2015 Innovation in Education Award: Dr. Henry Averns

1. Why did you become a rheumatologist? What or who influenced you along the way?

My mother had rheumatoid arthritis (RA) so I understood something about the effects of the disease on a family. I felt I was likely to want to practice in this area when I went to medical school and, as is often the case, my final decision was confirmed by the great fortune of spending two significant blocks of time with a rheumatologist, who had by coincidence spent a lot of time in Canada. Dr. John Winfield was the inspiration who confirmed my instincts to become a rheumatologist. Even at medical school I realized the only way I could spend my weekends fly-fishing was to choose the right specialty.

2. Please briefly describe the research project for which you won the Innovation in Education Award.

We have tried to engage in a clinical audit project every year for the last two decades, and I have no doubts that once one gets used to learning one's weaknesses and failures, that the initial shame and self-flagellation can produce improvements in patient care. This year we reviewed how effectively we assess risk-factors in patients taking biologic therapies, and identified some clear gaps that we believe we have now addressed.

3. Where have you provided rheumatology services to remote communities, and how has that influenced your regular rheumatology practice?

I have run clinics in several communities on the West coast of James Bay. Sadly, I have cut down on these lately owing to ongoing organizational challenges. The many difficulties faced in providing care to these communities are well recognized. This is certainly an area where one has to accept that the pace of change is far slower than one's own ambitions; that said, the rewards of learning from these communities are immeasurable.

4. If you could be any joint in the body, which would you be and why?

The sphenozygomatic suture in the skull, obviously.

5. You moved to Canada after already being a successful rheumatologist in the UK. Please contrast the two countries in terms of your experience as a rheumatologist in both.

I think the rheumatology phenotype is the same in both countries—each has managed to foster a combination of cutting edge outcome-driven practice whilst hanging on to the real art of clinical medicine.

One of the striking differences between the UK and Canada is that in the UK almost all Consultants are employed by the National Health Service (NHS), and whatever the specialty all are paid the same (increasing with seniority). In Canada, I was surprised that some specialties appeared to be valued differently from others. The UK system has many advantages and still has ways of rewarding the most deserving. A fee-for-service model results in a very different relationship between doctors, patients and their teams, and the government, and alters the way in which negotiations can take place.

6. If you could compete in the Olympics, which event would you participate in?

I tend to avoid getting my heart rate above 75 bpm so I think darts would work well.

Photo courtesy of Dr. Fred Doris, 2015.

A blur of innovative ideas, Dr. Henry Averns runs between duties as Great Debate Chair, award winner, and conference presenter.

7. A recent *Globe and Mail* article has highlighted the issue that there is a shortage of rheumatologists in Canada, especially in rural areas. What do you think some of the steps need to be in in order to start alleviating this issue going forward?

I do not feel there should be an expectation of where one will end up practicing. The current model has resulted in practice location being influenced by market forces as well as clinical need. We have a fairly good idea of how many rheumatologists are needed per 100,000 population. Clearly there is a reluctance to stray too far from the urban academic womb for many trainees. Perhaps there needs to be some incentive to do so—one can quickly brainstorm models which would encourage fledglings to fly further from the nest.

8. You have recently opened a new clinic to devote more time to your patients. How has this changed your day-to-day routine? What are the benefits and challenges of this change in practice for you?

Academic practice can be rewarding, but is also associated with barriers to clinical care. Moving to a private office allows one to escape from competitive—and sometimes sociopathic—environments and to develop efficient practice. What I had not appreciated is that not only does one have the freedom to develop teams and see far more patients, but there is still time to engage in academic activities, paradoxically more so, in my case, in the community than before.

On the other hand, I think there is the potential for younger rheumatologists who go into solo practice to quickly lose the peer support and learning opportunities that exist in academic settings. We do not focus much training on the business side of being a rheumatologist, and mentoring of younger specialists would be valuable.

9. If you could erase one day from history, which would it be?

The day the letter from the German art school went missing: "Dear Mr. Hitler…Your paintings are extraordinary… do not even consider any other career…"

10. You are currently working with the Ontario Rheumatology Association (ORA) to improve uptake of EMRs and develop patient assessment tools. How do you think this project will change the landscape of rheumatology? Are there any factors that will have to change alongside the project in order to facilitate its success?

The project has already helped us define our "data dictionary" and think more clearly about the relevance of the many data we collect. There are some familiar barriers to adoption, not the least of which is the significant variation in EMRs and the lack of a single lexicon of terms and definitions across the country. It will not be long, however, before we begin to share our outcome data with each other, and this will be a major step in informing our clinical practice.

11. You have stated on your website (*www.rheumors.com*) that you have a longstanding interest in medical databases, electronic medical records (EMR), and outcome assessment. From where do you think that interest stems?

I trained at the Haywood Hospital which had what was already a powerful database/EMR in the 1980s, and from there realized the potential of electronic information. Hence, I learned to code fairly early on. The Haywood also instilled in me the importance of robust collection of outcome data—I have almost complete data on every patient I have seen since 1996.

12. Something you think will become obsolete in 10 years:

What, other than me?

13. If you could live in any other time period in history, what era would you inhabit?

I would look good in a toga as I have the physique for it, but I would need to be a wealthy Roman as I am too lazy to be a slave.

14. You are the Chair of the Optimal Care Committee for the CRA and have been involved in initiatives designed to improve the care of patients with rheumatic diseases within Aboriginal populations. What have been some of the biggest challenges in implementing these initiatives?

Challenge is the wrong word. There is a massive interest and support for these initiatives across the country, and our ability to forge effective links with each other and with key stakeholders has resulted in small but important steps towards our goal. I cannot imagine making bigger steps until there is clear buy-in from all stakeholders, including the patients themselves and the Federal government. One needs a good imagination to picture this situation arising soon…

15. You are marooned on a desert island. What is the one book you want with you?

How To Build A Doerle Short Wave Radio by WC Doerle. I would be pretty lonely without Mrs. Averns.

16. What do you love most about living in Ontario?

The short, warm winters.

17. You have previously mentioned that "prestige and money sometimes distance doctors from their deepest values" and that doctors ought to work with "financial and emotional unselfishness, and humility". What or who led you to hold this view in high regard, and how do think this belief has shaped your career?

My father was a very successful but humble man who devoted much of his spare time to actively helping those in most need, and who truly held personal achievement above financial gain. Whenever he felt I was driven by ego, conceit, or money he would politely remind me of other values. After his death we learnt that we were indeed unaware of the true extent of his generosity to others, and I realized that I would never come close. If you judge me by my actions not my words, it turns out I am pretty shallow.

Photo courtesy of the CRA, 2015.

A jovial trio: Dr. Christopher Penney, Dr. Averns, and Dr. Cory Baillie share a laugh at the 2015 CRA ASM.

17. If you had a theme song that played whenever you enter a room full of people, what song would it be?

Is there a song called *Here comes that fat bald irritating English man*? That would probably work well.

18. What was your first paid job? How long did it last?

I applied to be a male model for a fashion magazine. When they saw me they gave me £20 to go away and never come back.

Graphics courtesy of Sara Heppner-Waldston, www.saragrafix.com, 2015.

He may not have made it as a model, but Dr. Averns cuts a rare form as a cartoon!

19. What is your biggest pet peeve?

Conceit.

20. If you could invent a gadget, what would it be and why would we need it?

I would love something that made me look as if I was paying attention when bored—my attention span is about 90 seconds.

21. What is something unexpected that has changed about you in the past few years?

I seem to have hairier ears—my Dad had warned me about this terrible thing occurring...

22. If you could go bowling with any three people, dead or alive, who would you take and why?

Stevie Wonder, Ray Charles, and George Shearing. We could talk music and I think I might win.

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