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This issue of the Allied Health Professionals’ Newsletter is an anniversary volume - our Allied Health Professionals (AHP) Committee has existed for 20 years as a part of the EULAR organisation. The European League Against Rheumatism is an organisation which represents the patient, health professionals, and scientific societies of rheumatology of all European nations.

We hope that our readers will enjoy this issue with a special historical theme as well as the words from EULAR executive director Fred Wyss. This issue also contains a fresh sample of the doctoral dissertations by health professionals which are introduced in this Newsletter as the Academic milestones. So far, we have found 55 doctoral dissertations by nurses, occupational therapists, physical therapists, and psychologists. The six European countries which have “produced” PhD’s by health professionals in the field of rheumatology are Austria, Finland, the Netherlands, Norway, Sweden, and United Kingdom. Please let us know if there are more!

With the support from EULAR our Committee has established valuable activities such as educational courses and visits, research grants for projects, many of them multidisciplinary and multicultural projects taking place in different European countries. However, Committee Members still need to volunteer to help with research projects in order to make them a success.

What we do as health professionals is essential. Let us therefore continue to work together across the Europe, to ensure that individuals with rheumatic diseases can expect the best evidence-based quality of patient-centered care and rehabilitation. While working together and using the terms in ICF (International Classification of Functioning, Disability and Health), we can also improve communication between the different professions as well as between the persons with rheumatic diseases and their relatives, which are important environmental factors for the patients.

As rheumatology health professionals, our goal is to support people with arthritis to achieve the ability to function and participate fully in the daily life and enable them to find their own solutions to their problems and an insight into their own possibilities. Therefore, it is of value to encourage research focusing on patient perspective and, also, use the patient-reported outcome (PRO) measures. Initiatives have also been taken to improve educational activities as post training programmes for AHP.

All scientific publications and research findings must be implemented into clinical practice to give the individual with rheumatic diseases the best benefit. This also means abandoning ineffective treatments, which is a question of cost-effectiveness.

History has shown that it is impossible to get to the destination without a “roadmap”. Our Strategic Plan has proved that health professionals are on the right way. The past years have generated a splendid progress with high quality in the scientific programme and with a network of health professionals in rheumatology which is continuously expanding in Europe.

I hope that the upcoming congresses and future work will bring for new scientific findings the health professionals to stimulate discussions on research and new evidence based interventions, fruitful dialogue as well as a new, deeper connection between researchers, clinicians, and patients.

My warm thanks go to EULAR for sponsoring this Newsletter. After eight years as the Editor of the Newsletter, I will hand it over to another member of the Committee.

I will take the opportunity to thank Fred Wyss for his support, the chairman of our committee, Jaana Hirvonen, for her interest and time-consuming contributions, our Vice president Peter Oesch, for his vital role in planning the programme for health professionals in the Barcelona Congress 2007, and all the members of the AHP committee for giving me a lot of new useful influences, rewarding mutual communication and warm friendship during all these years. I wish the Allied Health Professionals a large number of successful years.

Ulla Nordenskiöld
PhD, occupational therapist, Gothenburg, Sweden
To achieve its aims, EULAR fosters education and training in rheumatology in Europe. Up to now, EULAR educational activities for Allied Health Professionals (AHP) consist of the annual congress, travel bursaries and educational visits. This selection does not fully meet the learning needs of the European Allied Health Professionals in Rheumatology as there is a very broad variety of knowledge and skills among the different professions and different countries, resulting in different standards of care. There is a clear need for a post qualification course programme for AHP.

Members of the AHP education committee (Jana Korandova, Allison Hammond, John Verhoef, Peter Oesch), with the help of Robert Buff from the EULAR secretariat and Prof. Hans Bijlsma, Chairperson of the EULAR Standing Committee on Education and Training, developed a concept for a EULAR AHP post qualification Course. The concept acknowledges the difficulties of acquiring valid information on the knowledge and skills of the different AHP in the different European countries and, therefore, proposes to conduct a pilot course to establish a course programme on Rheumatoid Arthritis and Osteoarthritis and also to get information on the learning needs of the European AHP. This pilot course will furnish enough information to develop a multi-disciplinary introduction course in rheumatology.

This concept was presented at the latest EULAR Executive Committee meeting and received very positive response. A few adjustments will have to be made before we can start the detailed planning. Further information will be available after the Barcelona congress.

Collaboration of the AHP in the 2012 strategy

EULAR will undertake a review of its strategy in the light of the challenges the organization will be facing in the years ahead. A one day strategy development workshop was held on the 3rd of February 2007 involving the members of the Executive Committee meeting. At the workshop, a framework for structuring the strategy planning process into topical subgroups was developed. Peter Oesch was named leader of the AHP subproject with Tore K. Kvien as co-leader.

All the subgroup leaders, together with their co-leaders, were then asked to ponder what the overall EULAR objectives 2012 mean for their own topic. From the subgroup’s perspective, what specific goals does the team envisage to help achieve the overall EULAR objectives?

We developed a first draft of goals which are as follows:

- By 2012, the AHP in EULAR will have fostered the foundation of 10 national AHP organisations in Rheumatology thus enabling them to become official members in EULAR.
- By 2012, the AHP in EULAR will have established effective partnerships with national and international health professional’s organisations.
- By 2012, the AHP in EULAR will provide high quality educational programmes on relevant rheumatic diseases meeting the educational needs of European Health Professionals.
- By 2012, the AHP in EULAR will be recognized as a professional and effective organization, worth belonging to and working with.
- By 2012, the AHP in EULAR will have established recommendations for the non-pharmacological treatment of patients with important rheumatic diseases, e.g. osteoarthritis and rheumatoid arthritis.

This first draft of goals was shared with the members of the AHP standing committee. As these goals can still be viewed as a draft, any comments of yours are welcome. Please send them to Peter Oesch. In October 2007, the EULAR strategy workshop involving past, current and future leaders of EULAR will be held and the goals will be then finalised.

Best regards

Peter Oesch
Vice President
p.oesch@klinik-valens.ch
After nearly 22 years of service, I shall retire at the Barcelona Congress as Executive Director of EULAR. One can imagine that being in office for such a long time, good and difficult times have been seen at the EULAR Secretariat. Before I joined EULAR in November 1985, I had worked nearly 5 years for Rotary International and had good contacts with the industry, which helped a lot in my early years in EULAR.

Two days after I started my work with EULAR, I had to attend the EULAR Symposium in Vienna in 1985. Having had no idea about EULAR, I attended the EULAR General Assembly and Executive Committee meeting at the Symposium and faced – obviously – several problems with the medical terminology. EULAR’s finances were very limited. A very strict and prudent finance policy was necessary to make sure that EULAR would survive. With the quadrennial Congress in 1987 in Athens, a surplus of USD 100,000 for EULAR was made. In the following annual Symposia and Congresses, the financial situation improved and EULAR began to grant bursaries and other limited grants to projects of the Standing Committees. In my first years, I worked by myself in a small office in Zurich. At a later stage, the budget for the employment of a Secretary was granted and in early 1990, my wife Elly joined EULAR and worked full time and, later, for 2 or 3 days a week.

In the 1980s and early 1990s, EULAR Congresses and Symposia were often criticized for their low level of scientific programme, and the ACR’s programme was considered as the highlight of the annual Rheumatology meeting. This was one of the reasons that the annual Symposia were abolished in 1998 with a successful Symposium in Geneva with over 3000 participants, followed by the last quadrennial Congress in Glasgow which was considered to be a highlight of European Rheumatology with the number of participation being over 6000. It was certainly a milestone in EULAR’s Congress history. Since 2000, EULAR organizes its annual Congress of Rheumatology, which is much more work for the EULAR Secretariat, but it is also very rewarding. The Secretariat has now five staff members, of which four are working full time and one part time. A few years ago, the Executive Committee asked me to look for a house in the Zurich area for the Secretariat’s headquarters and with sufficient space for a larger meeting room. It was a difficult task, but now we are well established in Kilchberg, a suburb of Zurich. We have several offices in the house and also a wonderful conference room on the top floor which can hold up to 45 persons and two break-out rooms if needed. Since 2005, we have had over 30 meetings of Standing Committees, the Executive Committee, and the Scientific Programme Committee in the house and I must say that the participants of those meetings are delighted to come “home” to the EULAR house – it is so different from a meeting in a hotel and has its personal touch.

As Ulla Nordensköld writes in her article, the Standing Committee of Allied Health Professionals in Rheumatology was formally founded in 1989. After the International Symposium for Health professionals in Rheumatology held in Pellenberg-Leuven, Belgium, in September 1986, there were heated discussions on the EULAR Executive Committee whether a Standing Committee for Health Professionals should be founded. It was first proposed that the Health Professional organizations could become a Corporate Member of EULAR, i.e. similar as pharmaceutical companies! The By-Laws of EULAR indeed contain a clause according to which Rheumatology associations of medial assistant personnel can become a member of EULAR. It was, as many of you know, Vicky Stephenson from the U.K., who persuaded that Health Professionals should have their place in EULAR in the form of a Standing Committee. She was invited to the Executive Committee meeting on 19th of May 1989 in Athens, and the delegates of the EULAR General Assembly in 1989 ratified the recommendation of the Executive Committee to launch two new Standing Committees, i.e. Health Professionals in Rheumatology (Chair: Vicky Stephenson, UK) and Investigative Rheumatology (Chair: Prof. Ravinder Maini, UK).

I was very pleased to see Health Professionals in Rheumatology becoming a part of EULAR and the nomination of a EULAR Vice President of Allied Health Professionals in 2000 and the ratification of applications of Health Professional Associations as members of EULAR in 2006 (Switzerland and U.K.) completed the “success story”. I sincerely hope that more Associations join EULAR – Applications from Sweden and the Netherlands should be ratified at this year’s General Assembly in Barcelona.

Fred Wyss
Executive Director
EULAR Secretariat
Kilchberg/Zurich, April 2007
Two decades of engagement by Ulla Nordenskiöld

One could say that it all started in Sydney 1985 at a congress organized by the International League Against Rheumatism. Health professionals from all over the world participated in this congress, and I was working as the chairman in a workshop under the title: “Joint protection: fact or fiction”. This was the first international occasion in which I was personally in contact with other allied health professionals who shared the same interest in rheumatology. During the congress, we had the opportunity to gather up an informal network meeting which involved enthusiastic professionals wanting to keep in touch also in the future.

Two years later in Athens, I presented my first abstract in a EULAR Congress. It was about “Soft wrist orthoses effects on pain and gripping power in women with rheumatoid arthritis”. In the beginning, we had to send our abstracts to the same scientific review as the physicians did. When our abstracts were accepted, we presented them along with the same scientific programme. For this reason, the physicians had to listen and also take part in the discussion on our results. This was very important in order to highlight the significance of the health professionals’ work; their special methods, interventions and outcomes measurements, also from the patients’ perspective.

In Athens in 1987, a British nurse Vicky Stephenson arranged a new meeting for some 30 health professionals. This time, we voted on establishing our own group in EULAR for the allied health professionals (AHP). The elected health professionals for the group, including Vicky Stephenson and me, were occupational therapist Ingrid Due Pedersen from Denmark, pharmacist Angelica Kruse Jensen from Norway, and social worker Willy Peters from Belgium. These members formed the first official and active working group of health professionals in EULAR. Vicky Stephenson was very determined to elevate our group into EULAR’s actual Standing Committee. Ingrid Due Pedersen who already was involved in the EULAR Social League was as well a very big help in promoting the health professionals. Also from the very beginning, Fred Wyss, executive director of EULAR, gave valuable support to our efforts of building a Committee.

The seventh committee

The new Standing Committee of Health Professionals in Rheumatology was formally founded by EULAR in September 1989, and we became the seventh committee under the EULAR Executive Committee. Each European member country could propose a participant to the Standing Committee. In my case, the Swedish Rheumatism Association which was already a member of the EULAR Social League proposed me into the Committee. Vicky Stephenson was elected to be our first chairman. Willy Peters started as vice chairman and Ingrid Due Pedersen, Angelica Kruse Jensen and I were the first Committee members. The aims of the Committee were to disseminate information and experiences, plan and organize AHP’s meetings alongside with EULAR congresses, and to work towards a greater awareness of AHP’s work in scientific articles and symposia.

More members from other European countries were slowly participating in our AHP Meetings. In Amsterdam in 1995, British physiotherapist Nora Price was elected the next chairman. The following year, EULAR offered assistance to the Committee with the help of secretary Sophie Edwards from the British
HISTORICAL RETROSPECTIVES OF AHP

Society of Rheumatology. Thanks to this extra help, the Committee became more active and things began to happen. The new objectives for the committee comprised also encouraging the establishment of local AHP organizations in different countries and promoting the work of the Rheumatology Action for Eastern Europe. There were discussions on developing special teaching courses of which I will tell more about later in this newsletter.

In the beginning, the congresses were only held every fourth year but at the Vienna symposium in 1997, it was decided that there will be regular meetings for Health Professionals every second year. This made the decision making process more effective. This, of course, was very good news for us. Later on in 1999, the Allied Health Professionals had, for the first time, a full five day programme, at the Glasgow Congress. The programme was extremely popular, and 369 AHP delegates participated in it.

Turning to the millennium

In 2000, at the first Annual European Congress held in Nice, nurse Jana Korandova from Prague was nominated our first vice president. The most important tasks of the vice president are to improve communication between allied health professionals and to organize AHP sessions during the congresses with topics which would be beneficial to all professionals. The vice president has a seat on the Executive and the Scientific Committees in EULAR.

Also at the Nice congress, our first AHP Newsletter was introduced to the public. It was then that I started to act as the editor. The AHP Newsletter reports objectives of the committee, highlights news from the chairman and vice president, releases information about activities and views from the members. We decided to publish a spring and an autumn issue of the Newsletter every year and to send them to health professionals in all member countries. This we have done ever since.

In Prague 2001, we began to organize Round Table Discussions giving all health professionals the opportunity to discuss and exchange experiences and ideas for the future. The discussions formed also a forum for obtaining information about the ongoing activities in national organizations and for finding out the main research needs of health professionals. As a result of the feedback given in the round table discussions, EULAR decided to emphasize the need for a strategic review of AHP’s activities. The goal was to better understand the demands of the members, as well as to clarify the role and aims of the committee. A review meeting with a great deal of hard work took place with six volunteers in London in the same year.

In addition, in 2001, EULAR had agreed to support travel bursaries and educational visits for AHP’s and, next year, they also agreed to fund research projects. These new “privileges” from EULAR were a large step forward for us.

The first roadmap

Our Committee was the first in EULAR to have a Strategic plan which was announced in Stockholm in 2002. The Strategic plan 2002-2005 comprised five key aims. The aims were promoting high quality evidence based practice in interventions to people with rheumatic diseases, promoting the unique role of health professionals within the multidisciplinary team including clinicians and people with rheumatic diseases, supporting health professionals’ work and their national organizations and network in Europe, facilitating the sharing of information, skills and resources between health professionals in Europe and to give health professionals a voice through a strong, representative and effective Committee.

The advancing of the development in multidisciplinary research of the health professionals continued to be one of the main focuses in the Committee as well as encouraging health professionals to make educational visits. Our major challenge was still, however, to increase the participation of Eastern European countries and to develop our network there. So far, our committee had representation from seven different professions from nineteen European countries but, unfortunately, 24 countries were still not represented.

In 2002, Jana Korandova retired after a very demanding period of work and physiotherapist Jill Lloyd from United Kingdom was elected the second vice president. A year later, in 2003, at the Lisbon Congress, Nora Price retired after eight very successful years, and a Finnish psychologist Jaana Hirvonen was elected as our fourth chairman. In the congress, we had three joint congress sessions together with the Scientific programme and the Social league which discussed the following topics: socio-economic challenges, achieving best services, and assessment in quality of life.

In Vienna in 2005, Jill Lloyd ended her term after four respectable years leaving behind a growing and much stronger committee. Also Sophie Edwards left us after nine years of hard work. Our third vice president Peter Oesch, a
physiotherapist from Switzerland, was elected. He proposed a new submission process for the abstracts. Also in 2005, HP's working group presented a multidisciplinary research action plan to EULAR's Executive Committee.

Towards today
In Amsterdam in 2006, Jaana Hirvonen reported the results of the updated Strategic Plan. The updating process of the strategic plan was started with a Delphi analysis in which participants were asked to define the three most important tasks for the committee. Nineteen health professionals from Czech Republic, Denmark, Finland, Hungary, Netherlands, Norway, Poland, Slovenia, Sweden, Switzerland, and UK participated and suggested 70 tasks. The most agreed task was “to increase knowledge of allied health professionals from different countries concerning existence, targets and work of EULAR APHs”. The next highly agreed task was “to facilitate education, research and best practice throughout Europe, particularly in those countries where health professionals are struggling”.

The poster session was now organized according to the different professions that made it easier for researchers from other countries to meet and exchange information. Also, a special scientific meeting with working groups for research and education were established consisting of co-opted members as well as standing committee members.

It was proposed that national AHP organizations could apply for a membership in EULAR. For now, only the Associations from Switzerland and United Kingdom have been members.

In 2007 in Barcelona, Jaana Hirvonen’s term in office will come to an end after four years of very hard and exciting work, and physiotherapist John Verhoef from the Netherlands starts as the fifth chairman of our committee. For the first time, we have a third member in the EULAR’s Scientific committee, a British nurse Jackie Hill. We are very happy about this.

Our joint sessions this year will discuss patient education and empowerment, how new practice can be implemented, and other methodological issues. As in the very beginning in 1985 in Sydney, I was the chairman for a workshop Joint Protection – fact or fiction. This year I will be the chairman for the session: Patient education and empowerment. Patient education is as important as it ever has been.

Ulla Nordenskiöld
IN AHP FOCUS

MULTIDISCIPLINARY COLLABORATION:
The guarantee for good care in Europe
by Jaana Hirvonen

Health care provision can be seen as a continuum from solo provision, where practitioners work independently, to full integration of disciplines for the provision of preventive services, treatment and rehabilitation. The integration of disciplines can take different forms of teamwork.

In multidisciplinary teamwork team members carry out their assessments and treatments of the patient individually but communicate the outcome of their intervention and recommendations to other team members. When members of the team start planning solutions to the patient’s needs together, and treatment goals are set and reviewed jointly, the multidisciplinary team has become an interdisciplinary team. Team members collaborate to solve patient problems that are too complex to be solved by one discipline or many disciplines in sequence. Finally integrative team care is reached if the interdisciplinary team, based on a shared vision, provides a seamless continuum of decision making, patient-centred care and support.

The multiple meanings of teamwork
The preferred model of teamwork varies. Sometimes teamwork is multidisciplinary, at other times perhaps interdisciplinary. What is certain, however, is that teamwork in one form or the other is recommendable, because there is increasing evidence that teamwork is more effective and efficient than services provided individually.

The esteem of teamwork and its impact on the care of rheumatic disorders vary in different parts of Europe. Within specialised hospital care, teamwork is becoming increasingly common, but within primary healthcare is not used in many countries. Sometimes operation models not strictly meeting the criteria of teamwork are referred to as teamwork.

The figure on the right shows an ideal team including all the health care professionals possibly needed during some stage of the care of a person suffering from a rheumatic disorder. They all are important. Besides the rheumatologist, the nurse specialised in rheumatology and the physiotherapist often an occupational therapist, a podiatrist and/or a nutritionist are also needed. Occasionally, to guarantee optimal care, a psychologist’s consultation or discussing social security issues with a social worker are recommendable. The patient must also be considered a team member. One of the main goals of the currently ongoing Bone and Joint Decade is to promote the participation of the patients in the decision-making concerning their own care.

Depending on the care system, on the activity of the illness and on its effect on functioning capacity, a person suffering from a rheumatic disorder may be surrounded by several multidisciplinary teams, one in the home municipality, another one in specialised hospital care and a third one in a rehabilitation unit. The work of these teams should also be co-ordinated, and patient education received from different sources should be integrated into a reasonable whole. On the other hand not everyone wants to be surrounded by a team, some people are satisfied with a good care relationship with a physician or a nurse, especially if the disorder is undergoing a stable phase and no specific interventions are necessary.

The challenges of multidisciplinary collaboration
Even though the significance of teamwork is increasingly acknowledged, there still are many barriers preventing it, relating to attitudes, education and resourcing. People may feel their professional stature threatened if they have been used to making decisions or acting alone. Sometimes education differences between professional groups may result in a situation in which people with longer education tend to dominate a team and do not give others enough opportunities to act or do not esteem their expertise. In many countries the structures of the public health care system remain bureaucratic preventing the development of team-oriented working practices.

Even though there is a general desire to develop teamwork, in some EULAR member countries there are also national challenges to be overcome before sufficient room can be made for developing teamwork. In some countries there is a lack of rheumatologists, or some multidisciplinary team member professions such as occupational therapists or podiatrists are not widely known yet. Organising the primary healthcare can be challenging, too; the services are unevenly distributed geographically or...
no care chains have been created yet. A big challenge in many countries has been making new drugs available to everyone in need of them.

Prejudices may also be an issue related to teamwork, hampering its promotion. There are fears, for example, that one’s professional scope of activity could become narrower. In teamwork, however, everyone works as a representative of his/her respective profession: for instance the physician is still responsible for the diagnosis and prescribes medication and the physiotherapist provides physiotherapeutic counselling. In a good team you can focus on your own professional strengths, and by integrating everyone’s strengths, otherwise hidden solutions and models of operations beneficial to patients can be discovered. Multidisciplinary collaboration involves interaction, discussing and listening, whereby representatives of different professions bring their own special skills to the team and enrich the operation of the entire team.

Multidisciplinary collaboration should be seen as one key instrument with which the challenges of the health care sector and its diminishing resources can be met. The teamwork secures more equitable and higher-quality care. One central challenge of EULAR Standing Committee of the Allied Health Professionals in Rheumatology is to continue working in development and promotion of multidisciplinary collaboration. Much has already been done, but still it is most important to win prejudices and to develop optimal forms of collaboration for each care unit of rheumatic disorders.

The goal is not to offer one model of European multidisciplinary collaboration to be integrated everywhere but to find and forward well-functioning practices.

Discussing the theme of multidisciplinary care will continue in the coming issues. Please tell us about your experiences and thoughts. We are especially interested in hearing about recent projects in which multidisciplinary care of people suffering from rheumatic disorders has been developed locally.

**Jaana Hirvonen**
project manager, psychologist
chair, EULAR Standing committee of Allied Health Professionals on Rheumatology 2003-2007
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My term as the chairperson of EULAR Standing Committee of the Allied Health Professionals in Rheumatology is coming to end in June. Time has flown! Many issues have been dealt with together, but many challenges remain. It has been an enriching experience to get to know committed and skilful professionals from all over Europe. The future of rheumatological care is in good hands. Let me express my heartfelt thanks to all of you for our good collaboration!

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**Multidisciplinary team of person with rheumatic disorder**

![Diagram of multidisciplinary team of person with rheumatic disorder]

- Individual with rheumatic disease
- Nurse
- Physiotherapist and physical education instructor
- Occupational therapist
- Podiatrist
- Nutritionist
- Family, friends and peer groups
- Home community level
- Social worker
- Psychologist
- Rheumatologist and other specialists
Since year 2004 EULAR has awarded bursaries for educational visits to health professionals other than physicians working in the field of rheumatology. With the Educational Visit program, EULAR seeks to promote learning, collaboration and good practice among health professionals in rheumatology in Europe. The objective is to enable health professionals to carry out an educational visit to colleagues in another EULAR member country. Educational visit grants amount to a maximum of EUR 1,500 Euro each. So far EULAR has awarded 23 health professionals from eleven countries.

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For further information see www.eular.org.

**Health professionals educational visit grants 2004-2007**
In 2006, I had the pleasure of receiving an Educational Visit Grant which I used as partial funding for my post-doc visit to Bristol University, UK.

In September 2006, I left my position at Spenshult Hospital for an exciting period in Bristol. With a number of smaller grants, my arranged funding allowed me to stay for 7 months, and I applied for additional funding as I arrived in Bristol. I wanted to learn more on qualitative research methodology and mixed methods, on how to assess physical activity and motivation, and on factors that affect physical activity behaviour, among other things.

I have been working at the Medical Research Council, Health Service Research Collaboration (MRC HSRC), located at Department of Social Medicine in Bristol. The director of MRC HSRC is Professor Paul Dieppe.

During my very first week in Bristol, I attended a course in in-depth interview technique. This is crucial in many qualitative research projects, and we had good practice in how to conduct interviews. I was also introduced to techniques of organising data in qualitative analyses. Later on, I have had the possibility of practising some of these techniques on interviews from a group of physically active young people with anterior cruciate ligament injury. Analyzing the data will still involve a great amount of thorough reading, abstraction, and interpretation but the technique of organizing data in charts (Framework) before the final analyses does help in keeping track of the quotations during the process, and making the qualitative process transparent to other researchers.

After a while, I got to know the Somerset and Avon Survey of Health (SASH) dataset – a large, community based survey of 28,000 people aged over 35. People with hip and knee pain at baseline were invited for examination, and followed up 7 years later. The database contains data on the use of health care, and a number of other variables, on about 1200 subjects. I have been working on the data, and learned how to handle large datasets in STATA statistical software. The first abstract from my work with this dataset, on the use of health care in the population with hip and knee pain, was submitted to the ACR in the beginning of May 2007.

During my time in Bristol, I have gradually become more and more involved in research at the Department of Nutrition, Exercise and Health Sciences at the Bristol University. They are engaged in a research about health behaviour and physical activity. One of their ongoing projects is called Older People Active Living (OPAL). I have had the opportunity to work as a substitute for a physical therapist who is on maternity leave, and be involved in the final process of study design, as well as in the pilot work and first months of data collection in OPAL. Through interviews and tests of functional performance, we collect information about elderly people’s physical activity and physical function in their homes. To assess their physical activity patterns and the intensity of activities performed, the participants are also asked to wear an accelerometer for one week. Participants are stratified based on social deprivation. One of the main aims with the study is to describe patterns of physical activity in relation to amenity and distance to shops. The study aims at comprising 240 elderly people in Bristol. The accelerometer and questionnaires used might well be suitable for future Swedish studies on physical activity behaviour and effects of physical activity promotion.

At the Department of Nutrition, Exercise and Health Sciences, I have also had the opportunity to take part in a short course on Mental Health, to learn more about physical activity and its relation to mental health.

I have also visited some Rheumatology Units, in Keele, Leeds, and Truro, in order to meet people with similar research interests. Networking is valuable in future research. The knowledge I have gathered in Bristol through the many pathways has already been used in designing and planning for new research projects at Spenshult Hospital for Rheumatic Diseases.

My period at Bristol University is planned to end by the 27th of July. However, I hope and intend to go back to Bristol, now and then, to continue collaboration within the field of musculoskeletal pain, physical activity, and motivation.

With kind regards and thanks,

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ACADEMIC MILESTONES

DOCTORAL DISSERTATION:
Fibromyalgia patients’ sense of coherence, social support, and quality of life

Fibromyalgia syndrome is associated with a number of symptoms and conditions that can have an extensive impact on the quality of life. These include pain, sleeping problems, fatigue, and depression. This research describes the sense of coherence, social support, and quality of life of fibromyalgia patients, as well as the changes taking place in these areas over the course of one year. The objective is to produce data that can be used in developing the care and rehabilitation of fibromyalgia patients. The key theoretical and empirical concept used is Sense of Coherence (SOC) based on the theory by Aaron Antonovsky.

The data were gathered by means of a questionnaire at the beginning of the rehabilitation and, then, after approximately 4 and 12 months of rehabilitation. The data were gathered from a total of 169 patients in rehabilitation, of whom 151 were involved at all stages. Statistical methods were used to describe and analyse the data. Differences between groups were tested using the t-test and variance analysis, the Mann-Whitney test, the Kruskall-Wallis test, and the Chi-square test. Repeat measurements were carried out using the mixed model. The Pearson and Spearman coefficients were used as correlation coefficients.

Results of the research
SOC remained fairly stable during the one-year monitoring period, standing at 59 (SD 11) for the whole group at the beginning of the rehabilitation. Health-related quality of life (15D) rose in the lowest SOC category. Depression fell over the year, while life satisfaction did not increase significantly. The combined effect between the four SOC categories and time was statistically significant for the sense of coherence and almost significant for fatigue. In almost all areas of satisfaction, SOC was higher among those who were satisfied with their lives than amongst those who were not. SOC correlated significantly with the support received from relatives, health-related quality of life, life satisfaction, sleep, fatigue, general wellbeing, and depression. SOC correlated negatively, but not significantly, with pain. Most strongly, SOC correlated with depression and to almost the same extent, with health-related quality of life.

The research provides information regarding the resources and quality of life of fibromyalgia patients who have undergone rehabilitation, and about any changes that occurred in these areas during a one-year process of rehabilitation.

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A dissertation on orthotic insoles

Orthotic insoles are a common treatment in patients with foot pain and impairments but there is still little evidence especially concerning the long term effects of orthotic insoles. Arne Nagel has studied the biomechanical and clinical effects of individual orthotic insoles in his dissertation. The thesis will be submitted to the Faculty of Medicine at the University of Münster in 2007. The first part of the thesis comprising two studies investigated the effects on foot loading and foot motion. These two studies were conducted with healthy subjects. To investigate the motion of foot segments, their team developed a foot model for 3D motion analysis. In a third study, they analyzed the clinical effects of orthotic insoles in patients with Rheumatoid Arthritis (RA).

RA patients were chosen because they suffer from severe foot problems with massive pain and deformations in the advanced case. Nevertheless, the rheumatoid foot does not receive as much attention as it deserves. More in-depth research has to be performed to prevent or limit foot problems in these patients. Especially, conservative treatment with orthotic insoles is important for retaining the patients’ mobility. In a longitudinal study, Nagel’s team investigated the immediate and long term effects of orthotic insoles in 83 patients with RA. Study was completed a few months ago. The results revealed a...
significant improvement of 27.1% in the overall foot load to less loaded foot regions. Orthotic insoles seem to have only small effects concerning overall foot function as a long term effect. In further studies, the same group will apply the foot model to patients with RA to investigate the characteristic pathomechanics of the rheumatoid foot.

**Results of the thesis**

Conclusions from the study suggest that orthotic insoles decrease foot pain and foot impairment in patients with RA. They cause a load shift from high-

**Further information:**

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**HP Doctoral dissertations in Rheumatology**

Here is an incomplete list of the doctoral dissertations by European health professionals from 1975 to 2007 in chronological order. The list is being updated currently. Please let us now about the missing or forthcoming dissertations.

- **Ekdahl C.** Muscle function in rheumatoid arthritis, Assessment and training. Lund University, Sweden. 1989. (PT).
- **Lankveld WGJM van.** Coping with chronic stressors of rheumatoid arthritis. University of Nijmegen, the Netherlands. 1996. (Psycho).
- **Oosterfeld FG.** Heat and cold treatment in rheumatic diseases. University Twente, Enschede, the Netherlands. 1994. (PT).
- **Kroen K.** Quality of life in rheumatoid arthritis patients: the relation between personality, social support and depression. University of Groningen, the Netherlands. 1996. (OT).
- **Ward EM van der.** Rheumatic diseases in focus: a study into the image of, and public education about rheumatic disease. University Twente, Enschede, the Netherlands. 1997. (Psycho).
- **Manrmkerpi K.** Assessment and Treatment of Patients with Fibromyalgia Syndrome Quantitative and Qualitative aspects. Lund University, Sweden. 1999. (PT).
- **Howlett S.** Value, disability and personal impact in Rheumatoid Arthritis, University of Bristol, UK. 2000. (N).
- **Archenthal B.** Disease Impact and Quality of Life in Rheumatic Diseases, Göteborg University, Sweden. 2000. (OT).
- **Dekkers JC.** Psychophysiological responsiveness in recently diagnosed patients with rheumatoid arthritis. University of Utrecht, the Netherlands. 2000. (Psycho).
- **Delling B.** Hand function in Rheumatoid Arthritis. Göteborg University, Sweden. 2000. (OT).
- **Steultjens MPM.** Determinants of pain and disability in osteoarthritis. Free University, Amsterdam, the Netherlands. 2001. (OT).
- **Paulson M.** The meaning of pain of fibromyalgia type as narrated by affected men, their partners, nurses and physicians. Umeå University, Sweden. 2002. (N).
- **Savelkoul M.** The influence of coping on social support and quality of life of people with rheumatic diseases. University of Maastricht, the Netherlands. 2002.
- **Evers Andrea WM.** Prediction of disease outcome in rheumatoid arthritis: the role of illness cognitions, coping and social support. Radboud University, Nijmegen, the Netherlands. 2003.
- **Thyberg I.** Disease and disability in early rheumatoid arthritis. Linköping University, Sweden. 2005. (OT).
- **Swinkels RAHM.** Measurement instruments for patients with rheumatic disorders: a climetric appraisal. Free University, Amsterdam, the Netherlands. 2005.
- **Stamm T.** Conceptualising the Patient Perspective of the International Classification of Functioning, Disability and Health (ICF). Vienna University, Austria. 2005. (OT).
- **Dagfinrud H.** Ankylosing spondylitis: Disease impact and research evidence of physical therapy interventions. Oslo University, Norway. 2005. (PT).
- **Arkela-Kautialmen M.** Functioning and Quality of Life in Patients with Juvenile idiopathic Arthritis in Early Adulthood. University of Jyväskylä, Finland. 2006. (PT).
- **Halleret E.** Disease activity, function and costs in early rheumatoid arthritis. Linköping University, Sweden. 2006. (PT).
- **Strahle, Mathilde MH.** Facing the challenge of rheumatoid arthritis. A 1.5-year prospective study among patients and cross-sectional study among partners. University of Groningen, the Netherlands. 2006.
- **Kukkarainen ML.** Fibromyalgia patients sense of coherence, social support and quality of life. Oulu University, Finland. 2006 (N).
- **Veenhof C.** The effectiveness of behavioral graded activity in patients with osteoarthritis of hip or knee. Free University, Amsterdam, the Netherlands. 2007.
Since 2003 EULAR has awarded Research Grants for health professional research projects in the field of rheumatology that is in line with the mission, goals and strategies of EULAR. Projects are being funded up to a maximum of EUR 10,000 per year and for a maximum of 3 years. After the submission deadline (usually in the end of March) applications are being sent out for peer review by independent reviewers. Recipients of a research grant are obliged to submit an annual report to the EULAR Executive Committee on the progress of the project and the results achieved. So far EULAR has awarded the following five researchers:

Adaptation of the Educational Needs Tool for use in four European countries

Cross-cultural adaptation of the RA-Work Instability Scale

**Hanna Vuorimaa**, Finland (2005-2007)
Children’s and parent’s arthritis self-efficacy, psychosocial factors and pain in JIA

**Anita Williams**, UK (2006-2008)
An investigation into patients experiences of therapeutic footwear

Translation and validation of the Leeds Foot Impact Scale for rheumatoid arthritis into Dutch, German, and Hungarian, using Rasch analysis
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