(academic or community-based) so that they could fulfill these requirements. And again, it was something of a bold step; it wasn't universally accepted originally. But we've continued with it, and of course, it's now continued for many years. But in fact, we established a program, and the basic structure we established then is still being used in the programming today.

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?

I think there are a number of issues which face rheumatologists. But they're not unique to rheumatology. I think they probably are relevant to all practicing physicians, whether they're specialists or family doctors. I think the first thing in rheumatology is making sure that we maintain a good lifestyle balance between work and the home. There has been a massive change in terms of manpower. We have a large number, in fact, probably even now a majority of practicing rheumatologists who are women. And we need to respect their needs to balance clinical practice with their home life. I think to some extent that applies also to males in clinical practice. We need to ensure that this balance is maintained because I think maintenance of that balance is reflected in the quality of care that we give to our patients.

I think the second thing is that we need to ensure that we make maximum use of the time that we spend in the office. It's become increasingly apparent to me that physicians are spending huge amounts of time dealing with paperwork, bureaucracy, and this is unremunerated time, but more importantly, this is time that is being taken away from devoting ourselves to patient care. We need to ensure that when we're in the office, we're actually doing what we're specifically trained for, not bogged down by bureaucracy.

And finally, I think it's important to ensure that when we're in the office we are seeing the patients that we are specifically trained to diagnose and treat. There is increasing evidence now that an early diagnosis and early treatment leads to very positive outcomes. We must ensure through whatever mechanism, whether it be through screening processes or some other mechanism, that we get to give priority to those patients that we are particularly trained to treat, which would be patients with inflammatory arthritis and connective tissue diseases. Those are the patients that we can do the most for, and those are the people that we must give priority to; they should not be sitting on a waiting list for 6 months, 9 months, or a year.

What are your proudest accomplishments to date?

It's a difficult question because one doesn't like to blow one's own trumpet. But I actually in reflection, do think I've accomplished something, certainly in my time on the CRA Executive and as CRA President. I think I did significantly influence the development of the CRA, changed its focus, and helped to develop it into what it has become today.

I'm particularly proud of the fact that I, along with Bonnie Thorne of the Arthritis Society (now known as Arthrits Society Canada), co-organized Arthritis 2000. This was a one-off free-standing meeting involving all stakeholders in the rheumatology community. It was held in Ottawa. We had a huge attendance. It was very well received, and as a result of that, there are many other initiatives that evolved from that initial start, which persist today.

I must say I'm also quite proud of the fact that along with John Esdaile, we started the Western Alliance for Rheumatology. This was started off as a one-off meeting. We didn't expect it to go beyond just one meeting. In a couple of weeks, we'll be celebrating our 21st anniversary, and that is a local, regional meeting that has become hugely popular and has been quite a good focus for local rheumatologists, but also for supporting local trainees who subsequently go into rheumatology as a long-time career.

What do you enjoy most about being retired? What have been some of your other passions outside of rheumatology?

Well, although I don't have the chance to do it as much as I used to, travel has always been a passion, and I've been very, very lucky in that over the years, I've had the opportunity to travel both professionally and for personal reasons. I had the opportunity to practice in Zimbabwe and in Kenya, and, I've always had and continue to have a huge love of Africa. I'm not quite sure if I will ever get back there, but certainly that would be on my bucket list. I'm a huge fan of rugby, so I played rugby until I was I think, 40, and I continue to follow International rugby with a passion. And I guess, finally, I'm a collector. I collect toy soldiers, toy trains, English stamps, and I'm very proud of my Canadian art collection, which I enjoy every day.

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Arthritis Society Canada Invests to Stop Osteoarthritis in Its Infancy

Arthritis Society Canada is partnering with the University of Alberta to scale a revolutionary project to quickly and affordably diagnose and treat developmental dysplasia of the hip (DDH) in infancy.

The Newborn Arthritis Prevention Screening (NAPS) project is led by Dr. Jacob Jaremko, a pediatric musculoskeletal radiologist at the University of Alberta. This digital health innovation uses artificial intelligence (AI) and 3D imaging to capture images of babies' hips, comparing them to thousands of previously-recorded scans to determine — within seconds — if an abnormality exists. These portable devices, currently piloted in places like rural Alberta, can be operated by trained professionals already in communities.

Up to 40 percent of hip osteoarthritis is associated with DDH. Yet DDH that is diagnosed early in infancy can be successfully treated by wearing a soft brace — sparing newborns a lifetime of pain and discomfort.

Arthritis Society Canada is supporting the project's expansion, fundraising with an organizational goal of $5 million and seeking an additional $5 million in funding opportunities from government. This collaborative approach has the potential to save the healthcare system millions of dollars while reducing future cases of osteoarthritis due to undiagnosed and untreated DDH.