

## Roth's Rounds Continuing to Exert an Impact...

*"You were just too busy being fabulous..." --The Eagles*



Elliot J. Roth, MD

It is our Department's goal and a goal of each of us as individuals to have an impact on the care of people with disabling conditions. We do this both through the direct care of our patients and also more indirectly through the influence we exert on the care of patients throughout the world, by conducting teaching, research, advising and consulting, and by developing and promoting innovations in rehabilitation care practices that will change rehabilitation in the future. Our Resident Alumni have played, and continue to play, a major role in this mandate.

This concept was once again brought home to us very clearly at the recent AAPM&R meeting, at which the high visibility of RIC/NU PM&R Resident Alumni was most impressive. The large numbers of Alumni who serve as officers, committee chairs, active committee members, speakers and presenters, course organizers, and journal editors are indicative of the ultimate impact of our training program on the organization and on the leadership of the specialty, just as these roles also reflect the important influence of your own individual activities.

Additional evidence of our impact comes from stories that we hear from Alumni who describe the changes in residency curricula, research findings, clinical protocols, and other care processes that are implemented locally based on experiences gained during the residency. Learning about how these models become integrated at your own locations is enormously gratifying for us.

Your individual and collective successes are opportunities for us to take pride in your accomplishments. It also is important to note that it is not us alone who receive gratification from these successes. Your fellow Alumni tell us that they LOVE to read about your programs and activities. We frequently hear that Resident Alumni enjoy catching up on current activities, new positions, family updates, and other experiences from other Resident Alumni. So, please continue to keep us informed about them, so that we can report your successes and activities to your fellow Alumni. Your friends want to know!

Henry Betts frequently told us that when the RIC flagship hospital building was constructed in 1974, it was designed to serve as a "beacon" for people with disabilities. There are many indications that we have been successful in living that dream; the visibility and impact of our Resident Alumni are chief among those reasons. Your continued leadership means a great deal lot for the future of our specialty, for the advancement of science, and especially for our patients. This is a continuous process. The best is still to come!!!

*"I'd like to think the best of me is still  
hiding up my sleeve"*

*— John Mayer*

With warm regards,  
*Elliot J. Roth, MD ('85)*  
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## Joel Press MD ('88) - Nation's First Chair of Musculoskeletal Rehabilitation

Dr. Joel Press was honored recently as the first Reva & David Logan Distinguished Chair in Musculoskeletal Rehabilitation, the first such chair established in the nation, and it is accompanied by a \$1 million clinical research endowment. Under the leadership and vision of Dr. Press, medical director of the Spine & Sports Rehabilitation Center, RIC will build and enhance its research operations to apply evidence-based treatments and interventions to make a difference in the lives of those with musculoskeletal conditions.

# Sliwa's Thoughts

## Service Versus Education: *Are We Training For The Future?*



James Sliwa, DO  
The Regenstein  
Medical Education  
Director

As someone who has overseen resident training for over twenty years, it is difficult to admit that these are tough times for teachers. The pace has quickened and there seems to be less time to teach and less time when residents are receptive to learning. Service versus education is a very real

concern. In many specialties faculty blame resident duty hour limits for this decay in the educational environment. In July, 2003 the Accreditation Council for Graduate Medical Education (ACGME) implemented the resident duty hour restriction to reduce problems associated with sleep deprivation and to enhance residents well being. Studies that have looked at the effect of the new work hour restrictions on patient outcomes have been mixed with some reporting favorably outcomes, such as decreased mortality rates and medication errors while others have not. However in a recent survey of clinical faculty of Internal Medicine residency programs, respondents felt the work hour restrictions worsened resident's continuity of care, the physician-patient relationship, professionalism and education. Furthermore, faculty reported decreased satisfaction with teaching, ability to develop relationships with residents, and overall career satisfaction. But let's be realistic. While our residents work very hard, is working over 80 hours a week or being on call more frequently than every

third night really an issue for PM&R residents. While the work restrictions do impact on training in PM&R, the threat to resident education in our specialty has been more insidious. In an editorial in the Archives of Internal Medicine, Schuster describes challenges to educating Internal Medicine residents, many of which are common to PM&R.

Over the past decade, we have all experienced the "merry-go-round" of inpatient care, shorter length of stay with increasing admissions. Those simple cases on the Rehab unit are becoming fewer and diagnosis and medical issues that at one time would prevent you from going to "rehab" are now commonplace. Residents today spend more time directing and treating complex medical issues than residents of a decade ago. The need for attending supervision has increased and more time is spent discussing and reviewing medical interventions, leaving less time to discuss rehabilitation intervention.

Faculty and resident responsibilities now extend beyond clinical care. Patient safety concerns have led to the requirement of medication reconciliation forms at discharge and the need to be involved in continuous quality improvement activities. Documentation requirements have increased substantially and coding and billing properly has become as challenging (for me anyway) as patient care. The need to generate revenue through patient care requires larger volumes of patients seen, and is surpassed only by the number of forms and letters required to facilitate the care and services our patients need. I came close to drawing a line in the

sand when I was required to write a letter explaining why my patient who uses a wheelchair for mobility would need to use the accessible bathroom at work since its location would require additional time away from the job. I doubt anyone who has been in practice for awhile would disagree that times have changed. If you have been involved in teaching residents, I doubt you would disagree that the educational environment has changed. The sobering moment for me was when I realized this is reality; the way it is and the way it will be. These changes impact all who practice PMR, inpatient or outpatient, private or academic practices. In this light, I wonder if we are educating our residents to be successful in an environment where they will need to see more patients, in less time with more documentation and non-clinical responsibilities and possibly teaching students and residents. Maybe the issue of Service versus Education should be changed to Service as Education.

Many years ago I was engaged in a conversation about resident education and teaching residents to do quality care with one of my fellow attendings and an alumni of our program. He responded by saying, "Anybody can do quality but how many can do quantity"? I didn't realize at the time just how prophetic he was.

*Jim Sliwa, DO*

The Regenstein Medical Education Director  
Chief Medical Officer

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## Physiatrist and Horticulturist

Visit the website at [www.bluffcreekfarm.com](http://www.bluffcreekfarm.com) and see the wonderful tree farm, nursery, and habitat created by Dr. Robert Eilers ('82) and his family in Big Rock, Illinois. Their focus was to have a farm that was environmentally sensitive, with effective CO2 reduction. The farm has 350 acres with a half mile of one of the cleanest creeks in Illinois, draining over a 100 square mile area. They work to protect the habitat for great blue herons, beavers, wild turkeys red fox, coyotes, owls, hawks and deer. The creek contains fresh water mussels and has several threatened species of fish. They line out 15,000 to 30,000 trees per year for 8-10 year harvests and have established greenways and forested areas for naturalizing.

Assisting Bob Eilers with this restoration project has been wife Karen (an attorney and speech pathologist), sons Robert (a freshman at NU's Feinberg School of Medicine) and Steven (a junior at NU's Weinberg College and pre-med), and daughter Katie (a senior in high school, planning to study environmental sciences and marine biology).

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## Physiatrist and Horticulturist, *continued from page 2*

The Eilers have restored the buildings to preserve the agricultural heritage of the farmstead that dates back to pre-1880. After restoring the farmhouse, he chose to use it as an office for patient care, which has proven to be very popular with his patients.

Located only 2 miles from Aurora and other city developments, the rural character allows patients to wait inside or outdoors and provides their pediatric patients and families a very relaxed environment. Patients from rural areas feel comfortable in the setting and love to visit regarding various crops.

Dr. Eilers sees the selling of trees to individuals and commercial landscapers as a wonderful contrast to dealing with rehabilitation on a daily basis, and he sees horticulture is an experience that impacts our environment. The 9 buildings that have been restored were designed to preserve the structures with current uses for the nursery, and to avoid demolition of the buildings dating back to at least 1880. The efforts of Bob Eilers and his family have taken 18 years, and have resulted in a fully rehabilitated farmstead that is both aesthetically pleasing and environmentally sound. The Kane County forest preserve has purchased 600 acres contiguous to their borders and is preserving the greenway as well.

Dr. Eilers says, "I would never have expected to practice rehabilitation medicine in such a setting but I am delighted that I have had such an opportunity." In addition to caring for the farm and treating patients in that setting, Bob Eilers is also Medical Director for Rehabilitation Services at Hinsdale and LaGrange Hospitals. He has been at these hospitals for the past 25 years, and been on the NU faculty for the same length of time. ■

## RIC/NU Resident Wins Award

Christina Morton Sawhney, MD, PGY-4 at RIC/NU, was awarded the Electrode Store Award for best abstract submitted at the Annual Meeting of the Association of Academic Physiatrists (AAP). Her abstract was a study of Pregnancy Outcomes for Women with Disability. Her research mentor is Kristi Kirshner, MD ('90). She will present her paper as a platform presentation at the Plenary Session of the AAP in Anaheim on February 21, 2008, 12:30 to 1:30 p.m. Dr. Sawhney was honored earlier this year as the Sewell Resident, awarded each year to the RIC Resident showing the most promise in research and academic medicine. ■

## You've Come a Long Way, Baby!

Pediatric rehabilitation medicine has come a long way! I have been most fortunate to witness and usher in many of the changes by my continued commitment to patients and training of Residents and Fellows. Since most of you have had me as your Pediatric Attending at some time or other it is safe to assume that you are aware of my passion in this area. After completing a pediatric residency at the University of Chicago, I joined the PM&R residency program at RIC/NU, and started on the RIC pediatric service with Dr. Paulette Harrar and Dr. Miriam Kalichman. Both were brilliant in their own way, and both were instrumental in my understanding of families and children with disabling conditions. Neither of them were trained in Physiatry; but as Chronic Disease Pediatricians. Inspired by their commitment, my goal after finishing the residency program was to combine pediatrics and PMR. I felt that this approach would best enhance the lives of children in the context of the larger rehabilitation process. I joined the NU faculty at RIC in 1985 and worked with a pediatric team that consisted of Dr. Abe Phillips and myself. We covered the inpatient service, outpatients, and consults.

Dr. Charles Sisung came on board as the Director of the Pediatric Program in June 1992, and from there have continued to add faculty and develop our pediatric program to improve inpatient and outpatient service, consults, day programs, orthopedics, transition, and a well-defined spasticity management program. We have worked with Children's Memorial Hospital for many years, and look forward to new opportunities for care in the near future as Children's builds their new hospital nearby on the downtown medical campus.

The early Pediatric Fellows at RIC were like apprentices with duties and responsibilities that mimicked the attendings. A body of knowledge and a set of training guidelines were far from developed. Now there is a subspecialty board and accredited program for training in pediatric rehabilitation medicine. From bootlegged-type Fellows such as Dr. Lynn Stempien ('88) and Dr. Laura Wilner ('90), we now have bona fide learning objectives and competencies, which we all have grown to love!

The Fellowship draws from the nation and is a 2-year commitment devised to advance the field of pediatric rehabilitation in academic, leadership and clinical programs.

At RIC/NU we now have four board-certified pediatric rehabilitation medicine attendings (3 are triple boarded), one pediatric orthopedic surgeon, and 2 Fellows working with the always cheerful and dedicated pediatric team.

I was on the negotiating committee with ABMS when the construction of the subspecialty was taking place, and I worked with the AAPM&R to devise the exam to certify the pediatric rehabilitation medicine trainee. One victory is that maintenance of the certification procedure for pediatric rehabilitation medicine involves testing only in the pediatric subspecialty board, and not the PM&R board exam or the pediatrics exam!

RIC has gone through transitions with computers, administrations, and structure; however the commitment to children and pediatric rehabilitation has remained constant. The position that I have filled has had many rewards. RIC remains an educational opportunity for everyone. My continued involvement with teaching Fellows, Residents and medical students has all contributed to a life-long learning process for this ex-RIC/NU resident and probably RIC-lifer Attending!

*Deborah Gaebler-Spira, MD ('85)*

# Physiatrist and Musician!

Personally and professionally, things are good. My wife Sandy and my two girls, Eliza (10) and Mickey (12) are all healthy and happy. After I finished residency in 1993, I took a faculty position at The Ohio State University. I stayed there until 1999, when I moved to Gainesville, Florida to accept the position as Chief of the Physical Medicine and Rehabilitation Service for the North Florida/South Georgia Veterans Health System. This position has been rich and fulfilling as I have continued to pursue research on recovery from stroke and on wheeled mobility. I also direct a novel home tele-rehabilitation program. These involvements have led me to surprising encounters, including testifying before Congress and sitting on national CMS panels. Most recently, I have been charged with building a system of care in North Florida/south Georgia for returning combat veterans with mild traumatic brain injury. However, the most exciting changes in occurring in my life are in music, which is why I am writing to you today.

Since leaving RIC, I have continued to work hard at my avocation, playing and exploring traditional southern old-time fiddle and banjo. An unanticipated outcome of moving to Florida was the need to ramp up my playing so that I could make and fit in with new music friends. Soon after arriving, I was drafted as president of the Florida State Fiddlers Association (a 2-year term). From there, I have won statewide competitions in old-time stringband (3 times), and individual competitions in banjo (twice), and placed second in fiddle (twice). I also direct and teach at the Suwannee Old-time Weekend in the fall, and the Suwannee Banjo Camp in the spring where some of the country's most acclaimed bluegrass and old-time artists perform and offer instruction. We have attracted students across the nation and internationally. Last year, I released a CD, "Scratching and Clawing" on Red Dog Records. October's Banjo Newsletter had this to say: "Chuck's clawhammer banjo playing is intricate and engaging, but also consistently clean and tasteful throughout, a sort of ideal combination that many players seek but few achieve. He demonstrates particular

facility when playing six-string fretless banjo and really makes the most of that extra low string, but his work is delicious throughout." I am also an endorsed artist by GoldTone, a musical instrument manufacturer, which is in the planning stages of releasing a Chuck Levy 6-string banjo ([www.goldtone.com](http://www.goldtone.com)). ("Scratching and Clawing" is available at Elderly Instruments ([www.elderly.com](http://www.elderly.com)); County Sales ([www.countysales.com](http://www.countysales.com)); or for directly from Chuck at 426 SW 43rd Terrace, Gainesville, Florida, 32607 for \$17.)

*I am guessing that most of the readers of this newsletter haven't spent much time thinking about the banjo. This is a shame, since the banjo is so well-woven into the to American experience.*

I have also been working to unite my musical and rehabilitation interests. At RIC, I was lucky enough to work with Drs. Alice Brandfonbrener and Joel Press to publish a study of muscle activation amongst violinists using different kinds of shoulder rests. Now, once a month, I play music for patients and staff at Shands, the teaching hospital of the University of Florida. In October I was named chairman of the advisory board for the Center for Arts in Healthcare Research and Education at the University of Florida.

I am guessing that most of the readers of this newsletter haven't spent much time thinking about the banjo. This is a shame, since the banjo is so well-woven into the to American experience. It has long been recognized that the banjo has its origins in West Africa, and came to this country through the trans-Atlantic slave trade. In the 1840's, it came to the forefront as a centerpiece in the minstrel shows, America's first native expression of popular culture. Early banjo music forms the foundation upon which ragtime and jazz were based. Its journey from African-Americans to Anglo-Americans, where it is now at home in bluegrass and old-time music, mirrors economic, racial, and social trends of its times.

All of which led me to Gambia, Africa in July 2007, on an Artists Enhancement Grant from the State of Florida's Division of

Cultural Affairs, to search for and experience the African roots of the banjo. With only two weeks, I decided to spend my time amongst the Jola people, who play an instrument called the akonting. The akonting is a banjo ancestor. Like early American banjos, the body of the akonting is a round gourd covered with a head made of animal hide and features a bridge that floats on top. Both instruments feature a short string that originates about half way down the neck. Most interesting, is that the Jola method of playing, called o'teck (literally "to strike") is nearly identical to the early minstrel style of playing, referred to as "stroke style" in the banjo instruction books of the 1850's and 60's. This style is very similar a modern style known as "clawhammer."

My time with the Jola was amazing and fulfilling. I found the people warm and unfailingly gracious, vital and alive. The music of the akonting was hauntingly familiar and foreign at the same time. While I in Gambia, I made several trips to the Gambia's major hospital, the Royal Victorian Teaching Hospital. As a result, the University of Florida and the RVTH are working together to create rotations for UF students and faculty in Gambia. We are also collaborating on efforts to improve the RVTH Internet access and capability.

Additionally we have obtained a second grant from the Division of Cultural Affairs to create an international cultural exchange called "Aim for Africa: The Akonting Banjo Collaborative" which is working to bring traditional African akonting players to the US to tour Florida hospitals and participate in public performances, hopefully in March, 2008, if we can resolve passport and visa issues.

If you are interested in learning more about the akonting, visit [myspace.com/akonting](http://myspace.com/akonting) and [myspace.com/danieljatta](http://myspace.com/danieljatta).

I have 65 video clips from my visit posted at [www.arts.ufl.edu/CAHRE/senegambia\\_videos.asp](http://www.arts.ufl.edu/CAHRE/senegambia_videos.asp)

The following sites may also be of interest:

- [www.oldtimecentral.com](http://www.oldtimecentral.com)
- [www.suwanneebanjocamp.com](http://www.suwanneebanjocamp.com)
- [www.goldtone.com](http://www.goldtone.com)
- [www.myspace.com/fiddlevy](http://www.myspace.com/fiddlevy)

*Charles Levy, MD ('93)*