PRESIDENT’S LETTER

By Kristjan T. Ragnarsson, MD

THE VALUE OF SUBSPECIALTY TRAINING IN PM&R

During residency, most PM&R residents wonder if training in one of our subspecialties would be helpful to secure a desirable practice position. In 1974, as I was nearing completion of a three-year PM&R residency, I was offered a fellowship in “Clinical Spinal Cord Injury (SCI) Research”.

Basically, this was a non-faculty position at an academic medical center without a specific description of my responsibilities or the educational program offered. I knew that I was to provide care for patients with SCI, be involved in several SCI related research projects, prepare publications and presentations relating to my research and teach students and residents. This was a non-structured program which had no description of the scope of the training offered, the didactic teaching (there was none), textbooks or other literature to be studied, the knowledge and technical proficiency to be gained, and there certainly was no examination to be taken at the end of the fellowship. It was generally assumed that if a fellow was kept busy enough for the appropriate length of time, working with and supervised by experienced faculty, then one would ultimately learn enough and be considered well trained. Perhaps so, but why leave it up to chance? A structured accredited fellowship training program leading to a final examination seems to be a preferable approach.

During the 1970’s, subspecialty training in the form of fellowships was extremely rare among physiatrists, although fairly common in the fields of surgery and internal medicine. Today, it appears that most graduating PM&R residents apply for fellowships in different subspecialties, most commonly in pain medicine. Currently, the American Board of PM&R (ABPM&R) provides subspecialty certifications in the six different fields listed below:

- Hospice and Palliative Medicine
- Neuromuscular Medicine
- Pain Medicine
- Pediatric Rehabilitation Medicine
- Spinal Cord Injury Medicine
- Sports Medicine

For physiatrists to receive subspecialty certificates from the ABPM&R, the general rules are that the candidate must be a current Diplomate of the ABPM&R and hold a current, valid and unrestricted license to practice.

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PM&R has considerable volume of current literature, mostly clinical studies, addressing diagnosis and symptomatic treatment.
New Health Reform Law Increases Medicare GME Funding

Much has been said about the cuts to Medicare contained in the recently-enacted health care reform law. As much as $500 billion will be cut from Medicare to pay for expansions in coverage and other reforms to the nation’s health care system. What is less well known is that the new law increases funding for graduate medical education under the Medicare program. This makes a great deal of sense. If reform provides health insurance to an additional 32 million people, they will need access to primary care doctors, other physicians, hospitals and other providers.

The new health reform law will increase graduate medical education funding by redistributing unused medical resident “cap” slots and by increasing the types of activities that may be included in the resident counts that are used to calculate the payments. The additional funding creates opportunities for training in specialty care, including physical medicine and rehabilitation.

Medicare GME Background

The Medicare program is the largest financer of graduate medical education. From the start of the program, Congress recognized that graduate medical education is a legitimate cost of health care in teaching hospitals. The Medicare program was thus designed to ensure that it paid its share of the cost of graduate medical education. This remained true in the 1980s, when Medicare changed from paying hospitals for their “reasonable cost” of care to paying a fixed rate for each dis-

charge as part of the inpatient prospective payment system (IPPS).

When the prospective payment system was enacted, Congress created two payment mechanisms for graduate medical education, the direct graduate medical education payment (DGME) and the indirect medical education payment (IME). As their names imply, one pays for direct costs and the other pays for indirect costs. Although they are calculated differently, they both have one important feature in common: payment is determined, in part, on the number of full-time equivalent residents that a hospital trains. The resident count is determined differently for both, and the new law clarifies some of the differences.

In 1996, Congress sought to limit DGME and IME payments by imposing a cap on the number of residents that a hospital can count. The cap was set at the number trained in 1996. The cap has served as a significant limitation on graduate medical education funding because many teaching hospitals have exceeded their caps. Hospitals receive no Medicare graduate medical education payments for these residents that are over the cap. Consequently, many hospitals are hesitant to add new programs if they will not receive funding from Medicare.

Redistribution of Cap Slots

Congress did not lift or increase the caps in the health reform bill, but Congress did order a redistribution of unused cap slots. Although many hospitals routinely exceed their caps, a significant number of others are well under their caps. The new law redistributes 65% of the unused slots for urban hospitals of any size, and 65% of the unused slots in rural hospitals with 250 or more beds. Reallocation these unused residency slots to hospitals that will fill them will increase aggregate DGME and IME payments.

Seventy-five percent of the slots will be redistributed to primary care and general surgery programs, but this leaves room for 25% of the slots to go to other specialties, including physical medicine and rehabilitation. Preference for the redistributed slots will be given to hospitals located in states with a low resident-to-population ratio, states with a high percentage of the population living in health-professional shortage areas, and rural states. A hospital may receive a maximum of 75 redistributed FTEs. Redistribution will begin for cost reporting periods starting on or after July 1, 2011.

The new law will also preserve slots when a hospital closes. Resident slots from closed hospitals will be redistributed, with preference given to hospitals in proximity to the hospital that has closed. Resident slots will be redistributed for hospitals that closed on or after March 23, 2008. To receive resident slots, a hospital must demonstrate that it is likely to fill them within three years. These resident slots are not limited by medical specialty.

Training in Non-Hospital Settings

Teaching hospitals are already permitted to count time in non-hospital settings, such as free-standing physicians’ clinics and community health centers. Under the current rules, only

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time spent in patient care may be counted, and the hospital must pay “all or substantially all” of the costs of the training. The new health reform law liberalizes these rules considerably.1

Hospitals will only have to incur the costs of the residents’ stipends and fringe benefits, rather than substantially all of the costs. In the past, payment for the costs of the supervisory physicians at the clinic was a big issue because Medicare expected hospitals to incur costs for these teaching physicians, even if the physicians donated their time. Also, more than one hospital will now be able to share training costs. If more than one hospital incurs the training costs, they will count a proportional share of the residents’ time, as determined by a written agreement between the hospitals. These changes are effective July 1, 2010, a full year before the redistribution of residency slots begins.

Research and Didactic Activities

Didactic activities, such as conferences and seminars, that occur in non-hospital settings will now count toward the DGME resident count.2 Currently, only patient care activities in non-hospital settings may be included. Research that does not involve the treatment or diagnosis of patients will remain excluded from the count. The patient care limitation remains fully in force for the IME resident count. Neither research nor didactic activities may be included in the IME resident count. These changes were made retroactive to July 1, 2009.

Perhaps a more significant impact is the inclusion of didactic time in the IME resident count. Currently, Medicare policy is to limit the IME resident count to patient-care activities only. (Non-patient care activities that occur in the hospital are currently included in the DGME resident count.) The health care reform law requires that “all the time spent by an intern or resident in an approved medical residency training program in non-patient care activities, such as didactic conferences and seminars . . . that occur in the hospital shall be counted” for IME.3 This provision is effective on January 1, 1983, the effective date of the original inpatient prospective payment system. Congress forbade reopening any cost reports to take advantage of this, however. Only hospitals that appealed the exclusion of didactic activities will receive a retroactive benefit.

The new law also excludes bench research from the IME resident count as of October 1, 2001. This exclusion of research time ratifies a 2001 regulation issued by the Centers for Medicare and Medicaid Services (“CMS”). Thus, the statutory exclusion of research time will not actually reduce the resident count going forward because it merely codifies existing regulations. The addition of didactic time, however, is a change in policy that will increase the IME resident count for most teaching hospitals.

Vacation and Leave Time

Vacation, sick leave, and other approved leave must now be included in both the DGME and IME FTE counts.4 Medicare has historically included these activities in both resident counts, but in 2007, CMS proposed to remove them. Although CMS ultimately did not implement its proposal, it left the door open to excluding them at some future date. The new law ensures that approved leave time will remain in the resident count for both DGME and IME.

Conclusion

These changes will benefit many teaching hospitals. Hospitals that are over their resident caps will have the opportunity to obtain unused slots from other hospitals, allowing the receiving hospitals to expand existing programs or add new programs. For hospitals that are below their caps, the expansion of the types of activities that may be included in the counts will result in greater DGME and IME payments from Medicare. Although these changes are not targeted specifically at physical medicine and rehabilitation, the new law provides opportunities for increased funding of PM&R residency programs.

2 PPACA, § 5503.
3 PPACA, § 5506.
4 PPACA, § 5504.
5 PPACA, § 5505.
6 PPACA, § 5505(b).
7 PPACA, § 5505(a).
COMMUNICATION

By Tim Mead, MD

Dr. Tim Mead is a pediatric orthopedic surgeon and the medical director of CURE Kenya. He practices full time in Africa and is dedicated to caring for disabled children and to teaching modern medical techniques to indigenous doctors.

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Communication is a difficult aspect of life. How often are there difficulties and clashes due to a lack of communication or a misunderstanding? People often believe in rumors rather than a clear statement of fact. Anger can build into bitterness as hurt feelings are not expressed and dealt with sufficiently. Sometimes, my brain hears something completely different—or nothing at all—from what another person understands they have said. Sometimes miscommunications yield only minor or humorous results; sometimes the consequences are much more extreme.

I have had many experiences of communication failures while serving in Kenya. Some have a cultural basis; some follow language usage and understanding; and some are just purely ignorance on my part or poor listening.

The word, “Ndio,” is translated from Kiswahili to English as “Yes”. Now as an American coming here, when you hear Ndio as an answer to a question you may push vigorously onward with an activity or plan, thinking and assuming that you have approval. But that is not necessarily the case. Some people will agree because you act excited and they wish to please. Some agree with me no matter what, because I am the doctor. In jest, I ask the kids sometimes if the surgery for today is “Tutatoa kitchwa?” (We will remove the head?)

More often than not they will shake their heads yes and say Ndio! Kwele? True?

I hear Ndio often at governmental offices to answer questions. We applied together for a work permit. Jana received a 3-year permit; I received a 1-year permit. Why? Ndio! At the offices, Ndio can mean we decided and you do not need to know and even I don’t understand and won’t say so.

Projects can be written and proposed. At the initial meeting you receive an Ndio. But don’t start digging or spending funds yet. Relationships are key to life in Kenya. The initial Ndio may mean they are willing to think about the idea and discuss it further in the future. You may be talking to the wrong person or group and not even realize it. You may need a partner to discuss plans, goals, and options outside of the meetings. Even though you feel the project or whatever is obviously a needed, valuable addition to Kenyan life, the activity may have no priority to the people of this country or region. Ndio will allow the meeting to end and the idea be relegated to wither in neglect.

People arriving with a rigid timetable of change and their agenda to accomplish this change often hit a wall. At the wall, they either give up or realize what is traditional or expected in their home area is not necessarily true for this country or area. As we say in Kenya, Pole, pole. (slowly, slowly).

We have a patient in the hospital who demonstrates another form of miscommunication. This young boy was seen in a clinic in the Machakos area. He had a burn on his right arm about a year ago. The burn was not treated with anything more than a simple dressing and subsequently developed a significant contracture of the elbow. The CURE doctor who saw the child with the mother present planned to release the elbow surgically later in Kijabe. Prior to the scheduled surgical time, he asked the mom to wash the arm with soap and water and then apply petroleum jelly—Vaseline—to the scar. There was some breakdown of the scar that could be improved before the surgery time. The doctor did not speak Kiswahili or Kikamba, so enlisted the aid of a translator. The translator repeated the instructions and the mother shook her head yes. I am sure there was an Ndio there. Sounds fine? Nothing unusual, right? The child arrives and one of our resident physicians sees the rather raw appearing scar on the elbow. He asks what the mother had been doing to care for the arm. She replied that she had been washing it every day. Good! Then, as she was told, she put kerosene on the scar! Kerosene??!

She said that is what the man at the clinic said to do. Oh my! Well, you know if it burns then it must be helping! Mafuta in Kiswahili is a generic word for oil or fluid. You combine it to define its meaning. Mafuta kwa taa (oil for the lamp= kerosene) mafuta kwa gauzi (oil for skin) mafuta kwa gari (fuel for car) mafuta kwa matu (juice for drinking). I am not sure how Vaseline became kerosene unless the interpreter just failed to understand the doctor’s accent and did not ask for clarification. We cared for the child and he is healing well. The doctor is being gently harassed a bit about his new wound care techniques.

There are many causes for miscommunication. I feel the most important are related to poor listening and to false assumptions. I know I am guilty of both on occasions. I can climb within a project and not truly listen to questions people ask. I can push an agenda and not hear the concerns raised by others. I can falsely assume all is going well and ignore signs of problems. By this action, I can imply the difficulties have no importance to me and therefore you have no importance to me.

Communication is very important in aspects of our lives—our marriages, our family, friends, work, clubs, and more. I hope that I will become a better listener. I look for guidance from colleagues, friends, and family as I continue to seek to transform lives through emotional, spiritual, and physical care here in Africa.
Twitter, Facebook and YouTube have taken the world by storm. It has become impossible to ignore the current trend in social media—a trend that has yet to show any sign of slowing down. By making the decision to actively use social-media tools, the AAP can gain a staggering amount of visibility and awareness, especially in medical-student communities.

Facebook is the most popular site, in 100 out of 127 countries, reaching more than 400 million users across the planet. The opportunity to network and make your presence known in such a large and diverse community usually does not come cheap. Luckily, in this case, it’s free. Over the next few months, the AAP will reinvent its Facebook page, improving content and promoting interaction, by launching an active Social Media Strategy with the following goals:

1) To increase communication with AAP’s current members.
2) To intrigue physiatrists and medical students who are not members of the AAP…yet.
3) To network, network…network!

Allow me to elaborate on goal #3…

Facebook may be foreign to some of you, but I am confident you will come to find that it is an engaging and powerful platform to share pictures, videos, links, documents, and conversation with people of a common interest. The AAP’s Facebook page will serve as a comprehensive and interactive source of PM&R information, focusing on educational and career advancement. The page will provide an accessible option to individuals and groups seeking a more informal approach to information gathering and discussion. This method of communication is extremely popular within the student community and its popularity is rapidly growing in older generations as well. Baby boomers are the fastest-growing segment on social media groups, many logging on at least once a day, regularly updating their profiles and participating in online discussions.

The ultimate benefit to be gained by full heartedly embracing the social media phenomenon is that the specialty of physiatry will become better known by future MDs, and physiatrists at any level will be provided with another avenue to share experiences and stay up to date on current “hot topics” in the field.

When asked what type of content would be most helpful on AAP’s Facebook page, a current member answered “Student friendly content; Possible career paths in physiatry; News and updates in the field.” As of today, the request remains unanswered on Facebook. With your help and participation, we will begin to build another reliable source of information from the AAP. I would like to encourage you to join the Facebook World and become a member of AAP’s page.

**Discussion Question for JUNE**

To help facilitate initial interaction and communication, we will begin to post a Discussion Question each month.

Having been first introduced to Physiatry from my time with SpineMED Decompression, which you can read about in my bio below, I felt the following would be an appropriate and fun first Discussion Question:

Describe when you first became interested in physiatry. What was it about the specialty that initially compelled you to find out more?

Please share your thoughts and experiences by visiting the AAP Home Page at www.physiatry.org and clicking on the Facebook link.

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**NEW AAP COMMUNICATIONS MANAGER**

Bernadette M. Rensing has joined the AAP as Communications Manager. Bernadette earned her BS in Marketing at James Madison University in Harrisonburg, Virginia, in 2005. Prior to joining AAP, Bernadette was the Marketing Manager at CERT Health Sciences, LLC, in Baltimore, MD for 2 years. CERT Health Sciences’ flagship product was a non-surgical spinal decompression system called the SpineMED. It was here that she first worked with physiatrists and became familiar with PM&R. Before SpineMED, Bernadette spent 3 years in marketing and sales for Madison Avenue, Inc, in Columbia, Maryland, where she worked closely with corporate and association meeting planners.

In her spare time, Bernadette enjoys spending time with her family, playing sports and reading. Bernadette is extremely excited to be a part of the AAP and looks forward to contributing to the promotion and overall success of the organization.
The Council of Academic Societies Spring meeting occurred in Austin, Texas, March 4–6, 2010. The theme of the meeting was “The Role of Faculty Leaders in Aligning Priorities, Perceptions and Missions”.

Lilly Marks, Senior Associate Dean for Administration and Finance at the University of Colorado School of Medicine, gave a very thought provoking talk on the finances of academic medicine centers. She indicated that for public medical schools, approximately 81% of the budget is soft monies and for private it is 89%. She discussed how all academic missions are dependent on the clinical revenues.

In most settings, the practice plans are dependent on three or four major managed-care contracts and that the loss of one could mean a loss of 30–40% of the clinical revenue. Tuition and State dollars provide most of the resource base for education and tenure. This is very dependent on clinical supplements. On an average, about 30% of the clinical revenue is used to subsidize academic programs.

She discussed the concepts of “Principal and Principle” which gets into the philosophy and ethics of an institution and the economic realities. This raised issues concerning salary (incentives, risk based components, tenure, etc.). Issues with respect to conflict of interest, leverage, institutional culture, entitlements, and productivity were also discussed. This led to talks about departments, centers, institutions and service lines. It seems like some/man academic medical centers are becoming the safety-net hospital and not the “cutting edge” technology and programs. Some are still able to do both.

The concept of respect was stressed, especially as it relates to different specialties, basic science/clinical and allied health.

There was an update with respect to the committee that is evaluating the current MCAT examinations. Beside the natural sciences, the next version will probably test behavioral and social sciences and may have a writing sample evaluation. The Committee is exploring ways to measure professional and personal characteristics of issues. The earliest a new MCAT exam may be released is 2014.

Ann Bonham, PhD, the AAMC’s Chief Scientific Officer, indicated previously that the AAMC has placed its emphasis on arguing for increased NIH basic-science funding. She explained that we need to focus on sustaining the research model with an emphasis on quality not growth. Also, that the NIH and others need to diversify their research portfolio to include community-based participatory research, public health research, health services research and implementation science.

The Health Care Reform and Academic Medicine were highlighted by Bruce Vladeck, PhD, the Senior Advisor to Ernst & Young Consulting Group. The economics of our current health care program are scary—it may be very difficult to bring new/additional money into the system. We are one of the few sections of the economy that has not been hard hit by the Recession. However, it is probably coming and it does not look like there will be much in the way of additional GME slot funding. The major cost reduction appears to be physician and hospital fees. It is very unclear how much tort reform would reduce costs. People talk about evidence-based health care and prevention, but we are a long way from implementing this. A significant cost saving would probably occur if we address end-of-life care. This has political, religious, legal and a mixed response from our medical community issues. The issue of the American public’s psyche and what they want/expect with respect to health care, especially if it is paid by others, has to be addressed in this debate.

There was a session in “Faculty Leadership Development” and it included an interesting session on the “Perspective of Faculty Leadership Role Transition”. The concept that one is the custodian of the position, not the owner was stressed, as well as the need to plan for the next phase, including timelines. One of the issues discussed was “the last career change”. Once one leaves, it can be easy to over commit, as one may have a need to feel important, feel need ed. How the institution/department treats the individual is important, especially since it may cost resources—e.g. space, support, money. This is often handled badly.

There was a session on “How to Counsel Medical Students” by David Lambert, MD, the Senior Associate Dean for Medical Students Education at the University of Rochester, School of Medicine. His session was entitled “Career Dreams and Painful Realities”. Much of what he said applies to residents.

The CAS has an initiative to highlight faculty innovations with respect to education, research and patient care activities. It has formed two new committees: Membership and Leadership Development.

It was an excellent meeting with many topics and speakers that I believe would be of interest to Academic Physiatrists. It was my honor and pleasure to represent you at this meeting.

Joel A. DeLisa, MD, MS
AAP-CAS Representative
AAP 2010 ANNUAL MEETING AWARDS
The Electrode Store Best Paper Award Winners

Medical Student: Alcinto S. Guirand, MD
Tuning Algorithms for Control Interfaces for Users with Upper Limb Impairments
Alcinto S. Guirand; Brad E. Dicianno, MD, MS; Harshal Mahajan, MS; Rory A. Cooper, PhD
Alcinto “Steve” Guirand is a second-year medical student at the University of Pittsburgh. He currently participates as a research assistant at the Human Engineering Research Laboratories under the mentorship of Dr. Brad Dicianno. Steve attended The Pennsylvania State University where he attained a BS in Science. His interests include Physical Medicine & Rehabilitation, Sports Medicine, and Pain Medicine.

Resident: Sheng Li, MD, PhD
Respiratory-motor Interaction and its Potential Application in Spasticity Management
Sheng Li, MD, PhD
Dr. Sheng Li is currently a PGY2 resident of the University of Texas/Baylor College of Medicine PM&R Alliance program. After graduating from Beijing Medical University in China, he further pursued research training and obtained a PhD degree in Kinesiology at The Pennsylvania State University. He also completed his research fellowship in Neuro-rehabilitation at the Rehabilitation Institute of Chicago/Northwestern University. He developed his research interests in respiratory motor interaction and its clinical applications, for which he received an NIH R01 award, during his employment as an assistant professor at the University of Montana.
Currently, Dr. Li is on a clinical investigator pathway for his PMR residency training. He is conducting his R01 project “the respiratory-motor coupling” during his residency in the Motor Recovery Laboratory which is affiliated with The Institute for Rehabilitation and Research (TIRR) Memorial Hermann.

Fellow: Leslie R. Morse, MD
Suppressed Osteoblast Proliferation and Accelerated Osteoblast Apoptosis Contribute to Uncoupled Bone Remodeling Following Spinal Cord Injury
Leslie R. Morse, DO; Yan Xu, MD; Ricardo A. Battaglino, PhD
Dr. Leslie R. Morse is a current phase-II fellow in the Rehabilitation Medicine Scientist Training Program. She is a graduate of the University of New England College of Osteopathic Medicine and completed her residency in PM&R at Boston Medical Center. She is currently an instructor in the department of PM&R at Harvard Medical School and her research is focused on understanding the impact of spinal cord injury on bone.
Her long term goal is to develop therapies to stop ongoing bone loss and decrease fracture rates in this population. She currently studies osteoporosis in humans with chronic spinal cord injury to gain a better understanding of the factors associated with osteoporosis severity, to define the nature history of SCI-induced osteoporosis, and to improve fracture risk assessment.
Dr. Morse recently received a 2-year grant from the National Institute of Health to study determinants of bone density in spinal cord injured veterans. Dr. Morse also uses a rodent model to study the impact of spinal cord injury on the bone microenvironment. She is interested in identifying the specific mechanisms that trigger osteoclast activity leading to bone resorption that occurs immediately following damage to the spinal cord. She believes that identification of the pathway leading to bone loss will lead to new therapeutic targets and expand treatment options for osteoporosis triggered by neurological injury.

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Faculty: Qing Mei Wang, MD, PhD

Efficacy of Combined Atorvastatin and Sildenafil in Promoting Motor Recovery after Ischemic Stroke in Mice

Qing Mei Wang, MD, PhD; Ying Wei; Longde Lin; Richard Goldstein; Kevin Wu; Michael A. Moskowitz; Christian Waeber

Dr. Qing Mei Wang obtained her PhD and MD from University of Medicine and Dentistry of New Jersey and completed her residency training in Physical Medicine and Rehabilitation Program at Mount Sinai Medical Center at New York. Dr. Wang is now a staff physiatrist at Spaulding Rehabilitation Hospital and also holds an academic appointment in the Department of Physical Medicine and Rehabilitation at Harvard Medical School. She is currently in Phase II of the Rehabilitation Medicine Scientist Training Program (RMSTP). Her research is focused on translational research in developing new treatments to promote functional recovery after stroke.

2010 Association of Academic Physiatrists Awards

Distinguished Academician Award: John Whyte, MD, PhD

John Whyte, MD, PhD, joined the AAP in 1989. Dr. Whyte served on both the Research Council and the CME committee. In 1991, he was selected as the Chair of the Research Council and served in that office until 1999. In the same year, Dr. Whyte was elected to the AAP Board of Trustees as a Member-at-Large where he served for four years. In 2003, Dr. Whyte was elected as President-Elect (2003–2005) and served as the AAP President from 2005–2007. More recently, Dr. Whyte served as the first chair of the Leadership Recognition and Development Committee from 2007–2009. Dr. Whyte served as the Principal Investigator of the Rehabilitation Medicine Scientist Training Program (RMSTP), an NIH-funded training program for physiatric researchers. During Dr. Whyte’s tenure as PI, the program experienced three 5-year cycles/funding for the program.

Dr. Whyte is the Professor of Rehabilitation Medicine at Thomas Jefferson University and Director of the Moss Rehabilitation Research Institute at the Albert Einstein Healthcare Network in Philadelphia. He is a physiatrist and experimental psychologist with an active research program focusing on cognitive impairment in traumatic brain injury and other neurologic diseases. His research is funded by the NIH, NIDRR, the Department of the Army, and several private foundations.

Dr. Whyte is principal investigator of the Northeast Cognitive Rehabilitation Research Network, an NIH-designated infrastructure resource for cognitive rehabilitation research. Dr. Whyte has served for 15 years on the IRBs of MossRehab Hospital and the Albert Einstein Healthcare Network, and has been active in the development of ethical and HIPAA-compliant methods of facilitating participant recruitment for cognitive rehabilitation research. He has taught and written about the special ethical problems associated with studying cognitively-impaired patients.

Young Academician Award: Neil Segal, MD

Neil Segal, MD, completed his medical training at Vanderbilt University Medical School and Physical Medicine and Rehabilitation Residency at Mayo Clinic. Participation in the Rehabilitation Medicine Scientist Training Program (RMSTP) provided the critical mentorship and support he needed to begin a research career. Dr. Segal currently serves on the faculty of the University of Iowa as an Associate Professor in the Departments of Orthopaedics and Rehabilitation, Radiology and Epidemiology. Following completion of clinical training, he earned a Master of Science in Clinical Investigation. His initial research focused on investigating the mechanism for knee osteoarthritis development in the context of obesity. However, additional support from the Foundation for PM&R, PASSOR and the Arthritis Foundation enabled investigation of the symptomatic and biomechanical effects of laterally wedged insoles for patients with medial compartment knee osteoarthritis.

With the guidance of his RMSTP mentor, Dr. James Torner, Dr. Segal became a co-investigator in the National Institutes of Aging Multicenter Osteoarthritis (MOST) Study. In this epidemiological study of risk factors for knee osteoarthritis development and progression, Dr. Segal assessed how lower limb strength affects risk for knee osteoarthritis. To investigate differences in lower limb forces and energy expenditure in higher and lower functioning MOST participants who developed knee osteoarthritis, Dr. Segal

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Awards

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received an American Geriatrics Society Dennis W. Jahnigen Scholars Award. The findings of this study suggested foci for directed gait training for older adults with symptomatic knee osteoarthritis with mobility limitations.

To test whether these observational findings would be efficacious in a randomized controlled trial, Dr. Segal received a K23 Paul B. Beeson Career Development Award. This research has focused on whether directed gait training can reduce impairments, mobility limitations, and knee-specific disability in comparison with usual care. The goal of this research is to inform prescription of effective and efficient rehabilitation and to identify which community-dwelling older adults with symptomatic knee osteoarthritis will be most likely to benefit.

Recently, Dr. Segal’s research program has expanded to identify specific biomechanical factors which predict who will develop painful knee osteoarthritis in the future. The long-term goal of his research program is to reduce risk for disablement due to knee osteoarthritis and other lower limb musculoskeletal problems. Dr. Segal’s clinical practice involves use of ultrasound and other imaging modalities to serve patients with musculoskeletal impairments.

Outstanding Service Award: Walter R. Frontera, MD, PhD

Walter R. Frontera, MD, PhD, is the Dean of the Faculty of Medicine and Professor of Physical Medicine and Rehabilitation (PM&R) and Physiology at the University of Puerto Rico (UPR). Dr. Frontera completed his medical studies and a residency in PM&R in 1983 at the University of Puerto Rico and a doctoral degree in applied anatomy and physiology at Boston University in 1986.

After completing his training, Dr. Frontera returned to the UPR School of Medicine and in 1993 he became Chief of the Department of PM&R. In 1995 he spent a sabbatical year at the Karolinska Hospital in Stockholm, Sweden, in the Department of Clinical Neurophysiology studying the effects of aging on the biochemical and contractile properties of single human muscle fibers.

In 1996 he was recruited to Harvard Medical School to establish the Department of PM&R and was appointed the Earle P. and Ida S. Charlton Professor and Chairman of the Department of PM&R at Harvard Medical School and Spaulding Rehabilitation Hospital. He was also the Chief of Service at the Massachusetts General Hospital and the Brigham and Women’s Hospital.

His main research interest is the study of the mechanisms underlying muscle atrophy and weakness in elderly. Based on his studies of human sarcopenia, Dr. Frontera has developed rehabilitative interventions using therapeutic exercise to slow down and/or reverse skeletal muscle alterations associated with advanced adult age. His research has also included the study of skeletal muscle dysfunction in patients with neuromuscular diseases and muscle function with exercise training in patients with HIV. Dr. Frontera’s research has been funded mainly by the National Institutes of Health. He has more than 200 scientific publications including 76 peer-reviewed articles and 11 edited books.

Currently, Dr. Frontera serves as the Editor-in-Chief of The American Journal of PM&R. He is a Regional Vice-President of the International Society for PM&R, charter member of the Kottke Society (an honorary society in rehabilitation medicine) and a fellow of the Association of Academic Physiatrists, the American Academy of PM&R, and the American College of Sports Medicine. He is also a member of the American Physiological Society and the American Association for the Advancement of Science. In 2008 he was elected member of the Institute of Medicine of the National Academies (Washington DC, USA) and in 2009 Member-at-large of the National Board of Medical Examiners. Dr. Frontera has presented more than 214 invited lectures in 52 countries and served as a grant reviewer and graduate research examiner for Universities in Canada, South Africa and Hong Kong. Active in international sports medicine, he is president of the International Federation of Sports Medicine (FIMS).

Dr. Frontera has received several awards including the Distinguished Academician Award in 2005 presented by the Association of Academic Physiatrists, Best Scientific Research Paper (3 times) presented by the American Academy of PM&R, and the Harvard Foundation Award for his contributions to the field of PM&R. He is an honorary member of the Aragonese-Spanish Society of Sports Medicine, The Spanish Federation of Sports Medicine, the Chilean Society of PM&R, The Dominican Society of PM&R, The Euskalerria Society of Rehabilitation, and the Italian Society of PM&R.

Distinguished Member Award: Barbara J. de Lateur, MD, MS

Barbara J. de Lateur, MD, MS, Distinguished Service Professor of Physical Medicine and Rehabilitation, Lawrence Cardinal

(Continued on page 11...)
Shehan Professor Emerita, Joint Professor of Health Policy and Management, School of Hygiene and Public Health, is a 1963 graduate of the University of Washington School of Medicine, where she also completed an MS degree. She obtained her PM&R residency training at the University of Washington Hospital. Before coming to Baltimore, Dr. de Lateur’s medical career was centered in Washington State, where she held positions at the Harborview Medical Center in Seattle and at the University of Washington School of Medicine. She was Chairman of the Dept. of Physical Medicine and Rehabilitation at Johns Hopkins from 1994 to 2004.

Dr. de Lateur has been directly and continuously involved in resident training since 1967. She continues to serve as a clinical and research mentor for residents, fellows and junior faculty within the PM&R department. She has more than 200 publications and is currently the co-investigator for the National Institute on Disability and Rehabilitation Research (NIDRR) Burn Model System Grant at Johns Hopkins Bayview Medical Center and principal investigator on the Augmented Exercise Program (AEP) Study for patients with major burns.

She holds a joint appointment in the Johns Hopkins Bloomberg School of Public Health’ s Department of Health Policy and Management. Dr. de Lateur is the third physiatrist elected to the Institute of Medicine of the National Academies. In 1998, she received the Distinguished Academician Award from the Association of Academic Physiatrists.

Dr. de Lateur’s clinical and research interests include exercise studies in the prevention and treatment of frailty and obesity, as well as biomechanics of gait and muscle tone in stroke, transverse myelitis, normal pressure hydrocephalus and other conditions. She directs the Department of Physical Medicine and Rehabilitation’s Biomechanics Research Laboratory which provides assessment tools to researchers in the fields of Neurology, Neurosurgery and Internal Medicine (exercise physiology).

Dr. de Lateur taught applied musculoskeletal anatomy and other topics to medical students, residents and fellows in Tanzania, East Africa, 2004–2007, and continues to do so at Johns Hopkins University School of Medicine. She presented annually to the Italian Society of Neuropathophysiology and Rehabilitation in Italy, 2002–2006.

From an interview by Leslie Harrington, MD, Dr. de Lateur states, “I do want to help people, but the box boy in the grocery store is also helping people. In an ideal society, everybody’s job is important and everyone makes a contribution if they do their job in a cheerful way... For me, relevant research and teaching provide real impact, because that’s the future... If I train one doctor, then I’ve improved the lives of thousands of patients.”

Dr. de Lateur’s choice to become a PM&R doctor has profited the field of medicine immensely.

**American Journal of Physical Medicine & Rehabilitation Awards**

Dr. Whyte is a physiatrist and experimental psychologist specializing in traumatic brain injury rehabilitation. He directs the Moss Rehabilitation Research Institute and is Principal Investigator of the NIH-funded Neuro-Cognitive Rehabilitation Research Network. His research focuses on recovery from prolonged unconsciousness and attention and executive deficits that result from TBI. In both areas, he has studied the role that drug treatments can play in recovery of function. He has a longstanding interest in the special methodological challenges presented by rehabilitation research topics, including the definition of rehabilitation treatments and the measurement of treatment effects. His research has been funded by the National Institutes of Health, the National Institute on Disability and Rehabilitation Research, the Department of the Army, and a number of private foundations.

He is the past president of the Association of Academic Physiatrists, former chair of the National Center for Medical Rehabilitation Research’s Advisory Board, and past Principal Investigator and Program Director (now Associate Program Director) of the Rehabilitation Medicine Scientist Training Program, a NIH-funded program to train physiatric researchers. He is the 2002 winner of the William Fields Caveness Award, from the Brain Injury Association of America, and a committee member for the Institute of Medicine’s 2007 update on Disability in America. He was also the ACRM’s 2007 Coulter Lecturer, and 2008 recipient of the Robert L. Moody Prize for Distinguished Initiatives in Brain Injury Research and Rehabilitation.
AAP ANNUAL MEETING HIGHLIGHTS

Left: Dr. Kristjan T. Ragnarsson gives the Presidential Address

Below: AAP Award Winners receive a standing ovation

Residency and Fellowship Program Director’s Workshop with Timothy Brigham
Dr. Daryl Kaelin presents Dr. Pradeep Suri with Outstanding Poster Presenter Award

Poster Grand Rounds with Dr. Shu Q. Huang

Dr. Joel DeLisa and 2010 DeLisa Lecturer Dr. Darrell Kirch pose for a picture

Left: Dr. Eric Wisotzky, Residents/Fellows Chair, performs an ultrasound

Below: Program Coordinators gather for a group photo
Meet ‘n’ Greet at the Fellowship Fair

Dr. Boninger poses with his residents from the University of Pittsburgh Medicine and Rehabilitation (from left to right: Justin Hong, MD, Geera Sathe, MD, Heather Pauli, DO, Amanda Harrington, MD, Michael Boninger, MD, President-Elect, Cara Camiolo Reddy, MD, kneeling: Gary Chimes, MD, PhD)

Above: Fellow programs welcome and inform conference attendees

Right: Coordinators’ Council Officers discuss daily activities
Residents/Fellows Dinner

Breakfast in the courtyard provides opportunities for networking.

Residents/Fellows Reception

Below: Friendly competition during the Residents/Fellows Dinner
Writing goals and objectives is at the center of a competency-based educational program. The Program Specific requirements for Physical Medicine and Rehabilitation require overall objectives for the program which must be distributed to residents and faculty annually. In addition, competency-based goals and objectives for each assignment at each educational level must be distributed to residents and faculty annually, in either written or electronic form. These should be reviewed by the resident at the start of each rotation.

An educational goal states the broad target of an educational effort. Goals are typically not measurable, but offer a general focus for an activity or set of experiences. In contrast, an educational objective is a measurable target to be achieved by an educational activity or intervention. An objective is considered measurable when it describes a tangible outcome.

An Instructional objective is related to intended outcomes, rather than the process for achieving those outcomes. They are useful for providing a sound basis for selection of instructional materials and procedures. Sound objectives have three characteristics:

1) Performance—state what a learner is expected to be able to do and/or produce to be considered competent.
2) Conditions—describe the important conditions under which performance is to occur.
3) Criterion—describe the criteria of acceptable performance.

To prepare a useful objective, continue to modify a draft until these questions are answered:

• What do I want the students to be able to do?
• What are the important conditions or constraints under which I want them to perform?
• How well must students perform for me to be satisfied?

The best news… A comprehensive list of objectives for PM&R rotations is available online at www.physiatry.org

References:
ACGME Phase 3 Program Director Workbook
Preparing Instructional Objectives: A Critical Tool in the Development of Effective Instruction (1997), Mager

COMPETENCY BASED EDUCATION by Jennifer Peel PhD, UTHSCSA GME Presentation

RFC REPORT ON THE 2010 ANNUAL MEETING
By Eric Wisotzky, MD and James F. Wyss, MD, PT

The Association of Academic Physiatrists’ 2010 Annual Meeting, held in Bonita Springs, Florida this past April, was a large success due to the strong attendance of fellows, residents, and medical students. The attendance at the Resident Workshop, headed by Drs. Gary Chimes and Christopher Visco, was excellent and the feedback received was that it was a very valuable hands-on experience. The Fellowship/Job Fair was well attended and presented great opportunities for networking and learning about available jobs and fellowships.

The Residents/Fellows night program was highlighted by our speaker, Dr. Walter Frontera, who delivered an inspiring lecture about international physiatry. Afterwards, approximately two hundred people attended the Residents/Fellows Dinner, which was highlighted by dancing and volleyball. Later in the week, the Fellowship Panel gave an opportunity for residents to ask questions to a variety of current and soon-to-be fellows. The Medical Student Interest Session, allowed for an informal question-and-answer session between residents, attendings, and medical students from various programs around the country and Canada.

The Residents/Fellows Council’s (RFC) goals for the year, are to promote the new McLean Outstanding Resident/Fellow Award and to expand our list of PM&R student interest groups at medical schools across the country. We will continue to try to improve the quality of the programs at the Annual Meeting by remaining actively involved in the preparation of these events. The Resident Workshop at the 2011 conference in Arizona will be even better than this year’s, according Drs. Visco and Chimes. We also hope to recruit many medical students from the surrounding medical schools to the 2011 conference.

Please visit the resident section of the AAP Website (www.physiatry.org/Education_Residents.cfm) throughout the year for more details. If you have any questions, suggestions for RFC programs/initiatives, comments, or are interested in participating within the AAP, please contact Eric Wisotzky, RFC Chair, at erw9023@nyp.org

AAP COMMITTEES AND COUNCILS

PROGRAM DIRECTORS’ CORNER
Writing Educational Goals and Objectives
By Tracy R. Johnson, MD

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COORDINATORS’ CORNER

Residency Followup

The 2009–2010 recruitment season is almost behind us. We survived our last interview day and certified our rank lists. However, as we expectantly await Match Day, it is not too early for us to begin preparations for the next interview season, arrange a smooth send-off for our graduating residents and a grand welcome for our new residents.

Residency Recruitment

With only five months before ERAS opens on September 1, start your planning and organizing now for the 2010-2011 recruitment season.

As it is with all important projects, we should take time to reflect and to identify what worked well and what areas could benefit from a little tweaking.

The following are a few tools that can aid the review process:

- Feedback from interviewers
- Feedback from residents who were involved with interviews, e.g., residents who acted as tour guides, hosts at dinner, or participated in breakfast or lunch
- Review of interview evaluation forms
- Directions provided to interviewees—If more than two or three interviewees were late for interviews because they had difficulty finding you, despite the fact that you provided them with detailed directions, what can you do to eliminate this problem in the future?
- The number and pattern of canceled interviews—If several people did not attend their interviews because they could not leave home or were stranded at airports because of bad weather, you might consider starting and ending your 2010–2011 interviews earlier, say October–December, in order to avoid the very cold months of January and February.

A comprehensive list of interview season tips and interviewee preferences is available in the Coordinators’ Corner on page 10 of the Fall 2008 issue of AAP Newsletter, which is archive on the AAP Website.

Planning for Incoming Transfer Residents

ACGME requires that residency programs obtain written or electronic verification of previous educational experiences and a summative competency-based performance evaluation of the transferring resident.

Transfer Residents include:

- Residents entering a PGY-2 program after completion of a PGY-1 year
- Residents transferring into your program from another PM&R program or another specialty

Request the following from the current program director for all residents transferring into your program:

- A letter of good standing and date of expected completion
- Written or electronic verification of previous educational experiences
- Summative competency-based performance evaluation (Sample competency-based evaluation form can be found on the ACGME Web site).

Orientation TIPS

Incoming residents need to arrange for their departure and to make their travel plans early, therefore do not wait until you receive orientation dates from each institution but let them know the date of their earliest orientation soon the information is available.

E-mail the full orientation schedules to the residents no later than one week before they are scheduled to arrive. Also provide the orientation schedules to the chief-of-service of all rotations as early as possible; it might be necessary for them to change the dates and times of their service orientations.

New residents are often overwhelmed by the enormous amount of information they receive during the first few weeks of residency—medical school orientations, hospital institutional orientations, service orientations, various schedules including vacation, call, rotation, and didactic, policies and procedures, etc. Ways to help new residents become acclimatized to their new environments include:

- Arranging, in addition to the main orientation, several mini orientations during the months of July and August
- Big Brother/Big Sister program whereby each new resident is adopted by an upper level resident for the first few months of residency
- Getting-to-know-you party or other social event to which all residents and faculty are invited
- Welcome newsletter to introduce and welcome the new residents—This newsletter may include each new resident’s photograph, medical school, first year program, hometown, hobbies and other special interests. The newsletter may be e-mailed to the new residents, faculty, current residents and staff

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Coordinators’ Corner
Continued from page 17

before the arrival of the new residents.

Additional orientation tips are available in the Coordinators’ Corner on page 15 of the Summer 2009 AAP Newsletter, which is archived on the AAP Web site.

Graduating Residents Credentials Verification

It is not an exaggeration to state that requests for verifications have quadrupled over the past few years as physicians seek privileges at more and more institutions.

Physicians may maintain a professional portfolio with the Federation Credentials Verification Service (FCVS). The portfolio includes verified medical education, postgraduate training, examination history, board action history, board certification and identity.

At a physician’s request FCVS may provide this information to state medical boards, professional societies, hospitals, and other health care organizations.

This central data bank provides a valuable service which benefits not only physicians (past graduates of our programs) and the organizations or institutions who need credentials and training verification, but also the residency and fellowship program directors and coordinators who are called upon to provide the information.

However, it appears that this service is either unknown or is underused by many physicians, institutions, and residency and fellowship programs. How do we rectify this problem? Solutions that come to mind include:

• Place information in several issues of the Coordinators’ Corner.
• Inform graduating residents of the service before or during their exit meeting with their coordinators.
• Include the information of each program’s Web site.
• Inform past residents of the service when they request verification of training.

Send notices to past graduates.

If you have any questions regarding the AAP Coordinators’ Council, please feel free to contact any of the officers:

Chair: Terri Isbell at terri.isbell@utsouthwestern.edu
Chair Elect: Randa Karim at rkarim@metrohealth.org
Program Director/Secretary: Kimberley Garza at GarzaK@uthscsa.edu
Immediate Past Chair: Miki DeJean at miki_dejean@emory.org
Newsletter Editors: Daisy McKenzie at mckenzie@bcm.tmc.edu
Tammie Wiley-Rice at twileyr@med.umich.edu
Laura Manore at Laura.Manore@med.va.gov

The Coordinators Council & Your officers —
Terri, Randa, and Miki

President’s Letter
Continued from page 2

conditions without risky invasive procedures. Fluoroscopically guided, interventional spine injections for neck and back pain may not be superior to a program of comprehensive rehabilitation based on thorough evaluation and clear understanding for the patients’ physical and psychological condition. Various special PM&R treatments may be referred to as palliative, since they do not cure the condition, but perhaps more aptly they should be called compensatory as they aim to increase function, active participation and quality of life.

Third-party payments for clinical services are important for most specialties and subspecialties in order for them to thrive. The only readily apparent

MARK YOUR CALENDARS!

May 6, 7, or 8, 2010
AAM&R SAE Examination
AANEM SAE Examination

May 31, 2010
ERAS Post Office will close to prepare for the 2011 season. ERAS training schedule will be available in May, 2010. Check the ERAS Web site for the schedule.

July 1, 2010
Deadline for submitting July 2010 Resident Evaluations to the ABPM&R.

Note that residents whose evaluations are not received by the Board within deadline will not be able to take the August 2010 Part I Board Examination.

September 1, 2010
Residency programs may begin contacting the ERAS Post Office to download application files.

November 4–7, 2010
AAPM&R Washington State Convention & Trade Center Seattle, Washington

April 12–16, 2011
2011 AAP Annual Meeting Sheraton Wild Horse Pass Phoenix, Arizona

(Continued on page 19...)
AAP MEMBER HIGHLIGHTS

NEW AAP MEMBERS
The AAP Welcomes 77 New Members as of December 1, 2009!

Bamidele Adeyemo, MD
Syed Ahmed, DO
Adil Ali, MD
Sireesha Allamneni, DO
Stanley Allen, MD
Gina Armstrong, MD
Vanitha Asokan, MD
Allyson Augusta, MD
Maria Boiano, DO
Jose Campos, MD
Ning Cao, MD
Sarah Cederholm, MD
Edmund Chadd, MD
David Chu, MD
Robin Cohen, MD, MPH
Mariela Del Valle-Cruz, MD
Michael Derr, DO
Aisha Dharamsi, MD
Katherine Doerr, MD
Stephan Esser MD
Regina Eum, MD
Amanda Farag, MD
Sherin Fetouh, MD
Casey Fisher, MD
Jason Fogg, DO
Steven Fowler, MD
Jason Friedrich, MD
Molly Fuentes, MD
Heidi Fusco, MD
J.T. Gertken, MD
Penny Giovanetti, DO, MSPH
Jinghua He, MD
Garett Helber, DO
Grace Huang, MD
Nneka Ifejika-Jones, MD, MPH
Iqbal Jafri, MD
Stacy Kessler, MD
Mohammed Khan, MD
Phong Kieu, MD
David Lacey, MD
Bob Lee, MD
Jeremy Lee, MD
Bethany Lipa, MD
Meagan Littlepage, MD
David Majors, MD
Jimmy Mali, MD
Mohammed Mawla, DO
Bradley McCrady, DO
Paola Mendoza, MD
Ladelle Morse, MD
Jeffery Muir, MD
Nathan Neufeld, DO
Poonam Ochani, MD
Jared Olson, MD
Oluseun Olufade, MD
Nannette Pares, MD
Heather Pauli, DO
Matthew Pauli, DO
Ana Pizarro, MD
Jason Pothast, MD
Melissa Rusli, DO
Josh Scheidler
Kevin Schmidt, MD, MBA
Hyon Schneider, MD
C. Miryam Schussler-Fiorenza, MD, PhD
Kelly Scollon-Grieve, MD
Jacob Sellon, MD
Alexander Sheng, MD
Seema Sikka, MD
Kristin Stoner, MD
Nicole Stroud, MD
Andrea Terry, DO
Joy Tsai, MD
Teena Varghese, MD
Michelle Weiner, DO, MPH
Simge Yonter, MD
Ling Zhang, MD

President’s Letter
Continued from page 18

exceptions are specialties that focus on cosmetic procedures and can demand cash payments. These are rarely options for physiatrists. High reimbursement for simple procedures compared to relatively low payments for evaluation and management of patients attracts many physicians to better-paying procedure-oriented subspecialties. However, there is some inherent risk in exclusively planning a career in such procedure-oriented practices, since reimbursement policies may change without much notice. All specialties and subspecialties may suffer setbacks when a simple curative treatment or a better diagnostic method becomes readily available and turns out to be relatively easy to administer or order. During my years in practice, I have witnessed gastroenterology being threatened by H2 blockers to prevent and treat peptic ulcer, urology by drugs that shrink benign hypertrophy to the prostate, cardiac surgery by development of endovascular procedures done by cardiologists, neurology by introduction of MR and CT imaging interpreted by radiologists, etc. In the absence of cures for most types of physical disability and painful conditions, PM&R and its subspecialties do not appear to be currently threatened by such developments. It may seem amusing to some that physiatrists have been unjustly accused of being against finding a cure for chronic conditions, such as spinal cord injury, fearing that a cure may put them out of business. A complete cure is highly unlikely for any condition, but a partial cure is more likely to increase demand for any services. In the final analysis, when choosing a specialty and subspecialty, it must be the overall attractiveness and challenges presented in each field that will draw physicians. Financial rewards and comfortable lifestyle may be of great significance to some, but for most, these cannot replace the satisfaction of helping patients in need and receiving their gratitude and respect in return.

Kristjan T. Ragnarsson, MD
President
American Physiatric Education Council
Request for Research Proposals on Quality Improvement in the Inpatient Rehabilitation Setting

The American Physiatric Education Council (APEC) is offering up to $10,000 for a study focused on quality improvement, prevention of medical errors, and/or prevention of hospital acquired conditions, within an inpatient rehabilitation setting.

Eligibility: Members of the Association of Academic Physiatrists and non-members may apply for this research grant.

Proposal Content: The proposed research should be on a topic relevant to improving the quality of care provided in inpatient rehabilitation hospitals or units. The project may rely on newly acquired data or secondary analysis of existing data. The proposal must include the following sections: Objective (literature-based rationale for the study), Design (description of study, subjects, methods, timeline and data analysis), a summary of the Expected Results or Conclusions, Investigator biography, and a detailed budget. The budget requested from APEC must not exceed $10,000. Additional required funding can be provided by the applicant, if needed, from alternate sources to supplement the APEC award. Proposed studies must be completed within two years.

Application Process: To respond to this APEC RFP on Quality Improvement in the Inpatient Rehabilitation setting, submit a letter expressing an intent to respond to the RFP and a brief abstract of the proposed study to Lpencak@physiatry.org by June 30, 2010. Selected applicants will be invited to submit a complete proposal, limited to 1,000 words. Bulleted or outlined formats of presentation are acceptable as long as they are clear and address the above content. Electronic submission of the invited applications should be addressed to Lpencak@physiatry.org, and must be received by September 30, 2010.

Review Process: APEC will review proposals submitted for funding. APEC reserves the right to not make any awards if no proposal is deemed sufficiently meritorious.

Dissemination: Successfully completed projects should be submitted for publication consideration to the American Journal of PM&R.

Questions may be addressed to Lawrence Pencak at Lpencak@physiatry.org

No FAX applications will be considered.
AAP Excellence in Research Writing Award

Sheila Jean McNeill Ingham, MD, is winner of the Ernest W. Johnson Excellence in Research Writing Award for the best paper published in the *American Journal of Physical Medicine & Rehabilitation* in 2009 on which the first author was in training when the paper was written. Her research article “Transient Myocardial Ischemia in Patients with Vascular Lower Limb Amputation” was published in the February 2009 issue. Co-authors on the article were Therezinha Rosane Chamlian, MD, PhD; José Marconi de Souza, MD, PhD; Edson Stefanini, MD, PhD; Rudyney Azevedo, MD; Aurélia Mussi, MD; and Antonio Carlos Carvalho, MD, PhD.

Dr. Ingham completed medical school and residency training in Physical Medicine and Rehabilitation at the Federal University of São Paulo, Brazil. Afterward she completed additional specialized study in Acupuncture and Sports Medicine. Dr. Ingham completed a research fellowship from 2007–2009 at the University of Pittsburgh Department of Orthopaedic Surgery and the Department of Physical Medicine and Rehabilitation. While at the University of Pittsburgh, she completed a Master’s Degree in Clinical Research with Michael L. Boninger, MD, as her mentor. She returned to Brazil in December 2009 and is now pursuing a PhD degree at the Federal University of São Paulo, Brazil.

The *American Journal of Physical Medicine & Rehabilitation* (AJPMR) is the official scholarly journal of the Association of Academic Physiatrists (AAP). The AJPMR is also an official journal of the Asociación Médica Latinoamericana de Rehabilitación (AMLAR). The AAP Excellence in Research Writing Awards are sponsored by Lippincott Williams & Wilkins | Wolters Kluwer Health, the publisher of the *American Journal of Physical Medicine & Rehabilitation*. The purpose of the award is to encourage submission of high quality research. For more information concerning manuscript submission visit [www.AJPMR.com](http://www.AJPMR.com).
Pediatric Physiatrist

The Eastern Virginia Medical School Department of Physical Medicine and Rehabilitation seeks a double boarded or fellowship-trained pediatric physiatrist for faculty position. The selected applicant will join two pediatric physiatrists in practice at the Children’s Hospital of the Kings Daughters, a full-service, free-standing pediatric hospital with 180 beds and an 8-bed, inpatient, acute rehabilitation unit. Practice includes a busy outpatient practice and participation in multiple subspecialty clinics. Pediatric physiatrists manage a Baclofen Pump Program and Selective Dorsal Rhizotomy Program among other activities.

Eastern Virginia Medical School is the only school of medicine founded by a grassroots effort of the local community. Since the first class matriculated in 1973, the school has graduated more than 2300 physicians, including numerous academic physicians, researchers and practicing clinicians as well as an astronaut. The school’s faculty members have received national teaching awards including the Humanism in Medicine award from the AAMC in 2005. The Theresa A. Thomas Clinical Skills Teaching and Assessment Center at EVMS is one of the first and largest of its type and serves as a regional resource for graduate and undergraduate medical students. EVMS students have twice won the AAMC Nickens Award for community service.

EVMS is the largest biomedical research institution in southeastern Virginia and is currently building an $80 million expansion, including a new building, to provide additional instructional space and an area dedicated to translational research. Medical research at EVMS resulted in the first baby born in the United States by in-vitro fertilization. Prostate cancer detection and diabetes management are areas of special expertise and research endeavor at EVMS. The Department of PM&R currently partners with nearby Old Dominion University in research on stroke rehabilitation using virtual reality systems, in addition to other projects.

Norfolk, Virginia, is one of seven sister cities in the Tidewater area of Virginia, often referred to as Hampton Roads, with a population base of 1.5 million. Situated on the Chesapeake Bay, Norfolk is 15 minutes from the ocean front of Virginia Beach. Norfolk boasts a fine symphony orchestra, an outstanding opera company, a world class museum, and multiple venues for performing arts. Sports events include the Tidewater Tides baseball team, multiple college-level athletic activities, an abundance of water sport opportunities from kayaking to windsurfing, and a regional sports complex for youth and adults in Virginia Beach. In addition to cultural and sports activities, the area’s rich history provides wonderful opportunities for study and exploration. An excellent public school system, including public universities, round out the cultural advantages of the area.

Competitive salary and faculty rank commensurate with experience. EVMS is an Affirmative Action/Equal Opportunity Employer and is a Drug & Tobacco Free Workplace. Women and minorities are encouraged to apply.

Interested parties should send curriculum vitae and three letters of reference to Jean E. Shelton, MD at Eastern Virginia Medical School, Department of PM&R, 721 Fairfax Ave, Norfolk, Virginia 23507 or contact her at (757) 446-8496 (office)/(757) 446-5969 (fax), E-mail address: sheltonje@evms.edu.
The Foundation for Physical Medicine and Rehabilitation Seeks Nominations for Board of Directors

Candidates may be physicians or non-physicians who are interested in advancing the field of physiatry and medical rehabilitation through philanthropic giving. Elections will be held in June. The three-year term of office for new Directors will commence on October 1, 2010.

Submit nominations via e-mail: panderson@foundationforpmr.org or by mail: FPM&R, 9700 W. Bryn Mawr Ave, Suite 200, Rosemont, IL 60018

Questions?
Foundation Executive Director, Phyllis Anderson panderson@foundationforpmr.org
(847) 737-6062
Committee Chair, Bruce M. Gans, MD bgans@kessler-rehab.com

Find Us On Facebook

Join the 250+ individuals already on the AAP Facebook Page and begin networking with colleagues across the world.

• Follow the Facebook link on www.physiatry.org
• Watch for updated content and discussion groups
1—Newsletter
The AAP Newsletter is a quarterly publication that has grown to an average of 24 pages per issue with a circulation of approximately 1,300. It is received in nearly every PM&R Department and Residency Training Program and offers a low-cost opportunity to have your name, service, or product seen by PM&R educators, clinicians, and residents.

Publication Deadline to Send Copy:
- Fall Newsletter - September 1
- Winter Newsletter - December 1
- Spring Newsletter - March 1
- Summer Newsletter - June 1

Ad Specifications:
- Full page is 7” x 10” black and white copy, no bleed. Divide appropriately for smaller sizes, with 1/4” margin on all sides.
- Send copy camera-ready, as a digital file in EPS or TIFF format, or typed copy with instructions for typesetting (no additional charge for this service).
- The AAP reserves the right to decline advertising that in its opinion is not in keeping with the policies of the Association.

Ad Rates:
- Full page (7”x 10”): $275.00
- 1/2 page (7”x 5”): $250.00
- 1/4 page (3”x 5”): $175.00

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2—Web Ads
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3—American Journal of Physical Medicine & Rehabilitation
The American Journal of PM&R, published every month, is another excellent opportunity for your company or institution to advertise your position openings. For physician recruitment and classified advertising, contact:
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  American Journal of Physical Medicine & Rehabilitation
  Lippincott Williams & Wilkins
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  Baltimore, MD 21201-2436
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