



Elliot J. Roth, MD

*"Everybody needs an education"*

— The Kinks

## Roth Rounds Patient and Family Education

Several years ago, I was interviewed by the Northwestern University Feinberg School of Medicine's magazine in preparation for an article they were doing on the topic of patient and family education. In the interview, I was asked about my thoughts regarding patient and family education, including whether I thought that patient education should be considered as an "academic" activity, analogous to other departmental activities, and with similar academic departmental expectations and obligations as we have for resident, medical student, and specialty fellowship education activities. Interesting question.

Patient and family education is at the core of what we do in clinical rehabilitation. We provide knowledge, awareness, insight, wisdom, opportunities for practice, and immediate constructive feedback to our patients. We do this with our outpatients and our inpatients, with our musculoskeletal patients and with our neurological disability patients. Patients and fellow professionals have come to count on us to assume this role, and to provide them with knowledge and insight. We provide elucidation of the pathogenesis of pain and disease states that patients experience, explanations of the medications that we prescribe, and descriptions of the procedures that we perform. And most physiatrists are better at doing this than are physicians in most other specialties.

It always surprises me that there are very few medical textbooks, seminars, formal training,

and research related to patient education. Nursing disciplines are better at this than we are. They have expertise, textbooks, courses, and even advanced specialty degrees focused on patient education.

Several years ago, RIC created the LIFE (Learning, Innovation, Family, and Empowerment) Center to facilitate the dissemination of information and other supportive resources to patients, their families, and the general public. The Center has overseen the development of, and serves as an organized clearing house for multiple modular patient information and education sheets. BUT doing good patient education is NOT only about the printed materials that are given out to patients; good quality education is also about the ability of the professional to create favorable human-human interactions to facilitate learning by the patient and family. It is about the ability of the professionals to engage with the patient and our consumers to prepare the patient for how to deal with his or her disability or illness, and how to prevent these problems from occurring in the future. The capacity to understand the learning style and capabilities of the patient and family, an ability to explain technical concepts in understandable lay language, and a dynamic personal style, are as important as the content of the teaching material itself.

Various other methods of patient and family education have been implemented at RIC over the years. These have included: designated team

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**2011  
Alumni Reception  
in Orlando**

All reports from the RIC/NU Alumni Reception in Orlando last November were excellent! Dr. Elliot Roth hosted the event, and reported attendance to be around 120. Everyone seemed to have had a great time and have told me how wonderful it was to see classmates and peers that they have not had the chance to 'catch up' with in recent years. One told me she had not expected to have such a good time, nor had she expected to run into so many old friends in one place. I hope more of you will attend the reception this year!

## Roth Rounds

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members whose time was dedicated entirely or primarily to patient and family education; patient education checklists; education packets and resource books distributed to patients and families; files of patient education materials organized by topic; and patient education documentation modules contained in the electronic medical record system.

So there are a few take-home messages about patient and family education. It is

important to do it, and it is important to do it right. It also is a complicated process that is not as easy as it might seem. But it is meaningful, impactful for our patients and gratifying to us as professionals, and it has an effect on our patients' quality of life. For these reasons, we should not only do it, but also work toward making sure that our ability to do it improves. And this is precisely what makes it an "academic" activity.

Do you incorporate patient education in your practices? If so, how do you do it? Your thoughts and insights on this topic

might be very helpful to your colleagues across the country, and to their patients.

Warmly,

**Elliot J. Roth, MD ('85)**

The Paul B. Magnuson Professor  
and Chairman  
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*"If I've been taught from the beginning,  
Would my fears now be winning?"*

— Pearl Jam

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## From Working for Others to Working for My Patients

by *Nadya Sweden, MD ('96)*

**H**ello everyone! While I have been so out of touch and not academically present, I have been a little busy. I now have three kids, wrote another book, am working on another, and have established a cozy little private practice big enough to set me free from my 14 years of working under orthopedic rule. I have learned quite a bit and would love to share it with you here.

After residency, I took the typical inpatient rehab job. While the first lasted less than 2 months (because it was geriatric medicine disguised as rehabilitation), I soon switched to a true inpatient position at a lovely community hospital on Long Island. The nurses, PAs, doctors and staff were like a family and the patients were hard-working family people. You couldn't have a better inpatient job and I was happy, although I was a little nervous on call and spent many a late night working on transfers from cardiac surgery, trying to stabilize them, then trying to send them back. The lack of medical support took a toll on my I-don't-like-working-with-sick-people nerves. A few years into it, I got a lead for where my real dreams were (or so I thought): a Long Island orthopedic practice. I took the job with a big raise and fewer hours, no call but also no real decision-making. Basically I served as a figurehead so they could bill PT under

PM&R services: patients would be sent from the orthopedic office to therapy and have to be seen by me first. It was a billing scam but the therapists were good and I made some changes to how patients were seen so we physiatrists actually had a role in their care. We NEVER saw the surgeons, never communicated with them and it was less than ideal.

On a plane, I ran into a former sports medicine fellow I knew from Chicago, who I saw all the time at the gym while living in North Pier. He gave me his card and invited me to join his practice, a well-respected orthopedic group. I started there part-time, and transitioned to three days a week, which is full-time for me with my family responsibilities. My practice grew too, and several events led me to pursue my dream of leaving them to start my own practice sooner than expected. You may be interested in the main reason: MOST INJURIES DO NOT REQUIRE SURGERY!

I started to realize this as I saw patients who did not follow through on their arthroscopy recommendations for one reason or another but got better anyway. I started to realize this as I saw older patients with complete rotator cuff tears regain full range of motion and use of their shoulder after 6 months of PT. I realized this more fully when I had my

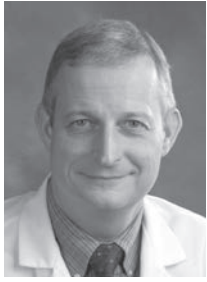
own C67 disc extrusion complete with tricep weakness and the worst pain ever, but I completely recovered without the recommended ACDF! I also realized this when my "very large" meniscus tear that I "wouldn't be able to do anything with" got better, although very slowly, over 1½ years, and now I can run and ski all without surgery. I tell my patients their options all the time, emphasizing that if they want surgery, I am not the person they want to see. Even though my group is pretty conservative, it is vital information I have had to whisper so that my fellow doctors could not hear.

I have learned a lot. I can read X-Rays, treat minor fractures, and I have gained expertise in all non-surgical orthopedic aspects. I have gained expertise in avoiding surgery in neck and back pain, treating pregnant women, and the finesse of matching the right physical therapist to patient. I have learned how to make people feel positive about recovering from pain, and how to inspire them to exercise without injury. I think often of learning points from RIC and even quote the attendings fondly.

I am so grateful to have chosen PM&R as a specialty. It is perfect. I rejoice in helping people help themselves, understand their injury, and work towards

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# Sliwa's Rounds — To Our Alumni — Thank You!



James Sliwa, DO

**P**reparation for our recent ACGME site visit made me realize just how much residency training has changed over the past quarter of a century. New rules, regulations, requirements and

the paperwork to document compliance has become daunting. We spent months in preparation for the visit calculating out percentages of time residents spend on each rotation and compiling lists of lectures, journal clubs, Grand Rounds and resident presentations at national meetings. We needed to provide the number of admissions, average daily census and outpatient visits for every category of disability and estimate the average number of inpatients, outpatients, admissions, consults and electrodiagnostic studies done by a resident during their training. This was in addition to the 100 pages of essay questions that needed to be answered ranging from “How do residents learn the basics of the history and physical examination” to “How do you foster professionalism in your residents”.

Compiling all this information and putting it in the required format was the work of many people and at times we all

felt we were preparing for a tax audit. But changes in the administration of a residency program have extended past the increased reporting needed for an ACGME site visit. For example we now regularly track resident work hours to ensure compliance with guidelines, we document resident and attending education in the consequences of sleep deprivation and resident participation in safety and quality improvement training. We are required to develop action plans to “opportunities for improvement” identified on the ACGME resident survey and our annual program evaluation. At times I have felt the parade of rules and regulations has overshadowed the goal of Graduate Medical Education which is to provide competent physicians capable of practicing our specialty and wondered if this has been worth it all these years.

I recently attended our alumni reception at the AAPMR Annual Meeting in Orlando. It has been quite some time since I made it to one of these receptions and it was a wonderful evening. I saw alumni I haven't seen in many years, heard about their practices and saw pictures of children, many born during residency, that are now young adults. We shared stories about events and patients. Unfortunately the evening was much too short and there just wasn't enough time to catch up with everyone. I spent the evening with a “lump” in my throat and found it difficult to sleep

that night. This typically happens to me when I am overcome with pride. What an amazing and outstanding group of people our alumni are and I was never more proud to be a program director. Is all the paperwork and struggles to stay in compliance with the rules and regulations worth it — without a doubt. I have had the best job in the world for the past 25 years. Thank you for reminding me. ■

## Thank you, Steve Wiesner!

**O**ur lecture series is a key component of our residents' education. We have always utilized a daily lecture format because it brings the residents together every day and allows for smaller quantities of information to be presented with hopefully better retention. However, we have always struggled with the issue of residents who are offsite on a rotation and cannot attend lectures. Well, through a generous donation to the residency by Steve Wiesner, MD, this problem has been solved. With his donation, we have purchased the necessary equipment and connection to implement the broadcasts of live meetings. The residents at our offsite locations can now watch the lectures as they are presented. Thank you, Steve; your generosity has made this possible and we are a better program today because of it.

James A. Sliwa, DO

## Working for My Patients

Nadya Sweden, MD ('96)

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recovery. In the process, I aim for better health for them. The hard work has paid off as my patient list is now big enough to open my solo practice. My patients will be my boss now; my lovely, self-motivated people who want to do for themselves. My referrals are from therapists, doctors, and, of course, patients. I am blessed and thankful for all my training and am grateful to RIC for providing me with a foundation of knowledge and experience that has guided and supported me daily. ■

## Alumni Update

■ The Rehabilitation Hospital of Indiana announced the appointment of **Lisa Lombard, MD ('03)** to the position of Medical Director. Lisa was previously the Chief of TBI Rehab for the Department of PM&R at Santa Clara Medical Center in California.

■ **Christina Richardson MD ('02)** was elected President of the American Osteopathic College of Physical Medicine & Rehabilitation by the membership. The one-year term runs from October to October, though she had also spent the previous year as president-elect. Christina now lives in Traverse City, Michigan, where she has recently joined the Neuromuscular and Rehabilitation Associates of Northern Michigan.

■ The Office of Representative Gabrielle Giffords hosted a panel discussion on TBI on December 14th at the Southern Arizona VA Health Care System in Tucson. Among the distinguished panelists was **Christina Kwasnica MD ('99)**, medical director of neurorehabilitation at Barrow Neurological Institute in Phoenix. Rep. Giffords has pushed for better insurance coverage and better care for TBI patients, based on her own experiences since the shooting one year ago.

■ **Fred Frost MD ('87)** was recently appointed to the position of Chairman of the Department of PM&R at Cleveland Clinic. Fred will continue in his role as Executive Director of Cleveland Clinic Rehabilitation & Sports Therapy, and he is an Associate Professor at the Cleveland Clinic Lerner College of Medicine. ■

## And How Did You Spend Your Summer?

*(The following article is put together from information from the Spokane Journal of Business, Volunteers of America-Spokane News Publications, and various blogs, including Lisa's own.)*

Sports & spine physician Lisa Bliss MD ('03) took on the epic challenge this past summer of being the first woman (and second person) ever to cross Death Valley solo carrying all her food, water and supplies in a 230-pound cart.

In addition to leading the medical teams for some of the toughest competitions in the world, Lisa has run thousands of miles in races all across the world. You might not know it to look at her small frame, but Lisa is a powerful mover and shaker. This 5 feet 1 inch person weighing all of 95 pounds ran the current race to help the homeless youth at Crosswater, a shelter for homeless and at-risk teens that is operated by the Volunteers of America of Eastern Washington and Northern Idaho. The funds raised by Lisa's endeavor would give homeless youth the opportunity to overcome their circumstances through education. She sought to raise \$10,000 in pledges for her race to help pay testing fees for the teenagers who want to take general educational developmental tests toward a high school diploma equivalent, the GED.

Lisa's hobby of doing extreme sports has drawn her to Death Valley before. For 9 years, she volunteered as medical director for the Badwater Ultramarathon, a footrace on 135 miles of the same course she just completed, but it stops about 11 miles short of the climb to Mount Whitney's peak. She ran the Badwater race twice, and in 2007, she won it as the women's champion.

Lisa began this trek in Badwater, Death Valley, which is North America's lowest elevation at 280 feet below sea level, and ended at Mount Whitney's peak, which is

around 14,500 feet, the highest summit in the lower 48 states. Completing the longer course to the tip of Mount Whitney proved to be her toughest obstacle, not because of the heat that reached a maximum of about 118 degrees during the 4 days or even the below-freezing weather at the top, but the steep, grueling mountain grades as she pulled her cart which was attached to her at the waist by a harness.

Just before midnight on July 28, 2011, Lisa finished the course in 89 hours, 38 minutes and 48 seconds, making her only the second person, and the first woman to cover this course under the rule of being self-contained, meaning she couldn't accept any help or supplies. A team of friends followed her, covering most of the way by vehicle, but couldn't assist her.

When not running the various peaks and valleys, her day job takes her to Inland Neurosurgery & Spine Associates PS on Spokane's North Side where she operates an affiliated practice called Northwest Sports & Spine PLLC, and she has been practicing there since 2003.

Lisa said, "One of the messages I want to give the kids at Crosswalk is there's no failure in trying. I didn't know if I could do this. There was a real possibility of failure, but I don't think the possibility of failure should keep us from trying." She says that the real meaning in what she did was in helping the kids to get a chance for an education. She says she thought about them during the journey.

Lisa has a map of the Death Valley Badwater course in her office, but she says she won't be doing the longer distance to Mount Whitney's peak again. Instead, she says she will help the man who dared her to race to the top if he ever needs assistance to complete the course. He tried the route once before but had to stop because of hypothermia. ■



## Position Available: Medical Director of RIC Center for Pain Management

We are seeking an experienced Physician or Psychologist with demonstrated abilities as a leader, clinician and researcher with interest and expertise in comprehensive pain management to lead our expanding Pain Management Center.

Our comprehensive outpatient Pain Management Center continues to grow in the range and complexity of subacute and chronic pain conditions treated. This interdisciplinary pain management program is located in a state-of-the-art facility which offers individually designed treatment programs and an ongoing outpatient pain management practice. Also available is the full range of resources of RIC and Northwestern University.

Qualifications for the position include: Board certification in Pain Management with at least five years of clinical experience beyond training, demonstrated leadership abilities and interpersonal skills. Research expertise in pain management supported by peer reviewed publications is preferred. The candidate will also qualify for faculty appointment in the Department of PM&R at Northwestern University's Feinberg School of Medicine at the rank of instructor or higher. Minority applicants are encouraged to apply.

**If you or someone you know is interested, please contact:** James Sliwa, DO, at 345 East Superior, Chicago IL 60611-2654; email [jsliwa@ric.org](mailto:jsliwa@ric.org).