximate cause" are causation and the limitation to foreseeable consequences. This may not sound very distinguishable but medical causation is often harder to prove than legal causation; therefore, physicians often apply the higher standard of proof of medical causation than the lower standard of legal causation which uses "the balance of probabilities," or that proof which is 51% in favour of one answer over the other.

How long a report is "too long"?
This always depends on the questions asked, the purpose of the report, and how the parameters and scope of the given tests are interpreted by the physician. We would prefer an accurate and complete report, regardless of length, to one that is incomplete and short.

Can you provide examples of unacceptable/unsatisfactory medical reports you have received?
When we see a report of a physician who is retained by the defense side of a legal dispute they often do not consider other causes to a patient's continuing complaints of pain, such as the patient's own psychological reaction to pain or that there may be other medical explanations. Not every patient's complaints of pain can be neatly reduced to an explanation within that physician's specialty. It also appears, at times, that physicians take the positions of the people who hire them (*i.e.*, the physician gratuitously provides his/her personal opinions which disfavour the examined party, without providing a medical explanation for that opinion).

In general, how would you grade physicians' medical reports?
This is variable across the spectrum and depends on the individual physician and his/her experience in preparing such reports. If a physician is new to the practice, we recommend that they meet with a lawyer or obtain examples of medicolegal reports from lawyers who practice in the area of personal injury or disability law.

Is there one medical specialty or primary-care group that is, overall, the most proficient at preparing medical reports to your specifications?
The physicians who are called upon most often by the legal system are usually general practitioners (GPs), orthopaedic surgeons, neurologists, neurosur-

geons, rheumatologists, physiatrists, and general surgeons. Those who have a clinical practice tend to have the time and facilities to prepare reports more accurately than surgeons.

Is there any group that provides particularly unacceptable reports? How would you grade them?
Again this depends on how frequently they are called. GPs tend to be less accurate in their diagnoses but this may be a result of their general training.

How would you grade rheumatologists and their medical reports?
Over the last 15 years, rheumatologists have been used more frequently than ever in legal matters. In particular, we see them being retained because they have a keener interest or knowledge in fibromyalgia and myofascial pain syndromes. Most of the accidents lawyers see involve soft-tissue injuries, and finding a specialist to accurately diagnose these conditions continues to be perplexing for the patients and the legal system.

Which medical specialty charges the most for their reports?
Specialists such as orthopaedics, neurosurgeons and physiatrists have expensive fees, as they are retained specifically to provide medical examinations. Currently, in Calgary, I am seeing orthopaedic surgeons, well respected in a particular subspecialty, charging over $2,000 for a medical examination, review of chart materials and preparation of a report. At the other end of the scale I just received a three-page, well-written report from a psychiatrist for $325.

BRUCE BOYD, MD
ASSISTANT MEDICAL DIRECTOR,
GREAT WEST LIFE ASSURANCE COMPANY
WINNIPEG, MANITOBA

Physicians are generally requested to interact with insurance companies at the following times:
1) when their patient is applying for an insurance product and the company is assessing the patient's risk; and 2) when their patient is sick or injured and applying for benefits and the company is determining the patient's eligibility for benefits.

In general, do rheumatologists understand the difference between restrictions and disabilities? How would you define these two terms?
There are two or three terms that are worth mentioning which some physicians may not understand:
1) "Limitation" refers to the inability of a person to perform a specific physical activity (*e.g.*, unable to lift heavy objects due to back injury or arthritis).
2) A "restriction" is a recommendation or an order given to a person by a physician or a legal authority to avoid or refrain from a specific activity (*e.g.*, a person who is blind is restricted from driving; a person with epilepsy may be restricted from roof work, etc.)
3) A "disability" is an impairment which is sufficient to prevent an individual from performing most of his/her job duties.

What are the three most common problems/greatest failings with the medical reports that you receive?
Many physicians write down a patient's complaints, signs and symptoms along with a diagnosis and assume that the patient can't do his/her job. However, many of these physicians do not indicate objective clinical signs. A good report should mention the patient's symptoms, signs, treatment requirements and responses to treatment. An example of a poorly written report is where a physician mentions only that his/her patient has "back pain" and that he/she has given the patient leave from work on disability. No other clinical signs are mentioned in the report.

What are three most critical pieces of information that you normally require in a medical report?
As mentioned above, the most important information to include is as follows: symptoms, clinical signs, any objective test results, current treatment requirements and responses to treatment. The insurance company's job is then to determine whether a patient's impairment is sufficient to prevent him/her from doing his/her job and whether he/she is eligible for benefits under the terms of the insurance policy.

How long a report is "too long"?
I don't think any report is "too long." Most of the information required in these reports can be provided within a page or two and, generally, physicians are quite concise and provide reports of an appropriate length.

Can you provide examples of unacceptable/unsatisfactory medical reports you have received?
As I briefly mentioned earlier, it is not really appropriate for physicians to write, "I have put this person out on disability." It is not the physician's responsibility to decide whether a patient is eligible for disability benefits. The physician's responsibility is to provide the patient's symptoms and signs and, if possible, to indicate the activities the patient cannot perform. It is also important to keep in mind that eligibility for benefits depends on many things: eligibility dates specified in the person's contract, the wording of the policy, exclusion riders, etc. Also, the insurance company may have additional information that the physician may not be aware of or have access to, such as the person's job description, tips from fellow employees or the employer (*e.g.*, a person seeking disability for hip injury but still playing hockey regularly). Therefore, it really is the insurance company's responsibility to decide on a person's eligibility for disability benefits. However, if the insurance company makes a mistake on a decision, the physician should seek a re-evaluation and clarify or further explain their patient's situation and why the patient cannot physically perform his/her job. But the onus should not be on physicians to prove a person is disabled, and physicians should explain this to their patients as well.

In general, how would you grade physicians' medical reports? How would you grade rheumatologists and their medical reports?
The quality of reports from all types of physicians varies from poor to excellent, however, in general, rheumatologists tend to have very clear, concise, typed, thorough reports. As a group, rheumatologists do a very good job at providing the appropriate and necessary information. Their reports provide an excellent review of the symptoms, clinical signs and treatments they've tried with respect to the conditions they normally deal with (*i.e.*, inflammatory, arthritic conditions).

Is there one medical specialty or primary-care group that is, overall, the most proficient at preparing medical reports to your specifications?
Orthopaedic surgeons are generally very good and objective on their reports. The quality of the report often depends on how much time the physician had to prepare it and/or what time of day the report was prepared (*e.g.*, late-evening reports sometimes are not the most proficient). The main problem is lack of objective information, as mentioned earlier.

Is there any group that provides particularly unacceptable reports? How would you grade them?
I don't believe there is any one particular group that provides unacceptable reports.

Which medical specialty charges the most for their reports?
I don't usually see the invoices for the reports so I don't know if there is one medical specialty that charges more or less than another. I do know that the charges vary and that one physician might charge $200 for a one-page report while another might charge only $100 for the same. Physicians in Canada, generally, may not be used to billing people. Many physicians may just want to clock the time they spend on the report and refer to their provincial medical association's directives for what to charge per hour. In general, physicians are pretty responsible when it comes to billing.

It is also important to keep in mind that in many situations, the responsibility to provide medical information to the insurance company, and to pay for gathering this information, lies with the patient/policyholder, and this is specified in the policy itself. Physicians often are not aware of this and this lack of awareness leads to frustration for physicians.

Independent Practice Management: Should it be Part of the Curriculum?

By the time a rheumatologist finishes training, he or she will know more about the etiopathogenesis of Kashin-Beck disease or the metabolic pathways involved in ochronosis than about how to earn a living. As medical schools have evolved over the past number of years, the local, on-site, full-time teacher has become the primary mentor for the trainee. Exposure to independent practice may be through occasional visits to office clinics—not a prolonged rotation. Yet, two thirds of Canadian rheumatologists ultimately choose to practice outside the teaching hospitals. Where will the skills necessary to effectively run a practice be learned?

Just like when we were younger, there appears now to be a great reluctance on the part of the older generations to talk about the "facts of life." There continues to be an attitude that the "birds and bees" of medical practice are best learned on the street because it is a difficult subject that should not be mentioned in polite company. Myths about various forms of practice abound. One learns how to be an independent rheumatologist by making mistakes and, hopefully, learning from them.

One consequence of failing to train residents in the essentials of medical business is the increasing trend of internal medicine specialists opting for the role of "Hospitalist." In this role, the community component to healthcare becomes secondary, but the fear of running an office is removed. If this is not a desirable outcome for rheumatology, how and what should trainees be taught, and to what should they be exposed as part of their training? This article examines the challenges of the independent practice and describes some steps being taken to increase exposure of trainees to the office-based form of practice.

– Glen T.D. Thomson, MD, FRCPC

Barry Koehler, MD
Clinical Professor of Rheumatology, UBC

What training do rheumatologists need to run their own independent practices?

I was fortunate to start practice in the setting of a large medical clinic. This permitted me to pay little immediate attention to the business aspects of my practice. It also gave me time to observe the things one must do and those that should be avoided. The only training I had during my training was fortuitous, and really only the result of the opportunities to work closely—and chat over coffee—with my various mentors.

There are invariably a few individuals within the faculty of a training program (usually not GFTs) who could offer a few seminars on the "business of medicine." Since the business aspect of running a practice can be as varied as the medical aspect, the opportunity for trainees to hear different points of view would be valuable.

The truth is that MD Management offers many excellent seminars and other resources, and trainees should be encouraged to access these during their programs. Things such as leasing arrangements, practice sharing, income-tax issues and saving for retirement all are addressed.

What aspects of running a practice and a small business should be part of new trainee curricula?

Once you have the office space, give careful thought as to how it is utilized. Patients are coming to avail themselves of your expertise, not to marvel at your interior decorating. Give some thought, and get some advice, as to how you will interview and examine patients, what you will do while patients are dressing and undressing (to respect patient privacy and utilize that time efficiently), and give your staff a comfortable and efficient working environment. Remember that most practices require staff to multitask, deal with patients, phones and doctors, and smile through missed coffee breaks.

Little or no advice is given to trainees regarding communication to the referring physician—and that's what a consulting practice is all about! Too many

consultation letters mimic the consultation notes on the charts of the teaching hospitals. There is a wonderful history (most of which the referring physician already knows), a competent physical examination (often couched in mystical rheumatologic jargon), and an opinion that offers little insight into the thought processes of the consultant as to how the diagnosis was reached and why the recommendations were made. Your plans for follow-up or for future care by the referring physician should be clear. If you are going to continue to follow the patient, it should be stated, to the patient and the referring physician, that you plan to do this in partnership with that physician. This involves keeping the referring physician apprised of all subsequent visits, not just an occasional missive. There are many ways to "skin the cat" of consultant practice, but I feel our trainees often get too little insight into these.

There is also more to patient communication than discussing the diagnosis and treatment. Patients need to know your role in their care. A handout at the first visit can be a great help in answering questions before they are asked.

Learning how to deal with medicolegal requests is rarely encountered in training. Like it or not, even if you refuse to do independent medical examinations, you will be caught up in legal issues when one of your patients is involved in an accident or you find the request for a "medical" opinion has a legal matter in the background. Trainees need to learn how to deal with these situations, and the basics are easily taught.

What "hard" lessons about practice have you learned that you wish you had more training to deal with?

Trainees should have the opportunity to learn how to bill. Each province has its own idiosyncratic fee definitions, and it is important to learn to use these efficiently, as well as ethically. You can deprive yourself of income or, even worse, bill inappropriately and find yourself on the carpet before the provincial health authority and your college. A clinic with two or three practicing rheumatologists could be profitable for most new practitioners.

I wish that I had read *The Wealthy Barber* the day before I started in practice. It would have inspired me to start a regular, structured savings programme, even while coping with medical school debt and a mortgage. One should never neglect the value of childhood immunizations nor of compound interest.

I should have developed a relationship with a reputable financial advisor early in the game. Physicians forget that their expertise is in the practice of medicine and they have a deserved, but regrettable, reputation as the dolts of the investment world. Even lawyers comment that it is time to sell a stock when physicians are buying it.

Who gave you the advice you needed to begin your practice?

I had no such advice but, as I have already said, I avoided the worst of it by starting out in a large clinic where there were established business practices and an accounting department.

There are many resources easily available to the physician, particularly through MD Management. Every training program should avail itself of the speakers and literature that this organization makes available. They may not have all the answers, but can provide a starting point.

Carter Thorne, MD
Lecturer, University of Toronto

What training do rheumatologists need to run their own independent practices?

Rheumatologists who enter community practice will need to consider whether they will practice solo, join with another rheumatologist, or enter a multispecialty or multipractice group. These decisions may obviate certain business decisions and costs, but in no way diminish the need to do one's homework. Fellows in training should have some instruction regarding the merits and downsides of each of the above scenarios. It would be preferable to not only have a formal didactic session, but also to spend time in the practice-setting of a mentor in a selected setting. Issues that should be considered include:

- Office: rent or condo?
- Secretary: how to hire; remuneration; expected duties
- Computer systems/billing programs

- Paperless office
- Insurance
- On-call issues
- Becoming "known" to the community
- Interaction with Industry reps
- How to keep up with CME
- How to organize patient flow/phone calls, etc.

What "hard" lessons about practice have you learned that you wish you had more training to deal with?
My first accountant recommended that we defer our first year income (not available today), and this was our biggest mistake. Our home and living expenses were moderate in the first year and we had no reason to defer taxes. It caught up with us later. I wished that we had had good financial planning advice.

Who gave you the advice you needed to begin your practice?
My first secretary was experienced, and she gave me advice. I also did a lot of reading and asking questions. This all occurred after I opened my office—the wrong way around!

Stuart Seigel, MD
Rheumatologist, Penticton, BC

What training do rheumatologists need to run their own independent practices?
I suspect most of that could be done through rotations in several (not just one) private rheumatologists' offices, paying specific attention to the actual business operation. Those heading in an academic direction could choose a different option.

What aspects of running a practice and a small business should be part of new trainee curricula?
Basic accounting practice, payroll, hiring and firing of employees (and associated liabilities), and business efficiency. Much of this (but not the accounting aspects) can be obtained through MD Management seminars. For the accounting, there are usually night courses available at local community colleges. Graduates can also pay their accountant more (actually, a lot more), and not have to worry about these things. Running an electronic office (with maximum use of computers, etc.) may also be useful knowledge.

What "hard" lessons about practice have you learned that you wish you had more training to deal with?
I've learned (and am still learning) about increasing the time and financial efficiency of my office "the hard way."

Who gave you the advice you needed to begin your practice?
Nobody gave me this advice. I have learned from the experience of doing private practice locums in my first year, as well as having the privilege of working in a large multispecialty clinic with a turn-key practice (a fairly safe place to make mistakes as there were professionals on staff to assist me). I have also learned from my mistakes.

In summary, the "figure it out yourself" approach does work, but I agree that some preparation as a trainee would have been very helpful. Many of the private practice staff could be encouraged to emphasize this component, and further training could be obtained via MD Management seminars, night classes at the local community college, etc.

Janet Markland, MD
Rheumatologist, Saskatoon, SK

What training do rheumatologists need to run their own independent practices?
This type of training should stress that practicing clinical rheumatology is not merely a question of diagnosing the problem, but of how you can help solve that problem. In the private-practice setting, there are no more "middle men" to help solve these problems—it's only you. Therefore, it is valuable to know how to set up appointments for orthotics for your patients, and how to arrange for treatment by occupational therapists and physiotherapists in your—or your patient's—area. Training on billing also is useful, and this can be obtained from MD Management seminars or local associations (such as the Saskatchewan Medical Association).

What aspects of running a practice and a small business should be part of new-trainee curricula?
In addition to the items mentioned above, such training should include how to efficiently pay the overhead costs of running a practice.

What "hard" lessons about practice have you learned that you wish you had more training to deal with?
I wish I'd had more training on the use of computers. I think this would make my practice more efficient and would allow me to depend less on others.

Who gave you the advice you needed to begin your practice?
I got some practical advice from two friends: a neurologist with his own private practice and a rheumatologist with a private practice in Regina. Additionally, I discussed billing, efficiency and staffing with another physician during my last stage of training.

Christine Peschken, MD
CRA Manpower Committee Chair

Two thirds of Canadian rheumatologists practice outside universities and institutions. Are there any faculties in Canada that provide instruction for trainees in the organization and maintenance of an independent practice in the community?
The Canadian Medical Association (CMA) provides practice management advice for residents as part of its "Practice Solutions" program. This program involves practice management education for residents across Canada to complement medical training. The Practice Management Curriculum (PMC) is a series of interactive and informal seminars customized for trainees. The objective is to help residents ask the right questions when evaluating opportunities, to share experiences and to encourage lifelong learning with respect to managing their own medical practice. The PMC is offered free-of-charge, as a benefit of membership in the CMA, but faculty and program directors must request that the program be incorporated into the trainees' curriculum. A generic PMC was developed and it is necessary for faculty to customize the curriculum to make it applicable to rheumatology. While this resource is available, I do not know how many (if any) rheumatology training programs in Canada have utilized this program.

Are rheumatology trainees exposed to any practice settings outside the university hospital during their training?
Absolutely! I can't speak definitively for all programs, but all those I am familiar with include exposure to rheumatologists in the community. I think this is a relatively recent change, having evolved over the last 5-10 years. Our own program includes regular participation in clinics with community rheumatologists, who also participate in our academic half-day program. Our program also allows for additional time with community rheumatologists to suit the trainee's career path. I suspect most other Canadian programs are similar. The Royal College of Physicians and Surgeons certainly sees diverse exposure as an important part of clinical training.

Are Canadian trainees tracked after graduation regarding their ultimate geographic location and practice setting?
Yes, the CRA tracks trainees to some extent. Individuals are not tracked by name, only by category (*e.g.,* whether or not trainees stay in Canada, and whether graduates are employed in academic settings or set up practices in the community). In addition, the CRA has tracked the chronic lack of trainees in recent years.

Is there a greater need to train rheumatologists for academic or independent practices in Canada?
That is difficult to answer, since global shortages in all areas are reported across the country. Although there is a lot of overlap, the majority of teaching and research is done in academic settings while the majority of patient care is done by community rheumatologists. Academic vacancies are easier to track, as an academic section will post a job or identify a specific clinical or academic void. In the community, shortages are more often reflected by long waiting lists than by posted vacancies. In Canada, almost all academic centres are currently reporting

vacancies, and most communities report unacceptably long waiting lists, so obviously both are needed.

Is there value in exposing trainees to various independent practices in community settings?

The reality is that the majority of trainees have already decided whether they wish to pursue academic or independent practice by the time they enter rheumatology training, but exposure to various settings will help them make more informed decisions. From a purely clinical perspective, trainees need to experience as broad a variety of clinical problems and practice settings as possible, to prepare themselves for future practice.

Is there value in incorporating basic training in practice management within the rheumatology curriculum?

Most definitely! Speaking from personal experience (I started practice completely clueless about practice management), I think some basic skills in practice management would make starting a practice (whether academic or independent) less painful, both from a financial and a "headache" perspective. It may also help trainees to make decisions about where and how they wish to pursue their careers in rheumatology.

What is the strategy of your Manpower Committee to address future vacancies in: a) university practices and b) independent practices in community settings?

The Manpower committee was just formed in September, and we have not yet added any new initiatives to the ones already in place. The most important program that the CRA has developed recently is the CRA/Merck-Frosst Summer Studentship Program. The CRA has realized that medical students generally decide very early in their studies which discipline they wish to pursue, so early exposure to rheumatology is key. If we wait until students have finished medical school, it is often too late, as they have already chosen another career path. Students in this program have the opportunity to work with a rheumatologist who is a member of the CRA. This program has proven to be an excellent way for medical students to become interested in our subspecialty.

The CRA uninsured-fees posters:

Soon to be delivered to you at your place of practice

For more information, contact
Michel Zummer
(zummer@attglobal.net)
or
Jamie Henderson
(jhenderson@health.nb.ca).

Noninsured Services Practice-fee Schedule

In the previous (Summer) issue of the *CRAJ,* as well as this Fall issue, you probably saw the ad for "CRA uninsured fees posters" (see adjacent page). The *CRAJ* had a chance to speak with Dr. Michel Zummer, Co-chair of the Economics and Manpower Committee of the Canadian Rheumatology Association (CRA), to discuss how and why this practice-fee schedule was created and what its goals are for Canadian rheumatologists.

Why was this schedule initiated?

The CRA has a retreat every year and after the retreat a couple of years ago, we were discussing the conditions of rheumatology practice across the country. We felt that an increasing amount of time was being spent delivering services that are not insured by the provincial health boards. The Executive of the CRA gave the Economics and Manpower Committee, which I co-chair with Jamie Henderson, the mandate to look at uninsured services to see the possibility of establishing a fee schedule. Jamie Henderson has done most of the work on the fee schedule itself.

How was the schedule developed?

The Economics and Manpower Committee reviewed what was being done by other specialties and family practitioners across the country. The Committee also reviewed what was being done by other rheumatologists across the country. Jamie Henderson then drew up a proposed fee schedule for uninsured, administrative, and medicolegal services. Once completed, representatives from each province reviewed the fee schedule to ensure it would be usable in their respective province. It was also presented to the CRA membership at a previous meeting for review.

After the schedule was finalized, it was sent to graphics/production and is now being sent to all fully paid members of the CRA.

Michel Zummer, MD, FRCPC is Vice-President of the Canadian Rheumatology Association, Assistant Professor at the *Université de Montréal,* and Chief of the Division of Rheumatology, *Hôpital Maisonneuve-Rosemont* in Montreal, Quebec.

What are the goals of the schedule?

The goal is to have guidelines for charging for services which are not covered by the provincial governments and to have a way of informing patients that there are uninsured services which may have associated fees.

How will the schedule influence rheumatologists?

The schedule will make sure that rheumatologists are compensated justly for what they do. There is more and more paperwork being done for governments that is not covered by the governments. More of rheumatologists' practice time is going towards managing patients, trying to get patients services and trying to get patients the medications they require. The schedule will help rheumatologists to be partially compensated for these.

Will there be any follow-up to determine if the schedule has altered the practice of CRA members?

At this time, there is no formal follow-up that is planned to evaluate what impact the schedule will have on rheumatologists' practices. The CRA does do a Needs Assessment periodically, and if the Executive decides that this issue should be included in the Needs Assessment that is sent out, to see how it has affected the practice of rheumatologists, then that would be a way of following up. But there is no formal follow-up being planned. The fee schedule is basically a tool to help rheumatologists in the management of their practices.

Are there any other comments you wanted to mention?

It is important to state that these fees are only guidelines. The schedule is not a statement from the CRA on what the value of a service is. It is a guideline for charging fees. Rheumatologists still need to set their own fees, of which the patients must be informed before a service is offered. The poster being distributed is one of the key mechanisms for informing patients.

It should also be noted that not all fees will be applicable in every province. It is up to each rheumatologist to verify which fees are applicable to his/her practice since certain services may be covered by health insurance in some provinces but not others. The fees are Canadian guidelines but not necessarily "province-specific."

In Memoriam

Dr. Peter M. Cosgrave, 1946-2003

Peter Cosgrave was born on January 11, 1946 in Galway, Ireland. From 1964 to 1970 he attended the University College Galway where he received his MB and BCh degrees. Following graduation he completed a rotating internship and subsequently one and a half years of internal-medicine training at University Hospital, Galway.

Wanting to pursue a career in Canada, he emigrated to Indian Head, Saskatchewan, where he practiced family medicine for two years. However, Peter always had an interest in rheumatic diseases and pursued this from 1976 to 1979 by completing his residency in internal medicine followed by rheumatology at the University of Calgary, Foothills and Calgary General Hospitals. He successfully obtained fellowships in both internal medicine and rheumatology from the Royal College of Physicians and Surgeons of Canada in 1979.

Looking to move even further west, he settled in Duncan on Vancouver Island where he established a very successful practice in rheumatology and internal medicine. For a brief stint, Peter moved to Bismarck, North Dakota but finding that the grass wasn't any greener there (especially in the winter), he returned to the Cowichan Valley and resumed his practice of rheumatology.

Peter was a skilled, dedicated, and compassionate physician. Patients traveled from all over Vancouver Island and the Gulf Islands to see him. He was much esteemed and loved by his patients. He regularly attended the Vancouver Island rheumatology group meetings and contributed significantly to help make these successful. He was the type of person one would seek out at a meeting, if only to experience his affable nature and serenity.

Peter was a man of many interests. He played the sport of hurling in Ireland and was a championship goalkeeper for the university. He started to play soccer when he settled in the Cowichan Valley and proved very accomplished at it. Soccer became his passion and, in addition to playing and coaching, he helped organize soccer trips to Mexico and Costa Rica.

He was an accomplished musician, being proficient with the guitar, less so with the banjo. He was talented enough to be able to make money at it during his student days. Unfortunately, he had to give up his musical instruments after breaking two fingers in a soccer match.

Peter had a keen interest in history, especially World War II, and read and collected books extensively on this subject. He was very proud of his Irish heritage and had extensive knowledge of Irish culture.

Peter loved spending summer evenings on his deck, barbecuing, and being with his family and friends.

Peter inspired everyone who knew him with his quiet courage and dignity in dealing with his illness over the past two and a half years. He continued to practice rheumatology as long as he could, not only to help his patients, but also to try and avoid overburdening his fellow rheumatologists on Vancouver Island.

On January 23, 2003, shortly after his 57th birthday, Peter left behind his wife Lois, and his four children Fionnuala, Paul, Eoin, and Michael; as well as many other relatives, colleagues and numerous friends, all of whom loved him very much. His passing leaves a real void and a profound sense of loss in the small British Columbia rheumatology community. Peter will be missed not only as a colleague, but as a special person. We will miss his pleasant, easy-going manner, his sense of fairness and decency, his sense of humour, and his cheery smile.

J. Paul de Champlain, MD, FRCPC
Victoria, British Columbia

Robert S. Rothwell, MD, FRCPC
New Westminster, British Columbia

Joint Communiqué

CRA News

ANNUAL GENERAL MEETING 2004, LAKE LOUISE, ALBERTA

Fairmont Chateau Lake Louise will be the site for the 2004 annual meeting of the Canadian Rheumatology Association (CRA), from February 25-28. The meeting highlights are as follows:

- Dr. David Felson speaking as the Dunlop-Dotteridge lecturer
- Osteoporosis: New Paradigms in Determining Fracture Risk
  Featuring Dr. Jacques Brown and Dr. David Dempster
- Spondyloarthropathies: Current Concepts in Pathogenesis, and the Interplay of Genetics and Infection
  Featuring Drs. RD Inman, F Tsai, W Maksymowych, M Stone, P Rahman, and D Gladman
- A multitude of educational workshops in which educational interactions are encouraged
- The Royal College Debate: Is Gold Therapy Outdated?
  Expect sparks to fly as Drs. Claire Bombardier and Alice Klinkhoff square off against Drs. Dianne Mosher and Janet Pope
- Spectacular social events, including the Annual Awards Dinner and the Lightning-fast Ski Race (sponsored by local orthopaedic surgery units within convenient air evacuation distance from Lake Louise)

Campus News

The *CRAJ* wants more news about the "what's what" and "who's who" and other "goings on" in the various academic arthritis centres (RDUs) across the country. Memorial University of St. John's, Newfoundland has been chosen to lead off the first contribution to "Campus News" from across the country. Different centre(s) will be featured every issue. Without further ado, enjoy the update below from Memorial University, compliments of the one and only Dr. Proton Rahman!

Memorial University, Newfoundland

What's new at The Rock? Lot's been happening b'ye! After almost two decades of exemplary service, Cathy Alderdice has left St. John's to set up practice in Ontario—a heartbreaking loss for her patients and colleagues alike.

Sean Hamilton just finished a seven-year sentence as the internal medicine residency director, and immediately followed this with a relaxing European vacation (running a marathon in Belgium) and becoming our new RDU director (talk about a glutton for punishment!).

Proton Rahman continues to tinker with genetics, and recently stumbled across a new gene in psoriatic arthritis and a $3 million grant for pharmacogenetic studies.

Last but not least, Majed Khraishi just purchased a stunning new house in an area we all would like to call home.

That's all for now from the three boy'z at The Rock!

– Proton Rahman, MD, FRCPC

The Canadian Rheumatology Association Journal can also be found online. Readers are invited to visit the website at: www.stacommunications.com/craj.html.