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ACR PRESIDENTIAL ADDRESS

Unity in the Field of Rheumatology

The Role of the ACR

David A. Fox

Colleagues and guests: it is my pleasure to again welcome you to this opening session of the 2008 Annual Scientific Meeting of the American College of Rheumatology, and to have the opportunity to deliver the ACR Presidential address. My topic is "Unity in the field of rheumatology—the role of the ACR."

Rheumatology is unique amongst the subspecialties of internal medicine in the United States in that the entire spectrum of our profession is represented by a single cohesive organization—the ACR. Not only does the ACR include virtually all rheumatologists in this country, whether they are engaged in clinical practice, research, teaching, or positions in industry—but it also encompasses the many other health professionals whose clinical practice or research is also devoted to improving the health of patients with rheumatic diseases. The program of this meeting reflects the broad scope of our College, and the tireless work of a terrific team of ACR staff and volunteers. I'm especially pleased to announce that beginning in 2009 the abstract submission deadline for the ACR Annual Meeting will be moved from early May to late June. This significant change, which will involve even more concentrated efforts by the many individuals who assemble the program for the Annual Meeting, will ensure that the science presented is as up to date as possible.

An organization like the ACR, whose membership is diverse, functions at its best when its multiple constituencies achieve a harmonious balance. A relevant analogy (relevant, at least, from the point of view of someone who does immunology research) can be found if one considers the cellular components of the immune system. These include several subsets of CD4 effector T lymphocytes, known as Th1, Th2, and Th17 populations, as well as regulatory T cells, CD8 cells, B lymphocytes, natural killer cells, and the myeloid antigen-presenting cells that include dendritic cells and monocytes. The collaboration of all of these cellular components is required to maintain effective host defenses, a task not achievable by any one cell type alone. Moreover, disproportionate activation of any one population or failures of regulatory mechanisms lead to autoimmunity.

In a similar vein, the ACR works best when each of its constituencies, adult rheumatologists and pediatric rheumatologists, researchers and clinicians, educators and trainees, nurse practitioners and occupational therapists, physicians' assistants and physical therapists—and all other members of the ACR—can assume roles that are dynamic and collaborative in the work of our College. Domination by any single constituency would be undesirable, analogous to breakdown of regulatory balance during an immune response.

A sign of the health of our organization is the remarkable extent to which members of the ACR care about, work for, and advocate for components of the College outside of their own constituency. This is evident in the exponentially expanded activities of our Government Affairs Committee and staff. With the help

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of hundreds of ACR members, and working together with many of our patients and with the Arthritis Foundation, together we helped to avert catastrophic cuts that threatened the Medicare program, the health of our patients, and the viability of our clinical practices—even though this required Congressional override of a Presidential veto. And we were finally successful in obtaining passage, through the House of Representatives, of the Arthritis Prevention, Control and Cure Act, a landmark step forward for our field and for our patients. We hope to soon see this bill make its way through the Senate as well. And we are thrilled that Representative Anna Eshoo, the architect of this bill in the House of Representatives, will be here at the start of tomorrow's plenary session as we recognize both her and Senator Edward Kennedy for their leadership in this important legislative initiative.

I also want to highlight the significant steps that our clinicians are taking to boost research in rheumatoid arthritis, through their fundraising roles in the Within Our Reach campaign, which is on track to hit its $30 million target on schedule next year. ACR members are also donating more to the core programs of the REF (Research and Education Foundation), exceeding our ambitious new goals for dollars raised from within the College.

Intergenerational unity is also a critical goal for the College, by which I mean strong links between our current and recent fellows and the more experienced members of the profession. Beginning in their first year of rheumatology training—sometimes even earlier—fellows become part of the ACR family by attending the Annual Scientific Meeting and the State-of-the-Art Meeting as guests of the College. For many of our fellows, part of their training is funded by grants from the ACR's Research and Education Foundation, which is on track to reach an initial goal for endowment of its core programs of $25 million by 2010. And 2008 marked the debut of the Rheumatology Research Workshop, which brought together many of our fellows and other young researchers with some of our best experienced faculty—to present their work, learn from and network with each other, and better understand their career development options.

As a unified College with clear goals, we are better positioned to work with other organizations to address a variety of challenges faced by our profession and our patients. This year we have significantly broadened our contacts with various institutes of the NIH, recognizing that funding for the broad scope of rheumatic disease research can potentially originate not only from NIMAS (the National Institute of Arthritis and Musculoskeletal and Skin Diseases), but from many other components of the NIH. We are grateful for the keen interest and warm welcome that we have received throughout the NIH, and these new relationships are already bearing fruit. At the same time, we are partnering with the NIAMS and with the Arthritis Foundation in new programs to address the critical transition points in an academic rheumatology career, transition points that have become more challenging as NIH funds have contracted over the past several years. One such initiative is the new K-bridging award, which will support research by young physician-scientists in the field of rheumatology whose NIH career development grants were ranked as excellent or outstanding but could not be funded by the NIH due to budget constraints. Recipients of the K-bridging award will be able to move their research forward while reapplying to the NIH for more long-term support.

Table 1. Demographics of rheumatology fellows: underrepresented minority groups*

	% of rheumatology fellows	% of total residents and fellows
Black	3.2	5.5
Hispanic	6.4	7.0
Native American	0	0.2

* From ref. 1.

The K-bridging award is only one of many ACR initiatives to address career development and work force issues in both academic and clinical rheumatology. As we assess our rheumatology work force development strategies, we need to also ask how the gender, racial, and ethnic composition of our specialty and our trainees compares to the demographics of our patients and of the medical profession as a whole. Rheumatology is clearly shifting towards a female-preponderant field—58% of rheumatology fellows are women, compared to 44% of postgraduate medical trainees overall. Out of 408 rheumatology fellows in training in 2007 (1) (Table 1), 26 were of Hispanic origin, close to the 7% mean among all house officers and fellows. However, only 13 were African American and none were Native American. That 3% of rheumatology fellows are African American may constitute slight progress over the past decade, but it is well short of the 5.5% proportion of medical trainees overall who identify themselves as African American. Furthermore, among over 70 rheumatology fellowship program directors who responded to a recent

Table 2. Important issues facing the ACR

Scope of practice
Economic viability of clinical and academic rheumatology
Health care system reform
Development and uses of an ACR clinical registry
Quality of care/quality measures
Maintaining educational excellence
Optimizing effective use of REF grant dollars
Possible new targeted research initiatives
Governance update/restructuring
Limited/declining resources
Setting/achieving work force targets

ACR survey, not one identified himself or herself as African American.

At a time when one of the major candidates for President of the United States is African American, it ought to be possible for some of our rheumatology division chiefs and fellowship program directors to come from this important and underrepresented minority group! A unified ACR will achieve its potential only when its composition better reflects our multiracial society, among our trainees and among our leaders. To tackle these critical issues the College has appointed a Task Force on Women's and Minority Issues, chaired by Dr. Betty Diamond, that will provide input during the development of a new ACR strategic plan in 2009.

Unity in the field of rheumatology extends beyond the borders of the United States, and beyond the specific issues that preoccupy rheumatologists in this country. Our links with our colleagues in other countries are stronger now than ever before. We are partnering with EULAR (the European League Against Rheumatism) in the development of new or revised criteria for disease classification, criteria for clinical response and remission, and appropriate parameters for assessing changes in disease activity in clinical trials. Through the international rheumatology organization, ILAR (the International League of Associations for Rheumatology), which has been reorganized in the past year, we are beginning to explore the possibility of coordinated global health initiatives in rheumatology. Worldwide interest in this new focus of ILAR is apparent from the response to an initial call for 2009 pilot grant proposals. With only modest funding offered and only a month in which to prepare applications, the new ILAR received 61 project proposals, which are currently under review. As a unified College, the ACR is proving to be an effective force for greater global unity in advancing the field of rheumatology worldwide.

What, then, is the common interest or vision that unifies all of the health professionals and scientists of the ACR? As always, the only possible answer must be that we seek to improve the lives of our patients and of all people who are affected by rheumatic diseases. As John Sergent said during his 1993 ACR Presidential Address, "It's the patient, stupid!" (2). Keeping this source of our unity firmly in mind can help guide our decision-making in everything that we undertake.

For example, what do we envision as the appropriate components of future relationships between the ACR and the pharmaceutical industry? If our activities as partners are beneficial for our patients and can stand up to public scrutiny and transparency, those activities should be encouraged. When industry supports the programs of the REF, with no strings attached, fostering the career development of future rheumatologists, it may be because it needs trained rheumatologists to prescribe the next generation of biologics—but it also means that there will be a better supply of physicians to take care of our patients. In this case the interests of the pharmaceutical industry, the profession, and our patients are well aligned. And they are also well aligned when industry supports the Annual Meeting of the College or contributes to the fellows' fund. However, when we are asked to engage in programs that are packaged as continuing medical education but which really are driven by a marketing agenda, we need to say "no thanks—we're not interested in seeing even more money spent on marketing that does not benefit our patients and that instead leads to higher prices for prescription drugs." That's our approach as a College, and it should be the response of each of our members as individual professionals. We need to think in similar terms about the costs and benefits of new technologies and new medications—realizing that the long-term value we provide to our patients in the management of difficult chronic diseases is of greater importance than short-term advantages that we can accrue as practitioners through overuse of novel technologies or procedures.

Our new strategic plan, to be created next year, will need to address the many significant challenges that

Table 3. Previous ACR and ARA Presidents from the University of Michigan

Richard H. Freyberg*
Charley J. Smyth*
William D. Robinson†
Giles G. Bole†
William N. Kelley*

* Significant portion of career at University of Michigan.
† Entire career at University of Michigan.

rheumatology is facing (Table 2): What should be the scope of our practice? What is a viable future business model for rheumatology practice in the community setting or in academia? What models of health care system reform can we support? What should be the roles of the new ACR clinical registry that is being developed? What are the top priorities for our still new and expanding initiatives in the quality-of-care field? How do we retain control of how quality is assessed in the practice of rheumatology while not creating hurdles for our members that could be exploited by insurance companies? How can we best meet the educational needs of our members, and make sure that our meetings and our journals continue to set the standard for professional education in our field? In the REF, how should the grant portfolio be updated? What future targeted research initiatives should be launched? Should we continue a focused program in RA research after the initial 5-year Within Our Reach campaign is over? Could a restructured ACR, with increased integration of the ARHP (Association of Rheumatology Health Professionals) into all activities of the College, serve the needs of our members more effectively? And, as we set our goals and strategies, how do we cope with what could be several years of struggles in the US and world economies, limited resources for health care and for medical research, and recent shrinkage of the value of the investment portfolios of the ACR and the REF?

The ACR has a talented and dynamic team of future leaders and dedicated staff who are ready to tackle these issues. But as we move forward it will be more essential than ever to maintain our unity in what will be stressful and difficult times. Our staff and leaders will need the ongoing engagement and ideas of all our members. I believe that we will also need to cultivate an increasingly explicit alignment of the interests of our profession with the needs of our patients, an alignment that will lead to more effective advocacy, and the right decisions about quality, clinical practice, relationships with industry, fellowship training, and health care reform.

In closing I'd like to thank some of the many people who have helped me to serve the ACR as an officer for four years and as its President this past year. I am the sixth ACR President from the University of Michigan (Table 3), and I've had the good fortune to get to know each of the previous five, two of whom—Giles Bole and Bill Kelley–were instrumental in getting my own career in rheumatology started. It's been a privilege to work with the other officers of the ACR, ARHP, and REF, as well as the Board members, committee chairs, and numerous other members of the ACR from whom I have learned so much. The ACR is especially lucky to have a superbly talented and dedicated staff led by Mark Andrejeski—this remarkable group of people deserves most of the credit for any successes that are achieved by the volunteer leaders of the College. The opportunity to work closely with our staff has been one of the highlights of my year as ACR President.

Over the past year my colleagues in the Division of Rheumatology at the University of Michigan have filled in on many occasions to accomplish tasks that I was neglecting while traveling on behalf of the ACR—I am grateful to all of you. I also want to thank my family for their support and encouragement, which have enabled me to tackle my duties as an ACR officer to the best of my abilities. It has truly been a privilege and an honor to serve you, the members of the College, as your ACR President, and I thank you for this unique opportunity.

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2. Sergent JS. It's the patient, stupid! [ACR presidential address]. Arthritis Rheum 1994;37:449–453.