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10th Anniversary
The Scientific Committee has again created an exciting educational program which can be viewed on the CRA website at www.cra-scr.ca.

Registration forms can also be downloaded via the CRA website, or phone the CRA for registration forms at 905-952-0698. The deadline for registration is February 3, 2003.

The Fairmont Tremblant will be the site of this year’s meeting. This wonderful venue will be enhanced by a number of activities, including the annual Ski Race.

Hotel accommodations in the CRA Room Block at the Fairmont Tremblant must be booked before January 25, 2003 (phone: 877-277-3767). Please make sure to indicate your wish to be part of the Room Block, and ensure that you are speaking with the hotel directly, not their Call Centre.

We look forward to seeing you there!
Holidays and the Promise of a New Year

How quickly a year seems to fly by. On a personal level, a year with a young family may present many important milestones punctuated by various school events. Although the school year may seem to drag on forever at times, the much anticipated summer vacation that follows seems ever-so-brief. On a professional level, a year is marked by travel to meetings and other various professional commitments that can either be a burden or a joy.

At the end of every year, when we look back, there seems to have been a lot of activity…but are our circumstances any different from what they were a year ago?

In the practice of rheumatology, the pace is usually more glacial than in other branches of medicine. The Romanow Commission, however, has brought about much activity for the Canadian Rheumatology Association (CRA) and many other medical groups, with respect to our thoughts on the health-care system. Episodically throughout the year, Roy Romanow punctuated the life of his Commission with speeches. At the time of this writing, the final report of his Commission is still several weeks away. Will we as Canadians and health-care providers be in a different position when his findings are finally released?

It is hard to imagine that a former New Democratic Party (NDP) premier of Saskatchewan would find any ideologic comfort with any aspect of private health care. It is also difficult to imagine that an individual who was once in charge of a public bureaucracy would have the background to consider models of care that are not based on public bureaucracy. The public coverage of the Commission has provided a forum for the polarized debate between left- and right-wing ideologies of health care. Private, “for-profit” health care has been characterized by some as a priori unethical, although the ethics of squandered public resources by entrenched institutions and their well-appointed administrators is never considered.

Few individuals in Canada want a free-market health-care system that denies access to individuals most at need. This stance, however, is being interpreted as an endorsement of a health-care system that can deliver emergency care to individuals at risk for life and limb, but denies access to state-of-the-art therapies for arthritis patients, who must endure the pain and gradual loss of their abilities and lives. The usual sense of “Canadian compromise” and finding middle ground has not been present in this health-care debate. There is almost a palpable fear that any alteration of Medicare, no matter how bad it is becoming, would destroy the principles of universality. As a rheumatologist practicing in an underserviced province, it is obvious to me that Medicare is not universally accessible, and that the quantity and quality of care varies logarithmically between regions. Preserving the status quo is to preserve mediocrity for many parts of Canada.

The Kirby Commission recently delivered its thoughts on health care. Marijuana has become a recurrent theme in the Liberal Party’s health-care strategy in recent years. If marijuana is made legal, perhaps the health-care system won’t have to change—we will be too lethargic and complacent to complain anymore.

The various well-intentioned reports and commissions over the years on various aspects of health care have not served Canadians well. The current deficit in physicians, generally (and in specialists, particularly), is a direct result of recommendations made more than 15 years ago, which concluded that if fewer physicians were trained there would be fewer health-care costs. The brain trust that put those recommendations together was rewarded handsomely, and provided with well-intentioned administrative positions. I imagine that some of those individuals are now the patients who complain about prolonged waiting lists for consultative appointments.

If history is our guide, the past year spent by Mr. Romanow may be just another year in the slow progression of health-care change in Canada.

In the coming year, through its policies and programs, the CRA will highlight the need for appropriate access to care for arthritis patients. As part of the “Decade of the Bone and Joint,” the CRA and Glen Thomson, MD, FRCPC is a rheumatologist and former president of the Canadian Rheumatology Association. He is the Director of CIADS and Associate Professor at the University of Manitoba in Winnipeg, Manitoba.

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We Once Had A Great Idea...

As this year has unfolded, I have seen the world of arthritis-oriented issues through the eyes of those who relate to us: our patients, our allied health associates, our fellow musculoskeletal professionals, and our research foundations. By virtue of the fact that rheumatology professionals are centered exclusively on the full spectrum of arthritis care, we cannot shirk our responsibility to play the dual role of collaborator and leader.

This past year, I have met with organizations that represent each of our affiliates.

Our patients are represented by a variety of disease-specific groups, but a major player rising on the field has been the Canadian Arthritis Patient Alliance. Encouraged and fostered through The Arthritis Society (TAS) administration, they have taken on a number of advocacy issues, and are becoming progressively more vocal. They have been empowered by TAS, the Canadian Arthritis Network (CAN) and the Canadian Institutes of Health Research (CIHR) to organize a massive national coordination of all arthritis-related research, professional and advocacy groups. Their effort is to be called the Canadian Arthritis Plan. The diagram of their plan of attack is a target, with patients on the bull’s-eye—probably quite appropriate. A major organizational meeting will have occurred by the time you read this. And the Canadian Rheumatology Association (CRA) will have been there.

The Allied Health Professionals Association has formed a national body just recently, and will be holding their national meeting, along with us, at the upcoming CRA annual meeting in Mont-Tremblant, Quebec, in late February. At our invitation, they will join our family, and although they have their own agenda of concerns, they, like us, are focused on bringing the best possible care to patients. They will submit research abstracts and hold their own workshop at Mont-Tremblant.

The orthopaedic push on arthritis has come through the Swedish-inspired international organization called “The Decade of the Bone and Joint.”

Recently endorsed by the Federal Ministry of Health, this movement may yet gain momentum, but, in Canada, rheumatologists are proving to be their greatest allies. Through our initiative to develop coordinated and more efficient access to care, the Bone and Joint Decade Committee will make this one of their premier platforms in Canada, and will take our ideas worldwide. We will play a leadership role in this initiative, as well.

There is an area, however, in which it has become evident that our rheumatology community has been delinquent. This lies in the area of our research foundations.

We once had a great idea. Our professional founding fathers created a federal organization that would raise money from the public, and seed it in the most strategic way, to leverage the education of rheumatologists and centres of excellence for arthritis research and care. This was the Canadian Arthritis and Rheumatism Society (now known as TAS). The strong leadership of that organization involved a very close collaboration between rheumatologists, the Chief Executive Officer (CEO) and the executive. The vision was very clear, and the evolution of the plan was largely successful.

There were, however, intrinsic defects in the original constitution of TAS. It was a federation of provincial divisions, with no built-in guarantee of strong national governance. Instead of being vigilant and proactive in the process of change for this organization, we rheumatologists went into a period of hibernation. When we awakened, we found an altered arthritis society. The Medical Planning Committee was no longer led by a rheumatologist. There were few rheumatologists on the national board or on its executive committee. There were no rheumatologists on most provincial executive boards. Without our leadership, TAS has found its leaders elsewhere.

Today, what we have is an organization constructing plans for the nation: the Institute of Musculoskeletal Health and Arthritis (IMHA) at CIHR, CAN, and now recently, the Canadian Arthritis Plan. Although advocacy has become the main focus of TAS, when we look carefully, we see that the emperor has no clothes. Fundraising has fallen short. As a consequence, TAS is in great dan-

Arthur Bookman, MD, FRCPC is President of the Canadian Rheumatology Association, Associate Professor at the University of Toronto and Clinical Coordinator in the Division of Rheumatology at the Toronto Hospital, Toronto, Ontario.

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Declining numbers is a common problem in most specialties. Unfortunately, this problem seems to occur during times of increasing need. Rheumatology has been hit particularly hard by decreasing numbers in trainees and training programs, due to multiple factors that we all recognize. Adequate compensation for the services we provide and the quality of support in our practices has been extremely poor.

That’s the bad news, now the good.

We all know that this is an incredibly exciting time in rheumatology. Our knowledge base is expanding exponentially, and the impact of our interventions is increasing in value to both our patients and society. These improvements will lay the groundwork for recognizing our value in the medical system.

What must we do to get this message out?

As your organization, the Canadian Rheumatology Association (CRA) is focused on the quality of care we provide our patients. Whenever possible, we are involved with other stakeholders in musculoskeletal care to assure that delivery of care is optimized. We advocate for our patients and their right to delivery of the best possible care. Increasing recognition that we are the “Experts in Arthritis” (as per our new logo) will promote interest in rheumatology as a specialty. Fair compensation for our expertise must be provided. The many hours of hard work put in by the executive, and all the committee members, is greatly appreciated, and is indispensible in providing us the ability to pursue our goals.

Individually, each of us is responsible for the future of our specialty. We must keep ourselves accessible, especially for patients with diseases on which our impact is greatest. Unfortunately, these patients are often managed by other specialists or by primary-care physicians, giving the perception that the rheumatologist is unnecessary. This is a great disservice to our patients and to our specialty.

We have been squeezed out of the medical schools and hospitals. With the help of the preceptorships offered by the CRA and the American College of Rheumatology (ACR), we can show medical students the benefits of choosing rheumatology as a career. Exposure to rheumatologists is essential, and both academic and nonacademic settings can illustrate that, with our cognitive specialty, we can tailor our lifestyle to our practice. We should facilitate the careers of community rheumatologists, who would like to share their knowledge and expertise with medical students and residents, to contribute in the academic settings as well. We should speak positively about our specialty, especially within earshot of our residents and our colleagues. Within the community, we should each advocate with decision makers and educate our patients. Career days, public forums or talks to specific lay groups help to define what a rheumatologist is and does—and why it is important that patients receive our expert care.

We have an individual and a collective responsibility to strengthen the specialty we all love. The opportunity to deliver quality care to our patients with adequate compensation must be insured, and will help in attracting physicians to rheumatology.

I wish you and your families all a happy and healthy holiday season.

Michel Zummer, MD, FRCPC
Vice-President, CRA

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its members will be actively promoting a number of issues. No doubt, access to care will be discussed at the annual meeting in Mont-Tremblant, and the spring issue of the CRA Journal will be dedicated to this endeavour.

The promise of the New Year lies in the hope that arthritis patients and their rheumatologists will be able to educate the public and their elected representatives that arthritis can be treated effectively when appropriate resources are available. I can’t imagine a better gift for those who are suffering.

The CRAJ Editorial Board, publisher, and I wish all readers a very joyous holiday and a happy New Year ahead. May there be some important and happy milestones that bring us and our patients to better circumstances than in years past.

Glen Thomson, MD, FRCPC
Editor-in-Chief, CRAJ
Canadian Rheumatology Around the World

As a special feature to this Holiday issue of the CRA Journal, the Editorial Board thought it would be interesting to examine the global character of Canadian rheumatology today. In doing so, we first looked inward, soliciting the thoughts of rheumatologists who arrived at our shores from distant lands, with the hopes of learning, practicing and sharing their skills. Drs. Anthony Russell and Paul Davis—both from the United Kingdom (UK)—and Dr. Visa Honkanen from Finland all share their opinions on the differences between practicing “here” and “there.”

We then spoke with Dr. Anne Eberhard, an Australian who moved to Toronto by way of England. She married a Canadian and practiced at the Toronto Hospital for Sick Children. She and her family now live and work in New York.

Finally, we looked outward, to several Canadian rheumatologists who have taken off for elsewhere. They’ve sent back their thoughts on their new jobs—and what they still miss from “home.”

Best wishes for a happy New Year to all our colleagues—wherever they may be.

THOSE WHO LEFT OTHER COUNTRIES FOR CANADA

Anthony S. Russell, MB, ChB, MA, FRCP, FRCPC
Professor of Medicine, Chief of the Rheumatic Disease Unit, Division of Rheumatology, University of Alberta
Edmonton, Alberta

“I trained at Cambridge University in the UK, had a research fellowship at the University of Texas in Dallas, and have been in Canada since 1971.”

Why did you move from England to Canada?
I moved to Canada because I was asked to! (And for the weather.)

In the then-UK system, one was not “recruited”—you applied for a job and with luck and/or contacts and the right horoscope you might get it. But to be sought out and recruited was, for me, a real novelty. Furthermore, I had just spoken at a CME in Jasper, in October, under bright blue skies, and with [the] fall color in full splendor. The contrast with the dull drizzle in London was overwhelming.

What have you enjoyed about practicing in Canada?
What I used to enjoy professionally was the ability to admit patients to hospital, and to share their care with interested students and residents...to have them get to know the patients as people. Weekly ward rounds with the whole group, including an integrated nursing and physio team, provided what might be described as a full and frank exchange of views regarding our individual patient-management patterns. These were always salutary experiences. The times are changing, though.

What do you miss about the UK?
What do I miss? By now, very little, except [for] a few remaining friends and family. In the first years, if I was ever homesick and overcome by the local politeness, and missed the routine of trading insults and barbs, as in the UK, I needed go no further than towards Paul [Davis] and the now sorely missed John Percy, to receive more than my due.

Indeed, I am still surrounded by foreigners—but they’re aging. Some replenishments would add variety (pace Canada Immigration policies).

What has made you proud about working in Canada?
I share the pride Canadian rheumatology can justifiably feel in its role on the world stage. [And] although most of us at times have felt upset with, or [been] annoyed by aspects of The Arthritis Society, we must remember [that] this role would not have happened without it.
Paul Davis, MB, ChB, FRCPC, FRCP(UK)
Associate Dean and Professor of Medicine, University of Alberta
Edmonton, Alberta

“| received my medical training at the University of Bristol, England, and pursued post-graduate training in internal medicine and rheumatology.”

Why did you come from England to Canada?
I came to Canada in 1974 for the Toronto Panlar meeting, and was offered a fellowship by John Percy and Tony Russell in Edmonton. I arrived in July 1975—for a year—but missed my flight home in 1976!

What compelled you to stay in Canada?
I stayed [in Canada] because I saw more opportunities for myself, [both] professionally and [for the] future of my family. I always liked Alberta, and enjoyed making life miserable for my colleagues!

What do you like most about working in Canada?
The University of Alberta and the Arthritis Society [have] provided plenty of support, which was not readily forthcoming in the UK.

What do you miss about the UK?
I miss very little about the UK. I hated the climate, and much prefer Alberta—even the winters. I only miss English rugby and proper beer.

Visa Honkanen, MD, PhD
Head, Paediatric and Adolescent Rheumatology Programme, Rheumatism Foundation Hospital, Heinola, Finland

“I was born 44 years ago here in Helsinki, Finland …[where] I got my MD in 1983, my PhD in 1992, and became a specialist in paediatrics in 1993.”

Why did you come from Finland to Canada?
I was particularly interested in paediatric rheumatology, and found out that possibly the best training was available at Sick Kids [the Hospital for Sick Children] in Toronto. I spent two years [there] from 1996 to 1998.

Why did you move back home to Finland?
I only got a temporary working permit in Canada, so it was [always] our plan to get back to Finland. Of course, at some point, my family entertained the idea of staying on to live and work in Canada, especially during the second year of our stay. But my main reason for coming back to Finland was the private life: my wife’s job (anaesthetist), and the fact that my long-standing friends and relatives live in Finland.

What do you miss most about Canada?
I especially liked the multicultural environment, and the clean and friendly city of Toronto.

How does practicing rheumatology in Finland compare to practicing in Canada?
The health-care system in Finland resembles that in Canada. In both countries, the health-care expenses are covered by tax money. This ensures equal quality of care to all citizens. This is something I like in both Canada and Finland.

The atmosphere at Sick Kids was [a] dedicated [one], and in terms of the clinical work, ambitious. There was an emphasis on teamwork and continuous, clinical, bedside teaching. This keenness [about] the clinical work is something I miss here in Finland. We are too “publication-orientated.”

In Canada, you work longer hours than we [do] here in Finland. I miss that too, since I like everybody doing their job, and not counting the hours too meticulously.

In terms of the salary, I guess that my income here in Finland is not much different from what it would be in Canada, if I [were] work[ing] there as a paediatric rheumatologist.

In Finland, there is, of course, not as much competition in my field as there is in Canada. But I never felt Canada [was] too competitive. In fact, sometimes I feel Finland is too uncompetitive.

Currently my work is around 40% clinical, 40% administration and 20% research. I like this versatility. In Finland, the atmosphere is nonhierarchical, and the attitude is “no frills.” Sometimes this is good and sometimes it’s bad.

Workwise, I think I may prefer Canada.
Regards to all—and thanks for asking!
What brought you to Canada?
I am originally from Australia. Although I am not a “true Canadian,” I am a Canadian citizen. How did I get to Canada? Well, many years ago when I was a second-year resident at the Royal Children's Hospital in Melbourne, I worked with a Canadian who was finishing his paediatric training and had accepted a fellowship in Pediatric Rheumatology in Palo Alto. That Canadian was Earl Silverman. I had expressed an interest in furthering my rheumatology training...[and]...was offered a job in the UK, working with Barbara Ansell, one of the pioneers in paediatric rheumatology. [Earl and I] kept in touch through the years, and when [he] visited London, accompanying his wife to a nephrology conference, he offered me a fellowship at the Hospital for Sick Children (HSC) [in Toronto], which I accepted. I arrived in Canada in 1988 and stayed until 1998. I spent from 1988-1991 in fellowship, then maternity leave. [From] 1992 to 1996, I was doing my Masters in immunology at the University of Toronto, and then in 1996, I started on staff at HSC. A lot of the methods I used to become a registered physician in Canada no longer exist, as the rules have all been tightened. You cannot do what I did anymore.

When I started out on my "overseas adventure" I had it all planned: four years away, return to Australia after trekking through Europe and Nepal...funny how things change!

Why did you eventually choose to move from Canada to the United States (US)?
In 1998, I was working part time (50%) at Sick Kids [HSC], to help out when Dr. Ron Laxer took on extra administrative duties. I also worked at a smaller peripheral hospital and was beginning to see some rheumatology there as well as general paediatrics. But the job at HSC was not, at least at that time, intended to be permanent. So I started looking around.

At the time, there were few [rheumatology] positions open in Canada. I applied for two positions outside the country: one in London, UK (my old unit) and the other at The Children’s Hospital, Boston, Massachusetts.

I was offered the job at The Children’s Hospital in Boston.

I could have stayed in Toronto, but the thing that really tipped the balance is that my husband [a Canadian citizen, originally from Poland] works for an American company, and was working 90% of the time in the States—a move that was economically sound for him. So I moved to Boston in July, 1998.

Economically, I took a significant pay cut (even with the conversion). I had been doing very well in private general paediatric practice in Canada. The job in Boston, it turned out, was not to my liking, but fortunately there were several other jobs available. For paediatric rheumatology there are 19 advertised jobs [in the US] now. So I moved here to [Long Island], New York in 2001.

Why New York?
Well, my husband’s office is in New York City. Although he still travels a lot, that was a plus.

Dr. Laxer and my new boss, Dr. [Norman] Ilowite, know each other, so I had some inside information regarding personalities, and it provided the type of group I had been used to working with. Also, this job is a merger of two hospitals, so I was given the bonus of becoming Chief of Pediatric Rheumatology. Here, my salary is guaranteed, which is often not the case in other jobs in the States.

What do you like best about practicing in New York?
The group of rheumatologists I work with is very involved in research and drug trials. Because of their networking, there is continued participation in both our studies and studies by other rheumatologists, putting us at the forefront of outcomes research and disease studies. I am this centre’s investigator for a possible new drug to treat Raynaud’s, for example.
Why did you choose to move to Tennessee?
To be sure, a move to settle and practice in the US was a major decision, but it was not because of any dislike for Canada or the Canadian health-care system. Practicing in Canada was still an open consideration. Rather, it was more of an opportunity that was interesting and suited the needs of me and my family in all aspects of our life. So, after lengthy deliberations and soul-searching, my road took me to Stanford [University in California] from Toronto.

What do you miss least about Canada?
In the States, we have better access to all the new agents used in arthritis and systemic lupus erythematosus (SLE). Some of these drugs have taken months to be approved in Canada, and some are still waiting for approval.

In the States, we have better access to radiologic testing as well. There is magnetic resonance imaging (MRI) on every corner, it seems. Here in New York, there is a group of paediatric rheumatologists, both in New York City and in New Jersey, that we refer to for a second opinion and also meet with regularly; they are a group with whom we can collaborate on trials, too. So, although the team in Toronto is big, it cannot compete with the numbers here.

What do you miss most about Canada?
I miss the research-time allotment in Canada. A “full” schedule of clinics, for example, was two to three clinics per week, and in-patient commitment. Here in New York, to support my salary I do twice as much clinic. I see patients five days a week, and have clinics every day. So that cuts into my ability to do research while in the hospital.

It also took me a long time to get used to the insurance around here, and New York is the worst. I think there are something like 50 companies, all with their own rules. Physical therapy (PT) is a resource that can only be used by a patient for 20 visits, for example, and no amount of appealing will change that ruling. So for half the year, some of our very sick patients are without PT. Insurance issues are, of course, moot in Canada, but a lot of my time here is spent on them.

My teaching time is [also] not financially supported here, as it was in Toronto. In Toronto, there are solid bench-type researchers who can help you on projects and with whom you collaborate for projects. That is not available here. Research—either clinical or bench-top—needs to be fully supported with grants in the States, and that money (especially start-up funds) is not as available here as in Canada.

At the HSC we had access to the Short-Stay Unit, but there is not an equivalent facility here. That [facility] enabled access for infusions and biopsies, and made it easier to organize and monitor therapy.

And [finally], the patients and parents here are typical New Yorkers and are very demanding and opinionated.

How did you like our Canadian weather?
I never really adjusted to the cold [in Canada]. But I did learn to ice skate!
shortly after completing my rheumatology fellowship. I was seeking an academic career, so I decided to go to Stanford to obtain research training. After spending my entire training career in Toronto, I felt it would be beneficial to have a change of venue and experience a different perspective in rheumatology practice.

In the US, I discovered that research collaborations were plentiful and interesting, and began to develop specific interests and partnerships. I felt good that these could continue here [in] Memphis, and this was definitely a factor for me remaining here in the US.

What do you like best about practicing in the US? Recently, I had a patient consult for a multi-system disorder. She was young, employed, and insured. ([Insurance] means a lot here, and it allows the system to shine.)

It turned out that [this patient] had aggressive-onset lupus, and needed several consultations and diagnostic procedures. Literally, within three days, she had seen the nephrologist, neurologist, and dermatologist, and had all her appropriate diagnostic tests, including a renal biopsy—all as an outpatient; and all the reports were in my hands. I appreciate this efficiency, and feel that this does add to the quality of care for patients. It also gives patients some confidence in their care, and often saves them from discouragement.

I temper this with the situation of the under-insured, however, and realize that as good as the system is, there are also many defects. I suppose that, so far, working in the US is no Utopia, but it really isn’t that bad, either!

What do you miss least about Canada? What I don’t miss about Canada is the feeling that resources are lacking for patient care. I left in the era of major hospital closures, when the system was awakening to the reality that underfunding was here today. Whether the atmosphere is better now I don’t know, but the long waits for appointments and for diagnostic services were disheartening. We have less of that here. One more thing: the lower cost of living in Tennessee is definitely refreshing!

What do you miss most about Canada? On a personal level, my family is still in Toronto, so that is something I definitely miss. Also, it is really true that Canadians are nice folks, and generally very polite. That’s something you don’t always get Stateside. In this “land of opportunity,” you need to be aggressive and aware, or you’ll either fall behind or be taken advantage of. So I’m learning some toughness, believe it or not!

Medical practice here is definitely more dependent on technology and less on the classical patient encounter. In a specialty like rheumatology, that’s like chopping off your right arm. On the other hand, being Canadian-trained, I feel like I can make a big contribution at the medical school, just teaching things like physical-examination skills and bedside diagnosis. The trainees say they love it, and wish they could have more.

Paul Peloso, MD, MSc
Associate Professor,
Department of Internal Medicine,
University of Iowa
Iowa City, Iowa, USA

These are some [of my] thoughts on the relative advantages and disadvantages of practicing in the US—in particular, Iowa—as compared to Canada.

Advantages:
1. [There is] access to advanced diagnostic studies in a timely fashion. It is possible to get an MRI, computed tomography (CT) scan and electromyogram (EMG) within several days, at the latest.
2. [There is] access to surgery. Individuals with advanced joint disease, carpal-tunnel entrapment, or [who] require simple things such as muscle biopsies for dermatomyositis can get
[surgery] rapidly. In fact, simple surgeries such as muscle biopsies or carpal-tunnel surgery can always be obtained within two weeks.

3. [There is] access to advanced therapeutics. Biologic therapy is available to most patients now, in the state of Iowa. If they are under a private insurance, [it] is no problem to get [infliximab] or [etanercept]. If they are on government support—either through the state or through the federal government—access to [infliximab] is also relatively straightforward, with some paperwork being required.

4. [There is] access to support services. Physical-therapy services [are available] in most areas of the state, within a couple of weeks of referral.

5. There is more time to spend with patients, given [the] differences in remuneration.

**Disadvantages:**

1. The US is a consumer-oriented society. There is the expectation that you will be available 24 hours a day, seven days a week to answer questions about the disease, the therapy, or the prognosis, for a variety of rheumatic conditions. Almost all of these calls would normally go through family physicians in Canada. Our office has had to hire a nurse just to return telephone calls for our group of eight clinicians.

2. While some people have outstanding medical coverage, those who are working but do not have health insurance through work may have virtually no coverage. The so-called “working poor” often cannot afford to do even the simplest of things—such as pay for an injection or take a nonsteroidal anti-inflammatory. And, for many, the cost of methotrexate or [hydroxychloroquine] is a hardship; people with inflammatory arthritis often live on prednisone. Those with pain-related conditions may have to choose to have the pain, as they cannot afford regular medications. Many pharmaceutical companies have programs to help obtain medicines for such people, but not everyone qualifies.

3. There is a high level of scrutiny of all medical records, to be certain that the services provided match the billing fee submitted. There is an extensive amount of paperwork involved to ensure that the billing requirements are met. There is more time spent dictating and correcting dictation here than in Canada.

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**Liana Fraenkel, MD, MPH, FRCP**
Assistant Professor of Medicine,
Section Chief of Rheumatology, Veteran’s Administration,
Yale University School of Medicine
New Haven, Connecticut, USA

**Why did you choose to leave Canada for the US?**
My husband (David Oelberg—intensive care unit, sleep and pulmonary medicine) and I left Montreal, after our internal-medicine residency, to pursue fellowship training in Boston, Massachusetts at Boston Medical Center (Boston University). At the time, our plan was to return to Montreal after completing our training. Both of us had positions waiting in Montreal.

**Why did you choose to stay in the US?**
We decided to stay in the US [after our fellowship training] because of two major events:

1. The referendum in Quebec, which split the province 50-50.
2. My mentor, Dr. John Esdaile, moved to Vancouver.
   After training in Boston, both my husband and I found good career opportunities in Connecticut. I am at Yale [University] now, doing 75% research; the [other 25%] is teaching/clinical.

**What do you like best about practicing in the US?**
The lack of government interference in everyday practice and the funding opportunities.

**What do you miss least about Canada?**
The Quebec health-care ministry and system.

**What do you miss most about Canada?**
Everything!
Keith Coulter, MD, FRCPC (1930-2001)
Shoulder pain was the initial symptom. It was mid-July, 2001. Keith and Donna—his wife and office manager—had just returned from their annual family cycling holiday in Quebec’s Eastern Townships. They were finishing a 23-patient day. The intensity of the shoulder pain took Keith to the hospital, where, in the course of the next 72 hours, he learned he had cancer—widespread and undifferentiated, primary unknown.

From that point until his death in early December, Keith, in a way so characteristic of him, went about organizing his final months. He shut down his practice, and wrote a letter of apology to his colleagues. He called his six children, scattered across the country, and, one by one, they came home. He sat in the shade of the garden he had made, with its flowers and its pond, and talked. He read, pursuing his lifelong interest in spirituality, and speculated on other dimensions of experience. In the evenings, alone, he wrote letters to those close to him and to his colleagues—letters they received after his death.

Keith graduated from the University of Western Ontario in 1956. He trained in both Internal Medicine and Pathology before going on to the University of Toronto. There, he learned rheumatology from Wallace Graham, Metro Ogryzlo, and Hugh Smythe. He returned to London in the early 1960s, establishing, with Manfred Harth, the University of Western Ontario’s first rheumatic disease unit (RDU). Although he remained in private practice, for the rest of his career he carried a full share (unremunerated) of University of Western Ontario’s medical-school undergraduate and postgraduate teaching load.

Keith was a quiet man, with an idiosyncratic sense of humour and a passion for athletics. He passed on this love to his children—athletes all. One child played for Canada in volleyball and another was in the National Hockey League (NHL). To talk hockey with Keith was to realize how much more there is to the sport than simply following the puck.

In his professional and private life, Keith went out of his way to make a difference. It might be advice to a colleague, a same-day appointment for a patient in crisis, or a place to stay for someone in need. These things were done quietly and willingly, as a matter of course.

Keith died peacefully, at home, on December 1, 2001. He was 71 years of age.

J. Bruce Frain, MD, FACP, FRCPC
President of the CRA, 1959-1961
Secretary of the CRA, 1953-1956

Bruce Frain was a native of Ontario and received his MD from the University of Toronto. He completed his postgraduate training in Toronto, as well as at the University of Pennsylvania in Philadelphia.

Bruce was a pioneer of rheumatology here in the Prairies. In 1952, he came to Winnipeg and began his practice at the Winnipeg Clinic. From 1953 to 1956, Bruce was secretary-treasurer of the Canadian Rheumatology Association (CRA). He later became president from 1959 to 1961. Bruce also served a term as president of the Manitoba Division of the Canadian Arthritis Society.

Bruce was an Assistant Professor at the University of Manitoba. Many residents did not know the significant contributions made to his patients and to the service of arthritis by this community rheumatologist.

Bruce was noted for his wry wit (and his crew cut). He was always willing to contribute his point
of view at rounds and verbally joust with other senior rheumatologists.

Bruce continued in active practice until his retirement in 1995. He passed away in March of 2002.

Ronald H. McFarlane, MD, FRCPC
A gentleman, in every sense of the word, Ron McFarlane was one of the earliest rheumatologists in Winnipeg.

A graduate of the University of Manitoba in 1941, Ron immediately entered the service of the Royal Canadian Navy. On rare occasion, he would talk about how he felt—being a physician from the Prairies—on a corvette or destroyer: seasick.

After Ron completed his specialty training, he joined the Manitoba Clinic, where he practiced until the late 1980s. He also attended at both the Winnipeg General and Misericordia Hospitals.

Ron was also a professor at the University of Manitoba. He never chose the limelight of a geographical full-time (GFT) position within the university, but was an excellent bedside teacher. His calmness and gentleness with his patients taught much about the art of medicine, and his quiet demeanor was his hallmark.

Ron retired as an Associate Professor at the University of Manitoba. He will be fondly remembered by the patients and residents that he touched. He passed away in May of 2002.

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ger of losing its independent Peer Review Research program—its "raison d’etre" until now. When the budget is viewed, the remarkable fact is that more money is being raised every year, yet the amount being transferred to the National Peer Review account has fallen. Money is being kept locally because there is no vision promoting the importance of research. Lay boards know only that their donors demand visible, local arthritis services.

We can only blame ourselves for the current state of TAS, and the diffusion of fundraising into a variety of organizations with local interests. We can only blame ourselves for the void in leadership that has been filled by lay personnel, researchers unaffiliated with arthritis programs, and other professionals.

Now, what are we going to do about it?

The CRA was instrumental in establishing a Medical Advisory Committee at TAS. It remains to be seen what impact this panel will have. A good next step would be the affiliation of a rheumatologist, or two, with the board of every provincial division. Rheumatologists, even those with local community interests at heart, know the importance of research. Local fundraisers need to see that research gives us the tools to deliver better care.

Most rheumatologists have little attachment to research programs. We may have more concern for our community, and local care facilities. But we know that there has to be an ideal goal of curing arthritis, and it is we who can talk to that vision. It is we that can communicate the fact that one research discovery can lead to a paradigm shift that has the potential to change the entire face of effective arthritis care. Molecular biology led to the creation of biologics. The polymerase chain reaction led to the uncovering of the human genome. Inhibitors of inducible nitric oxide synthase (iNOS) may lead to the first disease modulators for osteoarthritis. We can see these possibilities, and we are the people who can communicate with those who run our provincial divisions, raise the money, and contribute funds to peer-reviewed research.

A new year is dawning. Do we want to let TAS slip through our fingers? By virtue of the specialty we have chosen, each and every one of us sits front and centre on the panorama of arthritis-related issues. First and foremost, we must recognize that there is a crisis. That crisis is the very survival of an arthritis society that shares our ideals.

Rheumatologists were founders of this organization. It’s time to decide whether we support or abandon it.

Arthur A. M. Bookman, MD, FRCPC
President, CRA

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Q. There are many books arthritis patients can choose from on this subject. What does Living Well with Arthritis offer that is unique?
A. I think [what makes it unique is] the fact that it is a patient's sourcebook, as the subtitle says. Living Well with Arthritis covers so many aspects of the disease, across all stages of life, and outlines just about every management topic that might touch a patient with arthritis: coping with chronic pain; dealing with anger, depression and embarrassment; developing emotional and social coping strategies; and managing relationships and sexuality.

When I looked at the other books out there on this subject, it seemed they didn't have enough information. People want more information these days and are seeking it out. This book is 307 pages long, with many simple charts, tables and illustrations. There is also an informational appendix, glossary and index.

Q. How did you and the other authors determine what information was important to patients?
A. Before writing this book, a survey of my patients was performed, and they were asked how they would prefer to receive information on arthritis (i.e., from the Internet or a sourcebook). Seventy percent said they preferred a book [so that] they could sit down and read [from one source]. Later, my patients were again interviewed about what they would like to see covered in such a book, and their responses were useful in helping us decide what to include.

Q. Living Well with Arthritis is described as “written by Canadian doctors for Canadians.” What is it that is so purely Canadian about this book?
A. The section on workplace and disability is particularly Canadian; it includes sections on how to deal with the Canada Pension Plan and the drug plans, and what medications are available [here].

Outside the topic coverage, this book is also Canadian in that the authors, the illustrator (who is also an arthritis sufferer), the writer of the foreword (Denis Morrice, president of The Arthritis Society) and the introduction (written about artist Maud Lewis) are all Canadian, as well!

Q. What arthritis-related topic do you feel patients have the most difficulty accessing?
A. I think patients have difficulty finding information on the disease process—that is, outside the context of medical text. Also, [it is hard to find information elsewhere about] what to expect from surgery, and how the disease might [have an] impact [on] their lives.

Q. Which portions of the book did you and your colleagues each focus on?
A. Dr. Stein outlines a number of good points on how to manage pain and fatigue. He also addresses complementary therapies, including herbal, holistic and not commonly prescribed therapies, and compares mainstream therapy versus nonmainstream therapy. Dr. Stein actually defines what “complementary therapy” is, which is useful, I think. His other chapters include diet and nutrition; exercise; surgery (with Dr. Michael Gross) and an appendix on heredity and environment.

Dr. Kraag has a very useful chapter outlining what is not arthritis but may be confused with it (fibromyalgia, osteoporosis, regional rheumatic syndromes). There is something of value for these nonarthritis patients [in this book], too, as Dr. Kraag offers a number of good points on management. Dr. Kraag also wrote a chapter explaining research and involvement in clinical trials.

For my part, the past few years have seen the development of a number of new treatments for arthritis. I review these advancements and I also...
The Canadian Rheumatology Association (CRA) hosted a “Canadian evening” at the recent American College of Rheumatology (ACR) meetings in New Orleans. Close to 120 participants enjoyed Louisiana-style hospitality before a Town Hall meeting was held.

Prior to the *Journal of Rheumatology* reception, held one floor above, Nick Bellamy from “Down Under” made a brief appearance, as did Duncan Gordon and Yvonne Pigott. Chris Nelson from the Canadian Arthritis Network was spotted, as was Denis Morrice from The Arthritis Society.

Representatives from the host companies were present to receive appreciation for their sponsorship of the evening, including representatives from Abbott, Actelion, Amgen, Aventis, Boehringer Ingelheim, Ortho-McNeil, Merck Frosst, Novartis, Pharmacia, Purdue and Procter & Gamble. Jean-Claude Dairon, the CRA Industry Liaison Advisor, was also present, and ensured excellent interactions between CRA members and industry representatives.

The Town Hall meeting was brought to order by our fearless leader, Arthur Bookman. Past-President Dianne Mosher outlined the major policy thrust of the CRA: access to care. She discussed how the CRA will participate in the Decade of the Bone and Joint. Dr. Mosher outlined the strategy of the CRA’s interactions with government to highlight the need for rheumatologists, the need for appropriate therapies, and the need for patient access to these resources. The *CRAJ* will be devoting its Spring issue to this major initiative.

Michel Zummer, Vice President and Co-chair of the Manpower and Economics Committee, was received enthusiastically, with his discussion of remuneration for rheumatologists and fee schedules for noninsured services. The Quebec fee schedule for noninsured services was displayed. The Economics and Manpower Committee will make recommendations for a national standard.

Walter Maksymowych, Chair of the Scientific Committee, outlined the upcoming CRA Annual Meeting in Mont-Tremblant, Quebec. This premier event of the CRA will highlight Canadian contributions to rheumatology. The scientific portion of the program will likely draw a record attendance this year, as will the educationally robust industry symposia.

The chair of the Therapeutics Committee, Janet Pope, discussed the success of the summer studentship program, and the hope to expand it. The loss of aurothioglucose (Solganal®) as an injectable gold therapy—and the lack of a replacement—was one of the Therapeutic Committee’s active items.

Arthur Bookman discussed the possible coalition with the Mexican Rheumatology Association for an annual meeting in Mexico in 2005. He also discussed the Royal College’s new guidelines with respect to industry sponsorship of individuals. Milton Baker from Victoria discussed the implications of the new restrictions facing individual rheumatologists on accepting travel grants. The cost to attend meetings in the States is escalating to the point where most community-based rheumatologists cannot attend on a regular basis. The compulsory Royal College CME hours may have to be met without high-quality foreign meetings, it seems.

The Town Hall meeting was adjourned until the CRA’s annual general meeting in Mont-Tremblant. Be sure to book your hotel rooms early!

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*Glen Thomson, MD, FRCPC* is a rheumatologist and former president of the Canadian Rheumatology Association. He is the Director of CIADS and Associate Professor at the University of Manitoba in Winnipeg, Manitoba.
ANNUAL GENERAL MEETING, MONT-TREMBLANT, QUEBEC

Fairmont Tremblant will be the site for the 2003 annual meeting of the CRA, from February 26-March 1. For more details, check the ad on page 2 of this issue, or visit the CRA website at: www.cra-scr.ca.

EDUCATION COMMITTEE FORMED

A new Education Committee has been formed within the CRA. Its goal is to develop plans and strategies for education at all levels of training and practice. New ideas will be discussed by this committee at the CRA Annual Meeting in February of 2003. The committee includes:

Chair: Jerry Tenenbaum

Members: Diane Wilson, Evelyn Sutton, Carol Yeadon, Sue Humphrey-Munro, Heather McDonald-Blumer, Janet Pope, Rayfel Schneider, Lori Albert, Christopher Penney, Steve Edworthy (internet/web advisor), John Sibley, Avril Fitzgerald (rheumatology specialty representative), Paul Davis (CME representative), Kam Shojania, Paul Peloso, Hani El-Gabalawy (examination board head).

KUDOS TO OUR MEMBERS!

The CRA would like to congratulate the following members on their recent accomplishments:

• Mary Bell: appointed Head of the Division of Rheumatology at Sunnybrook and Women’s College Health Sciences Centre, effective September, 2002.

• Heather McDonald-Blumer: appointed Director of the Multidisciplinary Program in Osteoporosis at Sunnybrook and Women’s College Health Sciences Centre, effective September 2002.

• Rosie Goldstein: chosen as the first recipient for the Canadian Medical Association Woman’s Award.

• Robert Inman: elected a Fellow of the Royal College of Physicians of Edinburgh.

THERAPEUTICS COMMITTEE SENDS OUT STATEMENT ON BIOLOGICS

A statement advocating the use of the new biologic drugs in treating inflammatory arthritis was sent out in early December 2002 (at the time of this printing) to all provincial and third-party insurers from the Therapeutics Committee of the CRA.

The statement that was sent follows:

Statement on Biologics

Access to effective medications is a major problem for people who suffer from systemic diseases that cause joint inflammation, destruction and subsequent disability.

The Therapeutics Committee of the CRA strongly recommends that biologic agents be admitted for provincial-formulary and private drug plans, as there is strong evidence of enhanced efficacy in rheumatic diseases. The biologic agents are an important advance in our treatment of patients with inflammatory arthritis conditions. To date, these products include infliximab, etanercept and anakinra. Other products are in development.

It is critical that access to biologics be enhanced with provincial-formulary coverage and private insurance coverage.

Sincerely,

Dr. Janet Pope
Co-chair of the Therapeutics Committee

Dr. Vivian Bykerk
Co-chair of the Therapeutics Committee

Dr. B. Paul Haraoui
Co-chair of the Therapeutics Committee

Dr. Arthur Bookman
President of the CRA

Q. Which aspect of the book do you feel was most difficult to write?
A. For me, I’d say the section on the workplace and disability was the most difficult. To try to summarize so large a topic, without sacrificing too much, was challenging. But there is definitely enough information in there.

继续从第18页

讨论患者的医疗保健团队的角色；许多工作场所问题；管理孕期中的关节炎；以及如何以充实性生活的方式与关节炎共处。

最后，有一节关于儿童关节炎的书，由 Peter Malleson 和 Lori Tucker 医生撰写。