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Goal setting in rehabilitation

For many years I have worked in various development projects and administrative tasks. This spring, after a long break, I got an opportunity to work in my original profession as a psychologist and meet people with musculoskeletal disorders, during their rehabilitation periods. It has been great to meet people, hear their life stories, and learn about their future plans and dreams. This has also helped me develop in my own work: it has reminded me what is relevant in people's life, highlighted the challenges they face in present-day Finland, and helped to focus on the issues to be tackled by us employees through our work.

The Social Insurance Institution (Kela) is a major provider of rehabilitation services in Finland. Each year roughly 90,000 persons receive rehabilitation services funded by the Institution. This is a high figure in a country with a population of mere five million. In recent years, Kela has strongly developed its operation and created various norms for standardising the implementation and assessment of rehabilitation in different units. Rehabilitation is seen as a systematic and inter-/multidisciplinary long-term operation with the goal of supporting the rehabilitees' self-management skills. Indeed, not exactly a modest goal. Hence one key object of development work has been the creation of methods for helping to define the goals of a rehabilitation period as a systematic process.

Points for goals

In this work the so-called GAS method (GAS = Goal Attainment Scaling) has been in use for a few of years. In the method, a rehabilitee in collaboration with a multidisciplinary team defines his or her personal rehabilitation goals. There may be one or several goals, and naturally they ought to be realistic in the individual situation of each rehabilitee. In the GAS method the rehabilitees not only verbalise their goals but also establish a scale for easily measuring, during upcoming periods, how far or close the target level is. Well, for weight loss it is easy to create a scale of measurement. Five kilograms, for instance, is a reasonable goal, but for many people it has a real bearing on their health. Even a small weight loss is a step towards the right direction, and if the target level is exceeded, it provides additional boost for whoever may need it.

Increasing the frequency of exercise from once a week to three times a week is also an easy target to verbalise. But what about setting goals for correct allocation of own resources or for working capacity? The multidisciplinary team provides support for this, discussing the different goals and the steps to be taken for promoting them. After the goals have been set, the rehabilitee and a representative of the multidisciplinary team sign a document setting out the goals. The document supports commitment to achieving the goals. At later meetings the goals will be updated; they can be modified and specified.

How about the helper's own Goal Attainment Scaling

I admit I first had some doubts about the new method. It somehow felt so idealised, even though admittedly a good way to make goals concrete – however long the path to permanent lifestyle changes might be afterwards. In addition, used in a right way it provides the rehabilitee with a tool for prioritising one's own goals, as very often the goal setting of rehabilitation tends to be regulated by the views and values of health professionals. Thus the method may not be a “silver bullet” but can still provide a systematic tool for analysing the rehabilitee's situation.

And I, too, have now had an opportunity to witness how rehabilitees build the ladder of goals for themselves. These have been great encounters – let’s hope as many as possible of the goals set at the meetings will be realised in the lives of the rehabilitees.

It occurred to me during my latest session with a rehabilitee that I, too, must set a clear goal for myself for increasing well-being at work: I involved myself in these encounters with the rehabilitees so deeply that I have listened with my whole body, with the consequence that my neck and shoulders have gotten sore. Surely musculoskeletal symptoms caused by working postures! The symptoms must immediately be addressed to prevent them from becoming chronic. I have now filled out the GAS form and promised myself that in the future I will listen, not with my whole body, but with my ears – and the heart.

I wish everyone a great summer.

Jaana Hirvonen
Development director
The Finnish Rheumatism association

P.S. Mission accomplished. A multidisciplinary association operating in the field of musculoskeletal disorders has been on the agenda in Finland for as long as I remember. The 9th of February 2013 was the glorious day when the multidisciplinary MSD-Professionals of Northern Finland went national and became the MSD-Professionals of Finland. At last! Congratulations to the people who made it possible! When you read this newsletter, I hope we will be a member of EULAR’s growing European family of multidisciplinary health professional associations.
In this issue

Birger Hagen write about the HP tactical objectives in their farewell article. The new vice-president for HPs will be announced in Madrid.

In his contribution, fresh PhD Peter Oesch reveals his findings on work-related evaluation and rehabilitation of people with non-acute non-specific low-back pain. Hans Lund tells in his interesting article about why HP clinical guidelines are useful in daily practice. We have also an interview with Stene Prize winner Mette Toft who explores thoughts on healthy aging. Likewise, we keep you posted on the EULAR HP member campaign for national HP associations. Remember to apply for EULAR grants for educational visit and research.

….. to mention only a few themes of this issue.

“We’ve noticed that people with RMD are more motivated for health promotion when adjusting to preventive measures after relapse.”
EULAR health professionals - full speed ahead!

From the Vice-President and the Chairperson

The overall goal of EULAR is to stimulate, promote, and support the research, prevention, treatment and rehabilitation of rheumatic diseases. Health professionals (HPs) are one of three EULAR pillars. Nurses, occupational therapists, physiotherapists, psychologists, social workers, nutritionists, podiatrists, and other HPs play an increasingly important role as clinicians and researchers in European rheumatology. HPs are now taking advanced roles as health care providers both as 'single' practitioners and as team leaders and team members in inter-/multidisciplinary teams. An increasing number of HPs in Europe currently conducts PhD studies – thus educating themselves as researchers to get into academic positions at hospitals and universities.

HPs and EULAR strategy
As the first EULAR strategy running from 2007 to 2012 now is history, we entered 2013 with a new strategy labelled ‘Vision 2020’. The strategy development was designed as an embracing process, involving as many constituencies as possible, and encompasses seven strategic objectives, underpinned with a number of more specific concrete goals, the so-called tactical objectives. They are introduced in the yellow information box.

After the wording of the strategic and tactical objectives was finalised, each stakeholder group selected three tactical objectives from the entire portfolio of totally 20. The idea was that over the coming years the stakeholder groups will pay particular attention to helping implement the three tactical objectives chosen.

The tactical objectives selected by Health Professionals (HPs) to guide specifically our programmes, activities and thinking in the next five years are:

**Under objective 1 – Research**
By 2017, EULAR will have increased the quantity and quality of HP-led research projects and strengthened participation of people with RMD.

**Under objective 2 – Education**
By 2017, EULAR will have strengthened education for people with RMD and health professionals by developing tailored materials and improving access.

**Under objective 6 – Profile**
By 2017, EULAR will have developed and implemented a communication and PR strategy to address the individual needs of people with RMD, physicians/researchers, health professionals, and corporate members.

**EULAR membership of national HP organisations**
By 2009, the HP national organisations of Norway, The Netherlands, Sweden, Switzerland and United Kingdom had become members of the EULAR HP organisation. After the General Assembly in Berlin 2012, there were 11 national HP organisations as official members. To the General Assembly in Madrid this year, six new applications (Austria, Belgium, Cyprus, Finland, Ireland and Spain) have been submitted. Thus, when you read this we hope that six new HP member organisations have been approved as official members. Please read more about the HP member campaign on page 16.

**HP projects**
Currently, there are two EULAR Recommendations initiated by and of particular relevance for HPs: “EULAR recommendations for the role of the nurse in the management of chronic inflammatory arthritis” and “EULAR recommendations for the non-pharmacological core management of hip and knee osteoarthritis” are now published in the Annals of the Rheumatic Diseases (ARD), the official EULAR Journal. An implementation project for the recommendations on the role of the nurse in inflammatory arthritis has recently been carried out. We are also happy to announce that the project “Developing EULAR recommendations /points to consider for patient education of people with inflammatory arthritis” led by Mwdimi Ndosi from Leeds, UK was approved by the EULAR Executive Committee and will be executed in the next year.

**Objective 1 – Research**
By 2017, EULAR will be a central platform for facilitating and stimulating innovative basic and clinical research projects in rheumatic and musculoskeletal diseases (RMD).

**Objective 2 – Education**
By 2017, EULAR will be a pre-eminent provider and facilitator of high-quality educational offerings for physicians, health professionals in rheumatology, and people with RMD.

**Objective 3 – Congress**
By 2017, the annual EULAR congress will be the top congress for rheumatic and musculoskeletal diseases and will have broadened its offerings and reach.

**Objective 4 – Advocacy**
By 2017, EULAR will have a significant influence on EU level, and assists actions on national level, towards improving research funding, social policy legislation, and quality of care.

**Objective 5 – Standards of care**
By 2017, EULAR will have raised standards of care by elaborating and actively promoting, disseminating, and implementing EULAR recommendations and criteria for the most common rheumatic and musculoskeletal diseases.

**Objective 6 – Profile**
By 2017, EULAR will have raised its profile and visibility to people with RMD and health care providers.

**Objective 7 – National relations**
By 2017, EULAR will have actively engaged all national societies as well as related organisations in key EULAR activities.
We expect that the coming years will be even more successful for European health professionals. We will now step down as chairperson for the Standing Committee and vice-president, but hope you all will continue to support our activities and strengthen the partnership within EULAR among people with rheumatic diseases, health professionals and rheumatologists. We would like to take this opportunity to thank the large number of colleagues who are making major contributions to the successful activities of our organisation.

Thea Vliet Vlieland
Chairperson, EULAR Standing Committee of Health Professionals

Kåre Birger Hagen
Vice-President Health Professionals in Rheumatology

EULAR Standing Committee of Health Professionals in Rheumatology endorses interdisciplinary collaboration in the treatment of rheumatic and musculoskeletal diseases in Europe. The Committee was established in 1989 as a European platform for cooperation and shared information among the different health professionals working with rheumatology. The Committee encourages HP research and works also to improve the patient’s role as the key expert of his/her own treatment. Communication and your opportunities to be involved in the work of EULAR relies upon us hearing from you but also in your knowledge of what activities are going on through the EULAR HP Committee.

Here are some suggestions about how to keep informed.
- Review the website regularly for new information on activities and work streams: http://www.eular.org/st_com_health_professionals.cfm
- Make sure you have registered to receive the electronic newsletter which is full of information and time lines for specific activities
- Join one of the Study Groups (Further information in the HP News)
- Communicate with your National HP president (if you are not sure who represents your country on the EULAR HP committee – look it up on the website)
- Visit the EULAR HP stand at the congress and meet some of the committee members
- Submit proposals (again see the website or emails for further information) for future congress and get actively involved.
- If your country/national HP association is currently not represented in the HP network of presidents – read on page 16 how to become a member of EULAR.

EULAR Standing Committee of Health Professionals thanks warmly Thea Vliet Vlieland and Kåre Birger Hagen for their work in promoting the HP perspective within EULAR.

PS Find out during the congress who will be the new HP vice-president.
As the incoming chair, I would really appreciate the opportunity to meet up with as many HP delegates attending congress as possible – with this in mind all the HP Standing Committee welcome you to our own HP stand. The congress is a very busy time for everyone and the programme has been carefully prepared to provide interesting and stimulating sessions and other activities, but we hope you might find some time to pop in and meet us. Let’s make this one a memorable and exceptional event! As in the previous congresses, the EULAR village interlinks all EULAR social activities and sister societies in the same location and creates a cosy atmosphere for informal meetings.

The HP booth is also located in the EULAR Village, stands No 17. The beautiful city of Madrid provides us with an opportunity once again for all of us from all parts of the world to network on important issues relevant to all of us as Health professionals, HP researchers, students, national representatives, and colleagues.

So why bother to come and visit us?
Firstly, you will meet HPs across Europe, from a range of disciplines all with a vision and wish to collaborate together. We have national HP presidents representing their organisations, and the number of national HP members of EULAR is growing fast. We hope we can meet up informally on the stand and learn more about each other’s work. You can hear about our campaign to recruit more members to build our European presence and profile and support each other. You can get information on how to apply for a EULAR HP research or educational grant and much more! We also look forward to seeing some of you who have been awarded travel bursaries and research grants as well as those working on EULAR-funded projects – so some of the committee can meet you in person and hear how you have benefited from the grants. Most importantly, it is an opportunity for you to learn about what the HP committee are doing on your behalf and have a voice about the work of EULAR HP Standing Committee.

The HP stand is your information resource and you will not regret your visit!!

Take part – former networking meetings are now HP study groups
An exciting time! Yes, an exciting time as EULAR further supports the work of Health Professionals. As many of you will be well aware from previous congresses, there were informal meetings where professional groups met up.

Since EULAR wants to have a stronger framework that is robust in understanding the activity undertaken during the Congress, we now have study groups which offer us time to network, plan new initiatives and sometimes simply consider variance in different practices. The more time we have to understand the work we all do in our different European countries and share our experiences within our areas of interest the better!

It was wonderful to see how the previous network leads have worked with the HP Standing Committee to prepare the necessary documents to set up the new study groups. The study groups for nurses, physiotherapists, occupational therapists, social workers, and psychologists will coincide with the scientific HP programme of the congress. This year the podiatrists will have their first meeting ever to discuss starting a study group in future congresses. In the table are the times and places for the groups, please take advantage of them. You do not need to register in advance. The study groups are a great way to meet with HPs with similar interests. If you have ideas or projects you want to discuss with the different study groups, you can contact the leads directly.

Sue Oliver
Chair-elect for HPs
sue@susanoliver.com

EULAR Health Professionals News
Welcome! Groups are open for all if not indicated otherwise.

<table>
<thead>
<tr>
<th>HP meetings and study groups</th>
<th>Time</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>Finding your way around EULAR – hot tips for a successful conference</td>
<td>Patricia Cornell</td>
<td>13:30 – 14:30</td>
</tr>
<tr>
<td>Standing Committee Meeting for HP presidents and delegates</td>
<td>Thea Vliet Vlieland (Chair)</td>
<td>Wednesday 13:00 – 14:30</td>
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<tr>
<td>HP Scientific Sub-committee Meeting for Sub-committee members</td>
<td>Kåre Birger Hagen</td>
<td>Thursday 08:00 – 10:00</td>
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<tr>
<td>Nurses Study Group /Clinical</td>
<td>Jenny de la Torre-Aboki</td>
<td>Friday 08:00 – 09:00</td>
</tr>
<tr>
<td>Nurses Research &amp; Strategy Group</td>
<td>Yvonne van Eijk-Hustings</td>
<td>Friday 09:00 – 10:00</td>
</tr>
<tr>
<td>Physiotherapist Study Group</td>
<td>Rikke Helene Moe</td>
<td>Friday 08:00 – 09:00</td>
</tr>
<tr>
<td>Occupational therapist Study Group</td>
<td>Yeliz Greenhill</td>
<td>Friday 09:00 – 10:00</td>
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<td></td>
<td>Birgit Prodinger</td>
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<tr>
<td>Psychologist Study Group</td>
<td>Eric Taal</td>
<td>Thursday 17:00 – 18:00</td>
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<tr>
<td>Podiatrists networking meeting (first ever)</td>
<td>Anthony Redmond</td>
<td>Thursday 17:00 – 18:00</td>
</tr>
<tr>
<td>Social Workers Study Group</td>
<td>Margaretha Lundin</td>
<td>Thursday 18:00 – 19:00</td>
</tr>
<tr>
<td>Vision 2020 - get to know your EULAR Health Professionals; future goals and objectives</td>
<td>Thea Vliet Vlieland</td>
<td>Saturday 12:00 – 13:30</td>
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Anthony Redmond is glad to invite all podiatrists to their own networking meeting at the HP stand.

Milena Gobbo is leading the new study group for psychologists with Eric Taal. In previous congresses they both have been chairs for networking meeting for psychologists.
The new chair recommends – apply for a grant: Educational visits and research funding for health professionals in rheumatology

Educational visit grant
– I was the first HP to receive an EULAR Educational visit grant in 2003. In 2002, I received an award for setting up a nurse-led rheumatology nursing clinic in the UK. With the EULAR Educational grant, I was able to visit colleagues in the Netherlands and have an opportunity to explore how other teams worked and other models of nursing care. It was a valuable and enjoyable experience. Since then, many more HPs have undertaken educational visits – and the same possibility is there for you too, says Sue Oliver.

EULAR awards up to 10 bursaries for educational visits to health professionals other than physicians working in the field of rheumatology. The objective is to improve the standard of research and care in health professions and to foster collaboration across clinical units in Europe. Bursaries will not be granted to applicants who are already abroad in a visiting programme. The amount of each bursary is between EUR 750 and 1,500 (the annual total amount granted is EUR 7,500). Applications should be submitted by e-mail to the EULAR Secretariat at gabriela.kluge@eular.org. Recipients are required to submit a report (maximum 1 page) to the EULAR Secretariat after the stay, focusing on the results that have been achieved.

The EULAR health professionals research grant
– We all know how difficult research funding is and also how challenging it is to get high-quality HP research proposals fully funded and then adequately recognised internationally. So it is of great value that EULAR supports the HPs’ need to undertake research, Sue Oliver points out.

Every year, EULAR funds one health professional’s research project in the field of arthritis/rheumatism that is in line with the mission, objectives, and goals of EULAR. Projects will be funded up to a maximum of EUR 30,000. Recipients of a research grant must submit a mid-term report to the Scientific sub-committee of the EULAR Health Professionals on the progress of the research project. After completion of the project, the recipients must report to the EULAR Executive Committee on the results achieved. Furthermore, the recipients are expected to present their project in the EULAR health professionals’ newsletter and may be invited to present their findings at the annual EULAR congress.

Application process
Applicants must complete the official application form (including detailed budget), and include the full CV of the project leader as well as a project plan. For further instructions, see the official application form. Applications for 2014 should be e-mailed to Ms. Patrizia Jud at the EULAR Secretariat (patrizia.jud@eular.org) to arrive no later than 14 November 2013. Applications will be evaluated by the Scientific Committee of the EULAR Health Professionals in early 2014. Applicants will be informed by e-mail.

Evaluation criteria for research projects
• Project leader should be a health professional
• Involvement of at least three European countries
• Scientific value
• Implementation and relevance for EULAR Health Professionals (i.e., how the project may improve the non-pharmacological management of patients in a short and/or long-term perspective, and/or whether the project may foster the development of a research network of relevance for the future beyond the period of the project)
• Quality of the work plan and methods
• Feasibility of the study within the planned timeframe
• Patient centred approach (if applicable, please specify the following):
  • Describe patient involvement in the design of the study
  • Describe the patient specific outcome measures
• Budget realistic for the planned project
• Planned dissemination and implementation of the research results

Application deadlines for Educational visit grants are 31 March and 30 September each year.

Applications should include:
• Curriculum vitae with date of birth
• Objective of the educational visit
• Budget
• Written confirmation from the host hospital or institute that the educational visit has been accepted, indicating the tentative time frame of the training stay.

Applicants also need to sign an application form and contract. The form is available at http://www.eular.org/health_professionals_educational_visits.cfm.

EULAR’s Education Programme Coordinator Gabriela Kluge is happy to assist you when planning an HP educational visit.
On Monday morning, the airplane from Amsterdam to Oslo landed at Gardemoen airport. In a rainy Oslo, I received a warm welcome at the National Resource Center for Rehabilitation in Rheumatology (NRRK) in the Diakonhjemmet Hospital from fellow physiotherapists and researchers. On a guided tour through the hospital, they showed me the inpatient rehabilitation clinic for rheumatology patients from all over the country. The hospital has a national function for (complex) rheumatology patients from other parts of the country. This is different from my work as a physical therapist in Reade, centre for rehabilitation and rheumatology in Amsterdam. Our center has a more regional function due to the much higher population density in the Netherlands compared to Norway. It is good to see the differences. The long distances impede the patients in Norway from travelling to receive treatment on a weekly basis, especially when they need intensive multidisciplinary care. Therefore, an inpatient programme for three weeks is available. One of the research projects is an RCT concerning a telephone-based programme after a patient rehabilitation period with follow-up sessions and motivational interview training for patient for whom the Diakonhjemmet Hospital is too far. Via semi-structured interviews it is purposed to motivate patients with chronic musculoskeletal diseases and stimulate them to self-management. This project is also carried out in three other hospitals. In Amsterdam, patients can follow a multidisciplinary therapy programme twice a week for 12 weeks. It can be beneficial to use some of the methods used in Norway. Using telephone calls and follow-up sessions focussed on motivational interviewing could be beneficial for improving self-management and remaining treatment effects.

**Similarities in Health Professionals approach**

Different financial structures in both countries make it difficult to compare the health care services for rheumatic diseases. On the other hand, there are similarities concerning content of therapy, setting treatment goals, and evaluation. Insight in each other’s work gives new ideas for improving the quality of care. Goal setting and evaluation meetings in the presence of the patient are already successfully implemented in Norway. In Amsterdam, more patient participation is in development. Concerning the provision of aftercare, it is important to improve collaboration between primary and secondary care. In the Netherlands, there is more experience in network development between primary and secondary care. In Norway, there are plans to improve networking.

We started a discussion about developing quality indicators for osteoarthritis treatment. Based on involvement in a EUMUSC.NET project concerning quality indicators in Norway and experiences with development of indicators for physiotherapy in the Netherlands differences and similarities in methods used were discussed. Suggestions were made for appraisal of the quality of the indicators. Good quality indicators are needed in measuring the quality of care.

**Comparing guidelines**

Implementing physiotherapy guidelines in primary care would ease collaboration between different stakeholders regarding people with osteoarthritis. A project from the Leiden University Medical Center (LUMC) to implement a Dutch physiotherapy guideline for hip and knee osteoarthritis was presented for physiotherapists and researchers in the Diakonhjemmet Hospital. Together, different possibilities to use the same method in Norway were considered. The method contained an interactive workshop with participation of patient partners and following a process of clinical reasoning. This implementation strategy can also be used to promote more evidence-based working in primary care. The Diakonhjemmet Hospital is leading in rheumatology and frequently arranges both mono-disciplinary and multi-disciplinary courses for the different Health Professionals involved in treating, caring for and rehabilitating people with rheumatic diseases.

**Meeting new people involved in the same field of work interest is very inspiring and will almost certainly lead to more collaboration in the future.”**

Existing Dutch physiotherapy guidelines can be adapted to the Norwegian situation and used to implement evidence-based practice. One afternoon the care centre visited local physiotherapists outside Oslo to introduce the results of a randomized controlled trial (RCT) concerning patients with hand osteoarthritis assessment and the effects of exercise therapy. This was an example of research collaboration between the Diakonhjemmet Hospital and physiotherapists in the community.

**Collaboration in cross-cultural validation**

Plans were made to collaborate with Norway in an international EULAR-funded project concerning Patient Reported Outcome which started this year at the Department of Epidemiology and Biostatistics at the VU University Medical Center in Amsterdam. A new method to assess activity limitation in hip and knee osteoarthritis will be developed. A presentation was given about the development of a computerized Animated Activity Questionnaire (AAQ). Next year, different European countries are collaborating in a cross-cultural validation of this AAQ.

A very interesting and pleasant stay in the capital of Norway, Oslo, ended with some sightseeing. I can recommend educational visits to everybody.

Wilfred Peter
Physiotherapist and researcher

**Wilfred Peter**

Wilfred Peter is working as a PhD researcher at the Leiden University Medical Center in Leiden. He studies the development and implementation of the Dutch physiotherapy guideline on hip and knee osteoarthritis, the development of quality indicators for physiotherapy in hip and knee osteoarthritis, and the provision of physiotherapy treatment before and after joint replacement surgery in hip and knee osteoarthritis from the patient perspective.
My background and motivation for writing a doctoral thesis

For several years, I have been working in the Rehabilitation Centre Valens in Switzerland where we are frequently confronted with work disability due to nonspecific low-back pain (LBP). According to the general aims of rehabilitation, our interventions strive to maximise function and minimise the limitation of activity and the restriction of participation in these patients for which return to work is of major importance. We developed a specific work-related rehabilitation programme which showed its effectiveness compared to a pain-centred rehabilitation programme in returning people with non-acute nonspecific LBP to work. Exercise and work related evaluation of functional capacity, both from the patient’s as well as from a medical perspective, is a major intervention within our work-related rehabilitation approach.

Within the last years, we were faced with an increasing demand, but also with critical questions regarding such services. One of the pressing questions was whether exercise is more effective than usual care in reducing work disability and if so, to explore which type of exercise is most effective. A further question was related to the assessment of perceived functional self-efficacy in our rehabilitation setting where patients from various European nations are treated. Furthermore, Functional Capacity Evaluation has been shown to reflect physical capacity to some degree but is also influenced by non-physical factors such as perceived disability and pain intensity. Further research was therefore needed regarding the interpretation of Functional Capacity Evaluation results. These issues motivated me to write a doctoral thesis investigating work-related assessments in people with non-acute nonspecific LBP as well as the use of exercise to make it possible for these patients to return to work.

Assessment of perceived functional self-efficacy with a picture-based questionnaire

Perceived functional self-efficacy is a relevant psychosocial factor contributing to the outcome in people with chronic musculoskeletal pain. There are considerable difficulties in administering questionnaires in a European rehabilitation setting as such self-reported measures require an adequate literacy level and depend on linguistic abilities. Our study was among the first addressing these issues. We found good validity of the Spinal Function Sort, a picture-based questionnaire assessing perceived ability for work tasks in a European rehabilitation setting. The majority of the subjects involved were accustomed to heavy work, came from 10 different nations, were poorly educated, and had insufficient knowledge of the Swiss national languages.

Influences of physical and non-physical factors on Functional Capacity Evaluation

Our studies confirmed previous findings showing that Functional Capacity Evaluation results are influenced by physical as well as by non-physical factors. As perhaps expected, older people’s and women’s lifting performance, grip strength, and walking distance was on average less than the performance of younger people and men. However, non-physical factors such as perceived functional self-efficacy and ‘nonorganic-somatic-signs’ were also predictors for Functional Capacity Evaluation performance. We therefore propose that Functional Capacity Evaluation influenced by non-physical factors should not be interpreted solely as a reflection of the remaining physical function of persons with back pain. In accordance with previous authors, we interpret such behaviour as a form of communication between the person and examiner influenced by expectations and possibly arising from pain, fear of injury or neuromuscular inhibition. Some of these people may require a more careful examination and management of the psychosocial and behavioural aspects of their illness.
Exercise therapy

There is consensus among modern treatment guidelines considering subacute LBP and chronic LBP to use exercise. However, our physiotherapists wanted to know which exercise is best to achieve the treatment goal “return to work”. The available research findings did not provide the answers. A systematic review of trials with positive outcomes on work disability revealed that all had significant cognitive behavioural components combined with intensive physical training. Additional reviews found limited evidence for the effectiveness of behavioural graded activity in improving absenteeism outcomes. Strong evidence had been found that exercise reduces work disability in people with back pain. These reviews were based on studies published before 2004 that did not evaluate the effectiveness of different exercise characteristics. Therefore, the effect of specific exercise characteristics on work disability remained unclear; a more up to date review was required.

We retrieved 838 articles in the literature search. Of these, we included 23 studies using 35 different exercise interventions for further analysis. The final results confirmed the use of exercise interventions in achieving benefits on work disability in persons with non-acute nonspecific LBP. However, exercise interventions did not show a significant effect on work disability at short- and intermediate-term follow-up but only on the long term. Possible explanations for a lack of effect at short- and intermediate-term follow-up are the time required to improve physical capacity, to modify pain behaviour, or to search for work as well as the process of care to achieve return to work. No significant differences between different exercise types were found.

Conclusions and clinical implications for my daily practise

Our research findings confirmed that perceived functional self-efficacy for work tasks can validly be assessed with the Spinal Function Sort in our rehabilitation setting in persons with different mother tongues and literacy levels. The Spinal Function Sort may be used to identify people at risk of not returning to work and consequently guide our rehabilitation interventions.

When conducting a comprehensive Functional Capacity Evaluation of persons with non-acute nonspecific LBP referred for fitness for work evaluation, an assessment of their perceived functional ability for work tasks as well as the presence of ‘nonorganic-somatic-components’ should be considered. It will allow an interpretation of the validity of Functional Capacity Evaluation results as a measure of physical fitness for work.

We are assured to continue the use of exercise within our work-related rehabilitation program, despite the fact that no information was found on the effect of specific exercise characteristics. A further finding for us is the importance of the structure and process of our interventions aiming for early return-to-work. An open and fast access to our services might facilitate an early return to work.

Considering these findings as well as all the knowledge I gained on scientific work it was very well worth the effort to write a PhD thesis on work-related evaluation and rehabilitation of people with non-acute nonspecific LBP.

Peter Oesch
PT, MSc in Health Ergonomics, PhD
Physiotherapy Department Rehabilitation Centre Valens (Switzerland)

Further reading


Clinical guidelines - what is it? And are they really useful in my daily practice?

A short paper based upon the presentation at EULAR Congress.¹

We are told, by the Evidence-Based Practice concept to implement and use research findings in clinical practice. We follow that advice because we care for our patients and want them to have the best treatment possible. But with more than 47 million scientific references² the task seems unreachable, not to say impossible. We need a mediator – some way to deal with this huge amount of research.

The solution could be an evidence-based clinical guideline prepared for all clinicians by researchers, clinicians, and patients. Evidence-based means that someone had performed a thorough literature search, evaluated the scientific and clinical quality of the identified papers, and either calculated (meta-analysis) or estimated the overall effect of a certain treatment modality for a certain problem in the clinic. These are the main ingredients of a systematic review, and based upon such a systematic review a group of researchers, clinicians, and patients interpret the results and formulate a number of recommendations for clinical practice. Thereby, a clinical guideline is prepared.

Definition of a guideline

A clinical guideline is typically defined as a “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.”.³ The formulated recommendations should include proposals for the entire process - i.e. examination, prognosis, treatment plan, evaluation, and the interface between sectors, the understanding and opinion of the researcher, practitioner, person with RMD/ patient and society, and should be based upon the actual context.

Purpose of a guideline

The aim of a clinical guideline is to help clinicians and patients make appropriate decisions about healthcare, to achieve higher quality and improved cost-effectiveness of interventions, and thereby ideally resulting in improved health outcomes. In addition, a clinical guideline would decrease variability and increase transparency in clinical practice. One should bear in mind that a clinical guideline is not a fixed protocol that must be followed, but recommendations to assist responsible clinicians’ judgement on the management of patients.

The systematic review as basis

A clinical guideline should be based upon the evidence available but the clinical guideline includes something more than merely the evidence. It is typically that the clinical guideline is aimed for a multidisciplinary group of practitioners, the entire treatment process is dealt with, and the authors of the clinical guideline involves not only researchers (like in systematic reviews) but should always include practitioners, researchers, and patients. Another important difference is that it is not always possible to base the recommendations solely on the evidence. Maybe the evidence is lacking or it is not possible to evaluate the given clinical question. Thus many recommendations are also based upon expert opinion, patient experience, and consensus views.

How to develop a clinical guideline

If you search for clinical guideline you will see that there are many different ways both to prepare and present a clinical guidelines. Although the aim with a clinical guideline is the same, the ways to develop a clinical guideline are diverse. Thus a group called “Guideline International Network (GIN)” recently published a suggestion for how to develop and present a clinical guideline⁴. The suggestion is not formally agreed upon internationally, but the suggestion seems to include all the important aspects in an easily understandable way. The authors suggest the following steps in preparing a clinical guideline. Each step will be shortly explained in the following.

1. Composition of guideline development group
2. Decision-making process
3. Conflicts of interest
4. Scope of a guideline
5. Methods
6. Evidence reviews
7. Guideline recommendation
8. Rating of evidence and recommendations
9. Peer review and stakeholder consultations
10. Guideline expiration and updating
11. Financial support and sponsoring organization

¹ “Health Professionals Workshop Session” : “I've been asked to review a clinical guideline - where do I start?” June 8th 2012 8:30-10:00 – Hall 7 C, Room EUR2, EULAR 2012
² The number is based upon the search engine SCOPUS, indexing more than 19,000 journals, counted in May 2012.
⁴ Annals of Internal Medicine – April 3rd, 2012
⁵ Institute of Medicine. Conflict of Interest in Medical Research, Education, and
Composition of guideline development group

It is very important that all stakeholders are represented in the author group in order to be sure that all relevant aspects have been discussed and dealt with in the clinical guideline. Thus, the guideline development panel should include diverse and relevant stakeholders, such as health professionals, methodologists, experts on a topic, and patients. Preparation of clinical guideline involves many different scientific methods and it is important that practitioner and patients should have some basic knowledge of these methods, and the researchers should carefully consider the presence of stakeholders not familiar with these scientific methods.

Decision-making process

Even with GINs suggested development process, many details of the process are not accounted for. It is therefore mandatory that all authors have agreed upon the process before the preparation begins. The preparation of the “EULAR recommendations for non-pharmacological management of hip and knee osteoarthritis” is a good example of this. All authors of the clinical guideline agreed upon a certain process involving formulation of propositions by a Delphi process, principles for the literature search, and the ways in which the evidence was interpreted and formulated as recommendations.

Conflicts of interest

When an international guideline is prepared many different interests is involved. These different interests could be due to difference in opinion between the stakeholders, professional issues, and of course also economic interests. Conflict of interest could be defined as “a set of circumstances that creates a risk that professional judgment or actions regarding a primary interest will be unduly influenced by secondary interest”. Members of a guideline development group should therefore disclose any personal or household financial and nonfinancial COI relationships or other conflict of interests related to the guideline topic.

Examples of conflict of interests could be ownership of stocks or shares, paid employment or consultancy or paid board memberships, current patent applications, and research grants (from any source, whether restricted or unrestricted), honoraria, and gifts. Nonfinancial conflict of interests could be leadership or board or committee memberships, involvement with an advocacy group that may gain from a guideline, writing or consulting for an educational company, or having personal convictions (political, religious, ideological, or other) related to the guideline topic that may interfere with an unbiased evidence review or recommendation process.

Horton suggested a very simple question that all members of a committee preparing a clinical guideline should ask oneself: “Is there anything that would embarrass me if it were to emerge after publication and I had not declared it?”.

Scope of a guideline

Considering the enormous amount of scientific papers published an absolute prerequisite for a useful clinical guideline is a clear and unambiguous aim of the clinical guideline. This includes also the sub-questions based upon the main scope of the guideline. Without clear and unequivocal questions a useful literature search is impossible. This part is not as easy as it looks, but it is quintessential for a useful and relevant clinical guideline.

Methods

The validity of any scientific work is based upon the transparency of the methods used. If the reader understand how the authors have reached their conclusion, it is possible to understand the conclusion and thereby also accept it. In addition, it is also much easier to give constructive critique of the guideline, an important part of the development of our knowledge and recommendations for good clinical practice. As a principle, all the important steps in the process should be presented in a way so others, familiar with preparing clinical guidelines, could repeat the process. In some cases, the methods have been described elsewhere, and a reference to that is therefore enough.

Evidence reviews

As mentioned above, a clinical guideline is actual a systematic review with suggested recommendations for clinical practice based primarily on the evidence identified through the systematic review. To put it very shortly, a good systematic review includes a clear and unequivocal clinical question, inclusion criteria for relevant scientific papers, a comprehensive literature search, transparent selection of relevant papers, assessment of risk of bias of each included study, a transparent extraction of data/results from the included studies and either a quantitative or qualitative analysis of the results yielded.

Guideline recommendation

The very purpose of a clinical guideline is the formulation of recommendations. These recommendations should be clear, evidence-based statements that provide the reader with clear directions for effective delivery of care. However, the statements should not be so detailed that they look more like regimes with no possibilities for interpretation based upon the actual clinical situation. There will never be one and only one way to treat all patients with a specific diagnosis. When a clinician considers the suggested recommendations in a clinical guideline, she he should carefully also include the context in which she or he is working, the patient’s prerequisites and conditions and his/her own professional competency.

Rating of evidence and recommendations

As mentioned before, a valid clinical guideline is first and foremost based upon the evidence. However, evidence is not yes or no or black and white. The use of some form of a rating system is therefore necessary to help the reader to understand the strength of the evidence the statements is based upon. A clinical guideline should therefore state which kind of rating system is used and all the level of evidence should be added to all statements / recommendations.

Peer review and stakeholder consultations

When the first version of the clinical guideline is prepared it should be reviewed by experts within the field of clinical guidelines, clinicians with expertise within the given area and patients suffering from the relevant disease or disorder. In several cases, this review has pinpointed some important aspects the author group had overlooked or some inconsistencies between the statements and the evidence. In many cases, this review process involves both invited reviewers and a public hearing process. The review process itself also helps to improve the formulation of the statements and disseminate the guideline to a broader group.
Guideline expiration and updating

Not only is the number of scientific papers published very large today, but also the incidence of papers in the future is growing rapidly. The expiration date for a clinical guideline is therefore very close to the guideline’s publication date. The authors of a clinical guideline should consequently state an expiration date and how they have planned to update the guideline.

Financial support and sponsor organization

In addition to the disclosure of each author’s conflict of interests, the guideline should clearly state who had partly or fully paid for the preparation, publication, and dissemination of the clinical guideline.

Are clinical guidelines really useful in my daily practice?

Since no good practitioner has the time or skills to perform a comprehensive literature search and analysing the results of each paper, a publication delivering exactly that seems to be very useful in daily clinical practice. A clinical guideline is a very valuable professional publication, since you do not only find very clear and unambiguous statements about how to deal with specific clinical challenges but other colleagues’ opinion about the same clinical challenges will also inspire you. But remember: research findings, systematic reviews and guidelines are merely guidance and recommendations. The real implementation takes place in the unique meeting between the patient and the professional! Never lose your critical attitude towards original publications, systematic reviews, and clinical guidelines. The authors are only human beings. An international group has therefore developed a tool for evaluating a clinical guideline. This tool is called AGREE and it can be found on http://www.agreetrust.org/.

Hans Lund

The aim of a clinical guideline is to help clinicians and patients make appropriate decisions about healthcare, to achieve higher quality and improved cost-effectiveness of interventions, and thereby ideally resulting in improved health outcomes.

Health professional co-operation can include:

• rheumatologist
• nurse
• occupational therapist
• physiotherapist
• psychologist
• social worker
• nutritionist
• podiatrist
• and other health professionals
Can people with rheumatic or musculoskeletal diseases call themselves healthy despite having a chronic disease? Several of the 2013 Stene Prize essays asked this interesting question and wondered if this was a contradiction in itself. Mette Toft, who wrote the winning essay about this topic, says: “According to the WHO the definition of health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. But I find that, for those of us who have been diagnosed with an illness, it is particularly problematic and annoying that, according to the WHO, we cannot – by definition – be healthy because we are sick. The topic for this year’s Edgar Stene competition clearly takes a different definition of health as its starting point – one where health and illness are not opposites, but where health is something we can strive for whether we are sick or well.”

The inequalities in getting professional support

“Healthy Ageing” is the 2013/2014 focus of the EULAR Standing Committee of PARE. Connecting it with phrases like “growing up or growing older” or with the World Arthritis Day topic “Living Better, Ageing Well” demonstrates that it is inclusive of all age groups. We are all ageing from the time we are born. So every minute of our life and every stage is precious and requires our attention and care. Moreover, this becomes even more necessary when someone suffers from a chronic disease and has to face the resulting consequences.

Health professionals play an important part in supporting those of us with RMDs as we try to age healthily. Physiotherapists, nutritionists, psychologists and occupational therapists can give valuable advice to help us cope with pain, maintain our mobility, adapt our diet, stay at work and be emotionally well. At no matter what age, a team of such co-operating specialists is invaluable to people with RMDs. With their help, we can try to maintain a healthy diet, do some beneficial physical activity, and enjoy quality of life. However, the external factor we cannot influence is whether we have access to these specialists or not. What about our treatment options, access to specialists and a healthcare team? This still sadly depends on where you are living. The inequalities, even within Europe, grow from day to day with the economic crisis forcing policy makers to cut down on costs in the health care sector and to reduce the availability and quality of care for citizens. In several countries, access to care has become a serious issue for people with RMDs and they are striving to improve the situation.

Also the built environment impacts on our well-being – if people with RMDs have no access to schools or universities it might determine their career choices and considerably alter their future possibilities, status and income. Access to all parts of society is needed and this is something which is not yet guaranteed in many countries. In particular, people with RMDs living in rural areas are often disadvantaged and excluded.

Your ideal world?

What would a world for people with RMDs look like if all these barriers to living and ageing healthily were removed? On World Arthritis Day, 12 October 2013, the Standing Committee of PARE will launch an exciting competition. It will invite people with RMDs, their family and friends, health professionals of all kinds, designers, architects and politicians to be creative and to envisage their ideal world for the year 2043. Visions can be shared by photograph, collage, painting, song, or sculpture. A jury will choose the winning entry in each category. More information will soon be revealed on www.worldarthritisday.org
While EULAR currently includes 45 scientific member societies and 35 patient organisations, there are still “only” 11 health professionals associations in EULAR. Hence, additional interested and committed organisations from the health professionals’ community in Europe are welcome to join in.

Each member organisation can delegate a representative to work on the EULAR Standing Committee of Health Professionals in Rheumatology. In addition, the committee also includes interested professionals from other European countries who are planning to establish a national HP organisation that could subsequently apply for EULAR membership.

The member campaign has gained a lot of positive attention. Many national delegates visiting the HP stand during congresses are keen on hearing more about the procedure of becoming a EULAR member. Please get acquainted with the 5 step plan (next page) on how to establish a national HP society and become involved with EULAR. Contact us for further information.

**Motivation for membership**

- Receive first-hand information about and get involved in EULAR’s research and educational programmes designed for the needs of health professionals in rheumatology, such as the educational visits programme or the annual research grant. The objective is to improve the standard of research and care in health professions and to foster collaboration across clinical units in Europe.
- Delegate a representative of your organisation to work in the EULAR Standing Committee of Health Professionals in Rheumatology and actively contribute to shaping health professionals activities within EULAR. The committee, headed by a chairman, discusses on-going projects and new proposals to the EULAR Executive Committee, initiates and shapes ideas for the health professionals’ programme at the next annual EULAR congress, and reviews membership applications of national HP organisations. The committee, through its chair, also closely interacts with the other Standing Committees dealing with scientific, clinical, and patient matters. Each year, the EULAR Standing Committees hold their annual “business” meetings on the occasion of the EULAR congress.
- Make your national association heard on the European level by attending the EULAR General Assembly of our member organisations each year, where all sections of EULAR report on their activities, where constitutional matters are decided and elections to Executive Committee positions are being held.
- Enjoy the inspiring exchange with colleagues during the annual EULAR Congress where EULAR health professionals are operating a booth as a lively gathering point for health professionals. The congress is also an ideal platform for promoting the national association’s work as well as interacting with other health professionals from both EULAR member organisations and elsewhere.

National HP member organisations of EULAR
National HP organisations soon-to-be members of EULAR
Guest representatives preparing for membership
EULAR health professional member associations:
• Associazione Italiana Operatori Reumatologici Professionali - AIORP
• British Health Professionals in Rheumatology (BHPR)
• Bulgarian Association of Health Professionals in Rheumatology
• Czech Association of Health Professionals in Rheumatology
• Danish Interdisciplinary Forum (DIRF)
• health professionals in rheumatology Switzerland (hpr)
• Netherlands Health Professionals in Rheumatology (NHPR)
• Norwegian Interdisciplinary Organisation in Rheumatology (NIOR)
• Serbian Association of Health Professionals in Rheumatology (SAHPR)
• Swedish Rheumatology Forum (SveReFo)

These HP associations wait for the ratification of the EULAR General Assembly in Madrid:
• Irish Rheumatology Health Professionals Society
• The MSD-professionals of Finland, SUOMEN TULESAMMATTILAISET R.Y.
• Belgian Health Professionals in Rheumatology
• Österreichische Gesellschaft für rheumatologische Gesundheitsberufe (ÖGRG) - Austria
• cosmosrheuma+ - Cyprus
• OPENREUMA - Spain

IN BRIEF: As a EULAR member organisation you can:
• interact with colleagues on European and international levels
• obtain first-hand information on the latest recommendations in the treatment of RMD
• contribute to the HP research
• organise and participate in HP courses
• promote your national HP association’s work at the yearly EULAR congresses
• have an easy access to the information on EULAR’s HP facilities such as educational visits and research grants
• and most of all: be part of a European health professional network with direct connections to other national HP organisations

Join in!

Five steps to get involved for a national HP activist:

1. If a national interdisciplinary health professional organisation already exists in your country, please find out first whether this organisation has a guest representative in the Standing Committee of HPs. If so, please contact this person regarding your involvement in EULAR.

2. In case there is no organisation representing health professionals in your country, you can establish a national organisation first. Bear in mind that this organisation’s bylaws should be in accordance with the EULAR bylaws. You can obtain the bylaws from the EULAR Executive Secretariat, contact: eular@eular.org.

Importantly, this national organisation should represent different health professional groups (such as nurses, occupational therapists, physiotherapists, podiatrists, nutritionists, social workers, psychologists, and others) and should have a clear multi-/interdisciplinary perspective. All the professional groups mentioned above do not have to be represented in the organisation, but an open attitude towards all health professionals in the organisation is required.

3. Fill in the application form which you can also obtain from the Secretariat together with a letter stating that your organisation wants to join EULAR as a health professional organisation representing your country. Submit this application form to the EULAR Secretariat. The General Assembly meeting, held once a year before the annual EULAR Congress, will put your application and acceptance within EULAR to the vote.

4. When your organisation is a formal member, the person representing this organisation will also have a right to vote in the General Assembly.

5. The president of the national organisation will usually represent the organisation as delegate in the EULAR Standing Committee of HPs.

In the process of establishing a national organisation and even before this, the Committee welcomes any health professionals interested in founding a national organisation to become a guest representative in the EULAR Standing Committee of HPs. As a guest representative you are then welcome to participate in the meetings of the Committee and in other activities within EULAR. In this case, please contact the Chairperson of the Committee, Sue Oliver: sue@susanoliver.com

More information available at: www.eular.org/st_com_health_professionals.cfm
EULAR Congress 2014 - Paris, France 11-14 June 2014

EULAR will revisit PARIS after the very successful congress in 2008.

We will be in the same congress centre, Porte Maillot.

Abstract submission

The electronic abstract submission system will be open until the 31 January 2014.

Abstracts received after the deadline will not be accepted. Health professionals (HP) can choose to submit their abstract either for practice and clinical care (HP topics A5) or for clinical research work (topics 11-34).

Please note that when submitting to topics 11-34, you will be scored by rheumatologists, whereas the HP topics A1-A5 are scored by health professionals.

Further information will be made available from August 2013 on the EULAR website www.eular.org.

HPs had an own stand for the first time in EULAR congress in Paris 2008.

Read previous issues of EULAR HP News

EULAR HP News are available at http://www.eular.org/st_com_health_professionals.cfm

Do you have good news for the newsletter?

Since 2000, the HP Newsletter has functioned as the main information channel of health professionals in rheumatology within EULAR. The newsletter is published twice a year featuring the work of health professionals and all aspects of multidisciplinary collaboration.

Please give us tips about health professional thesis, projects, and new research themes in the musculoskeletal field. Contact the editor of newsletter for further information: jaana.hirvonen@reumaliitto.fi.


Enjoy!
The HP preliminary programme of the EULAR Congress

The EULAR Congress 2013 in Madrid will be the venue of high-quality HP scientific sessions introducing health professional research and issues of interest in the HP practice. There will be HP sessions, workshop, two abstract sessions and poster tours. In addition there will be an highlight session and joint sessions organised together with rheumatologists and the Standing Committee of People with Arthritis/Rheumatism in Europe (PARE).

The full programme is available at EULAR website: www.eular.org.

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See you at the HP stand!