The More Things Change...

By Philip A. Baer, MDCM, FRCPC, FACR

Recently, I have been working on systematically scanning the old paper files of my active patients into my relatively new electronic medical record system (EMR). It turns out to be a lot of work, but also very interesting. I have some rheumatoid arthritis (RA) patients who have been with me for close to 30 years, including some who followed me from my rheumatology fellowship to my private practice. Their charts are incredibly thick, and wading through them reveals just how much I have forgotten about what used to pass for effective treatment, both on my part and those of my teachers and peers. Did we really treat RA in 1985 by adding indomethacin at night to high dose acetylsalicylic acid (ASA) given three times a day? Sadly, yes. Next would come chloroquine (the dogma at one time was that hydroxychloroquine was safer, but also less effective), perhaps gold, and then very tentative use of methotrexate (MTX). The results were what you might expect: active disease with joint damage that could be seen with the naked eye.

Well, that's all history in the age of biologics and combination disease modifying anti-rheumatic drug (DMARD) therapy given in aggressive modern fashion; in fact, RA is now an "invisible disability". I learned that from an article in the Toronto Star in March 2014. The story relates to a patient with severe RA, Sandra Kendall, who has filed an Ontario human rights complaint asking for $100,000 in damages. She claims that the local transit authority has failed to maintain access to disabled parking spots. "Kendall doesn't use a mobility device... She says people who, like her, have invisible disabilities are frequently met with cold stares when they request priority seating or other assistance on transit."[1] She also had no luck getting the transit police to ticket people blocking accessible parking spots used by drivers with a disability permit, which she holds.

So, in some quarters, RA has been converted from an obvious and visible disability to an invisible one. In other arenas, however, nothing has changed from the 1985 mindset. Every three months, I receive a paper survey from IMS Brogan known as the Canadian Disease and Therapeutic Index (CDTI). The incentive is small, and I keep trying to resign, but this usually leads to a pleading phone call explaining how valuable the data is in understanding prescribing trends. Judging by the anguish on the other side, I must be the only rheumatologist contributing data to this project.

What I am asked to do? For two days each quarter, I am asked to record anonymized data about the patients I see and their prescribed medications. To help me get the idea, the company supplies an example at the front of each booklet. Who is this prototypical patient? A 67-year-old male with RA who was not referred to me by another physician, and whom I have seen four times in the last year, the last time 10 days ago. What is being prescribed for this patient? Naproxen 250 mg BID as an anti-inflammatory, and ECASA 5 grains prn for pain relief! No DMARD, no biologic, and how much is 5 grains of aspirin anyway? I do not think this was my 1985 standard of care, let alone what I do now, but the speed of knowledge translation from the world of the rheumatologist to the broader consciousness of society is clearly glacial.

Reference

1. Kalinowski T. "GO rider files human rights complaint after other drivers block disabled parking." Toronto Star [Toronto] 27 March 2014. Available at: *http://www.thestar.com/news/gta/2014/03/27/go_rider_files_human_rights_complaint_after_other_drivers_block_disabled_parking.html*

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