

Dr. Edworthy replies

To the Editor:

Haraoui, *et al*¹ have responded positively to the challenge of improving the care of patients with rheumatoid arthritis (RA), indicating that it is time to “specifically target remission/low disease activity state,” “use consistent measures and metrics,” “respond appropriately” to inadequate therapeutic response, and “optimize therapy.” These suggested actions are in response to data collected in the national audit, Assessments in Rheumatology (AIR) program, which identified, with a cross-sectional survey, that patients with RA do not always receive optimal medicinal therapy despite being in a state of smoldering or active disease.

The authors suggest a “national consensus,” utilizing an iterative Delphi process², in which experts respond to a series of questions, then defend their answers in response to other expert responses. This reflective process goes on until consensus is achieved (or the experts disperse). The authors feel this iterative process to develop an evaluation tool for daily clinical practice will allow it to be rapidly adopted and thereby will improve management of patients with RA. A great deal will depend on which “experts” they use. It would make sense that the experts are drawn from community practices where the majority of patients with RA are seen, and where the challenges of patient adherence to complex therapeutic regimens unsupported by clinical trial teams are best known. It also will be important to include primary care physicians in this process, who can significantly affect the decisions of care through their more continuous, and generally greater, involvement with the patients’ overall health management.

Notwithstanding the need for better care of patients with RA, and the value of “evidence-based, practical, and easy to use” evaluation tools, the caveat to this approach is contained in the final sentence of the authors’ letter — “that when implemented, those agreed-upon ‘best practices’ targeting remission will improve the management of patients with RA.” Implementation of any tool, particularly one that will alter medicinal therapy, requires administrative effort, clerical support, adequate information systems, and attention to the patient’s adherence. Nor is it sufficient to

adopt an “evaluation tool,” since tools do not replace the judgment required to implement therapeutic changes in light of the gathered information.

In the original AIR study³ it was shown that a significant number of rheumatologists work in solo practice, unsupported by adequate clerical staff, and are overburdened already with forms to support the use of medical therapy. It was also noted that patient preference was an important factor in determining whether changes to therapy would be agreed to, let alone adhered to. Although Canadian experts in rheumatic disease care may reach consensus on a measurement tool, social theories of technology diffusion⁴ would predict it will take a great deal more, across the 10 disparate provincial jurisdictions, to create the necessary support structures for implementing this tool. In addition, rheumatologists will also need other measures in place to achieve better care for their patients. Nevertheless, the proposed activity is a good, and necessary, first step.

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J Rheumatol 2009;36:12; doi:10.3899/jrheum.090669