RIC/NU ResidentAlumni NEWS

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Roth Rounds…

Change is a Constant

Elliot J. Roth, MD

"A change would do you good."
—Sheryl Crow

For those of you who graduated the NUFSM/ RIC PM&R residency program since I became chair, you may recall that my remarks at your residency graduation ceremonies held annually at the end of the year dinner usually implored you to commit yourselves to "continuous learning." One way to do that is to explore new experiences, and another is to interact with others who provide unique and differing perspectives.

Many years ago, I attended an AAPM&R annual convention at which a prominent physiatrist said to me "You guys at RIC do a good job, but you never change."

Currently, the opposite is true. Change occurs frequently now. Many organizational restructurings, 2 new CEOs, a few renovations, several hospital affiliations, 40 new sites, numerous major expansions of the system of care, more than 300 new research projects, and several other revisions of our portfolio later, a more apt observation of RIC at this time would be that for those of you who were last with us several years ago, you might not even recognize it now!

Some changes come from within, some are new to RIC. Recent changes in the complement of attending physicians within the RIC system of care are pertinent. I would like to share with you a few of the recent changes in our large, diverse, and constantly evolving RIC physician group:

Dr. Michael Berkowitz *('92)*, recruited as Executive Medical Director of Outpatient Services 6 years ago, is now Medical Director of the RIC @ Alexian Brothers Hospital Network and the Alexian Rehabilitation Hospital.

Dr. David Chen *('91)*, Eisenberg Chair in SCI, has assumed the role as Medical Director of the Acute SCI Center at NMH, in addition to his role as Medical Director of the SCI rehab program at RIC. He also serves as PI for the recently received SCI Model System Center grant.

Dr. Joshua Rittenberg, Attending Physician since 2000, was named Medical Director for Interventional Spine Procedures.

Dr. Aaron Gilbert, Attending Physician since 1998, was named the Henry and Monika Betts Director of Medical Student Education, taking over from **Steve Nussbaum** *('92)*, who recently has increased his clinical activity in both SCI care and NMH consultations.

Dr. Marc Applebaum *('97)*, former RIC/NU PM&R resident, rejoined RIC in 2005, and is now once again working at the RIC Orthopedic Rehab program, after serving as attending physician at RIC at Alexian Brothers Hospital Network during this past year.

Dr. Michelle Muellner *('98)* recently moved to the RIC at RML Specialty Hospital transitional rehab program, after serving as attending physician at RIC at Alexian Brothers Hospital Network.

Dr. DominiqueVinh joined RIC in 2005 after serving in the military and in private practice. He is now serving as attending physician at RIC at Alexian Brothers Hospital Network, after starting with us at RIC@RML hospital for about one year. Last year, **Drs. Rachna Hajela Soriano** *('02)* and **Anne Doroba** also transitioned to new positions within our System of Care.

Dr. Swathi Mothkur recently joined RIC as Attending Physician at RIC at Alexian Brothers Hospital Network, following completion of PM&R residency training at Loyola University Medical Center.

Dr. Julie Whittington-Cirton *('06)* joined RIC as Attending Physician, working in Skilled Nursing Facilities with which RIC has affiliations and also providing coverage at RIC. She graduated from RIC/NU's PM&R residency program during this past year.

Dr. Andrea Fraley *('06)* is involved with Outpatient Musculoskeletal care and Electrodiagnosis at several RIC locations, after completing her residency and service as Chief Resident at RIC/NU PM&R, and also some additional time in advanced training in musculoskeletal care and electrodiagnosis.

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Dr. Wesley Smeal *('05)* is involved with Outpatient Musculoskeletal care at several locations, including at RIC at Alexian Brothers Hospital Network sites, following advanced training as the Friedman-Keiser Fellow in Sports and Spine medicine at RIC's Center for Spine and Sports Rehabilitation.

Earlier last year, **Dr. Christina Hynes** *('05)* joined us as Attending Physician in Womens Health Rehabilitation.

Most recently, **Dr. Felise Zollman** joined us as Medical Director of the RIC Brain Injury Medicine and Rehabilitation Program.

Last year, **Drs. Joseph Ihm, Lynn Rader** *('05)*, and **Alex Kim** *('01)* joined our practice, and each of them has made a significant impact.

…And of course, **Dr. Joanne Smith** *('92)* became President and CEO of RIC during this past year, signifying a major change in leadership for RIC and her role within it.

We are proud of our new physicians and of our long-term physicians, and grateful to those who changed direction and to those who have maintained their course. We are pleased to have a physician practice that is dynamic, fluid, and full of diverse professional opportunities.

Each of these physicians, and each of the changes that they make in their career direction, enriches the RIC Physician Practice and provides a fresh perspective on physiatry care that collectively makes all of us, including our trainees, into better practitioners, researchers, teachers, thinkers, and leaders. By maintaining our orientation toward constant evolution and change, we become better at serving our various communities. In this way, we are enabling our Medical Staff to gain tremendous expertise and experience, to monitor and keep pace with changes in the rehabilitation market at large, and to lead the way to implement changes in rehabilitation practices to create a better future for people with disabilities.

We know that many of you have initiated, experienced, and endured changes in your own personal and professional lives, and we very much enjoy learning of them. Please continue to keep us informed of what's happening inside and outside of your own careers.

"Roll with the changes."
—REO Speedwagon

Warmly,
Elliot J. Roth, MD *('85)*
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What Kind of Doctor Are You?

I am sure many of us have heard this question from our patients. It just so happens to be one of my favorite questions to answer. Every time we address this topic, whether it is with a patient or a referring physician, we are helping to spread the word about Physical Medicine and Rehabilitation, and whether we pronounce it "fizz-ee-AT-rist" (Dr. Betts' preference) or "fizz-EYE-a-trist" (rhymes with podiatrist and psychiatrist), we have a wonderful opportunity to take a few minutes for patient education.

I became a little more interested in talking about our field when I had a patient who wanted me to be "his orthopaedic man." No offense to our orthopaedic colleagues, but I had decided early in medical school that I was not interested in being an orthopaedic surgeon and was not interested in masquerading as an orthopaedist. I began hearing stories of physiatrists marketing themselves as non-surgical orthopaedists, including a physiatrist in Colorado who refers to himself as "a non-surgical spine surgeon." I think this is ridiculous. I can't say I am even too fond of the term "Interventional Physiatrist," as it implies one does not deal with physical medicine or rehabilitation. Sadly, some of our colleagues have progressed down this path, but that is another topic for another newsletter.

Back to talking about our field, there are obvious benefits of taking 2 or 3 minutes out of your day to deliver a spiel regarding PM&R. First, it is a good ice-breaker. Often taking a little time to talk about something other than the chief complaint helps put the patient at east. Second, showing enthusiasm about what you do helps patients realize you are excited about your profession and more likely to go out of your way to help them. Third, as patients become aware of what you do, they may refer other patients to you. I frequently tell patients that getting a referral from another doctor is nice, but there is nothing nicer than a patient liking you enough to send their friends. And as Joel Press has said, "even (difficult) patients have friends."

So, what can we say to others about our field? I think it is helpful to give some historical perspective, and discuss how our field was born out of the need for care of injured soldiers in World Wars I and II. I also think it is interesting to point out that PM&R became a specialty of the American Board of Medical Specialties in 1947, some 20 years earlier than Dermatology, Family Practice and Emergency Medicine (and everyone knows what those specialties are). I do mention that we have somewhat of a silly "nickname," and that there are discrepancies regarding the pronunciation. The term physiatry is not very descriptive, but it is probably no worse than ENT/Otolaryngology. Also, I discuss that like most specialties, there has been increasing sub-specialization. Some physiatrists see those with TBI, or with SCI, others have a busy practice dedicated to EMGs, and others see patients with a variety of musculoskeletal complaints and include procedures in their armamentarium for treating these conditions. Most importantly, I discuss that at their core, each physiatrist is dedicated to improving the function of their patients. Physiatrists spend their time working at maximizing ability, and improving quality of life. Taking some time to spread the word about PM&R is the best marking tool you have, and it is free.

By **William Sullivan, MD** *('97)*

Sliwa's Seventh Competency

James Sliwa, DO
The Regenstein
Medical Education
Director

The Accreditation Council for Graduate Medical Education (ACGME) has implemented an outcomes project to change the focus of residency training from fulfilling requirements to teaching and documenting competency. This has resulted in the development of the ACGME's six general "Core Competencies" which include patient care, medical knowledge, practice based learning and improvement, systems based practice, professionalism and interpersonal/communications skills. Each specialty and program must define, implement and document achievement of competency for residents in each of these six areas.
For program directors who have always thought about residency training in terms of volume of spinal cord, brain injury or EMG, it is a dramatic shift in mind set to think about documenting resident's competence in caring for individuals with spinal cord injuries, brain injuries or performing EMG's. While it would seem logical to think that if you see enough patients or perform enough electrodiagnostic studies you will be competent, this isn't necessarily true. I have come to believe that this is a very good initiative by the ACGME and is an attempt to ensure competent physicians and efficient care in the future.
I have only one suggestion for the ACGME and that is to add one additional competency. Let me give you some examples why.

Recently a young woman in her twenties came to see me with back and leg pain. She had seen numerous physicians, had MRI's done and was told she had a herniated disc. Oral and epidural steroids, physical therapy and acupuncture had been tried with no relief and she wanted an opinion from someone at RIC. Her history and examination were consistent with a radiculopathy and her imaging studies confirmed this. She admitted she was not getting better, that her pain was becoming intolerable, her weakness was getting worse and it was difficult to do her job as a third grade teacher. We talked and agreed she had done everything possible conservatively and it was time to get a surgical opinion as soon as possible. At the thought of surgery she became tearful and upset. I had little to offer her and could only attempt to facilitate a quick surgical intervention and hopefully relief. I called the selected surgeon's office and asked to speak to the nurse in hopes of getting a quick appointment. When I got her on the line I explained the patient's history, her degree of pain and MRI findings and asked if she could get in to be seen soon. The nurse was very nice but said the doctor would not see a patient until he had seen the MRI. I asked if it wouldn't be better to see the patient first so as to get an appreciation of her pain and weakness but was told she was doing her job and we would have to provide the MRI's or the reports before we could schedule an appointment. Fortunately the patient had time so we faxed a copy of the report along with my pager number over to the nurse and waited. About 45 minutes later the nurse called back and said that the doctor had reviewed the MRI report and agreed she is a surgical candidate and he could see her tomorrow. Without thinking I replied, why does he have to see her if he has seen the MRI? As soon as the words were out of my mouth I know I shouldn't have said it. I apologized, the patient was seen, operated on and is happily teaching her third graders.

It wasn't long after that I saw a gentleman for worsening ambulatory status. He was accompanied by his wife who reported multiple falls at home and was very concerned about his safety. After talking to him and completing my examination I thought he might have Parkinson's disease. I spoke to the patient and his wife about therapy but raised the possibility of seeing a specialist to clarify the cause of the decline. They were both very stressed by his condition and agreed. I called to schedule an appointment with Dr. X in the Parkinson's clinic and spoke to a very nice lady who I shall call Betty. I explained to her I would like to refer a patient to Dr. X who I think might have Parkinson's disease to which Betty replied she could only schedule someone for the Parkinson's clinic if they have Parkinson's disease. I thought she was kidding and when I said I wanted Dr. X to evaluate him first to see if he has Parkinson's disease she offered to schedule him to see another physician and then if he has Parkinson's disease schedule him for the Parkinson's clinic. When I stopped hitting my head on the table top in front of me I told Betty that he definitely had Parkinson's disease and we scheduled an appointment.

We have all probably had some interactions like this and they are the exception not the rule. But if the purpose of the competencies is to ensure competent physicians and efficient health care in the future, I think we should add a seventh competency called – COMMON SENSE.
All applying to medical school or anyone working in a hospital or health care facility would have to demonstrate competency in this area. You are probably wondering how could you evaluate someone's competency in this area? It would be easy. If you are thinking of hiring someone to work for you, have them call Betty and try to schedule someone you "think" has Parkinson's disease for the Parkinson's clinic. If they hit their head on the desk top you hire them. Call me I'll send you the number. (While the incidents are true, the names and Departments have been changed to protect the innocent).

James Sliwa, DO *('84)*
The Regenstein Medical Education Director

Alumni News

Venu Akuthota, MD *('98)* and wife Sonja Stilp welcomed twin boys, Clark Aiden (5 lbs. 4 oz.) and Everest Andrew (4 lbs. 1 oz.) on December 30, 2006. Mom, dad and the boys are doing well!

Richard Zorowitz, MD *('89)* is now Chairman and Associate Professor of PM&R at Johns Hopkins Bayview Medical Center in Baltimore, Maryland.

Among the slate of officers nominated for approval at the upcoming Association of Academic Physiatrists' Annual Meeting is our own **Larry Robinson, MD** *('85)*, for Member-at-Large. The AAP Annual Meeting will be in April, 2007 at the Caribe Hilton, in San Juan, Puerto Rico.

Happenings in Hawaii!

On November 9, 2006, **Dr. Henry Betts** was 2006 recipient of The Frank H. Krusen Award, which was established to honor one of AAPM&R's founding fathers who has been a leader in the development of our specialty. This gold medal is the highest honor the Academy can bestow upon one of its members. Also, earlier that month, Dr. Betts was awarded the Equip for Equality's Civic Leadership Award for his exceptional public commitment and achievement in advancing the human and civil rights of people with disabilities.

Dr. Joel Press *('88)* assumed the office of President of AAPM&R. Though he doesn't really have an 'agenda,' he hopes to "work toward the reorganization of the governance structure in ways that will foster more direct interaction between committees and the Board of Governors; to streamline strategic thinking and channel energies so that we remain focused on the needs of our patients and members of the Academy." This summer, Joel will embark on a 3,700-mile cross-country bike ride from San Francisco, CA to Norfolk, VA to build awareness of physiatry and raise funds for rehabilitation research. More information will be forthcoming on his ride, and how you can help support his effort.

RIC Alumni Rule!

The new PASSOR Board of Governors was elected:

President......................**Heidi Prather, DO** *('95)*
Vice-President.............**Sheila Dugan, MD** *('98)*
Secretary/Treasurer.....**Anne Z. Hoch, DO** *('97 Fellow)*
Member-at-Large........**Venu Akuthota, MD** *('98)*
Member-at-Large........**Brian Casazza, MD** *('95)*
Member-at-Large........**Joseph Zuhosky, MD** *('97)*

Finding a Diamond on Diamond Head!

Jennie Jet, MD *('97)* and a friend hiked up Diamond Head during a break in AAPM&R activities. Her friend proposed to her at the top of Diamond Head, she said 'yes' and came down from the mountain with her own souvenir of the hike! Wedding plans have not yet been announced.

RIC's Influence is (Almost) Nationwide

A recent study of the practicing sites of RIC/NU Alumni shows they are located in 41 of the 50 states in the U.S. and 2 foreign countries. There are no RIC/NU-trained physicians practicing their specialty in the states of Delaware, Idaho, Kansas, Montana, Oklahoma, Rhode Island, Tennessee, West Virginia or Wyoming, according to our records. However, there are 17 members of the Alumni Association for whom we have no forwarding address. That number grew from 5 after the last Newsletter mailing, because they relocated and did not provide us with a forwarding address. In many instances, the U. S. Postal Service has sent the new address after the forwarding period expires, but for these 17, the mail was simply returned to us.

Soon, we will send to you the annual Profile Update Form, so you can keep us informed of changes in your practice sites, home addresses, and personal updates about your family and other information we can include in the Newsletter. We will also send you a list of the Alumni for whom we have no address in case you might be able to provide that information. We hope also to be able to include photos from the Alumni Reception in Hawaii last November, as there was not enough space in this edition of the Newsletter.

RIC Expansion Announced

In a move to advance RIC services outside of Illinois, CEO Joanne Smith ('92) announced that RIC has entered into a strategic alliance with St. Joseph Regional Medical Center in South Bend, Indiana, and has assumed management of rehabilitation services there. With 3 acute care hospitals, one long-term acute facility and one freestanding outpatient surgery center, it is the region's leading health-care provider serving more than one million people in the area.

Before becoming CEO, Dr. Smith was Vice-President of Business Development for RIC, and a focus has been on such expansion. RIC has had talks with hospitals in California, Arizona and Nevada, and has fielded calls from foreign countries (most recently from Dubai).

SAVE THE DATE!

The 68th AAPM&R Annual Assembly and Technical Exhibition will convene in Boston this year with an early fall meeting date, September 27-30, 2007. Host hotels are the Sheraton Boston and the Boston Marriott Copley Place, with assembly sessions also at the Hynes Veterans Memorial Convention Center.

Our Annual RIC/NU Alumni Reception will be on Friday evening, September 28th, 7:00 until 10:00 p.m. at the Sheraton Boston, 39 Dalton Street, Boston MA 02199. More details to follow in the next Newsletter.