# Working As A Rheumatologist on Three Continents

By Ramin Yazdani, MD, MRCP(UK)

I graduated from Tehran University of Medical Sciences in late 1993 and, like many of my friends, I decided to go overseas for specialization. This was a decision that proved difficult and time-consuming, but rewarding and satisfactory.

I had to do my military service and complete my commitments to the Ministry of Health to be able to emigrate, which took four years. During these years I worked less than full-time, in order to devote sufficient time to prepare for various English and medical exams. Although the curriculum and the books we studied in Iran were American, for obvious reasons, it was not possible to get any type of visa to enter the U.S. at that time. As such, I applied to take the Professional and Linguistic Assessments Board (PLAB) exams in the U.K. in 1998 and managed to start my postgraduate training as a House Officer in 1999. I became Senior House Officer of Medicine in 2000 and finally I completed my specialist training in Rheumatology and General Internal Medicine in 2009 from Nottingham Deanery.

I worked as a consultant rheumatologist as of September 2009 in the U.K., until I came to St. John's, Newfoundland in August 2011 to work as a Consultant Rheumatologist for Eastern Health and a Clinical Assistant Professor at Memorial University. Since I became a consultant, I have also engaged in some charity work/consultations as a rheumatologist in Iran.

One of the advantages of working in different health care systems is that you can easily identify the areas that you need to improve, while comparing and contrasting different methods of management. You bring your past experiences and learn new practice approaches.

## U.K.

I begin with the U.K.'s National Health Service (NHS), which is the third largest organization in the world after China's army and India's railways. In 2011, its annual budget was £120 billion GBP. By the Royal College's guidance, there should be a rheumatologist for every 80,000 individuals; many centres fulfill this criteria. Nearly all of the rheumatologists employed by the NHS work 40 hours a week, which consists of five to six clinics. Rheumatologists may give up one or more of their clinics to take on other responsibilities, such as management roles, with the consent of his or her managers. Waiting times for new patients are especially important in judging hospital performance, so managers make sure that this time is not breached. Generally there is no more than a few weeks of waiting time in rheumatology. If patients can and choose to travel a bit further, they can be seen sooner. Private practice waiting times are much shorter, usually only a few days. About 25% of individuals have private insurance, especially in the larger and more affluent cities. Significant numbers of rheumatologists allocate a few hours of their week to see private patients. The Conservative government has recently been encouraging private services as an alternative to the NHS, to reduce the costs, to ensure the NHS improves its quality of care, and to give patients more choice in treatment options.

Patients do not pay to see NHS rheumatologists and pay a nominal fee of less than £10 GBP for their medications, including disease-modifying antirheumatic drugs (DMARDs) and biologics. Most of the investigations requested by rheumatologists are usually done within a few weeks, and are free of charge. Patients can also opt to go private if they do not want to wait too long. A private rheumatology consultation costs about £150 GBP, which is paid by the patient or by private insurance. NHS costs are covered by National Insurance contributions, which are

paid by the individual and consist of up to 14% of their income. These contributions are separate from the income tax, which can amount to more than 35% of one's salary.

## Iran

Medical care in Iran is state run, but there is a thriving private-care sector as well. The majority of people have state insurance, and many also pay additional fees to receive better insurance plan coverage. Patients can claim the fees paid for investigational tests in the private sector through insurance companies, and thus get most of these costs refunded. As a rule, however, if a patient has only state insurance, getting medical care outside state-run hospitals will be very expensive.

A current issue of discussion between the government and insurance companies is coverage of the cost of the biologic therapies. At present, patients have to pay 10% to 30% of the drug cost, and many patients find the expenses of biologic therapies unaffordable. Compassionate drug provision and clinical trial enrollment are exceptional if not impossible. There is a relative shortage of rheumatologists in the larger cities, but waiting time to see a rheumatologist is not long at all. The consultation fee to see a specialist is about $25 USD, but procedures and operations are relatively expensive. A joint steroid injection can cost between $50 and $100 USD. On the other hand, investigations such as magnetic resonance imaging (MRI), bone scan, and the like can be performed very quickly and are relatively inexpensive. I usually can obtain the results of an MRI, magnetic resonance angiography (MRA), or a bone scan within two to three days. An MRA costs between $60 and $90 USD.

Unfortunately, in Iran, I have not managed to find any radiologist who has an interest in musculoskeletal ultrasound (USS), and finding therapists with musculoskeletal interests has proven difficult as well. Having said that, I have not had any difficulty borrowing the USS machine of the radiology department to perform hip injections and assess a few early arthritis cases.

## Canada

The practice of rheumatology in Newfoundland is not dissimilar to the U.K., although the waiting times here are atrocious. Geographical distribution is a real challenge; I have many patients who cannot travel to see a physician as often as desired, due to financial and weather conditions.

In Canada, there are biologics frequently employed that I had never used in the U.K., for example, abatacept for the treatment of rheumatoid arthritis (RA). On the other hand, there are other treatment agents with which I do have extensive experience which are rarely used here. I have had positive experiences utilizing rituximab for treatment of RA and antineutrophil cytoplasmic antibodies (ANCA)-associated vasculitis while in the U.K., yet these agents are rarely used in Newfoundland.

Interestingly, when I compare the price of medications, including biologics, the equivalent U.K. prices are cheaper overall. My guess is that the pharmaceutical industry invests less on marketing to doctors in the U.K.: we have to follow National Institute for Health and Clinical Excellence (NICE) and local guidelines.

When I ask myself, "where would I want to be if I were to develop RA?", my answer usually is the U.K. There is no complex and confusing system of private insurance companies. There are no top-up fees for prescriptions, and although many physicians do not agree with all of the decisions of NICE, I do believe the organization is trying to provide homogeneous care for the whole population of the U.K. I have never heard any patients in the U.K. complain that they cannot afford their medications. Even if I become unemployed, my NHS care will continue; that is, of course, providing the U.K. economy does not continue to deteriorate further.

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