



## *The Journal of the Canadian Rheumatology Association*

Volume 14, Number 1

Spring 2004

### *focus on* **Privacy, Paperwork and Pain**

#### *Editorial*

Privacy, Paperwork and Pain

Glen TD Thomson, MD, FRCPC

#### *Topical Medical Issues*

PIPEDA

Interviews with Dr. S. Patel, (President, Canadian Medical Association) and Dr. P. Ceresia (Canadian Medical Protective Association)

#### *Topical Medical Issues*

The Disability Tax Credit

Interviews with Keith Pitzel, CA, CBV and The Arthritis Society

#### *Northern (High)Lights*

Farewell to the Chief (Interview with A. Bookman, MD, FRCPC)

Words of Wisdom (Interview with C. Thorne, MD, FRCPC)

Words from a Distinguished Rheumatologist  
(Interview with W. Buchanan, MD, FRCPC)

#### *Joint Communiqué*

CRA News

Provincial News from Manitoba and New Brunswick

Campus News (University of Montreal, Queen's University)

The *CRAJ* is online! You can find us at: [www.stacommunications.com/craj.html](http://www.stacommunications.com/craj.html)



**Mission Statement**

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



**Editor-in-Chief**  
**Glen Thomson, MD, FRCPC**  
 Former President, Canadian Rheumatology Association  
 Rheumatologist  
 Director, CIADS  
 Associate Professor  
 University of Manitoba  
 Winnipeg, Manitoba



**Steve Edworthy, MD, FRCPC**  
 Associate Professor  
 Department of Medicine and  
 Community-Health Sciences  
 University of Calgary  
 Calgary, Alberta



**Gunnar R. Kraag, MD, FRCPC**  
 Vice-President, Canadian Rheumatology Association  
 Professor of Medicine  
 University of Ottawa  
 Chief of Rheumatology  
 The Ottawa Hospital  
 Director, University of Ottawa Rheumatic Diseases Unit  
 Ottawa, Ontario



**Michel Zimmer, MD, FRCPC**  
 President, Canadian Rheumatology Association  
 Assistant Professor  
 Université de Montréal  
 Chief, Division of Rheumatology,  
 Hôpital Maisonneuve-Rosemont  
 Montréal, Québec



**Ronald M. Laxer, MD, FRCPC**  
 Vice-President, Clinical and Academic Affairs Staff  
 Rheumatologist  
 The Hospital for Sick Children  
 Professor, Pediatrics and Medicine  
 University of Toronto  
 Toronto, Ontario



**Denis Choquette, MD, FRCPC**  
 Clinical Associate Professor and  
 Director, Rheumatology Program  
 Université de Montréal  
 Montréal, Québec



**Arthur Bookman, MD, FRCPC**  
 Past President, Canadian  
 Rheumatology Association  
 Associate Professor  
 University of Toronto  
 Clinical Coordinator  
 Division of Rheumatology  
 The Toronto Hospital  
 Toronto, Ontario



**Diane Lacaille, MD, FRCPC**  
 Assistant Professor of Rheumatology  
 Rheumatology Department  
 University of British Columbia  
 Vancouver, British Columbia



**Dianne Mosher, MD, FRCPC**  
 Past President, Canadian  
 Rheumatology Association  
 Associate Professor  
 Dalhousie University  
 Active Staff  
 Queen Elizabeth II Health Sciences  
 Centre  
 Halifax, Nova Scotia

*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.*

**Publishing Staff**

**Paul F. Brand**  
 Executive Editor

**Russell Krackovitch**  
 Editorial Director,  
 Custom Division

**Stephanie Costello**  
 Managing Editor

**Marie Laliberté**  
 Editor-proofreader, French

**Donna Graham**  
 Production Manager

**Dan Oldfield**  
 Design Director

**Jennifer Brennan**  
 Financial Services

**Robert E. Passaretti**  
 Publisher

## Privacy, Paperwork and Pain

If you are a Canadian tree, be afraid: be very, very afraid! That time of the year when income tax forms are fast upon us; few forests will be left as undisturbed habitat as the need for official paperwork again reaches a crescendo. Our patients will again line up for your signature on disability tax credit (DTC) forms, even though the regulations prevent most disabled persons from benefiting. While governments preach preventative medicine, the exercise and other equipment that may assist may be precluded as a medical expense. Keith Pitzel, a leading chartered accountant with Deloitte, leads us through some of the maze of regulations (page 8), and The Arthritis Society's effort in making changes to the DTC to help those in pain is also featured (page 9).

The Personal Information Protection and Electronic Documents Act (PIPEDA) now directly effects every physician in Canada—sort of. Whether you practice independently or in an institution will determine some of your obligations under the act. Of course, the federal government foists this new regulation on physicians but without any additional funds for the increased paperwork to create their clinics' privacy policy, privacy officer or, if you so choose, privacy policy consent form. Dr. Sunil Patel, president of the Canadian Medical Association (CMA) comments on the CMA involvement with PIPEDA (page 4). The Canadian Medical Protective Association (CMPA) also provides some practical help with this new administrative pain (page 5).

Northern (High)Lights features interviews with two outgoing—but not retiring—personalities: the Canadian Rheumatology Association (CRA)'s Past President Arthur Bookman and Past Secretary-Treasurer Carter Thorne (pages 11, 13). An interview with the 2004 Distinguished Rheumatologist, Watson Buchanan, also presents some interesting views of medicine and life (page 15)!

Look forward to the Summer issue which will feature interviews with the 2004 Distinguished Investigator, Rob Inman, and the 2004 Young Investigator, Rae Yeung, as well as the thoughts of President Michel Zummer, Vice-President Gunnar Kraag, and new Secretary-Treasurer Jamie Henderson.

There is news aplenty from the the CRA (page 18), the provinces of Manitoba and New Brunswick (page 22), and the campuses of Queen's University and University of Montreal (page 23). Plus ... tonnes of photos from "Louise!"

Stay tuned for the Summer issue where the *CRAJ* will announce our talent search. We don't want a "Rheumatologic Idol," but we do want to profile Canada's 10 **most interesting** arthritis specialists. This talent search has nothing to do with the ability to do Western Blots or climb the committee ladder. This has to do with the ability to do Western line dancing and climb rock faces. More to follow about the *Fickle Finger of Fame*.

Glen T.D. Thomson  
Editor-in-Chief



**Editor-in-Chief taking a late spring stroll in Winnipeg...**

# The Personal Information Protection and Electronic Documents Act (PIPEDA)

CMA/DR. SUNIL PATEL

The Canadian Medical Association (CMA) has been representing the interests of physicians regarding the issues of privacy and PIPEDA. The *CRA Journal* asked Dr. Sunil Patel, CMA President and physician from Gimli, Manitoba for some advice on this issue and his thoughts are presented herein.

*\*Please note that the following responses should not be interpreted as legal advice.*

*PIPEDA, new federal privacy legislation, impacts all physicians. It appears to be redundant as the provinces and local colleges of physicians and surgeons already had guidelines and guarantees in place for patient privacy rights. Did the federal government consult with the CMA while drafting the legislation?*

In 1998, in anticipation of impending privacy laws across the country, the CMA developed its Health Information Privacy Code, which formulated the desired regime for patient privacy protection. When PIPEDA was introduced, the CMA was present both at the house and senate committee levels to put its perspective forward—in particular, that the legislation was not designed to take into account the health sector and was consequently deficient. The CMA's perspective was largely ignored, partly because there were differences of opinion within the healthcare community as to the appropriate privacy regime.

At the federal level, the CMA has strenuously argued that the current territorial/provincial provisions with respect to the protection of privacy and confidentiality—through the colleges or legislation—are adequate. In some measure, this perspective has been taken into account through the federal government's interpretation of PIPEDA (developed in conjunction with stakeholders, such as the CMA). The interpretation, done in the form of questions and answers, can be found through the CMA website ([www.cma.ca](http://www.cma.ca)) by doing a key-word search for "privacy resources" and clicking on "Health Canada Q & As for Healthcare Providers" under the National subsec-

tion. In addition, I have made a number of statements that point to the fact that physicians are already highly regulated with respect to privacy and confidentiality (e.g., see the letter at the front of the CMA's physician handbook *Privacy in Practice*, which can also be found on the CMA website).

Finally, there is a challenge to the constitutional validity of PIPEDA, which may indirectly give greater clarity with respect to these issues.

*It is unclear to many physicians, especially those practicing outside hospitals, what their responsibilities are under the new PIPEDA regulations. Does the CMA advise physicians to comply with the PIPEDA requirements of having a privacy officer and a standard operating procedure for handling of patient information for each practice?*

Again, I would refer to the CMA handbook *Privacy in Practice*, which takes the approach of "enhancing" physicians' privacy practices. With respect to appointing a privacy officer, the handbook states (in keeping with college requirements) that the physician has ultimate responsibility for his/her patient records. With respect to policies and procedures, the CMA handbook does provide some guidance and also points to advice provided by the Colleges and the CMPA. To assist physicians further in this regard, the CMA is currently developing an online "privacy wizard," which will enable physicians, through answering a series of questions, to customize a privacy policy for their office, in addition to auditing their privacy practices and developing a comprehensive office policy.

*Should physicians obtain written consent from each patient to be in compliance with PIPEDA?*

In so far as the circle of care is concerned (see "Health Canada Q & As for Healthcare Providers" referred to above), it has been clarified that "implied consent" is sufficient—which would not require written consent. As far as the interpretation of implied consent is concerned, this is under the condition that patients are provided with information concerning the uses to which the information will be put. To assist physicians in this regard, the CMA



produced a privacy poster, which was disseminated via the *CMA Journal* to the majority of physicians. The poster is also available online at the CMA website.

*Quebec is challenging PIPEDA in the courts. What can you tell us about this action and how this may affect CMA members?*

The Quebec Government has asked the Quebec Court of Appeal to rule on the constitutional validity of PIPEDA, claiming that the Act is unconstitutional because it operates in areas of provincial jurisdiction. While this challenge brings the Act's validity into question and thereby creates uncertainty, there is no direct affect on members. Ultimately, even if the Act is found to be unconstitutional, given the growing trend to enact privacy legislation across the country and to specifically address health information privacy, it is unlikely that the challenge will make a practical difference to members.

*It will cost physicians working outside of hospitals and universities time and money to meet the current requirements of PIPEDA. This is federal legislation and physician funding is a provincial matter. What is the CMA doing to mitigate the costs of administering the PIPEDA regulations to practicing physicians?*

As noted above, the CMA has produced a number of tools to assist physicians and is in the process of producing the privacy wizard—all of which should assist physicians in enhancing their privacy practices and, if necessary, in demonstrating compliance. In addition, the CMA website contains a clearing-house of privacy materials and links on a jurisdictional basis, which further assists physicians.

*The costs of new computer software for booking, billing and maintaining medical records that are in full compliance with PIPEDA is sometimes staggering. Will the CMA be lobbying the federal government to revise this aspect of the Act as it pertains to doctors?*

PIPEDA does not require the use of electronic means to maintain medical records. PIPEDA covers both paper-

based and computer-based systems. The precise requirements with respect to security safeguards in a computerized setting have yet to be determined.

*Do you see a positive benefit to this new legislation?* PIPEDA has raised awareness of the importance of privacy in all sectors, including the health sector.

#### CMPA/DR. PATRICK CERESIA


The Canadian Medical Protective Association (CMPA) has taken great interest in the implications of the PIPEDA legislation. The *CRA Journal* asked Dr. Patrick Ceresia, Managing Director, Corporate Services of the CMPA for some advice on this important issue and his thoughts are presented herein.

*PIPEDA was passed several years ago. Why is it now (as of Jan 1, 2004) relevant to physicians?*

PIPEDA came into effect on January 1, 2000; however, its application to types of information classes or activities was staged over time. Application of the legislation to personal health information came into effect on January 1, 2004. The healthcare community at large, and physicians in particular, have been long-time champions of the protection of personal health information. Privacy legislation is relevant to physicians because it emphasizes and enshrines in law the principles regarding the protection of personal health information that have been core to the practice of medicine.

*Many physicians still are uncertain if this new Act pertains to them. Are any physicians exempt from PIPEDA? Does PIPEDA apply to all health professionals (dentists, physiotherapists, etc.)?*

PIPEDA is federal legislation and applies to all of Canada, including physicians and other healthcare providers, unless excluded by specific exemption. While the legislation will continue to undergo clarification of its applicability, several exemptions already clearly exist. One example is provincial legislation that has been deemed substantially similar. For



---

example, Quebec has had privacy legislation since 1994 and it has been deemed substantially similar by the Privacy Commissioner's office. Also, an exemption under the legislation exists for activities covered by other legislation, such as in the case of legal actions, or investigations by tribunals.

*If a doctor works exclusively in a hospital with no outside clinical practice, is it safe for the doctor to assume that his/her institution meets the requirements for PIPEDA?*

This is a very complicated question.

First, the legislation applies to organizations and individuals, so one or the other cannot assume that the onus of responsibility rests elsewhere. Confusing the situation and in follow-up to the issue of "exemptions" discussed in the second question (above), activities that are not of a commercial nature are exempted from the application of this federal law. There is indication from the limited clarification that has, to date, been provided by the Privacy Commissioner's office, that medical care and treatment provided by a physician (or other healthcare professional) within a hospital is not seen to be commercial in nature while work provided by a physician in a private office or clinic is seen to be commercial. Formal interpretation has not as yet been issued in this regard and it would be premature to surmise that a physician or a hospital, under the circumstances of this question, are exempt from the implications of the legislation.

*For independent practitioners who either run their own clinic or are in an independent clinic with other physicians, what specific requirements must they meet to be in compliance with the Act (clinic privacy officer, clinic privacy standard operating procedure manual)?*

It must be clear that the law must be complied with. In the private or independent clinic environment, the majority of healthcare professional regulating bodies, including the colleges of physicians and surgeons, have taken a position on what compliance means in their jurisdiction. Similarly, the representative medical organizations have interpreted and published compliance recommendations for their members. The Canadian Medical Association (CMA) has taken a

national lead in this regard, as have others, such as the College of Family Physicians of Canada and the Canadian Dental Association. The CMPA strongly encourages its members to refer to the direction of the applicable regulating body and to take advantage of the advice and tools provided by the various representative medical organizations.

*There is some confusion about whether patients should be asked to give written consent to the privacy policies of physicians or their clinics. What is the CMPA's advice regarding verbal or implied consent for PIPEDA?*

There is an evolving opinion that the concept of implied consent in the provision of clinical care and treatment reflects adequate compliance with the legislation. This position seems to have been adopted by the various regulating bodies and is certainly reflected in the compliance measures recommended by the CMA. The CMPA recognizes the appropriateness of this interpretation by the regulating bodies and representative medical organizations and counsels compliance with their advice and direction. We further suggest that if any doubt or concern exists, a documented informed consent should always be considered.

*Quebec may be challenging PIPEDA. Will this alter the way physicians should currently abide by PIPEDA?*

Until such a time that the outcome of the Quebec constitutional challenge of PIPEDA has been determined, PIPEDA is law and should be complied with.

*What other advice/information can the CMPA provide to physicians about patients' privacy rights?*

I would repeat that physicians have historically valued, respected and championed the protection of patient health information. The CMPA expects that the recent attention to privacy will see the understanding and adoption of these important principles extend well beyond the healthcare community. We encourage physicians and other healthcare professionals to look to their regulating bodies and representative medical organizations for advice and direction on compliance issues and engaging patients in understanding their rights.

# The Disability Tax Credit (DTC) and Medical Expenses

## WHAT THE LAW SAYS

The DTC has very definite criteria with regards to who qualifies and who does not. Individuals with arthritis who are not bed-ridden or wheelchair-bound or unable to perform their basic activities of daily living do not qualify according to the letter of the law. Despite this fact, many patients who do not meet the criteria still approach their physician to complete the form.

The *CRA Journal* approached **Keith W. Pitzel CA, CBV** to ask him his thoughts on the DTC and medical expenses. His responses are herein. Mr. Pitzel is a partner with Deloitte and is based in Winnipeg, Manitoba.

*If the DTC form is completed by the physician indicating that the patient does not meet the criteria, is there any benefit for the physician to add a note stating that the person has arthritis and difficulties? Will he/she qualify for a portion of this tax credit?*

The DTC is an all-or-nothing application. If the taxpayer/patient does not meet the criteria for the credit, there is no partial claim available. Therefore, the doctor's comments added to the form have no relevance.

*The status of patients does change. Individuals may deteriorate over time but sometimes will markedly improve after surgery or with the introduction of a more effective therapy. Do physicians have an obligation to report to the Canada Customs and Revenue Agency that a patient who previously met the qualifications for the DTC now no longer meets them?*

The DTC is an income tax issue solely. The taxpayer is making the claim, and the doctor's comments and preparation of the form are only to support the claim. The Canadian tax system is based on a self-assessment principle where the onus is on the taxpayer to prepare his/her return accurately and completely. In submitting a claim for disability on his/her tax return, the taxpayer is responsible to determine if the criteria for the credit is met. The onus is solely on the taxpayer to review the credit claim in every year.

*Some new disease-modifying drugs may cost more than \$15,000 per year. Are health deductions based on the income of the individual and is there a maximum deduction?*

The medical expense credit, which is separate from the DTC, is based on the following calculation:

Medical expenses for the year

Less the lesser of:

- a) 3% of net income or
- b) \$1,755

There is no maximum amount for the credit calculation.

*Patients may approach their physicians stating that their new hot-tub really relieves their pain and discomfort. A physician may suggest that a patient purchase a treadmill or an exercise bicycle to improve their health. Can any of these devices be deducted as a health expense, like the costs for prescription medications, custom orthotics, etc? When, if ever, would a hot-tub, sauna, or exercise equipment be allowed as a deduction?*

The Income Tax Act has regulations that list the types of equipment that are prescribed medical devices and equipment which qualifies for medical-expense purposes. The list is contained in the Canada Revenue Agency interpretation bulletin IT-519R2, which can be obtained at any Canada Revenue Agency office, or at their website ([www.ccr-a-drc.gc.ca/menu-e.html](http://www.ccr-a-drc.gc.ca/menu-e.html)).

Hot-tub or whirlpool bathes prescribed by a medical doctor will qualify if paid to a public or licensed private hospital. Purchase of a hot-tub or whirlpool bath is specifically excluded in IT-519R2, paragraph 58.

*How can physicians best help their patients with regards to health deductions for income tax?*

The most beneficial help a physician can give to the patient is knowledge. Having a copy of the disability certificate—which explains the criteria needed to be met together with the prescribed list of medical devices available—in the reception area would help patients gain knowledge as to what criteria need to be met to claim the DTC, or what expenses are eligible for the medical expense claim.

## THE ARTHRITIS SOCIETY

*At tax time, Canadians with arthritis will present their DTC forms to their rheumatologists. Yet, since 2001, the criteria to qualify have become more stringent and less people with arthritis are being approved for this benefit. Has The Arthritis Society (TAS) been involved in any advocacy effort to improve the DTC program on behalf of people with arthritis?*

TAS has been a member of The Coalition for DTC Reform since its inception in the fall of 2001. The DTC coalition is comprised of leading national patient organizations and individuals representing Canadians with disabilities. The goal of the coalition is to improve the structure, design and delivery of the DTC program to ensure that it is meeting its legislative objectives.

*What have been the historical shortcomings of the DTC program?*

The historical shortcomings have included:

- language of the Income Tax Act;
- interpretation of the Act by the Department of Finance and the Canada Customs and Revenue Agency (CCRA);
- content of the DTC certificate form T2201, which is completed by a healthcare professional
- administrative appeal process within the CCRA

*Who are the current members of the DTC coalition?*

- ARCH: A Legal Resource Centre for Persons with Disabilities
- Alzheimer Society of Canada
- The Arthritis Society (TAS)
- Canadian Arthritis Patient Alliance (CAPA)
- Canadian Association for Community Living
- Canadian Hard of Hearing Association
- Canadian Mental Health Association
- Council of Canadians with Disabilities
- Easter Seals / March of Dimes National Council
- FAME (Family Association for Mental Health Everywhere)
- Family Mental Health Alliance
- Learning Disabilities Association of Canada
- Mood Disorders Association of Ontario
- Multiple Sclerosis Society of Canada
- National Network for Mental Health
- Ontario Brain Injury Association

- Ontario Federation of Community Mental Health & Addictions Program
- Parkinson Society Canada
- Schizophrenia Society of Canada

Please note, CAPA works with TAS to implement our national advocacy strategies. CAPA is a national organization which creates links between Canadians with arthritis, assists them to become more effective advocates and seeks to improve the quality of life of all people living with arthritis.

*Have there been any recent strides made in DTC reform?*

Yes, including the federal government's establishment of an independent technical advisory committee. A press release was circulated in March 2003 by the federal government:


- John Manley, Deputy Prime Minister and Minister of Finance, and Elinor Caplan, Minister of National Revenue, announced the appointment of Sherri Torjman and Robert Brown as co-chairs of the Technical Advisory Committee on Tax Measures for Persons With Disabilities. The establishment of the committee was announced in the February 2003 budget.
- Targeting eligibility for the DTC involves the difficult task of identifying those most in need. In the Budget 2003 speech, Minister Manley said the Government would "work directly with these groups [representing the disability community] through a new, independent advisory committee."
- Over the next 18 months, the committee will advise the Minister of Finance and the Minister of National Revenue on the eligibility criteria for the DTC as well as other tax issues affecting persons with disabilities.

Please refer to the DTC coalition's June 2003 recommendations that address many of the problems individuals and health professional experience with the DTC certificate form T2201. The recommendations are on the Internet at <http://www.disabilitytax.ca/subs/cdte.html>.

*What improvements have been made to the DTC certificate form T2201 since the 2003 consultations have occurred?*

The Canada Customs and Revenue Agency has made significant improvements to the T2201 form for the 2003 taxation year as a result of the consultations held in 2003 with a number of organizations representing persons with disabilities and health professionals. Although the





form is considerably longer (eight pages), only two pages need to be completed by the qualified person. The new T2201 form is available at regional tax offices or on the Internet at:

<http://www.ccraadrc.gc.ca/E/pbg/tf/t2201/t2201-03e.pdf>.

### *Should patients who were denied the DTC as a result of the October 2001 Canada Customs and Revenue Agency (CCRA) review reapply?*

Absolutely. In October of 2001, the CCRA carried out an extensive review of its files. The CCRA sent letters to 106,000 taxpayers in October 2001 informing them that they no longer qualified for the DTC. To claim the DTC for the 2001 and future taxation years, they were required to submit a new T2201 form. The letter resulted in a great deal of misunderstanding and confusion. Many DTC recipients did not respond. For those who did respond, there are numerous examples of successful appeals. We believe this indicates that among those who did not respond, for whatever reason, there are many who would also win an appeal.

Thus, those individuals who lost their DTC, when the CCRA carried out an extensive review of its files in October 2001, are encouraged to reapply with the new form. We also suggest attaching a letter to the T2201 form titled, "Request for an Adjustment;" ask for a reassessment of the 2001 and 2002 taxation years based on the fact that "your doctor indicated that you became 'markedly restricted' in a basic activity of daily living such as walking, speaking, hearing, dressing, feeding, elimination, or perceiving, thinking and remembering," during or prior to the 2001 taxation year.

### *What are the next steps?*

The government has agreed that more needs to be done to ensure that the DTC effectively meets its intended purpose. The Technical Advisory Committee (est. spring 2003) is responsible to advise the Ministers of Finance and National Revenue on tax measures for persons with disabilities. The Committee supports the extension of eligibility to individuals with mood disorders and other episodic conditions, such as multiple sclerosis and arthritis, that substantially impair their ability to carry out a basic activity of daily living. The final report of this Committee is due by October 31, 2004.

*The physician is the one who must fill out the portion of the DTC as the "qualified individual." In view of the large numbers of patients that you are advising to reapply, and the time required of the physician to do this paperwork, has TAS or the DTC coalition asked the government to remunerate the physicians for their time in completing these forms?*

The Committee recommends that:

- a) The CCRA send a letter to every individual who received the letter, dated 19 October 2001, requesting DTC recertification. This correspondence should apologize for the tone of the letter and provide a complete explanation as to why the CCRA requested recertification.
- b) All individuals who obtain recertification as a result of the October 19 letter be compensated upon the production of receipt for any costs incurred in obtaining the services of a qualified person to complete Form T2201 or for providing the CCRA with any supplementary information.
- c) The CCRA inform all recipients of the October 19 letter that anyone who has been reassessed and refused the DTC can reapply once Form T2201 is redesigned (See Recommendation 5). In the meantime, the CCRA should also advise these individuals of their right to appeal the decision.

The Government of Canada's response to the seventh Report of the Standing Committee on Human Resources Development and the Status of Persons with Disabilities was as follows:

- a) No letter of apology. The CCRA contends that "it made every effort to ensure that the tone and content of the recertification letter were sensitive and appropriate. It is unfortunate that, despite these efforts, some people who received the letter were offended." In the future, the CCRA will ask for input from members of disability groups regarding the "wording of these types of letters."
- b) No compensation to be offered because it will be "inequitable for government to compensate only individuals who were involved in the review of the pre-1996 DTC claims for these expenses."
- c) No response.

For further information about the initiative to reform the DTC, visit [www.disabilitytaxcredit.com](http://www.disabilitytaxcredit.com). For further information on the Technical Advisory Committee, visit [www.disabilitytax.ca](http://www.disabilitytax.ca).

## Farewell to the Chief: An Interview with Arthur Bookman on His Term as President

---

Arthur Bookman, 39th president of the Canadian Rheumatology Association (CRA), was recognized for his great efforts at the Annual Awards Dinner of the CRA. He was given a gavel for his time in office and a camera from the CRA as a gesture of thanks. The *CRA Journal* has asked for his thoughts, upon completion of his very successful term in office, which are presented herein.

*As president of the CRA, there are certainly highs and lows during the term of office. What were your major challenges during the past two years? What do you see as your most important accomplishments?*

You know the saying, “We stand on the shoulders of giants.” By the time Glen Thomson became President of the CRA, we had accumulated enough financial resource to begin branching into areas other than holding annual conferences. Glen put down the foundations of committee structure that enabled us to move forward. Dianne Mosher used that structure to collect vital statistics and information on Canadian rheumatology and, during her tenure, we fought some major battles. We used media to become recognized by the public as an organization and a specialty. We demanded an advisory role at The Arthritis Society (TAS), and no longer allowed TAS to speak for us. We spoke out in public and set standards for use of biologics in Canada.

I saw it my natural mandate to move Canadian rheumatology forward into the role of public leadership that behooves us. If we do not lead, others will, and the result will be wasted effort and resources in research dollars, care and organization. To move that agenda along, we hosted the first combined discussion of representatives from the Canadian Orthopedic Association, Arthritis Health Professionals, Patient Advocates, the Canadian Arthritis Patient Alliance (CAPA) and TAS on the common issue of Access to Care for arthritis patients. We took this issue to the Federal Ministry of Health and we made it a national platform of the Alliance for a Canadian Arthritis Plan. From a position of strength, we have fostered closer interaction with the Arthritis Health

Professionals Association and a true affiliation with the Canadian Pediatric Rheumatology Association. These alliances will move forward and they will give us a stronger national voice.

We also established a more formal structure for our organization. We created a printed binder of standard operating procedures, we set out our rules for membership, we created a formal disclosure form and a code of ethics for the CRA executive.

Perhaps the greatest high for me was the move we made to celebrate our own excellence in Canadian rheumatology at our conference in Lake Louise, Alberta. The biography posters of our distinction awardees, our young podium award winners, the Great Debate by four brilliant women in our specialty and our Saturday morning lectures from Drs. Rae Yeung, Robert Inman, and Watson Buchanan made me burst with pride.

*The CRA has had an interesting relationship with The Arthritis Society (TAS) over time. You have formalized this relationship and brought more rheumatology input to TAS. What concrete steps have been taken to improve the interaction between rheumatologists and TAS?*

The Medical Advisory Committee (MAC) was formed at TAS at the insistence of the CRA. We fought for this because we felt that TAS needed our leadership and was making its decisions at the behest of many constituencies, and moving in directions that were making it difficult for us to support this important organization. The committee consists of seven rheumatologists, an orthopedic surgeon, an Arthritis Health Professional, a patient advocate and two members of the board. My first battle was to define a role for the MAC, especially since the Alliance for a Canadian Arthritis Plan (ACAP) (*i.e.*, CIHR, CAN, TAS, CAPA, CRA and COA sitting as “Knights at the Round Table”) made it difficult to understand what it was that TAS stood for. After a day-long meeting with the ACAP executive, I think we have clarified that they hold national conferences to direct the research agenda in arthritis. TAS can now set its own direction.



*President Michel Zummer and President Arthur Bookman:  
Why are they both smiling?*

I sit on the board and act as spokesman to the board for the Canadian Council of Academic Rheumatologists (CCAR) as well as the MAC. I also sit on the Scientific Advisory Committee (which adjudicates grants) and the MAC adjudicates clinical manpower awards, such as the Geoffry Carr and the Metro Ogryzlo fellowships.

*You will continue as the chairman of the Medical Advisory Committee (MAC) of The Arthritis Society (TAS). What are your policy priorities in this role?*

The MAC is just starting to roll. We feel that we must recreate a culture that supports research at TAS. This means meeting with the Divisional Executive Directors to see how we can best communicate the success of TAS-funded arthritis research to fundraisers, and how we can advise on policy that will make contributions to a national research agenda more palatable at the divisional level. We will create a larger role for rheumatologists on the board of every division of TAS.

There is also an opportunity to work more closely with the new Chief Executive Officer of TAS, Mr. John Fleming. I will explore means of achieving this, including regular meetings, and perhaps an expanded role for a "Medical Officer" within the organization.

We will develop a protocol for validating the impact and financial benefit of any regional or national program developed by TAS, so that any funds siphoned away from research and into programs must be justified.

*You will continue to have an active role in the CRA. One of your roles will be in completing the*

*arrangements for the Canada-Mexico Joint Meeting in 2006. Tell us about this process and what Canadian rheumatologists can anticipate.*

The Mexican College of Rheumatology (MCR) is a well-run organization of very warm and enthusiastic physicians. Michel Zummer will strike an arrangements committee and a program committee to work with members of the MCR. It is evident that they have their way of meeting, that is much like the American College of Rheumatology (ACR), and they depend on pharmaceutical revenue as much as the CRA. The venue will, thus, likely consist of both individual and combined sessions. There are many opportunities to develop unique interactions, including panels on manpower, regional disease manifestations, discussion of systems of health delivery and research consortiums. We can also develop working groups to evolve opportunities for education and research interactions.

Our expectation is that a very large proportion of our membership will attend and our greatest responsibility is to assure very careful financial planning to protect the resources of the CRA.

*What advice would you like to give to the President-Elect Michel Zummer and the Vice-President Gunnar Kraag?*

Michel needs to listen to his wife more and should give up his love for chocolate-covered chicken enchiladas! I have every confidence that he knows his own mind without my advice and he is going to be a very strong voice for the CRA. Gunnar never listened to me before, so why would I try to give him advice now? I am delighted that he has resumed his role with the CRA executive.

I would advise every executive of the CRA to maintain the tradition of proactive planning. This organization cannot afford to drift. I think that Michel is the perfect president to explore our relationship with our colleagues in Quebec. Participation of eastern Canada is lower in our organization than in the west and Toronto is underrepresented on our board. To remain vital, we must remain cognizant of the many regional meetings that are springing up around our country and try to catalogue their various issues to prevent division within our very successful organization.

Our Annual Conference is growing, and this threatens the intimacy and special cohesiveness of our meetings.



We are going to have to make some choices and look at novel venues to maintain the special feeling that we all have each year when we get together.

*What message do you have for the CRA members?*

Do you know that I celebrate every day that I went into rheumatology? Professional satisfaction among our specialty is very high despite the rotten income, the paperwork and the long hours. I have made wonderful friends among my colleagues, I love to teach my students and I have the most fascinating group of patients.

I think that this specialty is worth fighting for. It makes my blood boil when I hear colleagues say “I can’t be

bothered,” “I don’t go to the Annual Meeting because it’s in the mountains,” “I don’t have time to participate.” We are fewer than 300 rheumatologists in a country of 31 million people. We drown every time we remain silent. There is no room in this specialty for apathy, silence, abdication.

If you take pride in the CRA, get on a committee. Come to our meetings. If you take pride in rheumatology, demand your place in the teaching curriculum, fight for your hospital facilities. If you want a voice of empowerment, sit on the board of your Arthritis Society Division, teach and inspire them.

Thanks for letting me serve as President of the CRA. It has been a highlight of my life.

## Words of Wisdom: Carter Thorne’s Reflections on Eight Years as the CRA Secretary-Treasurer

---

**C**arter Thorne is the 15th Secretary-Treasurer of the Canadian Rheumatology Association (CRA). The list of those who have served before is a list of the most dedicated of all Canadian rheumatologists. Starting in 1996 and ending this year, Carter’s duration in the toughest job of the CRA is only surpassed by W.S. Barnhart who was secretary-treasurer first of the Canadian Rheumatic Disease Association (1936-1946) and then of the Canadian Rheumatism Association (1946-1947).

During the “Thorne Era,” the CRA experienced logarithmic growth in its financial resources. The CRA executive also expanded and took on greater responsibilities. The Incorporation of the CRA is a reminder of Carter Thorne’s lasting influence on our national association. The members present at the CRA Annual Business Meeting and later at the Awards Dinner at Lake Louise thanked Carter with a standing ovation for his sincere stewardship of the organization. The *CRA Journal* approached Carter Thorne to ask him his thoughts upon

completion of his term in office. His responses are presented herein.

*You are the longest serving Secretary-Treasurer in the history of the CRA. On your watch the CRA has metamorphosed. What were the key turning points in the evolution of the CRA in the last decade?*

Paul Davis’ leadership in the early 1990s allowed the CRA to begin its transformation into a meaningful organization for rheumatologists—both academic- and community-based. Furthermore, development of a Mission Statement gave both the membership and the Board a direction for strategic planning. Finally, the decision of the Board to establish a unique meeting venue, program style and professionalism, has allowed the CRA to develop not only a tool for education of its members, but an opportunity to network with other members, partners and organizations, while at the same time accruing financial resources that have allowed the organization to attempt to meet its mandate.



*Carter Thorne accepting a gift from the CRA for long service as Secretary-Treasurer... but refusing to return the bank card.*

*You have presided over an exponential growth in the budget of the CRA. How has the CRA managed to accomplish this? Is the growth in our budget sustainable?*

The growth in the budget and the reserves of the CRA have resulted from strategic planning of the Board and establishment of both priorities and achievable outcomes. We have had, as your responsible representatives, to be cautious in our commitments and planning and this has allowed the CRA to continue to support growth without taxing our reserves or our members. The CRA faces more challenges in the short and medium term, and the Board must continue to be vigilant and responsive to changing circumstances, which are often unanticipated.

*The role of Secretary-Treasurer is one of attention to the smallest of details. Those who have served with you would say that you may be the most organized person alive. How do you stay on top of so much information?*

I have had the support of the executive (five different presidents) and fantastic colleagues. The arrival of the Internet (hi-speed always on) has facilitated communication and the ability to attend to issues as they arise and even when away from the office. The support of

Christine Charnock, who joined us as Administrative Assistant while on “my watch;” the hiring of Sylvia Clayton, our book-keeper, to help us keep track of bills and payments; and my own office staff have allowed me to keep track of both the macro- and micropicture.

Finally, the understanding of my wife, Jena, was imperative to allow to me pursue what has been a wonderful adventure.

*What were the greatest challenges for you in your role and the greatest sources of pride?*

1) Convincing the Board of the need for a concise Mission Statement and 2) presenting the Mission Statement to the membership for ratification.

This allowed us to move forward with a clear direction. I feel confident that the CRA will continue to be a source of professional pride and support as we attempt to improve the care for those who have arthritis.

*You are now the founding Secretary-Treasurer of the Canadian Rheumatology Research Consortium. Why did you agree to take on this complex and important role with this new organization?*

I have always enjoyed “organizational challenges” and I saw the opportunity to work with and for my colleagues as both a privilege and a challenge. I believed in the vision that Paul Davis had to make the CRA an inclusive association, and I wanted to be in on the ground floor!

*What advice would you give to the CRA’s new Secretary-Treasurer, Jamie Henderson?*

Look at the horizon while keeping your feet firmly planted on the ground. I also saw my role as being that of the “memory” of the organization. Jamie, “keep good records” and don’t lose them!

*What’s the next challenge for Carter Thorne?*

I have both clinical objectives (e.g., continue to improve our delivery of care to patients) as well as professional objectives (e.g., attempt to put PANLAR on track) in my role as executive member and Treasurer. I am currently organizing a Strategic Planning retreat to develop a Mission Statement for PANLAR.

My time with the CRA Board and its members has been one of my most rewarding activities!



# Words from Distinguished Rheumatologist Dr. Watson Buchanan

---

(Introduction by Dr. Gunnar Kraag)

**M**ention the name “Watson” in rheumatology circles anywhere in the world and you will undoubtedly see a broad grin appear and hear a story. Watson Buchanan became a legend as the driving force at the Centre for Rheumatic Diseases in Glasgow, where countless students of rheumatology spent time and never forgot their experience. His greatest attribute was that of mentor and facilitator, and at last count, 39 of his disciples now hold senior academic positions. Shockingly, he left his beloved Glasgow and came to Canada. When asked why, he always replied that, “bees come to honey.” I always suspected that he couldn’t resist working at a place called “McMaster,” a name with close links to the “Clan Buchanan.” Destiny?

Watson has over 500 publications and continues to write as well as see patients. He remains a facilitator, role model, academic, mentor, ambassador and physician without parallel. He has very recently been awarded the prestigious Cullen prize by the Royal College of Physicians of Edinburgh, founded during Queen Victoria’s Jubilee Year, “for the greatest benefit done to practical medicine.”

Watson Buchanan is most definitely a distinguished rheumatologist.

P.S. Although I must say, I was shocked that the following interview with Watson is so “short” and that he didn’t say anything absolutely outlandish!

*What aspects of your career bring you the most pride?*

I would say the number of doctors and laboratory scientists with whom I have worked and who now hold senior academic posts throughout the world. At a dinner at Loch Lomond Golf Club House in 1999, some 200 colleagues attended. Of course, I have been in rheumatology for some four decades, which, in part, accounts for the number.

*If you had to do it again, what parts of your career would you change?*

None.

*Which individuals most influenced your career? How?*

These are largely from my formative years in Scotland:

- **Dr. Peter McKenzie.** Chief Practitioner at Belvedere Hospital in Glasgow. This was the largest “fever” hospital in Europe. I gained experience in dealing with a large number of acute medical emergencies, especially in infectious diseases, both in adults and children, and not only in Glaswegians, but in people from abroad (with malaria, leprosy, etc). Dr. McKenzie was a superb clinician who taught me how to take a history and how to examine patients. He was also a talented musician, as is his son, and he proved an admirable mentor.

- **Dr. Lawrence D.W. Scott.** An internist at one of Glasgow’s hospitals, he gave me experience and guidance on how to diagnose patients with a variety of diseases, from malignant hypertension to scurvy. Also a great mentor.

- **Professor Sir Edward Wayne.** I spent my research years under his guidance. With him I studied endocrinology and took my exam in the Edinburgh College of Physicians in that discipline, not rheumatology. Professor Wayne was one of the old-type professors who actually professed and practiced medicine as well as gave advice and encouragement in research. His particular influence on me was to appreciate the use of mathematics and statistical analysis in clinical problems, and to determine the “evidence.” He was, alas, the last of a breed since most modern chairmen are largely administrators and concerned with finances.

- **Dr. Joseph J. Bunim.** One of the people who had the greatest influence on me was the late Dr. Joseph J. Bunim who was in charge of the arthritis research group at the National Institute of Health in Bethesda, Maryland. I spent two years with him and his talented team, including Leon Sokoloff, Jarvis E. Seegmiller, Norman Talal, Nathan Zvaifler and Kurt J. Bloch. Dr. Bunim was a superb clinician—an internist as well as a rheumatologist. His concern was not his own career, but the careers of those who came to work with him. There have been many giants in the American College of Rheumatology, but none, in my opinion, as great as Joseph J. Bunim.



*Centre: Dr. Watson Buchanan,  
2004 Distinguished Rheumatologist*

Not only had he come to grips with the science of rheumatology, but he was also in the Olsen tradition.

*Throughout your career, many changes and developments have occurred in rheumatology.*

*Which do you consider the most important?*

All of them! The whole field has developed and expanded in the last 40 years. Radiology has been transformed with CT scans, MRIs, ultrasound and radionuclide scans. Indeed, today radiology is in its golden era. I believe the time is now to make radiology part of a large department which also includes anatomy and pathological anatomy. Anatomy needs to be reintroduced into the undergraduate curriculum. Immunology has also developed in a most breathtaking way. It is part of every rheumatology work-up. Genetics have intruded with the discovery of certain HLA types associated with certain disorders. It has transformed bacteriological “gardening” into consideration of not only bacteria and viruses, but also the soil. The evaluation of drug testing has been much improved and I am happy to say that some of the advances have been made by faculty at McMaster University (it should be noted that *Mac Mhaighster* means “son of the master

or scribe” and, as such, *Mac Mhaighsters* were members of the *Clann nan Cananach*, i.e., the Clan Buchanan). So we should not be surprised that McMaster University has played such an important role in developing the methodology and outcome measures of clinical trials!

*Had you not entered medicine, what path would you have pursued?*

A hypothetical question difficult to answer. I might have entered politics, but I would have been worried, had I run for election, of actually being elected! I would have found opposition most objectionable. My ideal government is a dictatorship—punctuated by fairly regular assassinations! No, I might have been interested in a career in history—provided, of course, I would be allowed my own prejudiced views!

*As an international figure, you have had many opportunities on where to live and work. Why did you choose Canada?*

Canada has always fascinated me. Of course, many Scots came to this country. The first two Prime Ministers were Scots—the first being from my hometown of Glasgow: John A. Macdonald. A man of great spirit, albeit of the wrong kind! McMaster University fascinated me, especially its revolutionary character. I must say I have been very happy in Canada, but whether Canada and Canadians have been equally happy with me is another question! The medical school at McMaster University has now established its system of medical education, and has exported it to many universities around the world. But does it need a renewal of its mission? Yes, I would agree, but this is difficult to achieve. Most revolutions in history resist a second revolution.

*If you could meet and have a discussion with any historical figure (medical or not), who would it be and why?*

Another difficult question. There are so many people I would like to meet. I have always had an admiration for Scots who have been successful. Andrew Carnegie is one such person—the richest man in the 19th century, who



offered to buy the Philippines their independence when the United States took them over. Also, he pleaded with Kaiser Wilhelm not to start World War I. Of course, there are others—perhaps William Shakespeare. Who was he? Was he just an actor? Or was he a member, as I suspect, of English royalty?

*What advice do you wish to impart to Canada's rheumatologists?*

I would urge them to be bilingual, *i.e.*, to know not only clinical rheumatology, but also one other "ology," be that immunology, biostatistics or genetics. We must ensure that the specialty doesn't become inward looking, like cardiology, but that it develops expertise outside the locomotive system. A clinical rheumatologist who is also an expert in clinical pharmacology or some other discipline is the way

I would suggest we go. I would also suggest that the Canadian Rheumatology Association (CRA) have combined meetings with other disciplines. It is essential that clinical rheumatology continue to be in the mainstream of medicine—not in a side eddy—and to ensure that it becomes even more important in the years to come. Canadian rheumatologists should also consider combined meetings with other national groups. Small meetings, not large meetings, are the answer. So the CRA could have a meeting with the Scandinavians—in Iceland. Canadian rheumatologists should continue to ensure their papers also are published in general medical journals. The *Journal of Rheumatology*, under the editorship of Duncan Gordon, has been one of Canada's success stories. Dr. Gordon will not, I am sure, disagree that rheumatology papers should also be published in general journals.



*Left: Dr. Walter Maksymowych, Scientific Meeting Chair; Right: Dr. David Felson, 2004 Dunlop Dotteridge Lecturer*



*Left to right: John Thomson; Sindhu Johnson (Toronto), winner of the Dr. Ian Watson prize for Best Lupus Paper; Bin Liu (Toronto), winner of the Dr. Phil Rosen prize for Best Clinical Paper and also the winner for Best Overall Paper; LeeAnne Luft (Calgary), winner of the prize for Best Basic Science Paper; and our beloved Arthur Bookman.*



## CRA News



*Ricardo Cartageena in Banff asking, "Where is Chateau Lake Louise?"*



*Emily Kelsall, Vancouver's 2010 Olympic hopeful, with dad (John Kelsall).*



*The real reason Tony Russell lives in Alberta.*

Having completed a successful CRA annual meeting, the new executive is making plans to move the organization into the future. One of the most important undertakings is to complete a new needs assessment of the membership. Under the guidance of Denis Choquette and Glen Thomson, the survey is being completed online this year. It is hoped the membership will complete the survey in time for the results to be compiled and presented at the forthcoming executive retreat at the end of April.

The executive relies on the findings of this survey to guide the future of our annual scientific meeting. We are seeking input on desired topics, preferred locations and many other topics pertinent to a successful meeting. Members are encouraged to go online ([www.cra-scr.ca](http://www.cra-scr.ca)) and let us know what you think.

Plans are proceeding to arrange a joint meeting with the Mexican Rheumatology Association next February in Cancun. Michel Zimmer and Arthur Bookman will be traveling to Cancun to look for the best venue to hold the meeting. It is tough work but we send our best and brightest! A committee has been formed to begin planning and making the arrangements to ensure a great meeting.

The executive and committee chairs will be traveling to Montreal on April 23rd to participate in the annual retreat. There is a full agenda, with the structure and cost of the annual meeting being put under a microscope. The cost of the annual meeting has been escalating annually and we will examine ways to control costs without compromising what has become a successful program. The executive will also continue exploring ways to integrate the Canadian Pediatric Rheumatology Association into the CRA and ensure the annual meeting provides ample content



*The future CRA Ski Team*



*Mosher, Lacaille & Kaminska:  
The CRA's "Crazy Canucks."*



*Another editor! Duncan  
Gordon, photojournalist.*



*Milton Baker wondering,  
"Where are my skis?"*

for their group. We will also continue discussions with the Allied Health Professionals, who have indicated that they would like to hold their annual meeting in conjunction with ours on a regular basis. Other topics for discussion will be: the ongoing evolution of the CRA website under the guidance of Kam Shojania, the therapeutics committee under Vivian Bykerk, the education committee under Jerry Tenenbaum, the liaison with the Royal College and many other undertakings. The tasks are many but there are willing spirits to help.

Following the retreat, there will be our annual sit-down with the various pharmaceutical companies that sponsor the meeting. This is a unique opportunity for them to give us feedback on their involvement with the CRA and for us to publicize the principles that allow us to continue to maintain control over the scientific content of the annual meeting. This year will mark the first year board members will sign disclosure documents to prevent any conflict of interest whilst making decisions on behalf of the CRA.

The table is full, the topics are many. The expectations are high. The team is ready.

– Jamie Henderson



*Olga and Maureen from U of Alberta CME  
removing a rowdy rheumatologist refusing to  
pay registration fee.*

**Erratum:** The recent report that Dr. Harold Fireman of Ottawa had retired was greatly exaggerated. Dr. Fireman was running a busy office when the CRAJ arrived and his retirement was indeed "news" to him and his secretary. He assures me that he is not retired. He refuted my claim that he knew Methuselah personally, but did admit a close association with Ponce de Leon. We hope to interview Dr. Fireman for an upcoming issue of the CRAJ.

– Gunnar Kraag

## Provincial News

---

### *Rheumatology in Manitoba*

Spring is finally approaching and here in Winnipeg thoughts are turning from snow and ice to greens and sand.

A highlight of the next few months should be the second annual Western Alliance of Rheumatology (WAR) meeting in Kelowna, British Columbia from May 28-30. The WAR meeting was founded last year by Paul Davis and John Esdaile and has clinical rheumatology as its focus. However, a secondary goal is promoting collaboration and collegiality amongst Western Canadian rheumatologists. All attendees are strongly encouraged to contribute to a portion of the program. Presentations are all clinically relevant and interactive. Along with the academic aspects of the meeting, the venue in Kelowna offers opportunities for many recreational options, including golf, wine tasting or an afternoon on the lake. Last year's meeting received overwhelmingly positive evaluations and I'm sure the 2004 edition will meet with similar results.

Preparations for the next round of fee schedule negotiations are beginning in Manitoba. The most recent contract, ratified in early 2003, recognized the divisions of rheumatology and family medicine as the most poorly remunerated and rewarded them with the highest proportional fee increases of slightly more than 15% over the three-year length of the contract. Manitoba rheumatologists' priorities for the next negotiations include another higher proportional increase relative to other divisions, better remuneration for injections, and new fee codes for disease-modifying therapies.

– Cory Baillie

---

### *Rheumatology in New Brunswick*

Rheumatology is alive and well in New Brunswick. We currently have eight rheumatologists in the province with one more planning to join the group in Moncton this year. This cadre is tasked with coverage of a population of 750,000 people, divided evenly between rural and urban locations. There are rheumatologists present in the three major urban centres. The majority are required to participate in the Internal Medicine call schedule in their respective centers.

The fee schedule for rheumatology has improved significantly in the past three years. The key was to separate ourselves from the hegemony of the Internal Medicine negotiating process and set out on our own as a separate section with other specialty groups. Our fees increased about 25% with the last distribution. We have now reached the lofty heights of "the middle of the pack." Lacking any highly remunerative procedures, it is not likely that there will be any further quantum leaps in the near future.

The provincial formulary was slow to approve biologics for use by clients of the provincial drug plan, but with the persistence of patient advocates success was achieved. A recent decision by Atlantic Blue Cross (the major insurer of private health plans) has caught us off guard. They have stipulated that all clients requiring biologics will be required to utilize etanercept as the initial drug of choice. Their justification for this is their contention that the cost of infliximab has been in the order of \$7,000 in excess of etanercept. They have indicated that patients failing etanercept will be entitled to a trial of infliximab. At the time of this article, we are contacting all rheumatologists to see if any protest to this policy should be mounted.

Most of the rheumatologists participate in traveling clinics to bring their services to outlying areas. With the imminent return of spring, it will be time to get on the road again.

– Jamie Henderson



## Campus News

### *University of Montreal*

We are at the end of the obscure tunnel of new rheumatology resident recruitment at the University of Montreal. The number of new recruits has been varying between one and zero per year for the last four years. The number of hospitalization beds was severely cut down, thus decreasing our visibility inside the hospital. Visibility of rheumatology is also poor because of the decreasing number of practising rheumatologists, especially in university hospitals. That being said, many initiatives, such as the resident weekends supported by Pfizer, the Merck-CRA studentship and many other locally administered events, such as the review by E. Badley of the impact of arthritis in Canada (completed last December), are demonstrating efficacy. Three new rheumatology trainees will start their residency in July 2004 at the rheumatic disease unit (RDU) of the University of Montreal. On top of that, there are tentatively two more trainees entering the program in 2005 and one more in 2006.

New training centers have been added to Notre-Dame Hospital which, up to very recently, was the last french-speaking centre for post-graduate training in rheumatology. Dr. Michel Zummer and his team at Maisonneuve-Rosemont Hospital have recently joined the RDU, and the Institute of Rheumatology of Montreal—with its clinical research unit—has also been accredited for rheumatology training. These three centres will bring the essential varieties of practice for new trainees. Expertise in osteoporosis, collagen-vascular disease, osteoarthritis, rheumatoid arthritis, clinical research, epidemiology and biostatistics will be very well covered by these three training centres.

– Denis Choquette



### *Queen's University*

The Division of Rheumatology at Queen's University remains relatively stable. We are still under the Alternate Funding Plan (AFP), which is both good and bad. Good because of stability of funds; bad because of constraints in recruiting and other factors.

Dr. Peter Ford has taken early retirement and we have been fortunate in being able to replace him with Dr. Mala Joneja, who joined our division on January 1, 2004 as an Assistant Professor. The other division members with clinical responsibilities, Drs. Tassos Anastassiades, Isaac Dwosh, and Tanveer Towheed, are pretty much doing the things they were doing before, as is Dr. Inka Brockhausen, our Arthritis Society Clinical Scientist in Glycobiology.

Dr. Ami Mody, our senior Clinical Fellow is doing very well and will likely stay another year, likely focusing on osteoporosis.

The two Research Associates, Drs. John Carran and Karen Ress-Milton (Anastassiades Lab) are also doing quite well. The project on new derivatives of glucosamine has progressed to the point of the technology being licensed through Canada for veterinary use—although it is not quite ready for your human patients yet! The multicentre CaMOs project has been renewed and there is good support from the Natural Sciences and Engineering Research Council (NSERC) and Canadian Institutes of Health Research (CIHR).

In Ontario, the new Liberal government will apparently move quickly to abolish mandatory retirement, an issue also dear to the heart of the Ontario Medical Association.

– Tassos Anastassiades