Roth Rounds

“Cause I’m serving up quality
It can’t be beat
If you’re not down
Vote with your feet
My quality, biology
Enhanced with high technology.”
— Barenaked Ladies

Recently, I ate at a restaurant (well, a sleazy bar, really) where there was a sign on the wall that said the following (as a joke, we think!):

<table>
<thead>
<tr>
<th>Quality</th>
<th>Service</th>
<th>Price</th>
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<td></td>
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<td>...You pick 2</td>
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When you give it some thought, there is a great deal to consider and to learn from this sign. It highlights a dilemma many of us seem to face in our medical practices.

If we choose "high quality" and "low price" as my "2 picks," do we necessarily sacrifice the expectation for friendly service and amenities?

If we choose "strong service" and "low price" as my "2 picks," do we sacrifice the opportunity for exceptional quality?

And if we choose both "high quality" and "good service" (as many of us would want), would it actually cost more?

Is it really true that providing both high quality care and friendly accommodating service can NOT be associated with low price? Or is this stated concern simply an excuse to give for failing to provide for what patients need? It’s hard to be sure. Many experts in the quality management field in industry and in healthcare will tell you that providing true quality actually lowers cost (and therefore price), because of the reduction in rework of the product, or fewer medical complications, and because there is less need for the costly damage control activities that are used to address customer satisfaction problems.

It also is important to note that quality and service are two different and distinct entities. This is important to recognize, because so many existing patient satisfaction assessment instruments actually measure satisfaction with service issues (e.g., staff friendliness, facility cleanliness, food quality, ease of scheduling, etc.) as their indicators. But are these really appropriately as quality measures? Patient satisfaction is often (but not always) considered a component of a quality evaluation program. Patient satisfaction is targeted to be one of the key attributes (but not the only one) on which the new proposed physician reimbursement system will be based. This is not necessarily a bad thing, but its value will depend heavily on how it is carried out.

So if we are to survive and be successful in the new environment of the near future where reimbursements can be anticipated to be greatly reduced, is it necessary that either service or quality suffer? Do we cut back on the quality of what we provide, which at the end of the day, reflects the technical knowledge, expertise, skill, and ability of ourselves and the professionals who work directly with our patients? Or, do we cut back on "the amenities,” i.e., those seeming “extras” that are often implemented to enhance the experience of the patient during the course of their rehabilitation (i.e., "service")?

What about compassion? What about that friendly demeanor or simple smile that we know often influences a patient’s recovery and treatment? Is compassion a component of "quality" or "service," or both? Do kindness, empathy and thoughtful behavior need to be sacrificed in order for the practice of the institution to reduce expenses? One would think NOT. We fully expect that what we have traditionally considered as important ingredients of a good physician and physiatrist, including friendliness, patience, and ability to empathize, will continue to be important, as will the technical knowledge and skill. Can we say which is MORE important? This is hard to tell. Although we often

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would like to believe that it is primarily the quality of our technical skills that is the most significant influence on patient outcomes and experience, it is likely the case that for some patients, it is the nature of the interpersonal interactions between the patient and the professionals that drives much of their success. The question of which aspects of the professional-patient interaction are most predictive of more favorable rehabilitation outcomes or satisfaction levels has not been well studied to date. Despite all of our interest and experience in studying correlates of outcomes after rehabilitation, we still don’t know the complete answers to these questions.

To what extent do strong technical skills by the physicians, nurses, and therapists enter into the equation of factors that are associated with positive rehabilitation outcomes? Is having a favorable service experience really necessary in determining outcomes? Is it even necessary for influencing positive satisfaction levels, for that matter? These areas are ripe for study.

Among many other changes, it is expected that implementation of the recently passed Affordable Care Act, which outlines the blueprint for the “health care reform,” will create the need for the following:
1. Reduced costs of providing care;
2. Increased attention to developing and recording measures of quality of care;
3. Using these metrics to assess the quality of care provided by individual professionals and institutions; and
4. Providing incentives, in the form of greater financial reimbursements to those practitioners and organizations that provide higher quality care, as defined by those metrics and conversely, reduced reimbursements for those individuals and institutions whose measurements do not demonstrate that they provide higher quality care.

Therefore, we all need to be ready to address these issues. There is simply no escaping it. We as physiatrists, who are used to finding the balance of providing firmness with providing support, are in a good position to be able to establish the needed balance to address the issues of quality, service, price, and many other issues, simultaneously. Measurement of quality already has become a significant focus for many practices and programs, and it is most likely that these will expand.

While the humorous and almost flippant nature of the original sign posting makes my attempt to consider this in too much detail seem like I’m making a mountain out of a molehill, it is interesting to consider the issues raised by the potential implications of the statement contained in the sign.

By the way, both the quality of the food and the service at the bar were pretty good, and the price wasn’t too bad!

Your comments and thoughts are welcome.

Fondly,

Elliot J. Roth, MD (’85)

“I can’t change the world and make things fair
The least I can do is care.”
— Kid Rock

Abe Philip Retires from RIC!

Dr. Abe Philip, (’80) retired on May 31, 2011, just 33 years and 11 months after he first stepped into RIC. Dr. Philip spent the first 2 years and 6 months as a Resident Physician, and the next 30 years and 5 months as an Attending Physician at RIC, his home away from home. He says he was able to grow and become who he is today because of the training he received and the lessons he learned with at RIC. He has seen tremendous changes within the organization, but the commitment and determination to serve our fellow disabled human beings has never changed.

Dr. Philip served as an Attending Physician at RIC from January 1981 until May 31, 2011. During those years, he was in Pediatrics from January 1981 until June 1993; in Brain Injury Medicine and Rehabilitation from June 1993 until May 2011. Also, from March 1981 until April 2011, he was in Electromyography, and from 1995 until 2005 he was in the Orthotic Clinic. Dr. Philip wishes to thank all members of the RIC family, both in Chicago and extended, for the support, professionalism, and friendship through the years, and pays tribute to his co-workers in the medical staff including residents, the staffs of various RIC departments, and RIC administration for helping make his career at RIC a special chapter in his life.
Colleen Fitzgerald, MD

As a medical student, Colleen worked at RIC in women's health during a summer externship. As a staff physician at RIC, she continued working in this little-known area, but realized there was little research to back up what she was telling her patients. She had to figure it out for herself, one question at a time. Colleen recently wrote a first-person essay on her experiences for the *Journal of the American Medical Association*, May 4, 2011—Vol. 305, No. 17.

Colleen speaks of turning 40, and realizing that as a physician she can be more than just a clinician. Working at RIC during that summer externship in women's health was a choice that proved to be pivotal in her career. She relates in the article that she worked under the guidance of a strong female attending physician in PM&R with a clinical interest in women's health, and gravitated toward this specialty where she began a therapeutic journey with patients after other physicians had “finished” their clinical workups. That mentorship and guidance she mentions in the article was provided by Joanne Smith, MD (‘92), current RIC President and CEO.

During her residency in PM&R, she was exposed to many women's health issues, and had her own taste of women's health when her first child was born. With a fervent desire to succeed in clinical medicine, she managed to become chief resident with a 1-year old child in tow.

Colleen writes in the *JAMA* article that as a staff physician after residency, she was thrilled to be living her dream, and did a little “research” on her own. She agreed to see patients no one else seemed to know what to do with, patients who had already seen several other physicians. Many of these patients improved significantly, though she was not confident that the multi-modal treatment had led to the success. The more experienced she became, the less sure she felt about the answers she was giving to patients’ questions, mostly because what she was telling them in clinical practice was not evidence-based. Medical literature helped very little.

Eight years into her career and after the birth of her second child, Colleen learned about the Building Interdisciplinary Research Careers in Women’s Health (BIRCWH) scholarship, a National Institutes of Health K12 grant. Though older than other colleagues applying for the same grant, and though friends and family discouraged her from this undertaking, she was disheartened but not discouraged. Her husband thought she could and should do it and gave her overwhelming support. She had to write the grant proposal within 1 month, and was encouraged by 2 women supporters who helped her realize that this was the direction medicine needed to go, as PM&R physicians moving from old-school concept of disability to a brave new world of evidence-based cures. She urged Colleen to follow her heart in becoming a physician-scientist, and encouraged her to take the risk.

Colleen won the award! She told in the *JAMA* article that her project was on the use of musculoskeletal ultrasound in the etiology of pelvic girdle pain (classic “sciatica”) in pregnancy. To develop her skills in research, she enrolled in a Master of Science in Clinical Investigations program.

Currently in the 3rd year of the BIRCWH grant, she is engrossed in the recruitment and collection of data. Her hope is to provide mechanism-based treatments for patients and move toward early diagnosis and treatment of acute pelvic pain to prevent chronic pelvic pain. She sees patients only 1 day each week, but is constantly studying their problems and formulating clinical research hypotheses with the questions they ask her. Colleen says she is still living her dream in taking care of patients but now can look a patient in the eye and tell her that she is working hard to figure out why she has her pain, and to determine the best way to treat her.

Colleen says that as a physician, she was trained in the scientific method and learned how to give hope and deliver truth in pragmatic ways. As a mother, she has discovered that pursuing what she believes in is the best medicine for her entire family. She believes that she made the right decision to become a physician, and now to be a clinical investigator. The *JAMA* article states that Colleen believes that women should not settle for a lack of diagnoses and unclear explanations. Women deserve to have all disabilities addressed, those that are visibly apparent and those that are hidden. She states that in order to truly provide our patients with outstanding care, clinicians must persist in their pursuit of patient-oriented research. Whether a new attending or a physician with 20 years experience, she feels it is never too late to become a physician-scientist. For her, turning 40 was just the beginning!

For more insight into Colleen Fitzgerald's journey on this path, please read her *JAMA* article in the May 4, 2011 issue, entitled “It’s Never Too Late.”
National Multiple Sclerosis Society Recognizes Comprehensive Care Model

Last month, RIC and Northwestern Memorial Hospital sent out a press release announcing that a collaborative program led by RIC and Northwestern’s MS program was recently recognized for providing exemplary care and is the first in the Midwest region to be designated as a National Multiple Sclerosis Society (NMSS) Affiliated Center for Comprehensive Care.

The collaboration between RIC, NMH, and NU’s Feinberg School of Medicine was founded in 1986 by RIC’s James Sliwa, DO (‘84), and Bruce Cohen MD, neurologist at NMH. The two doctors first met as residents in their respective fields, and have seen tremendous advancements in the treatment of MS, “with new pharmaceutical options that favorably alter the course of the disease, suppress acute symptoms and treat persistent symptoms,” stated Dr. Cohen.

This collaborative program was one of the first to provide a multidisciplinary approach to the treatment of MS by combining medical, physical and rehabilitative strategies. Specialists in neuro-ophthalmology, neuro-psychology, neuro-urolology, neuro-otology, neuro-radiology and psychiatry collaborate in the care of individual patients to address the symptoms of the disease.

Collaborative MS Program Earns Recognition

SkyRise Chicago 2011

The third annual Skyrise Chicago will be held on Sunday, November 6, 2011, from 7:00 a.m. until noon at the Willis Tower.

Not only is it the planet’s tallest indoor stair climb, it is RIC’s biggest fundraising event.

The event sold out last year, with climbers from across the nation and many countries. If you can’t participate in the climb, you might want to contribute in other ways. Log onto www.ric.org for more information.

2011 RIC/NU Alumni Reception

The annual RIC/NU Alumni Reception will be held on Friday, November 18, 2011, 7:00 until 10:00 p.m. in St. George 104, Emerald Bay, Atrium Level at the Gaylord Palms Resort and Convention Center in Orlando.