

Knowing Your Audience: The Challenge of Teaching Physiatry

Fred Bagares, DO (PGY3–Rehabilitation Institute of Chicago; RPC President)



I was recently asked to give an “Introduction to Physical Medicine and Rehabilitation” lecture at a local medical school here in Chicago. I jumped at the opportunity to lecture and educate first- and second-year medical students about the wonderful field of physiatry. I remember giving the exact same talk to my medical school’s PM&R interest group as a fourth-year medical student. I thought to myself that this would be an easy lecture to give since I already had a PowerPoint presentation to update; but this ended up being a much bigger endeavor.

In my original lecture, I went through a case of a young male who underwent a traumatic spinal cord injury starting from the acute care setting. I proceeded to describe the physical exam findings, diagnostic imaging, medical issues related to the injury, complications, and pharmacotherapy. As I flipped through my slides, I started to wonder if the lecture was way too technical for pre-clinical medical students to understand.

Teaching medical students about rehabilitation medicine can be very

tricky. In order to “rehabilitate” or “restore,” one must understand how the body functions when it is free of disease. Thus, it can be very difficult to teach rehabilitative medicine when the students are still learning basic anatomy, physiology, pharmacology, etc. How do you explain the purpose of performing an ASIA exam to the first-year student that has not even had a physical exam class yet? Will the second-year student who is still learning pharmacology understand how baclofen works in relation to spasticity? How do we make students understand what it is we do?

A 1995 study of graduating PM&R residents showed that 60.1% made the decision to go into physiatry in their third and fourth years of medical school. Of these residents, 69.2% were exposed to PM&R in their first year of medical school. This study shows that there is an association between early medical student exposure and career specialty choice. On the other hand, many medical schools do not offer PM&R rotations until fourth year which is often very late for the average medical student. Given that this seems to be such a critical period for medical students, we as a specialty should start thinking if we are effectively teaching medical

students about our field. Residents have a unique perspective since we are closer to medical school compared to our attendings. We still have the ability to “think like a medical student” and hopefully teach them in ways that they will understand, given their variable knowledge base.

After numerous hours of revising my lecture, I finally had my presentation ready. I took out any slide that had too much technical detail for the pre-clinical student to understand. I started off the lecture with my “elevator one liner” definition on physiatry and then moved on to what I thought a medical student wants to know. I focused on what diagnoses we see, residency structure and application process, fellowship opportunities, and the almighty “how much can I make” question! Most importantly, I ended with the caveat that “you still may not know what physiatry is by the end of this lecture.” I reassured them that this was okay since what we do is hard to define. I encouraged them to think about this lecture as they transition into their clinical rotations. The Q&A session was very lively and I think it went very well overall!

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Knowing Your Audience: The Challenge of Teaching Physiatry

Fred Bagares, D.O. (PGY3–Rehabilitation Institute of Chicago) *continued*

Putting this presentation together was an excellent self-reflective exercise. It forced me to take complicated concepts and translate them to a level that would hopefully captivate and educate medical students. More importantly, it gave me an opportunity to stop and define what it is I do on a daily basis, which has made me a better teacher. We spend four years learning how to diagnosis and manage acute medical illness. There is very little (if any) emphasis about rehabilitative medicine in the under-

graduate curriculum. It is no wonder that the public and our colleagues do not understand what physiatry is. I challenge all of you to help “bridge the gap” between acute care and rehabilitative medicine by teaching medical students and helping them appreciate the art of physiatry.

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“Putting this presentation together was an excellent self-reflective exercise.”

Hooray for the VA

Monique N. Diaz, MD (PGY3–Loyola University)



“How VA heavy is this residency program?” That is the question that makes my heart sink

when giving tours to applicants. It is not asked with excitement about the prospect of working with veterans, rather it is spoken with hesitation and at times annoyance. As the crowd of medical students stands before me, looking more like lawyers in their fitted dark suits, I prepare to give my spiel hoping that it will open hearts and minds.

I tell them that a Veterans Affairs (VA) hospital is an ideal place to train in PM&R. In addition to learning the bread and butter aspects of rehabilitation we are continually challenged by cases unique to those who have been in combat. Prosthetic fitting, for example, might require additional modifications if the vet-

eran has bone malformations due to shrapnel injury. Axonal demise from chemical agents used during wartime may reveal itself during a routine EMG. Traumatic brain injuries can also be quite complex in origin, which then develop into varied clinical presentations. The list of experiences specific to working with this patient population goes on and on and enriches our education.

Beyond pathology, of course, is the special spirit imbued by the VA. Have you spent time with a World War II vet? If not, you’re missing out on one of the most inspiring and humbling opportunities of our time. I have seen how these and other aged soldiers continue to rally the troops on the rehab floor by offering words of encouragement to the “young fellas.” Moreover, a marine from any conflict will remind everyone to never retreat from the demands of physical therapy. As you have these

and other unique experiences, you begin to feel like an insider. You’ll know when to say “Hoo-ah” versus “Doh-Rah.” If you’re fortunate, the dogfaces, squids, and jarheads will share their funniest moments and their deepest sorrows with you too.

I won’t deny that, as a female physician, treating this mostly male population requires some adjustments (while keeping in mind the number of women continues to rise among veterans). For example, I had one elderly patient who insisted on calling me Doctor Baby-Girl and I confess to letting him do so. But for every moment like that there are far more times when I’ve seen the “banding of brothers” display the best manhood has to offer. My favorite memory of this is when a new traumatic brain injury patient (TBI) was assigned to a room shared by three other patients.

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“It’s important not to forget the difference PM&R can make in the lives of veterans.”

Hooray for the VA

Monique N. Diaz, MD (PGY3–Loyola University) *continued*

When it was time for bed, the TBI patient attempted to climb over the rails only to be held back by his neighbor while the others called for help. One of them yelled “we put our buddy back in bed because he still needs assistance [with transfers], right?”

It’s important not to forget the difference PM&R can make in the lives of veterans. By treating the whole person, not only do we

restore function in these patients, we also rebuild hope where it was once shattered. I can vividly recall the day we brought a Vietnam veteran stroke survivor into our conference and outlined the services we would be providing for him during and after his stay. He immediately began to suggest that he didn’t merit such attention, but our committed social worker looked him square in the eye and said “it’s the least we can do for

your service.” As the tears flowed down his cheeks the veteran said that he had never been cared for so well.

So yes, our program is “VA heavy” in the first year of residency— and what a year it is! I join my fellow residents in saying we are proud to work in this capacity and hope others will see training in the Veterans’ system for the unique opportunity that it is.

“As the tears flowed down his cheeks the veteran said that he had never been cared for so well.”

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Captured from original sessions at the 70th Annual Assembly in Austin, Texas in October 2009 these activities address:

- Developing an attractive and effective curriculum vitae that will lead to invitations for job interviews
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Visit the [Resident section](#) on [acadeME](#)[®] to find these podcasts and more activities tailored specifically for residents. Check back often for additional offerings.

Annual Assembly Registration Opens Soon

If PM&R residents attend only one national meeting this year it should be the AAPM&R 2010 Annual Assembly, November 4–7, in Seattle, WA. With close to 500 residents attending each year, the AAPM&R Annual Assembly is the largest annual gathering of PM&R residents.

The Assembly mixes the clinical with the practical, with expanded sessions on interviewing, negotiating

contracts, MSK ultrasound, and MRI. The popular Job Fair and town hall meetings will be repeated this year, with an opportunity to network with your peers at the Residents’ Reception.

Notify your residency coordinators and program directors that registration opens March 31, 2010, at www.aapmr.org.

This year, resident members of AAPM&R pay only \$200 when registered by the September early bird deadline. Non-members pay \$275 during early registration. This fee covers four days of educational sessions, business meetings, scientific presentations, resident-only networking events, and the Job Fair. Register soon, as ticketed resident workshop attendance is limited, due to hands-on participation.

