2015 Distinguished Rheumatologist: Dr. Carter Thorne

1. Why did you become a rheumatologist?

My first six months as a "straight intern" in medicine included two months on the rheumatology service at Wellesley Hospital, where Dr. Metro Ogryzlo, that "giant" of a man, was chief of Service; he was also head of the Division of Rheumatology at the University of Toronto. Dr. Ogryzlo was an exceptional man—thoughtful, compassionate, and saw not only the trees in the forest, but the forest in the country-side.

In addition, I was influenced by the other remarkable individuals who have influenced so many others, as well—Dr. Murray Urowitz, Dr. Hugh Smythe, Dr. Dafna Gladman, and Dr. Peter Lee. I also had the privilege of meeting and getting to know Mr. Edward Dunlop.

Another huge influence was the patients—the hunt was on to become part of this program, this journey…

2. What or who influenced you along the way to do so?

- For rheumatology as a specialty: Dr. Ogryzlo.
- For learning how to observe and count: Dr. Gladman, Dr. Smythe, and Dr. Urowitz.
- For learning about kids with arthritis: Dr. Abraham Shore.
- For teaching me about teams and the value of patient education: the Allied Health Professions staff at Wellesley RDU, especially Ros, and my two consecutive years working with them.
- For research support and encouragement: Dr. Gladman, Dr. Edward Keystone, Dr. Inman, Dr. Bombardier, Dr. Boulos Haraoui, and Dr. Pope.
- For becoming involved: Dr. Smythe, who appointed me Chief Fellow, even though I had declared that I was not inclined to the academic stream; Dr. Bill Vail, General Surgeon from Newmarket—who was President of the Ontario Medical Association (OMA) when I was first a Professional Association of Interns and Residents of Ontario (PAIRO) representative to OMA—for telling me about Newmarket, and encouraging me to apply; and Dr. Paul Davis, who had the vision to change the format and direction of the CRA and who championed the inclusion of community members in the executive of this re-born CRA.
- For counsel, advice and support: Mr. Denis Morrice.
- For my colleagues, who were always there to help whenever I had another idea. My patients for their patience.
- My wife, Jena, and our children Sarah and Daniel, who survived my long practice hours, endless meetings, and unexpected absences.

3. What do you believe are the qualities of a distinguished rheumatologist?

- Respected by his peers.
- Contributes to the rheumatology community through participation in education, professional organization, research, advocacy, and/or patient care.
- A "go-to" person, for care, education, and sharing.

4. You have served in leadership roles within the CRA, the ORA, PANLAR, and as a member of the York Region District Health Council. How do you feel your work in these organizations has helped shaped the field of rheumatology in Ontario?

Those who desire to make a meaningful difference must

look beyond their immediate environs to appreciate what indeed may be achieved. Working with different groups, interconnected as health planners, payers, and providers allows one to more easily consider and appreciate the opportunities for convergence, integration, and keeping the long view in clear focus. Clinicians are well placed to consider the latter, as we are the only ones, of those previously mentioned, who will see the fruit born of these labours.

Concepts of treat-to-target (T2T), Models of Care (MoC), and systematic musculoskeletal (MSK) assessment reflect principles that have provided a framework and platform to advocate for best practices to ensure best outcomes.

5. What do you love most about living in Ontario?
The seasons passing, the range of landscapes (the cottage), the opportunities, the multi-ethnicity, the shared values, and new concepts.

6. Given your extensive work in the field of rheumatic diseases, where do you anticipate clinical research moving within the next decade?
The time of randomized control trials (RCTs) is past—not for drug development, but as the source of knowledge of best practices. The development of clinical cohorts, such as Canadian Early Arthritis Cohort (CATCH), Ontario Biologics Research Initiative (OBRI), Spondyloarthritis Research Consortium of Canada (SPARCC), and Canadian Scleroderma Research Group (CSRG), will provide us with valuable insights as to what may make a difference in clinical care and outcomes. However, the next step will be the development and maturation of robust practical trials utilizing these cohorts and investigators to direct our care to notions of enhanced adherence, patient engagement, and continuous improvement.

7. If you could live in any other time period in history, what era would you inhabit?
This has been the **best** time for our profession!

8. What is the greatest professional and organizational challenge you have faced, and how did you address/overcome this challenge?
Professionally, it would be maintaining the concept and integrity of The Arthritis Program (TAP) at Southlake Regional Health Centre, in Newmarket. Despite its

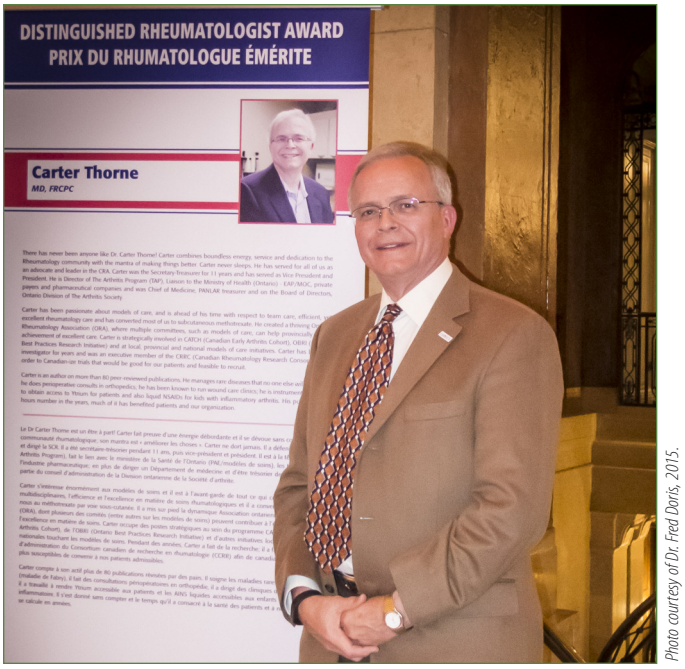

Photo courtesy of Dr. Fred Doris, 2015.

Dr. Thorne, looking every bit the Distinguished Rheumatologist.

successes and accolades (by patients, administrators, accreditors, universities, Ministry of Health, and peers), we still face challenges, not least of which is the lack of recognition of interprofessional care, not as an add-on or "extra" but as essential to the outcome success of our patients.

From an organizational perspective, engaging the CRA to consider a new sponsorship model to ensure transparency and sustainability of the organization, and an evolution to a new administration and governance framework. This responsibility has been very ably assumed by Dr. Cory Baillie.

9. What do you feel is your lasting legacy within the rheumatology community?
The blurring of "town and gown" ensuring that those who work in the trenches have a voice at the table. I am attentive to the role of good clinical care in addition to thoughtful and optimal use of medications that can ensure best outcomes. Finally, the value I place on interprofessional MoC in caring for our patients.

10. I never anticipated that I would be so blessed with my decision to enter the field of rheumatology... until it happened. This has resulted in much success in team building, research, advocacy, and professional growth.

11. What changes to the landscape of rheumatology have you witnessed over the course of your career?

The evolution from RCTs as the arbiters of care and practice to the role of clinical cohorts—being more reflective of our patients and our practice—in guiding us towards best practices.

12. How do you envision the landscape changing before you retire from service?

That more clinicians will accept that they can combine research with clinical care and improve their practice at the same time.

Possibly the concept of "bundling" rheumatology care, as has been done to an extent in cancer care, implying a responsibility for the envelope of costs associated within our scope of practice.

13. In 2013 you were awarded the Queen's Diamond Jubilee Medal; what did this honour mean to you?

I was nominated for this recognition by Janet Yale at The Arthritis Society (TAS). This represented two separate but connected successes: the first, organizational, reflecting the renewed rapprochement and commitment of the CRA and TAS to work to our strengths, for our common goals; and second, the recognition of a valued member of the arthritis community, who was not my professional colleague.

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

Teleporter: save travel time!

Photo courtesy of the CRA, 2015.

Dr. Thorne receiving his Distinguished Rheumatologist Award from Dr. Baillie.

15. You are known for rapidly mobilizing the rheumatology community in response to crises arising out of "left-field", such as the withdrawal of naproxen suspension, issues surrounding antimalarial eye monitoring, and Health Canada warnings about methotrexate drug interactions. How have you been so successful in getting action on these files?

Identifying the leverage points, the responsible parties and who can make the decision. The need must be real and easily identified. It helps to ensure that there is "natural justice" to the endeavour, and that any member of the general community could identify the merit of the exercise. I would be remiss if I did not identify the major role that Mr. Morrice has played in our successes. He has worked tirelessly on behalf of patients and our members; he has kept the door ajar as we doctors attend to our other professional imperatives, and he has kept us honest, if we should waiver from our argument.

16. You are handed a plane ticket to anywhere in the world. Where are you going?

My cottage: comfortable, familiar, full of memories, and I'm able to share with family and friends.

17. What do you foresee as challenges to Canadian rheumatologists in the future and what can individual rheumatologists and the CRA do to meet these challenges?

Ongoing fiscal constraints will limit our access to new therapeutics. Thus, as individuals and as a community we must make a commitment to husband our resources, engage our patients, share our care responsibilities (with allied health professionals), and measure and share our experience and knowledge.

18. What was your first paid job?

As a paper boy for the *Toronto Star*, when I was ten to 13. I used the money earned to buy my wife's engagement ring (it was not very large!).

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