

Roth Rounds...

The Joy of Our Everyday Professional Activities



Elliot J. Roth, MD

"The secret o' life is enjoying the passage of time" – James Taylor

Those of us who are privileged to be able to interact with our mentor and "folk hero", Dr. Henry Betts, on a regular basis often get the opportunity to hear him publicly state certain pithy yet inspirational comments about various events that affect him.

In recent months, he has been the recipient of several local and national awards, from organizations like Equip for Equality and the American Academy of PM&R. His acceptance speeches for these awards were gracious yet thoughtful, appreciative but not arrogant.

In these "acceptance speeches", he acknowledged that receiving the awards was meaningful to him, but he noted that **the joy of coming to work every day, being able to collaborate with highly dedicated and capable people, being able to derive satisfaction by interacting with patients and others affected by the disability experience, and having the opportunity to serve in a warm and positive environment constituted enough reward for him.**

He made these comments in a way that was not corny or trite, but rather heartfelt and most inspirational.

What a great attitude! All of us have a great deal to learn from this outlook. Our daily routines, even if they are "routine," form the significant events of our lives. While most would agree that awards and honors are effective ways to recognize substantial professional or personal contributions, it would seem that living a fulfilling life is the most significant reward of all.

For most of us, our daily lives are filled with activities that benefit others; these are activities that are designed to enhance the quality of lives of those who need us the most. This is the true spirit of altruism. As professionals, we have an imperative to devote ourselves to the betterment of others. We do this both individually with each patient we see, and also more broadly by having a bigger impact on our communities through education and advocacy.

The real gifts that we have been given, then, are the opportunity and the capacity to assist and support others

in their time of deep and substantial need. This is a rare opportunity, experienced by few others, and in many ways this is more valuable than the awards bestowed upon individuals by organizations.

While the financial rewards of a career as a physician may be significant, the real payoff of our work as physicians is the rare opportunity to serve in a unique and important role in the lives of our patients, and in the lives of people with disabilities in general. We do this through our day-to-day interactions with patients, and through the care, compassion, and dedication we share with others.

Often we are unaware of the deep impact that we have on our patients. At times, a passing comment or a fleeting interaction with a patient makes a lasting impression on a patient or family member. I am repeatedly struck by the extent to which this occurs, especially when patients come back and remind me of a decision that I made or a seemingly minor interaction that I had with them or a brief recommendation that apparently had significant meaning for them. How did *that* happen?

We should never underestimate the real and potential influence that we have on the lives of our patients.

(Of course, for that matter, we should never overestimate our effect either.)

While few of us can expect to receive the number and types of awards that have been showered upon our teacher Henry Betts, we should remember and be comforted by the fact that our true rewards lie in the interactions that we have with our patients and in the opportunities that we have to serve them. What a great gift this is, shared by very few others!

"The love you take is equal to the love you make"

– John Lennon and Paul McCartney

With warm regards,

Elliot R. ('85)

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What Price Will We Pay for Acceptance?



James Sliwa, DO
The Regenstein
Medical Education
Director

If you have practiced for any length of time, you have an appreciation for the growth and acceptance of our specialty within the medical community. Years ago, patients were not referred for care because physicians didn't know what went on at "Rehab" and what we as physiatrists did. PMR survived and grew because we provided a service and filled a need. It really is a very simple and basic principle that applies to all service industries – if you identify a need and fill it, you will be successful. What need did our specialty fill all those years? We thought about and addressed patient's function. In doing so, we worked in a team, considered the big picture, investigated home needs, helped plan for discharge and addressed family concerns. We cared for patients in a way no other specialty did or could. There wasn't much science to what we did and it was more 'warm and fuzzy' than evidence-based medicine.

The acceptance of PMR as a part of the medical care system is a wonderful thing, but let me share with you a few facts about our medical care system. The United States has the most expensive health care system in the world. Health care costs over \$6,000 annually for every person in the U.S. and exceeds 16% of the gross domestic product, far exceeding that of Switzerland, our nearest rival. Yet life expectancy in the U.S. ranks 45th in the world, and infant mortality is higher than almost every other developed country. Many patients are 'medically homeless' and receive care in the emergency room; care that is expensive and fragmented. The American Academy of Pediatrics defines a medical home as a site of comprehensive care that is accessible, continuous, coordinated,

compassionate and culturally effective. The concept of medical homes for patients is supported by the American Academy of Pediatrics, American Academy of Family Physicians and the American College of Physicians. Emergency Room Physicians complain that emergency rooms are clogged with the medically hopeless. Yet fewer American Medical Graduates are entering specialties that could provide this medical home for patients such as Internal Medicine and Family Practice. With the development of the hospitalist or specialty of hospital medicine even those patients with a primary care physician are at risk for fragmented care. In a study published in the Journal of the American Medical Association, direct communication between hospital physicians and primary care physicians occurred infrequently (3%-20%). In addition, discharge summaries were frequently not available for the primary care physicians and often lacked important information such as test results, discharge medications and follow-up plans.

Some would say that recognition of what a physiatrist is will determine the future of our specialty. While understanding what a physiatrist is would be a wonderful thing, I doubt if it will happen or if it really matters. Stop anyone on the street and ask them what an Otolaryngologist is, or better yet, what an Osteopath is, and watch the blank stare you get. Our specialty will grow if we continue to fill a need. There seems to be a big need for comprehensive, accessible, continuous, coordinated, compassionate and culturally effective care. So while the science within PMR is now blossoming and we should embrace all it has to offer, let's not forget our roots. A little bit of 'warm and fuzzy' may not be so bad.

Leadership Changes at RIC

Joanne C. Smith, MD ('92), President and CEO, announced the following important changes in the RIC leadership organizational structure:

Dr. Elliot Roth ('85) is now the Chief Academic Officer of RIC and oversees all academic and research functions. He will help to ensure that science and discovery are translated into the best of clinical practice at all RIC sites of service, setting new standards for the rest of the world. He will also facilitate the conduct of research by clinicians. Dr. Roth retains the position of Chairman of the Department of PMR for Northwestern University/Feinberg School of Medicine. Dr. Zev Rymer continues

as Director of the Searle Rehabilitation Research Center and reports directly to Dr. Roth.

Dr. James Sliwa ('84) is now the Chief Medical Officer, Chief Quality and Safety Officer of RIC, and retains the role of Residency Program Training Director. He will oversee the physician credentialing and privileging functions, as well as compliance with external agency requirements (JCAHO, CARF, etc.). He will lead quality and safety improvement processes throughout the RIC system of care aimed at achieving the highest level of performance for patient care and outcomes.

Perspective from the Dean's Office,

(University of Washington
School of Medicine)

Elliot kindly asked me to write a piece for the Alumni Newsletter when I saw him at a recent AAP meeting. I thought it might be most interesting to write about PM&R from my perspective in the dean's office at the University of Washington (UW).

Since finishing residency in 1985 (with a spectacular group of colleagues including Elliot), I spent 4 years at the University of Pittsburgh under the late Jeff Nicholas. In 1989 I moved to UW as assistant professor and chief of the Harborview Medical Center electrodiagnostic laboratory. Gradually I moved up through the ranks to Chief of Rehab Medicine at Harborview in 1994, Professor in 1998, and Chair in 2000. In 2005 I also took on the role of Vice Dean of Clinical Affairs and in 2006 stepped down as chair to fill the Dean's office role full time (though I still do EMGs and some teaching).

I'd like to comment on three areas where I believe that PM&R departments can play new or enhanced leadership roles in medical schools and academic medical centers.

First, many medical schools are now becoming more convinced of the need to emphasize chronic disease management in medical school curricula. It's now recognized that most medical school graduates will see more chronic disease and disability than acute curable disease, and they need adequate training as students in these areas. There is no specialty better prepared to participate in this teaching than PM&R, a field for which the chronic disease management model has been a core part of practice. I encourage those in medical schools to lead multi-departmental efforts to enhance the focus on chronic disease management, both at the classroom and clinical levels.

A second area of enhanced opportunity is musculoskeletal physiatry. Physiatrists are the perfect entry point for patients with musculoskeletal problems, whether it's spine pain, sports medicine issues, or joint pain. Institutions are gradually understanding the value of having PM&R at the forefront rather than asking surgeons to give non-surgical care. Even if the institution needs to subsidize physiatrists they more than make it up by putting surgeons in the OR rather than the clinic, and from imaging and injection revenue. I encourage physiatrists to both treat their medical colleagues who personally have back pain (most do) and to work with their local colleagues to build multidisciplinary musculoskeletal clinics with PM&R as the entry point.

The third area I'd like to emphasize is exercise. More of our colleagues in medical schools are recognizing the immense value of exercise both in their personal lives and as a part of patient care and disease prevention. We offer tremendous expertise and experience in exercise physiology and prescriptions and can serve as role models in this regard. This can be emphasized in CME, as well as medical student and resident education.

Finally physiatrists have training (much from our RIC days) that has prepared us to participate in medical school leadership. We are used to working in teams. We are comfortable with multidisciplinary approaches. We are neither surgeon nor internists, but understand perspectives from both. We have a lot to offer to the broad area of medical education and I encourage you to take on medical school leadership opportunities when they are available.

Best regards from Seattle.

Larry Robinson MD, '85

Professor of Rehabilitation Medicine

Vice Dean, Clinical Affairs

University of Washington School of Medicine

Alumni News

1977

George Bonis, MD, PhD, retired from medical practice in October 2006. He and wife Inge have 3 children and live in Evans, Georgia.

1979

William Adair, MD, is Chair, Department of PM&R and Medical Director-Rehab Services, at Advocate Christ Medical Center in Oaklawn, Illinois. He and wife Linda have 3 children.

1984

Molly Hoeflich, MD is still practicing in Portland Oregon. She and husband Tom Phipps have 3 children. Son Dan graduated from college this year on Mother's Day, which was exciting for Molly.

1986

Mark Goddard, MD's accomplishments, honors, and titles at various medical centers and the University of Cincinnati are too numerous to list in this short paragraph, but I will say that he was named one of Cincinnati's "Top Doctors" in April 2007, by Cincinnati Magazine. He and wife Cathy have 3 daughters and 1 son.

1988

Leland Berkwits, MD, received his Board Certification in Pain Management last year. He and wife Barbara Hall live in Asheville, North Carolina.

1992

Michael Berkowitz, MD, is Administrative Medical Director of Alexian Rehab Services LLC and Medical Director of Alexian Rehab Hospital, a partnership of RIC and Alexian Brothers Hospital Network. He and wife Leslie have 3 sons.

Melanie Houle, MD had a poem published in JAMA, April 18, 2007 issue. In addition to her practice, she has had poems in multiple poetry publications and small press literary journals in the U.S. and Canada. Melanie and partner Dr. David DesJarlais live in Honolulu. She has 2 step-children.

1995

Larry Frank, MD is Chair of the AAPM&R Medical Practice Committee, and is with the Chicago Institute for Neurosurgery & Neuroresearch. He and wife Carol this year celebrated a 16th wedding anniversary with kids, Gloria (10), Andrew (7), Justin (4) and Evan (4).

1996

Walter Conlan, MD is medical director of several wound care centers in Central Florida. He, wife Kristin, and son Alex (12) are enjoying the Florida weather and are involved in sailing.

1997

Jennie Jet, MD, became engaged in Honolulu during AAPM&R last November, and will be marrying Michael D'Antonio on August 18, 2007 in Santa Cruz, California. Congratulations Jennie and Michael!

1998

Sheila Dugan, MD is Chair-American College of Sports Medicine (ACRM), Strategic Health Initiative (SHI) on Women, Sports & Physical Activity; Co-Director of the Program for Abdominal & Pelvic Health at Rush University; serves on the Research Committee-AAPM&R, the Strategic Planning for Women's Services at Rush University Medical Center, and the Rush Women's Advisory Group. Sheila and husband John Simpson have one son, Jack. (Personal note: It's been wonderful to watch Jack grow from a baby who I first met at the AAPM&R meeting in Atlanta several years ago, to the fine lad he has become, having seen him only at the AAPM&R Meetings each year. vb)

2002

Lynn Michelle Fosson, MD is on leave of absence from RIC, due to a severe lung disease. She hopes to return in late 2008 or 2009. Michelle is currently in her hometown of Ashland, Kentucky. Prayers for Michelle's recovery are appreciated.

2003

Jerod Cottrill, DO is partnered with Rebound, a premier Orthopedic and Neurosurgery clinic in the Northwest, Portland/Vancouver area. He is also team physician for the Portland Trailblazers, Winterhawks (hockey), and Portland State University. He and wife Judy have one child, and are expecting a second child, a daughter, due this month.

2004

Devyani Hunt, MD is with Washington University in St. Louis. She and husband Mitchell have a new baby boy, Kiran Young Hunt, born April 12, 2007.

2006

Kenneth Bunch, MD and wife, **Tina Chadha Bunch, MD**, work at Coordinated Health, recognized as the premier musculoskeletal facility in the Lehigh Valley, Pennsylvania. Ken and Tina's daughter, Alina Rochelle, was born on March 31, 2007.



The Annual RIC/NU Alumni Reception

Friday, September 28, 2007

The Annual RIC/NU Alumni Reception during the AAPM&R Annual Assembly will be on Friday, September 28, 2007, 7:00 – 10:00 p.m., in Ballroom H-K, at the Marriott Boston Copley Place, 110 Huntington Avenue in Boston.

If you will note on page 46 of the AAPM&R Preliminary Program, the majority of the alumni receptions will be held in the Sheraton, but a few expecting larger attendance has been scheduled in the Marriott. If you plan to attend a reception in the Sheraton, please save time to join our group at the Marriott! Most receptions will end by 9:00 or 9:30 p.m., but ours will go until 10:00 p.m.