Passing the Baton of Arthritis Research Canada's Scientific Leadership – Celebrating the Legacy of a Visionary Leader

By Diane Lacaille, MD, FRCPC, MHSc

Dr. Diane Lacaille

Dr. John Esdaile

On July 1st, after 21 years at the helm, Dr. John Esdaile retired as Scientific Director of Arthritis Research Canada/Arthrite-recherche Canada (ARC). I am deeply honoured to have been handed over the scientific leadership of this amazing organization. Dr. Esdaile was a visionary leader who leaves behind an incredible legacy, not only from his own personal research achievements, but also because of what he built.

From its roots in 1999 as a single centre with himself, one scientist, one graduate student, and an administrative staff member, Arthritis Research Canada has evolved into a leading arthritis clinical research organization, with a team of more than 100 research scientists, trainees, and staff. Our centres are located across three provinces, British Columbia, Alberta and Quebec, with scientists affiliated with five major universities, University of British Columbia, Simon Fraser University, University of Calgary, Université Laval, and McGill University. Dr. Esdaile assembled a team of research scientists with a breadth of expertise to conduct research across the disciplines relevant to arthritis. Our team of 41 scientists spans the disciplines of rheumatology, orthopedics, physiotherapy, occupational therapy, pharmaceutical sciences, biostatistics, epidemiology, health services research, public health, health psychology and behavioural change, health economics, health systems assessment, and knowledge translation. Beyond what can be measured by numbers, Dr. Esdaile created a culture of scientific rigour and excellence, of innovation, pushing boundaries for new discoveries, and fostered an environment of collegiality and collaboration, which has been key to Arthritis Research Canada's success.

Dr. Esdaile has always been a strong advocate of supporting the next generation of arthritis researchers, making supporting trainees and mentoring new scientists one of Arthritis Research Canada's top priorities. The many established scientists, previously mentored by him, who contribute to advancing rheumatology research across Canada and the U.S. are another important part of his legacy. I, myself, have had the privilege of benefiting from his mentorship over many years, from the time he supervised my summer studentship as a medical student, through being a graduate student when Arthritis Research Canada was founded, until today as I am following in his footsteps as the newly appointed Scientific Director. I can speak first-hand to the amazing mentor that he is!

Dr. Esdaile has also been a champion of meaningful engagement of patients in research well over a decade before it became popular. He had the vision of ensuring the patient voice is represented in all facets of our organization and that patients are engaged in all aspects of research. Instrumental to this was the creation of Arthritis Research Canada's Arthritis Patient Advisory Board. His commitment to ensuring the patient voice be heard has always been at the forefront of all we do. At Arthritis Research Canada, we will continue to work for and with patients to make sure our research is relevant, meaningful and helpful.

I look forward to leading the organization over the next decade. I deeply value the research conducted at Arthritis Research Canada/Arthrite-recherche Canada because of the impact it has on the everyday lives of people with arthritis. I am inspired by the incredible resilience of arthritis patients, the dedication of the research scientists and staff, the innovative ideas of my colleagues, and the sharp inquisitive minds of our trainees. I am excited at the thought of the future discoveries that will transform how health care is delivered and change how people with arthritis live their lives. These are exciting times. At Arthritis

Research Canada, we will continue to expand the breadth of expertise of our research team in order to respond to the evolving needs of patients, and to harness the opportunities that arise from new trends, such as big data, artificial intelligence, and smart technologies. We will also continue to tackle health inequities affecting people living with arthritis, especially Indigenous peoples, so that all Canadians regardless of race, ethnicity, or social circumstances, have access to the care they need and the best care available. And of course, we will continue to invest in the future of arthritis research by training and mentoring the next generation of arthritis research scientists.

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Burnout and the Rheumatologist

By Lester Liao, MD, MTS

Rheumatology is not often thought of as a particularly busy or stressful specialty. When we think of burnout, our mind jumps to high stress, acute disciplines that afford less control. Emergency medicine. Critical care. So, it may seem unusual to consider the problem of burnout for the rheumatologist. Are we not, after all, the best discipline?

For what it's worth, the annual Medscape Rheumatologist Lifestyle Happiness and Burnout Report suggests we tend to be less happy than the average physician at work, happier than the average physician outside of work, and roughly 40% of us are burned out.[1] By far the biggest contributor is bureaucratic tasks, which include charting and paperwork. The data aren't perfect, but they provide a springboard for at least two brief observations for rheumatologists.

First, we are not immune. This would seem obvious (no less because we pride ourselves on our understanding of immunology), but it is worthwhile to emphasize since we have a tremendous capacity for self-deception.[2] Low stress does not effectively mitigate burnout because the suspected etiology is unrelated. And we deal with an unusual batch of drugs and diseases. Our consults and charting are perhaps a touch more detailed, and from one Exceptional Access Program to the next, we have our fair share of forms. At the most superficial level, reducing tasks of this nature would be a fine place to start.

But second, and more importantly, clinical interest is not enough to banish burnout. I presume many of us joined the ranks of rheumatology due to genuine curiosity. We attract a particularly cerebral group. But that earnestness, which I see persists in many colleagues even over decades, provides little drive to continue with the paperwork, the meetings, the electronic medical records (EMRs). We need something more riveting. And this lies in the humanity of any practice. A disease is interesting, but a person is inestimable. This is of particular relevance for the rheumatologist, whose orientation toward medicine is at least mildly skewed toward a fascination with pathophysiology. The orthopedic surgeon has a different tendency on her hands. But for us, we must be mindful of this pitfall. If our goal is in satisfying curiosity, in gathering data, or even in the cure, we have missed the mark. This makes the patient a means to an end.[3] And when the patient is subservient to another goal, the heart atrophies. Chronic pain becomes a nuisance, paperwork a drag. These issues become impediments to the thing we want or need. And this, in my mind, is the deeper issue at hand.

The process, of course, is subtle. But it is inevitably present, and I recognize it in myself. Yet if my child were ill and needed paperwork, it'd be completed in a flash. The human element is overpowering. Certainly, we must take other measures to reduce burnout. But there are things the surveys have trouble capturing. The totality of our work resides in the patient before us. Lose this vision, and our work will always leave us numb and disenchanted. Remember it, and we may know we've changed a life forever.

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