

Roth Rounds... Are They Out to Get Us?



*“Just because you’re paranoid
doesn’t mean they aren’t after you.”*

—Kurt Cobain, Nirvana

At times it seems that they’re out to get us, doesn’t it? The administrative and financial pressures that we endure in order to maintain a successful practice and provide necessary and appropriate care for people with disabilities seem enormous. This becomes especially prominent when viewed in the light of the rapid growth and unfettered opportunities in so many other industries outside of medicine and rehabilitation.

A few examples of the daily issues that we face include: proposed reductions in Medicare reimbursement rates for rehabilitation hospital stays; proposed reductions in Medicare reimbursement rates for physicians; continuous reductions in managed care reimbursement amounts; loss of physician decision-making authority regarding patient care decisions (as more of these decisions get relinquished to insurers); increasing malpractice judgments against physicians; concomitant increasing malpractice insurance premium rates; increasing external reviews of physician activities by non-physicians; increasing scrutiny of billing, documentation, practice, and other compliance areas; denials of inpatient stays based on so-called “lack of medical necessity” as deemed by Medicare fiscal intermediaries using inconsistently defined and enforced Medicare Local Coverage Determinations (LCDs); reduced access to care for patients with certain diagnoses created by the Medicare “75% Rule” (which, incidentally, is the first Medicare rule to also have a potential negative effect on the care received by *non-Medicare patients*); the Medicare outpatient therapy reimbursement caps; and others. There seems to be plenty of bad news to go around.

Geographic and individual practice differences may influence the extent of the effect, if any, that each of these factors may have on your own individual practices and patients. However, we are all affected in some way by many or all of these issues. More importantly, our patients are adversely affected by these issues, as they experience

decrements in their ability to access high quality services and as they have reduced opportunities to receive excellent comprehensive care. This has the potential to negatively impact their outcomes. Another important side effect of dealing with these issues is the negative impact that they have on our own experience as professionals. As we put more of our time, energy, and focus into addressing these financial and administrative issues, the act of providing care is at risk for becoming less fun, engaging, and interesting.

I am usually not one to see the gloom and doom or the “conspiracy” in the aggregation of issues. Nor do I typically complain about external factors in the medical practice environment. I expect that we have the capabilities to address them ourselves through ingenuity, energy, and hard work. However, the recent unfavorable trends in practice, reimbursement, and oversight for physicians, rehabilitation professionals, rehabilitation facilities, other providers, and patients, compel all of us to take note and raise our objections at this time.

An important message that we conveyed during your Residency training with us is that it is important for you to do more than take care of patients (although clearly patient care is the most important activity that we do!). We urged you to have an impact on the care of people with disabilities, not only for your own patients, but also for the disabled community as a whole. We have encouraged you to advocate for people with disabilities, influence future PM&R practices, advance the specialty, and impact the care of people with disabilities. Your “indirect” influence, through research, advocacy, committee participation, education, policy development, and other means, can be as important and rewarding as your care for individual patients. Our goal all along has been to train *leaders*, not only care providers. Now would be a very good time to engage in these activities...

“We’re not gonna take it...”

—Twisted Sister AND The Who

Yours always,
Elliot J. Roth, MD (‘85)

Hope

By Michelle Fosson, MD ('02)

The mission of the Rehabilitation Institute of Chicago is to be “the best in healing and hope.” So, what is hope? According to Webster’s Dictionary, hope can be defined as “believing something is possible even when there may be evidence to the contrary.” Christopher Reeve once said, “Once you choose hope, anything is possible.” But how can physicians help patients keep their hopes alive during recoveries from illnesses or accidents that result in life-altering effects?

Based on my own experiences with frequent intensive care unit admissions, it is sometimes difficult to continue to have hope that I will get better or stabilize. However, I am extremely fortunate to have doctors in Chicago and Ashland, Kentucky, who are encouraging and hopeful. That is all too rare these days.

After reading Dr. Sliwa’s column in a recent issue of this Newsletter, I thought a lot about how medical students and residents today are superior to me in their knowledge of the world of technology. I still tend to use paper and pen, rather than my palm pilot, and I am “ok, but not brilliant” with computerized order sets, notes, etc. I have concerns that, by relying so much on technology to make diagnoses, we are at high risk of losing the most important part of the art of medicine. Sure, everyone can enter a patient’s room, flip out the old palm pilot, plug in the symptoms, and get a preliminary diagnosis without ever having to touch the patient. Speaking as someone who has often been a patient, that worries me. A computer or palm pilot cannot bond with a patient, hold the patient’s hand, or give that patient hope. In my opinion, a significant part of the art of medicine involves taking an accurate history, performing a thorough physical exam, and the importance of the human touch to someone who is sick. When I am extremely ill, no matter how badly I feel, I start to feel better and more hopeful when my own physician just enters the room. Why? I know that it is because he has gained my trust and he always pats me on the back and tells me that he is going to do everything he can to help me to feel better. No computer system can do that for a patient. We must not lose sight that as physicians, it is so important to listen (and I mean REALLY listen) to our patients, and to shake their hands, or pat them on the backs every once in a while.

Anyone who really knows me knows that my favorite place in the world is Disneyworld in Orlando, Florida. I visited there 2 years ago with my family, but spent most of the time in the hotel room due to illness. However, I did make it to the park one night for the “Wishes” fireworks show. While I was watching the show, I met a woman who had terminal metastatic breast cancer. She told me that one of her final wishes was to go to Disneyworld with her family. There were a lot of people there with similar stories. Why Disneyworld? I think it is because something happens to you when you enter the park. For a brief moment, no matter what is going on in your life, you have that childlike hope and wonder again. You just feel it when you are there. You can put away all of your worries and concerns for a little while and focus on hope. That is priceless.

I know that computers are our “friends” (maybe if I keep telling myself that over and over I will start to believe it), and that there are definite benefits to the technological advances and reliance on computers as adjuncts to our history and physical exams. But, just remember, medicine is an art. The goal is to help the patient to FEEL BETTER! No computer can comfort patients, listen to patients, or encourage them to maintain their hope. As a physician who has been a patient way too many times, I cannot stress enough that you, as physicians, need to make sure you are still practicing the art of medicine and not just the science of computers. Nothing can take the place of the human touch or the encouragement and hope you can give a patient.

“The best in healing and hope.” That is RIC’s mission. Please do not lose sight of the hope component. Remember that ‘Superman’ Christopher Reeve said, “Once you choose hope, anything is possible.” Listen to your patients! Encourage your patients! Help them to be realistically hopeful! In my opinion, physicians will never be expendable because technology cannot substitute for physicians who are human beings taking care of fellow human beings. Patients want, and need, hope. The best healing we can provide involves helping our patients keep their hopes alive for as long as possible.

Sliwa's Thoughts



James Sliwa
The Regenstein
Medical Education
Director

It is hard to believe that another interview season is upon us. If this year is similar to previous ones, we will interview over 100 students and rank almost as many. Every year, I am impressed with the quality of individuals we interview, and can attest to the fact that from my perspective, our specialty is alive and well. This is why I find information from the National Residency Matching Program (NRMP) so puzzling. In the 2005 Match, the NRMP reported 356 available positions in PMR but only 208 US senior student applications. This is an average of 0.58 applicants for each position or roughly 1.7 spots for each US medical student applicant. Only Family Medicine was lower in attracting US medical students with a 0.40 applicant to position rate. There were 251 "other" applicants to PMR programs that year, which included Canadian, osteopathic and international students. The relatively low number of US allopathic medical school applicants does not reflect on the quality of individuals entering PMR because many outstanding physicians in our specialty are international medical graduates or osteopathic physicians. It does, however, reflect on the appeal of our specialty to US medical students. With increasing awareness and acceptance of

what we have to offer patients, why are we not more attractive? Let me share some additional information with you that may help answer this question. The most popular and competitive specialties among US medical students in 2005 were Plastic Surgery, General Surgery, Dermatology and Orthopedics, all with more applicants than positions available. Those clustered around PMR as least attractive were Family Medicine, Psychiatry and Internal Medicine. So what do all of us less attractive specialties have in common and what separates us from those more popular ones? Could it be the chronic nature of the problems we treat and the need to provide comprehensive treatment without immediate gratification? Even those in our specialty who practice musculoskeletal medicine do so in a comprehensive manner and consider all treatment options. I hope this isn't the case, because if it is at a time when the population is aging and individuals are living with more chronic conditions, the comprehensive care they need is becoming less attractive to medical school graduates. It does put what we do and what those medical students interviewing for PMR want to do in a new light, doesn't it?

Alumni News

Alumna is RIC's CEO

RIC announced on October 4, 2006 that the interim appointment of Joanne Smith, MD ('92) as president and CEO was made permanent, following a comprehensive search by the RIC Board of Directors. After completing her residency in 1992 at RIC/NU, Dr. Smith joined the Institute as an Attending Physician and has established an impressive record of achievements. She became Director of Medical Planning in 1994, Medical Director of RIC's innovative DayRehabCenters in 1995, Senior Vice president and Chief Operating Officer of Corporate Partnerships in 1997, Senior Vice President for Corporate Strategy and Business Development in 2002, and President of the RIC National Division in 2005. Dr. Smith is an Assistant Professor of PM&R at NU's Feinberg School of Medicine, and participates in civic organizations. She holds an MBA from the University of Chicago's Graduate School of Business.

Alumnus Receives Prestigious Award

On September 25, 2006, Vinod Sahgal, MD ('72) received a Lifetime Achievement Award for his contributions in Rehabilitation. Dr. A.P.J. Abdul Kalam,

President of India, bestowed the award at a ceremony held at Rashtrapati Bhavan (the Indian 'White House'), home of the President. This ceremony took place during the meeting of the World Congress of Clinical and Preventive Cardiology.

Alumnus Extends Reach of Bionic Arm

RIC extended its leadership in engineering and rehabilitation science by successfully fitting patient Claudia Mitchell with the most advanced prosthesis of its kind, the RIC neuro-controlled Bionic Arm which allows her to move the arm simply by thinking, as if it is a real limb. The arm also empowers the patient with more natural movement, greater range of motion, and restores lost function. The technology was developed by Todd Kuiken, MD, PhD, ('95) Director of RIC's Neural Engineering Center for Bionic Medicine and a team of leading rehabilitation experts, with the support of grants from the National Institutes of Health (NIH). Using key learnings from the first successful Bionic arm recipient, Dr. Kuiken and his team also have made significant advancements in the area of sensory feedback so that the patient can feel if they are touching hot or cold objects.

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Alumnus Active in Medicine & Music

Richard T. Katz, MD ('84) recently received a promotion to Professor of Clinical Neurology at Washington University School of Medicine (St. Louis). He actively instructs PM&R residents in electrodiagnosis and occupational musculoskeletal medicine. While previously specializing in spinal cord and head injury, Katz's practice has focused on "forensic psychiatry" in the last ten years. Forensic psychiatry, analogous to forensic psychiatry, involves the interface between medicine and the law. When is a carpal tunnel syndrome work related? How much treatment is reasonable after a soft tissue injury to the neck? What is the cost of caring for a child with cerebral palsy over a lifetime? How many years would an amputee with coronary artery disease be expected to live?

Katz has resided in St. Louis, MO, since 1992, and has a busy private practice in the Central West End. He shares an office with psychiatrist Stacey Lee Smith, MD, his wife. His daughter, born at Northwestern Hospital in 1986, now is a junior in pre-med at Northwestern University in Evanston. His son, Julian, is a drummer and shares his father's interest in karate. Richard will receive his black belt in Okinawan karate this fall.

Musically, Katz has completed two jazz fusion albums entitled, "Rock Etudes" Book I and Book II, which were released in 2002 and 2006. He has also completed a number of transcriptions of great works for piano 2 hands, including the Ravel String Quartet, Bach Brandenburg Concerto #5, and Schubert Fantasia for Piano 4 Hands; all published by SLS Music.

He performs his two CDs and other classical works in solo concerts, as well as with members of the St. Louis Symphony Orchestra.

Other Alumni News

1982

Kenneth Richter, DO, is Medical Director of Rehabilitation and Palliative Care at St. Joseph's Mercy-Oakland, Michigan, and this year won the Circle of Life Award as the top Palliative program in the nation.

1992

Rita Ayyangar, MD, is enjoying pediatric psychiatry at the University of Michigan in Ann Arbor. She and husband Rick have 2 children, Maya (7) who wants to be a rock climber and rock star, and Marcus (4) who wants to be the President of the United States or a Power Ranger. They look forward to many biking trips in the Upper Peninsula and Ontario.

1994

Gayle Spill Ephraim, MD, continues to practice at Schwab Rehabilitation Hospital and the University of Chicago. She works part-time so she can have more time with her daughters Eden (6) and Lilah (4). This past May, she completed a Fellowship in Clinical Medical Ethics at the University of Chicago.

1995

Nathan Rudin, MD, runs a busy practice at the University of Wisconsin-Madison's Pain Treatment and Research Center. He and wife Felice are kept on their toes by Shoshana (12), Isaac (10) and Deborah (4). Feel free to call him if you're in the neighborhood!

1996

Kathleen Fink, MD, is still working at the National Rehabilitation Hospital's Outpatient Center in Bethesda, Maryland. She has been there for 9 years, and is active in resident and fellowship training. She and husband, Matt, live in Virginia with their 2 boys, Alex (9) and Nicholas (6).

2003

After finishing residency at RIC, **Lisa Lombard, MD**, headed east to do a Fellowship in Traumatic Brain Injury at the University of Pittsburgh, with her mentor from medical school, Dr. Ross Zafonte. Due to staffing changes, her Fellowship was rather brief, and she spent most of the year as the inpatient TBI attending. She stayed on as faculty at the University of Pittsburgh and has seen the department go through changes, most notably the move of most of the inpatient rehabilitation beds from a stand-alone facility to 60 beds at UPMC-Southside Hospital in June 2005.

2006 Alumni Reception in Hawaii

The RIC/NU Alumni Reception during the AAPM&R Annual Assembly will be on Friday evening, November 10, 2006, 7:00 until 10:00 p.m., in the Lehua Suite and patio, in the Kalia Conference Center, a part of the Hilton Hawaiian Village. Please note something different this year: RIC will provide the food, but there will be a cash bar, with the Alumni paying for their own drinks. No drink tickets will be provided at the door as we have done in past years. If you are attending the AAPM&R Annual Assembly meeting, please plan to come to the reception and mingle with your peers and fellow Alumni. See you there!