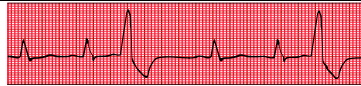


# ALUMNI PULSE



Department of Physical Medicine and Rehabilitation  
New Jersey Medical School

**December 2010**



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Dept. of PM&R

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## Chair's Corner

Greetings and welcome to our alumni newsletter. I want to wish each of you a safe and happy holiday season and a healthy, peaceful and prosperous New Year. **HELP!!**

The 2010 year has been very challenging for our Department. We have had tremendous growth within the NJ Veterans Administration System (page 7) including the start of a significant remodeling of the East Orange 13<sup>th</sup> floor. Children's Specialized Hospital is one of the programs many gems. We have applied for ACGME accreditation and expect to receive for our Pediatric Rehabilitation Medicine subspecialty program.

The Select/Medical Rehabilitation Institute was once again ranked #2 by U.S. News & World Report. It continues to be our site to teach comprehensive inpatient rehabilitation.

The problem area is New Jersey Medical School and University Hospital. Both are under a severe financial crisis that markedly affects each department. After this fiscal year started (July 1), University Hospital cut its payments to the Department by 19.5% (\$131,000) and over the next three years they are proposing a 58% cut. They have made and are proposing similar cuts in all departments. This is an incredible obstacle. We currently only have 5 physiatrists (including myself). If I have to cut this meager staff any further, I am not sure of the Department's viability. We have little flexibility with respect to providing basic needs with our training programs. In turn, this may make us less competitive in further Matches.

**I am asking you for any charitable donations you can make.** Historically, this request has not been very successful. For the sake of the Department, we need your help. Please make your checks payable to: NJMS, Department of PM&R.

I have completed my term as President of the International Society of Physical and Rehabilitative Medicine (ISPRM). I encourage each of you to go to their website ([www.ISPRM.org](http://www.ISPRM.org)) and consider becoming members. This price is 35 euros for one year and 65 euros for two. This gives you immediate on-line access to their journal, Journal of Rehabilitation Medicine. ISPRM is the official professional organization linked to the World Health Organization, and all the issues that deal with individuals with disabilities.

The 5<sup>th</sup> edition of my textbook, DeLisa's Physical Medicine and Rehabilitation, was released November 15, 2010. I am the emeritus editor and Walter Frontera, MD, PhD, is the editor-in-chief. It is 2,432 pages and the cost is \$249.00. All royalties are used to fund academic programs in association with the Association of Academic Physiatrists.

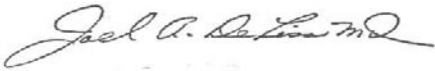
A textbook devoted to Jim McLean's course on teaching Electrodiagnostic Medicine has been released (Demos Medical Publishing). This is authored by two of our graduates: Christopher Visco and Gary Chimes.

The very popular and successful 23<sup>rd</sup> annual PM&R Board Review Course will be held March 17 – 25 at the Westminster Hotel in Livingston.

The trainees are getting ultrasound musculoskeletal training including guided injection of many areas at the Veteran's Hospital and DOC (page 8).

Thank you for reading this. Contact us at [truppvc@umdnj.edu](mailto:truppvc@umdnj.edu) or [muhammde@umdnj.edu](mailto:muhammde@umdnj.edu) with questions or comments.

Best wishes,



Joel A. DeLisa, M.D., M.S.  
Professor and Chair



We are putting together a directory of those of you who practice in and around the tri-state area for when we get requests for referrals. Kindly send your practice contact information to [truppvc@umdnj.edu](mailto:truppvc@umdnj.edu), so we can include you in our directory.

## *f*rom the residency director...

**Greetings all, and best wishes of the season!**

Well, another year is drawing to a close here, marking 5½ years since I became Residency Program Director. I am reminded this time of year what a great program we have (thanks to applicants asking “why do you think this is such a great program?”). I believe that our clinical care is our greatest strength; not only do we have world-class facilities like Kessler Institute (highly ranked by US News and World Report), but we have phenomenal teaching faculty. And our patient populations are so diverse, thus enriching the learning environment. After all, I believe great physicians continually learn from their patients...! And the quality of the training really shows: look at our Board Scores, Elkin's winners, and where our resident land for their fellowships! These external markers of success really show that we are able to train the best and brightest PM&R residents in the country. You can go to our website and read more about these accomplishments at [http://njms.umdnj.edu/departments/physical\\_medicine\\_rehabilitation/residency/index.cfm](http://njms.umdnj.edu/departments/physical_medicine_rehabilitation/residency/index.cfm).

Interviews are well underway, with six of our thirteen interview days for the season completed. We have invited 96 applicants to interview, and will be interviewing through December 31<sup>st</sup>.

I made a table for us to look at the trends in applicants over the past few years. The number of applicants has remained stable, but the proportion of US graduates and osteopaths applying to our program are increasing. I think this says great things about the increasing visibility of our field in US allopathic and osteopathic medical schools!

Interviewees	2008-2009	2009-2010	2010-2011
# of applicants (for # of positions)	365 (10)	352 (8)	351 (9)
US graduates	199	170	218
Osteopaths	74	71	89
UMDNJ (all schools)	19	16	20
# Invited for interview	96	96	104

On our interview day, applicants get an overview of the program by me, and then interviews with me, two other faculty, and one of our chief residents. The chief residents are considered key to this process, as it allows us to get their important perspective on each applicant as a future colleague. The hardest part is choosing among a group of really excellent candidates, with the goal that every person we bring for an interview is high caliber and will have a chance of being in our program.

The curriculum and learning environment continues to evolve and improve. We continually are updating our didactic curriculum, with the chief residents taking a leading role in innovations in the way we teach. We just had a four-hour workshop on vestibular rehabilitation, taught in part by one of our own residents who is a PT/MD with expertise in this area. The Research Course just finished, and the residents are exciting about designing their own research projects. We have two new rotations; one is an elective at the VA focused on performing interventional spine injections. The other is a revival of the very popular rotation with Dr. Malanga, doing private practice sports medicine (including prolo and PRP, as well as lots of ultrasound and some spinal injections). Our goal is to be continually updating the residency to meet the needs of our graduates and stay at the top of our game!

Planning is underway for this year's Annual Board Review Course. This course is now fully digital and this has been very well received. We anticipate the course to be outstanding, and as usual our seniors and fellows will be able to attend the entire course. This course is primarily for Boards Part 1, but we've found that it also serves as a great review for those taking the MOC (Maintenance of certification) exam. We also have Mock Oral Exams, specifically targeted at those taking

Part 2. We have standardized this format, based on the ABPM&R information about the exam provided on their website, so that the format will be similar to what you may encounter during your Oral Board exam. We also have one entire day of Prosthetics & Orthotics on Sunday, as a special "Program," which will be open to all our residents, as well as residents at other programs in the New York/New Jersey area. Hopefully, you have fond memories of your time spend here in training. Please remember us on your Holiday Gift list, as we always appreciate donations aimed at resident education!!

Please remember that I am always available to help with job searches or advice; just drop me an email at [susan.garstang@va.gov](mailto:susan.garstang@va.gov) or [susan.garstang@verizon.net](mailto:susan.garstang@verizon.net). Take care, and again Happy Holidays...!

Best wishes,  
Susan Garstang, M.D.

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**Note:** For those of you alumni out there who may be seeking a job change, please be aware that I keep every job offer that comes into our office (several per month) from all over the country. I'd be happy to share these with you at your request. Just e-mail me with your preferred location or job type and I'll send you the information.

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### Updates at Kessler Institute

The West Orange campus has increased its occupancy to 152 patients. To help accommodate for our growth, as well as a loss of some physicians over the last few years, it is a pleasure for me to introduce you to three of our new attendings that have joined us.

Dr. Jeremiah Nieves joined the West Orange campus two years ago. Dr. Nieves completed his medical school and residency training at UMDNJ-New Jersey Medical School. After completing his residency, Dr. Nieves completed the Spinal Cord Injury Fellowship Program at UMDNJ/NJMS and Kessler Institute for Rehabilitation. Post-graduation, Dr. Nieves worked as an attending physician in the Chester facility and then moved to the West Orange campus when Dr. Gary Galang left to return to University of Pittsburgh. Dr. Nieves' expertise in spinal cord injury and related disorders is a great addition to our staff. In addition, for those who trained with Dr. Nieves, he was recently married.

Dr. Neil Jasey joined our staff approximately one year ago. Dr. Jasey was a classmate of Dr. Nieves at UMDNJ/New Jersey Medical School as well as for residency program. He completed a Brain Injury Fellowship at Kessler Institute for Rehabilitation under the guidance of Dr. Elie Elovic. Post-graduation from the Fellowship, Dr. Jasey was an attending physician at Mount Sinai Medical Center in New York City.

Dr. Jasey has returned home, and is now the Director of the Traumatic Brain Injury Fellowship Program, and recently had a new baby.

Dr. Radhika Bapineedu is the newest member to join our staff, just starting in November 2010. Dr. Bapineedu completed her residency at Marianjoy Rehabilitation Hospital in Illinois and then underwent a Fellowship at Harvard Medical School/Spaulding Rehabilitation Hospital. From 2008 until November 2010, she was employed as a brain injury physician at Harvard Medical School/Spaulding Rehabilitation Hospital until moving back to New Jersey and joining our staff.

These three individuals will make a wonderful addition to the treating and teaching staff and join our longstanding group of physicians that most of you trained with at the West Orange campus. It is truly thrilling for me to see the growth of our staff with young, energetic, and highly motivated teachers, educators, and clinicians.



### AAPMR Meeting a Success

At the annual meeting of the AAPMR in Austin, Texas held October 22-25, 2010, four of our residents presented posters as first authors. Under our school's GME policy, these residents were entitled to receive reimbursement for their airfare, course registration and two nights' accommodations, subject to UMDNJ's usual restrictions on travel reimbursement. The following residents are congratulated for this accomplishment:

Jose Campos, M.D.  
Eduardo Cruz-Colon, M.D.  
Bethany Lipa, M.D.  
Christine Roque-Dang, D.O.

#### Elected Positions in the AAP and AAPM&R:

**Amanda Farag, M.D.**, Liaison to Advancement Committee for the Association of Academic Physiatrists  
**Amrish Patel, M.D., PT**, AAPM&R-RPC Delegate to AMA-RFS  
**Christine Roque, D.O.**, Secretary for the AAPM&R



**The AAP meeting will be held in Arizona, April 12-16, 2011.**



## FACULTY & ALUMNI NEWS

**Gary Chimes, M.D., Ph.D.** (Class of '06) announces he co-authors a textbook "McLean Course in Electrodiagnostic Medicine," with Christopher Visco, M.D. (Class of '08), which is dedicated to the memory *James McLean, M.D.* (Class of '06).

Congratulation to **Gary Chimes, M.D., Ph.D.** (Class of '06) who has been named the Fellowship Director for the Musculoskeletal Sports & Spine Fellowship at the University of Pittsburgh, Department of PM&R. "I want to thank those mentors from UMDNJ who have inspired me to help teach future fellows, particularly thanking Gerry Malanga, Pat Foye, and Todd Stitik."

**Patrick Foye, M.D.**, associate professor of PM&R, has been named chair of the Clinical Curriculum Committee at UMDNJ-New Jersey Medical School.

**Patrick Foye, M.D.**, associate professor of PM&R, was the course director and moderator for a program titled, "Medical Students with Disabilities: challenges and successes," on November 6, 2010, in Washington, DC at the AAMC (Association of American Medical Colleges) annual meeting. The session was sponsored by the AAP (Association of Academic Physiatrists).

**Gautam Malhotra, M.D.** passed the 2010 American Board of Electrodiagnostic Medicine (ABEM) certification examination. He also scored in the top 10% of passing scorers on the certification examination and will be listed in an issue of the journal *Muscle & Nerve* and the American Association of Neuromuscular & Electrodiagnostic Medicine's (AANEM) newsletter.

Congratulations to **Gautam Malhotra, M.D.** and wife, Monica on the birth of their first child, *Kavina Samaya*. Little Kavina was born on August 9, 2010, weighing 6 lb and measuring 18 in. Dr. Malhotra shares that "all of the grandparents, great grandma, and uncle were there to greet her" and that she has changed their lives forever in a good way.

### 2009 Postdoctoral Fellowship Graduates

#### *Where are they?*

Sarah Dubowsky, Ph.D., Devry College of New York  
Nam H. Kim, Ph.D., Rutgers University  
James Sumowski, Ph.D., Kessler Foundation  
Kevin Terry, Ph.D., University of Texas at Austin

### Current Fellows

Victoria Leavitt, Ph.D., MS  
Denise Krch, Ph.D.  
Abjhit Das, M.D., Stroke Research  
Elizabeth Galletta, Ph.D., Stroke Research  
Lawanda Ford-Johnson, PsyD



## Alumni Donations

Thanks to the following individuals for their contributions to the *PM&R Residency Training Program Fund* during the July 2010 mailing.

Philippe Chemaly, D.O., MPH  
Roger Klima, M.D.  
Tai Qing, M.D., Ph.D.  
Boqing Chen, M.D., Ph.D.



### Medical Students with Disabilities: Challenges and Successes *Patrick Foye, M.D.*

On November 6, 2010, in Washington DC, I had the opportunity to run a 3 hour session at the annual meeting of the AAMC (Association of American Medical Colleges). The session was sponsored by the Association of Academic Physiatrists (AAP). The panel included a current medical student, a current resident physician, and a current attending physician (recent fellowship graduate) all of whom shared their experiences about going through medical school with significant physical disabilities (each of them has a spinal cord injury, resulting in either tetraplegia or paraplegia). The panel also included a medical school Dean of Student Affairs, giving a 'central administration' perspective on welcoming and supporting medical students with a variety of disabilities.

I was moved and impressed by the panel members. In PM&R, we consistently talk about enhancing the functional activities of individuals with disabilities and we dedicate our professional lives to achieving these goals for our patients. Here was a group of panel members who live that mantra. I was impressed by the courage, motivation and persistence that the 3 individuals have demonstrated. Medical school is of course a challenging experience for all students, but imagine going through with the additional challenges of:

- How do you navigate physical obstacles at the patient bedside on the hospital floors or in the outpatient clinic (e.g., various items obstructing wheelchair access to your patient)?

- On your surgery rotation, if you are in a wheelchair, then how do you physically get up high enough to see into the operating field which is at torso-level to the surgeon who is standing up next to the patient on the operating table?
- How do you listen to your patient's heart or lungs if your tetraplegia has impaired your ability to physically grasp a stethoscope? Can you modify the stethoscope? Can you have an assistant hold the stethoscope for you?
- On rounds, how do you diplomatically address it when the rest of your team takes the stairs from one floor of the hospital to the next, while you and your wheelchair need to take the elevator, missing out on some of the discussion?
- When interviewing for medical school (and eventually for residency, perhaps fellowship, eventual attending physician jobs), how do you help the interviewers to see beyond your disability?
- These are just a tiny sampling of the issues that came up.

On the side of medical school administration and admissions committees, how do you embrace the "Americans with Disabilities Act" (ADA), which in many situations legally prohibits discrimination against individuals with disabilities? If you are running a medical school that requires certain standardized rotations, and experiences, competencies that include physically performing certain physical exam maneuvers, etc., how do you modify your available curriculum and/or physical environment and/or adaptive equipment (so that students with disabilities can successfully access the educational experiences and so that these students can have the opportunity to demonstrate their abilities to perform the required medical tasks, albeit perhaps in a modified way)?

It was a fascinating overall presentation by the panel members, followed by an engaging question-and-answer session with the audience members. I thank Dr. DeLisa and the AAP for providing me the opportunity to arrange and moderate this session. I also appreciate the AAMC interest in this area and the commitment they expressed to help further support this area (with online listserves, etc.) so that students and medical schools facing these issues nationwide would not always have to start from scratch in learning about possible solutions to common challenges.

I encourage those reading this to consider how you can personally make a positive difference in this area. Can you ask your local medical school what accommodations they provide for applicant/students with disabilities? Can you offer, as a physiatrist, to serve as a free consultant or liaison when these issues come up? Can you serve on your medical school admissions committee? Can you serve as a mentor for medical or pre-medical students? Can you provide insight/perspective/resources that would improve other's abilities to access and succeed within medical school? Our field of PM&R has so much to offer in this area and I encourage you to seek opportunities to contribute.



2010 AAMC Panel on Medical Students with Disabilities: Cheri Blauwet, M.D., Patrick Foye, M.D., Jesse Lieberman, M.D., Neil Parker, M.D. (Dean of Student Affairs at UCLA), and medical student Brian Waldersen.



### Faculty Appointments

**Denise Krch, Ph.D.**, joined the department as an Instructor, coterminous with the Kessler Foundation Research Center. Her current research interests include the efficacy of cognitive rehabilitation in persons with Multiple Sclerosis and Traumatic Brain Injury, with a special interest in the relationship between intervention outcome and pattern of cerebral activation using functional Magnetic Resonance imaging.

**Victoria Leavitt, Ph.D.**, joined the department as an Instructor, coterminous with the Kessler Foundation Research Center. Her current research interests involve exploring the neurocognitive implications of Multiple Sclerosis through co-registry of neuroimaging techniques that include diffusion tensor imaging, functional magnetic resonance imaging, and near infrared spectroscopy.

### Faculty Awards/Honors



Kessler Foundation established the Joel A. DeLisa, M.D. Award for Excellence in Research and Education in the Field of Physical Medicine & Rehabilitation. The award seeks to identify and reward the physician and/or scientist who has demonstrated a significant impact on the field of PM&R, particularly as it relates to the translation of research and education to patient care. Each year for the next 20 years, this annual award of \$50,000 will recognize a leader and role model in the field of PM&R. Applicants must be nominated by a second party who can attest to the individual's qualifications. The application must include a cover page,

accompanied by a concise, two-page statement from the nominator that summarizes the impact that the nominee has had on the field of PM&R and why this individual should be considered for the award. The applicant's current CV and two letters of recommendation must be included. Applicants at all levels of their career are eligible for nomination. To be considered for this award, a nominee must demonstrate significant accomplishments in the following six domains: Publications, Funding, Program Development, Education/ Training, Service and Leadership. Further details can be found at the following link:  
<https://kesslerfoundation.org/research/articles.php?id=99>

### Faculty Publications

Abbasi A, Malhotra G. The "swimmer's view" as alternative when lateral view is inadequate during interlaminar cervical epidural steroid injections. *Pain Medicine*, 2010 May; 11(5):709-12. Epub 2010 Mar 26.

Bach JR, Martinez D, Saulat B. (2010) Duchenne Muscular Dystrophy. The Effect of Glucocorticoids on Ventilator Use and Amputation. *Am J Phys Med Rehab*, 89 (8), 620.

Barrett, A.M. (2010). Rose-colored answers: Neuropsychological deficits and patient-reported outcomes after stroke. *Behavioural Neurology* 22(1-2): 17-23.

Craver-Lemley C., Bornstein R.F., Alexander, D.N., & Barrett A.M. (2010). Imagery interference diminishes in older adults: Age-related differences in the magnitude of the perky effect. *Imagination, Cognition and Personality*, 29(4), 307-322.

Eller, M., Hreha, K. and Barrett, A.M. (2010). Treating post-stroke spatial neglect: Establishing a clinical research-clinical care (CRCC) spatial neglect partnership program. *Advance for Occupational Therapy Practitioners*, 26(7), 16.

Foye PM. Anal nerved risks with paracoccygeal lumbosacral fixation. *Surgical and radiologic anatomy (SRA)*. 2010 Oct; 32(8):805.

Goverover, Y., O'Brien, A.R., Moore, N.B., DeLuca, J. (2010). Actual Reality: A new approach to functional assessment in persons with multiple sclerosis. *Archives of Physical Medicine and Rehabilitation*, 91(2), 252-260.

Hillary, F.G., Genova, H., Medaglia, J., Fitzpatrick, N., Chiou, K., Wardecker, B., Franklin, R., Wang, J., & DeLuca, J. (2009, In press). Speed of information processing deficits following traumatic brain injury: Is less brain more? *Brain Imaging and Behavior*, 4, 141-154.

Jones, L.A.T., Lammertse, D.P., Charlifue, S.B., Kirshblum, S.C., Apple, D.F., et al. (2010). A phase 2 autologous cellular

therapy trial in patients with acute, complete spinal cord injury: Pragmatics, recruitment and demographics. *Spinal Cord* [E-pub, April 13]

Leavitt, V.M., & DeLuca, J. (2010). Central fatigue: Issues related to cognition, mood and behavior, and psychiatric diagnoses. *Archives of Physical Medicine & Rehabilitation*, 2, 332-337. doi: 10.1016/j.pmrj.2010.03.027

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Linsenmeyer, T., Maddox, T., Chambers, L., Cowell, F., DuBose, J., Dyson-Hudson, T.A., Tevnan, K. Wilber, T. (2010). Bladder management following spinal cord injury: What you should know. A guide for people with spinal cord injury. Washington, DC: Paralyzed Veterans of America.

Malhotra G, Abbasi A, Rhee M. Complications of transforaminal cervical epidural steroid injections. *Spine* 2009; 34:731-9.

Slavin, M., Kisala, P., Jette, A., & Tulskey, D. (2010). Developing a contemporary functional outcome measure for spinal cord injury research. *Spinal Cord*, 48(3), 262-267.

Sumowski, J. F., Wylie, G., Chiaravalloti, N., & DeLuca, J. (2010). Intellectual enrichment lessens the effect of brain atrophy on learning and memory in MS. *Neurology*, 74, 1942-1945.

Sumowski, J.F., Chiaravalloti, N.D., & DeLuca, J. (2010). Retrieval practice improves memory in multiple sclerosis: Clinical application of the testing effect. *Neuropsychology*, 24(2), 267-272.

Sumowski, J.F., Wylie, G.R., DeLuca, J., & Chiaravalloti, N. (2010). Intellectual enrichment is linked to cerebral efficiency in MS: fMRI evidence for cognitive reserve. *Brain*, 133, 362-374.



### Jordan Grafman, Ph.D. Joins the Kessler Foundation

Dr. Jordan Grafman joins Kessler Foundation as Director of the Traumatic Brain Injury Laboratory.

Kessler Foundation announced that Jordan Grafman, Ph.D., will join Kessler Foundation Research Center as Director of the Traumatic Brain Injury (TBI) Research Laboratory. He will assume his position on January 3, 2011.

President and Chief Executive Officer of Kessler Foundation, Rodger DeRose, said, “We’re very excited to have Dr. Grafman lead Kessler Foundation’s TBI research team. With his decades of national leadership, depth of expertise in TBI and our rich research environment, I’m confident that we will develop new ways to help people restore their abilities to think, learn and remember.”

Dr. Grafman currently serves the National Institutes of Health as Chief of the Cognitive Neuroscience Section at the National Institute of Neurological Disorders and Stroke. Dr. Grafman has studied brain function in dementia, depression, and degenerative neurological diseases, as well as TBI.

Dr. Grafman has nearly 30 years of experience in brain injury research at Walter Reed Army Medical Center and the National Institutes of Health (NIH). As Director of Walter Reed Army Medical Center, he led the Vietnam Head Injury Project. He is the leading expert on the long-term effects of penetrating brain injuries in military personnel.

He has authored more than 300 research publications and sits on the editorial and review boards of more than 30 medical publications. Dr. Grafman is the recipient of many prestigious awards including the 2010 National Institutes of Health Director’s Award.

At Kessler Foundation, Dr. Grafman will focus on ways to tailor interventions for individual patients in order to achieve the best outcomes. Research into neuroplasticity shows that the brain has greater capacity for healing than previously thought. Dr. Grafman’s goal is to translate that concept into more effective, targeted rehabilitation.

“Our genetic makeup influences how our brain heals after injury and how it responds to various strategies used in rehabilitation, including medication and cognitive and behavioral therapy. By taking advantage of genetic information,” he explained, “we will learn which treatments are likely to be most effective for individual patients.” This genetic approach, which will expand upon Kessler’s current cognitive and neuroimaging research, will broaden our knowledge of the impact of TBI, as well as other diseases that impair brain function, such as stroke, multiple sclerosis and degenerative diseases.

Brain injury is a major public health issue with tremendous costs for care and lost productivity. Costs for acute care exceed \$8,000 per day, and for inpatient rehabilitation, they exceed \$2,000 per day. Each year an estimated 1.56 million Americans require medical treatment for brain injury sustained in accidents, falls, violent encounters, and sports. TBI is the signature wound in military men and women returning from Iraq and Afghanistan.

Even mild brain injuries may result in symptoms that impair

their ability to function in the community. For example, of the people who are injured, 63% are employed at the time of injury, but only 28% remain employed at one-year followup.

Dr. Grafman will also have a leadership role with the Northern NJ TBI Model System (NNJTBIMS). NNJTBIMS is one of 16 federally funded systems that encourage individual and collaborative research to improve the quality and standard of care for treating people with TBI. Kessler Foundation is one of only eight institutions to have Model Systems for both TBI and spinal cord injury.

“Dr. Grafman’s leadership will greatly enhance Kessler Foundation’s ability to translate research into patient treatment,” said John DeLuca, Ph.D., Vice President of Research at Kessler Foundation Research Center. “We anticipate that his novel approaches will lead to substantial improvements in the standard of care for TBI, which will mean a better quality of life for people recovering from brain injuries. With his participation, we look forward to broadening our collaborations nationally as well as within our Research Center.” Kessler Foundation also conducts research in neuropsychology and neuroscience, stroke, spinal cord injury, outcomes, rehabilitation engineering, and movement analysis.

Dr. Grafman received his Ph.D. from the University of Wisconsin in 1981. He plans to reside in NJ with his wife and two children.



### **Exciting Changes at the VA New Jersey Healthcare System!**

The Physical Medicine and Rehabilitation service (PMRS) at VANJHCS continues to undergo significant changes. We have expanded the number of residents rotating at East Orange, been recognized nationally for excellence in management of mild TBI, added EMG’s at Lyons, started a new rotation for providing residents with experience performing spine injections, and even begun research. Read on!

#### **Construction**

In our continuing commitment to improve quality and access to patient care, the East Orange VA will undergo significant renovations over the next two years, with specific focus of trans-disciplinary care and "one stop shopping" for the veteran. This will include an expansion of our current therapy areas to integrate PT, OT, wellness and recreation into a large open treatment space that takes advantage of our unique views on the 13<sup>th</sup> floor. Physician areas will become more centralized around a large waiting area and patient resource center. As part of this effort, we have also worked with national leadership to improve our telemedicine program,

which currently serves veterans who have significant geographic barriers to care. New high resolution cameras and improved server capacity will allow VA clinicians to see and examine more patients at clinics close to their homes. These technologies have also helped our continued commitment to resident education with more didactics and exposure to technological advances in clinical medicine.

### **General Organization**

We have nine residents and eight attendings in the VA system, at two locations (the East Orange and Lyons campus). One resident is assigned to the SCI Service at East Orange, and works with Dr. Gill. Two residents and two attendings are at Lyons, the others are at East Orange on the 13<sup>th</sup> floor. At both East Orange and Lyons, we see patients in a variety of outpatient clinics every day; in addition at Lyons we have two half-days set aside for inpatient team meetings, consults, and multidisciplinary rounds. One resident at East Orange is on elective, and spends time in Pain Management clinic with an interventional anesthesiologist.

### **Musculoskeletal and Injections**

Our outpatient practice sees a variety of general physiatric patients, with a majority of issues being musculoskeletal. Our population ranges from recently returning veterans from Iraq/Afghanistan, up through the geriatric age group with more degenerative conditions. We are seeing many more new injuries and problems in a younger, more female, "weekend-warrior" and acute/sub-acute sports-injured population, as well as veterans just entering the VA system for the first time to seek medical care with a variety of previously undiagnosed problems.

At both East Orange and Lyons, residents have continued to participate in a variety of non-imaging guided peripheral joint and soft tissue injections. Throughout the week residents participate in injections to treat conditions such as subacromial bursitis, trigger points, DeQuervain's tenosynovitis, knee arthritis, greater trochanteric bursitis, and pes anserine bursitis. These injections are done every day during the course of clinics. In addition, due to increase patient need, at Lyons we have designated Wednesday afternoons dedicated to knee viscosupplementation injections. We also perform Botulinum toxin injections using a combination of motor point and EMG guidance (Clavis) at both campuses.

Our faculty at East Orange routinely perform ultrasound guided injections of many areas including glenohumeral, bicipital tendon sheath, acromioclavicular, hip, carpometacarpal, carpal tunnel, and ankle. Dr. Rex Ma initiated, and continues to lead the way for residents to learn ultrasound associated injection techniques, appreciation of anatomy, and even some diagnosis! He has broken the glass ceiling that is *research at the VA* with his ongoing study comparing the efficacy of ultrasound guided versus blind

carpal tunnel injections.

This year, our residents have begun to assess veterans and actually perform fluoroscopically guided spine injections with the PAIN/anesthesia service at the East Orange Campus. Currently, the numbers of procedures are small, but as the program grows, we anticipate far more procedures for the residents prior to graduation.

Dr. Shenoy has set an example for other VA's on how to approach TDRLs (Temporary Disability Retirement List evaluations). These are similar to IME's and are requested by the Department of Defense. He has specifically been commended by West Point executives for his approach to the encounter and documentation.

### **Electrodiagnosis and Neuromuscular Medicine**

One resident and attending are in the EMG lab at East Orange every day. In addition, we have started performing electrodiagnostic consultations at the Lyons campus using the XLTEK machine that many alumni trained on. Usually this is an R1's first exposure to an actual electrodiagnostic evaluation. Although the number of procedures is relatively small (4 per week), the residents get a very deep and focused teaching experience during these encounters.

Dr. Malhotra is now triple board certified since he added the Electrodiagnostic Medicine (ABEM) certification to Neuromuscular Medicine and PMR. He, Dr. Im, and Dr Susan. Garstang are working together with other services toward establishing an interdisciplinary Neuromuscular Clinic. Thus far, veterans with amyotrophic lateral sclerosis and advanced Charcot-Marie-Tooth disease have benefitted from a day of intensive evaluation and management.

Drs. Im, Malhotra, and Shenoy also recently published chapters in the McLean Electrodiagnostic Course book.

### **Inpatient**

As noted in prior Alumni Pulse issues, PMRS at VANJHCS maintains four inpatient rehabilitation beds at the Lyons campus. The geriatric extended care service (comprised of internists, geriatricians, & palliative care specialists) serves as primary caregiver for these patients while PMRS acts as a consulting service. Residents rotating at Lyons participate in a different the role as consulting physiatrist (compared to the intense primary role they are familiar with at Kessler). Functional considerations then become the primary emphasis as medical perturbations are seamlessly managed by the internists. We are preparing for another CARF evaluation where we hope to again be commended for appropriately utilizing this paradigm and scoring in the top 10%.

### **Traumatic Brain Injury**

Residents rotating through VANJHCS are exposed to the complexities of treating mild traumatic brain injury (mTBI),



the signature injury of Operation Enduring Freedom and Operation Iraqi Freedom. Under the direction of Drs. Im and Shenoy, VANJHCS has developed an interdisciplinary team to address various components of mTBI including vestibular rehab, neuropsychology, community reintegration, technology integration, and close continuous follow-up by case managers. While it is unfortunate that there is scant literature to guide clinicians at this time, residents in training are appreciating the excitement of contributing to this nascent and unfortunately growing field.

Dr. Lawrence Weinberger (Neuropsychology) has been serving as a co-coordinator since his recent hiring. He maintains very close ties with this population of veterans who are known to be easily lost to follow up. We are fortunate to have his expertise, experience and friendship.

Dr. Malhotra was recently invited by the Central Office to speak at a national conference about how NJ can serve as a model for other VA's around the nation. His co-lecturer was Kessler grad Ronald Tolchin, who is the chief of PMR in Miami, Florida. When asked, Dr. Malhotra said "Ron Tolchin is a fantastically energetic and charismatic example of the kind of clinical and leadership skills that our program has consistently fostered. As far as the rest of the trip, what happens in Orlando, stays in Orlando."

#### **Didactics**

VA faculty continues to lecture on various topics throughout the year as well as at the review course. A formal system for lunchtime didactic sessions was implemented with video teleconferencing between campuses thanks to Dr. Im's tenacity. Future sessions hope to incorporate speakers from hand surgery, vascular surgery, orthopedic surgery, radiology, neurology, pathology and prosthetics. The VA rotations continue to be strong sources of hands-on and bedside teaching, and are highly rated by residents.

#### **Prosthetics**

The recent hiring of certified prosthetist Brian Bedotto has afforded VANJHCS the ability to now offer veterans comprehensive interdisciplinary care with open access on a daily basis. Old and new amputees are provided quality componentry including energy storing and/or microprocessor technology. Brian continues to be available to the residents for any questions that come up. Recently, the residents got a chance to see a veteran with a biceps cineplasty (only at the VA!).

#### **The People**

It is abundantly clear to the current residents that camaraderie is a fundamental requirement for the people working at VANJHCS despite a number of changes in staffing over the past decade. Along with Drs. Malhotra, Pankaj Patel, and Vipul Shah, Dr. Garstang splits her time between both the Lyons and East Orange campuses, runs wheelchair clinic and

spasticity clinic for the Spinal Cord service, and continues to serve as Program Director since her arrival last year. With this much exposure to the residents, she also has a great big finger on the pulse of the residents, and continues to serve as a liaison between residents and faculty. She has also co-established a lauded veteran-centered care in-service for VANJ clinicians.

#### **The Future**

Our future plans include more involvement with interventional spine procedures, integrative medicine, prolotherapy, further enhancement of cardiac and pulmonary rehab, and continuing to blaze the trail on the national stage for mTBI treatment. An influx of veterans is anticipated in the coming years who we feel fortunate to be able to serve, with a complex set of functional problems and a need for our unique talents. Our residents will be uniquely sensitized to handle their needs as they go out into the community as practicing physiatrists.



### **Postdoctoral Fellowship Program at UMDNJ and Kessler Foundation**

The UMDNJ/Kessler Foundation Postdoctoral Research Training program is designed in response to the shortage of doctoral-level investigators, working on important, unsolved problems relevant to the ever-increasing physically and cognitively disabled population. The program is designed to solicit postdoctoral applicants from biomedical sciences and clinical rehabilitation disciplines, including fields such as biomechanics, physiology, psychology, psychiatry, neurology, nursing, physical therapy, occupational therapy, and rehabilitation engineering. The program particularly seeks to attract applicants from the field of physical medicine rehabilitation, rehabilitation sciences and rehabilitation engineering, where the need for research training is intense. The program has several innovative features including self-direction, mentors from other areas of biomedical and social research, and team building. Each Fellowship is based on an individualized Research Training Plan written by the Fellow with the advice and consent of his/her mentors. In general terms, each Fellowship consists of:

- Intensive work and training with a team of mentors who are highly experienced in: a) rehabilitation research; b) a special discipline or topic relevant to rehabilitation; and/or c) in a necessary methodological tool.
- Formal coursework or directed study to remedy deficiencies and master a) advanced knowledge of rehabilitation, b) a scientific or medical specialization area, c) a statistical or research design skill, and d) a research tool.
- Attendance and participation in conferences, lectures, and seminars offered by the Department of PM&R, by other

departments at UMDNJ, Kessler Foundation Research Center, Rutgers and by other institutions in New Jersey and the New York Metropolitan Area. The Fellow will be exposed to rehabilitation administration and encouraged to participate in a grant-writing project to enable future funding.

- Above all, research experience in the laboratory or office of more senior investigators, and completion of published research projects and a submission of an NIH grant application.

The fellowship program is directed by Dr. John DeLuca, Professor of Physical Medicine and Rehabilitation at UMDNJ-New Jersey Medical School and Vice President for Research at Kessler Foundation. The program is funded by two NIDRR training grants, one in Neuromuscular Rehabilitation, with Drs. Gail Forrest and Peter Barrance, both Assistant Professors in the UMDNJ Department of PM&R and Kessler Foundation, serving as co-principal investigators, and the other in Neurocognitive rehabilitation, with Dr. Nancy Chiaravalloti, Associate Professor in the UMDNJ Department of PM&R and at Kessler Foundation, serving as principal investigator. The program is also funded by a postdoctoral fellowship grant in neurorehabilitation by the National Multiple Sclerosis Society, with Dr. DeLuca serving as principal investigator. Additional funding is provided by Kessler Foundation and by an NIH grant to Dr. Anna Barrett, Associate Professor in the UMDNJ Department of PM&R and at Kessler Foundation, serving as principal investigator.

This Fellowship program provides an opportunity to either broaden Fellows' skills by remedying deficiencies in important areas relevant to their type of rehabilitation research or to increase the depth of their knowledge or skill in an advanced topic. At a conceptual level, we believe that Fellows beginning a career in rehabilitation research need skills in each of the following three areas: Knowledge of biological/disease processes, disablement, and rehabilitation; knowledge of statistics, methodology, and research design, and other specialized research tools and subjects.



**Will the PFC Mature in Time for  
Holiday Season Giving?  
*John Bach, M.D.***

The population of the planet is doubling every 40 years; the federal debt is increasing by greater than \$1 trillion per year; Chinese demand for petroleum is doubling every 10 years as world supplies may now be declining; 50 to 100 species of plants and animals become extinct per week, a rate greater than that during the 5 previous global mass extinctions that resulted in 75-95% of global species extinctions. Now for the good news, considering the above you might as well

contribute to our Residency Training Fund since at the current rate of unsustainability your money won't be worth anything very soon anyway. Also, we now know why all of this is occurring. It is related to the Triune brain, basically the reptilian basal ganglia, the limbic system, and the neocortex.

The prefrontal cortex (PFC) is the executive sector of our brains. It permits us self-reflection, self-consciousness, rational analysis, innovation and creativity, the ability to plan for the future, to distinguish reality from fantasy and falsehood, and to repress impulses. Perhaps its most important function is to discern truth from fiction. This requires a definition of "the truth". First, the truth is never absolute. One can never be absolutely certain that "the sun will come up again tomorrow morning" or that in fact you did actually go to work yesterday. Both events are highly likely (probable) but there can be other explanations or unanticipated events that could render these false. The brain is subject to illusions just as the natural world is subject to cataclysmic events that we do not yet always have the technology to predict. The Truth, or what should be considered most likely to be the truth until proven wrong, is what is most likely to have happened, that is, after a rational analysis of natural probabilities. There is no evidence or reason to think that any miracle has ever taken place. Indeed, even the least likely natural explanation of an event is infinitely more likely to be its explanation than "a miracle" so the most likely explanation should be considered to be the "Truth" unless or until more data are revealed. It should be the natural function of the PFC to undertake these analyses and determine the "Truth" but because of its immaturity in our species and it being under the yoke of lower brain (basal ganglia) impulses that evolved for self-preservation, it is often unable or not permitted to determine the truth.

The PFC has had only 160,000 years to evolve in our species as opposed to almost 400 million years for lower brain centers that are concerned only with the immediate, that is, instinct, feelings, and subconscious pattern recognition to trigger reflex and other sudden responses to stimuli such as hitting a 90 mph fast ball. Once concepts (paradigms) are accepted by the PFC, no matter how unsubstantiated by nature, reason, or fact, the PFC accepts information consistent with the accepted paradigm and filters out, or better, ignores that which is not. This can make it impossible to "see" and learn better ways of doing things or discerning truth from fiction and fantasy. The failure to reassess accepted paradigms and analyze new ones ("paradigm paralysis") is the reason why it is rare for a Yankee fan to become a Red Sox fan, a Jew a Muslim, a Muslim a Christian, a liberal a conservative, or a patient's lungs to be ventilated noninvasively rather than invasively. It is the reason that the microscope and infection theory were buried by our profession for 200 years, why 300,000 new mothers and their newborns died from childbed fever although it had been proven and published in articles and books that chlorine antiseptics prevents it, and why patients are left to weaken and develop ventilatory failure and die or

be managed by tracheostomy rather than noninvasively. Failure of the PFC to check lower brain impulses for immediate gratification is also why 120 million American families have an average credit card debt of over \$9000, the federal government is going bankrupt, the drain on our natural resources and our population growth are unsustainable, and our species is provoking the 6<sup>th</sup> great mass extinction in the geological record of this planet. Caudate nuclei inhibition of PFC activity is perhaps the most important of all PFC filters to learning new ideas and analyzing old ones, responsible for genocides, slavery, unsustainability, and paradigm paralysis in general.

We are all subject to the structure and function of our brains with their immature neocortical centers. For example, photos of a starving child stimulate the mirror neurons and the primary primate morality areas to make one want to offer help. However, statistics of millions of suffering or dying people do not. "The depressing numbers leave us cold; our minds can't comprehend suffering on such a massive scale. This is why we are riveted when one child falls down a well but turn a blind eye to the millions of people who die every year for lack of clean water. And why we donate thousands of dollars to help a single African war orphan featured on the cover of a magazine but ignore widespread genocides in Rwanda and Darfur." The emotional brain, conditioned by the "brain washing" of our youth into religions and cultures, contributes to the basal ganglia's grip on the PFC to avoid the truth. Slavery, jihad, and other cultural and religious paradigms atrophy the brain's empathy centers as does child abuse. All Western religions have committed, and have divinely justified genocides. We are running out of time to mature our PFCs! It can be done but is beyond the scope of this article. To find out how, you will have to read my next book.



**Mirrors for Haiti**  
***Eric Altschuler, M.D., Ph.D.***

On January 12, 2010, at 4:53 local time, a magnitude 7.0 earthquake struck not far from the capital city of Port-au-Prince, Haiti. The death toll is estimated to have been ~250,000. In addition to those killed, the number of severely acutely injured was also such as trauma and orthopaedic surgery. The world response was fast and significant for these needs. The acute needs have dissipated, the most significant medical issues then became subacute and chronic health care for earthquake associated illnesses such as patients recovering from trauma. A particular medical need that stood out was to help treat for phantom pain and other problems the estimated four to six thousand individuals with amputations.

When I heard about the devastation of the earthquake, I felt, as any physician or non-physician would, that I wanted to

help if I could. I thought that mirror therapy (see references) could be very beneficial for the thousands of amputees in Haiti.

However, at first, the logistics, just in terms of getting myself there, let alone finding and treating patients, seemed impossible. I had heard that Sandra R. Scott MD, Chief of the Emergency Department at New Jersey Medical School, was going to Haiti and had done missions to other countries previously. I needed to talk to Dr. Scott about something completely unrelated - rotation scheduling for some exceptional medical students (one whom I am extremely pleased to say will be starting her PM&R residency with us next year!). I briefly mentioned to Dr. Scott that mirror therapy might be helpful for amputees, but that logistically things seemed impossible. Dr. Scott said that quite the contrary: Arrangements could be made in terms of logistics and hence the therapy made possible. Dr. Scott is one of the leaders of a non-profit organization, Unified for Global Healing (UFGH).

I may have conceived the idea of 'Mirrors for Haiti' but the development and delivery process was far from trivial! Eventually, through fundraising efforts, UFGH was able to purchase 200 mirrors weighing about one pound each. The mirrors were made by Glassless Mirror Manufacturers Inc., in Irvington, NY, of a very light caulk-like ceiling tile material that had a Mylar sheet on one side providing the highly reflecting mirror coating. Dr. Scott and her outstanding ED residents, in particular Rolando Valenzuela, MD and Matthew Davis, MD figured out how to pack these in bags of fourteen mirrors each. A number of us carried one or two bags of mirrors with us on our flights to Haiti.

I was just one of twenty-four people: physicians, nurses, EMT's, social workers and others who went with the UFGH mission to Haiti. In addition to mirror therapy for amputees, the team provided emergency, inpatient and rehabilitation care for adult and pediatric patients, and social work and art therapy for children. There are numerous challenges in healthcare delivery in Haiti, many of which are a result of the overall poverty level which predates the earthquake. There are many more new challenges such as the destruction of hospitals and other facilities by the earthquake and the uncleared rubble that resulted from the destruction, and now cholera.

We were based at Hopital Adventiste in Carrefour, a neighborhood in Port-au-Prince. We saw patients at the hospital and at a field medical facility run by Johanniter International in Leogane (about a two-hour drive from Port-au-Prince). Leogane is also an area of Haiti that was devastated by the earthquake. Indeed, on the drive we often had to shift to four-wheel drive to get over all the rubble!

We saw about one percent of the amputees in the country. A majority had phantom limbs, and a majority of these could move their phantom limb. Many patients did not have particularly severe phantom limb pain. But typically we found that the patients thought the mirror aided in moving their phantom limb. Patients typically asked to take a mirror home with them, and we gave them one.

A number of patients noted itching on the bottom of their phantom foot. We found that many of these patients could scratch an itch on their phantom foot by watching the reflection in the mirror of the intact foot being scratched.

One patient we saw had trouble closing her hand and using it for everyday activities such as washing her face, due to an immobile phantom finger after amputation of the right ring finger at the proximal interphalangeal joint, secondary to trauma from the earthquake. This patient found the mirror technique most helpful in closing the hand, including the phantom finger.

I did not see any local physiatrists while I was in Haiti, and only a single other visiting physiatrist. In contrast, there were a lot of foreign physical therapists and prosthetists working there and training local people in these disciplines. I did not meet any experienced Haitian physical therapists or prosthetists. However, I found the trainees extremely bright, motivated and hard working. I expect that before long Haiti will have many excellent therapists and prosthetists. Specific to mirror therapy - I gave a lecture and demonstration to the physical therapy and prosthetic trainees. I then had the trainees see patients with me. Crucially, after a short time the trainees were able to explain mirror therapy to patients!

The trainees also asked excellent questions such as: How can bilateral amputees be helped? Answer: Often I have found that if a patient watches a therapist's limb, the reflection in a mirror helps these amputees move the contralateral phantom.

The need for physiatry in Haiti is great because of the unprecedented number of amputees there (estimated to be 3-8 thousand) and also patients who had serious musculoskeletal and neurologic injuries from the earthquake. As I mentioned, a generation of what I think will be outstanding physical therapists is being trained. Physiatrists can help by providing physician PM&R care.

I am working with organizations with a presence in Haiti to set it up so that, on a rotating basis, teams consisting of a faculty or private practice physiatrist could go to Haiti with three residents and other trainees for one to two weeks and visit four or five hospitals and other healthcare facilities. Physiatrists with a desire to help could then work with their institutions or practices to free up physician and trainee time to do this most important work. I am quite confident that travel and logistical costs can be covered by organizations

that work in Haiti. It would be an excellent experience for trainees in the United States to work in a developing country, and also a great opportunity for PM&R as a field to help patients with rehabilitation needs.

#### Mirror Therapy:

The principle behind mirror therapy is that when a patient watches the reflection of the remaining limb in a sagittally placed mirror, vision of the reflection of the intact limb (which looks like the amputated limb) is able to substitute for absent proprioception from the amputated limb and help the patient to move the phantom. This allows, for example, a patient to relieve the pain of a clenched spasming phantom hand by unclenching the intact hand while watching the reflection of the intact hand in a mirror. Indeed, try clenching your own fist tightly and then imagine if you could not open your fist to relieve this pain. The mirror allows an amputee to do this.”

Dr. Altschuler was the first to publish mirror therapy for hemiparesis following stroke (Altschuler et al., 1999). His teacher in medical school, Prof. VS Ramachandran, was the inventor of mirror therapy for phantom limb pain in amputees (Ramachandran et al., 1995) (See also Ramachandran & Altschuler, 2009 for a review of mirror therapy.)

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### **Does "Cultural Sensitivity" Sometimes Impede Patient Care?**

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With the December holidays upon us, it is perhaps a good time to reflect upon the various religious/cultural traditions that will be celebrated this month by ourselves, our patients, our staff, etc., and how these may affect patient care.

Having recently undergone training in "cultural competency" (mandatory for employees in our setting), this year I am viewing the holidays with perhaps more questions than ever.

The politically-correct mantra is to embrace the religious/cultural/ethnic diversity of our patients, staff, colleagues, etc., and this is an idea that I wholeheartedly support. But problems arise in the nuances of implementing this acceptance of such diverse viewpoints, particularly in cases where cultural practices may impede patient care and thus may go against my commitment to patients' health. Below I will outline just a sampling of the types of cultural sensitivity questions that have already arisen in our culturally-diverse medical practice.

Not long ago I was treating a patient with recalcitrant coccyx pain and I was reviewing for him the spectrum of available medical treatment options (oral meds, topical meds, cushions, manual medicine, injections, nerve ablation, surgery/coccygectomy, etc.). At my mention of *coccygectomy*, he cut me off to tell me that as a "*staunch creationist*" there is no way he would ever even consider surgical removing the coccyx, since "*God put the coccyx there for a reason so there's no way that I am going to have it removed.*" What should my response have been? The culturally sensitive/accepting response would be perhaps to nod in agreement, or to tell him that I respected that viewpoint... but would such a response imply that I really agreed with that train of thought? Should I have asked him why he had previously undergone surgery to remove his prostate cancer and then asked him whether his God had put that there too? Would my response have been a laudable culturally-inquisitive dialogue (I genuinely would be fascinated to know his thoughts on that), or would it have been an inappropriate and offensive challenge to his particular religious worldview?

During Ramadan a few months ago, I had an Islamic patient who told me she was unable to comply with any medication regimen that required taking oral medicines during her time of fasting (from sunrise to sunset, lasting for either 29 or 30 days depending upon when the crescent moon is first sighted). Was I culturally sensitive to offer longer-lasting nonsteroidals and longer-lasting opioids which could be taken once a day before sunrise and thus provide relief throughout the entire day without violating the religious fasting? Or was I somehow subverting the patient's religious tradition by offering modern pharmacodynamics that would deliver therapeutic medicine throughout the fast (i.e., was I somehow cheating her religious fast by using a technicality that the medicine could be swallowed before sunrise). Would I be more "culturally-sensitive" by bringing this up, or by dodging the issue? Further, was it ethical for me to offer this prescription knowing that her insurance company's prescription plan would need to pay substantially more for the longer-acting, brand-name-only medication (as compared with the less-expensive, short-acting generic option I had recommended first, which could have been taken throughout the day if it had not been for the religious fasting)? Do I have an ethical duty to document or inform the insurance company that the reason for the additional expense is so that I could be culturally

sensitive to the patient's religion? Similarly, consider if the patient is out of work for an on-the-job injury, and if the patient's religious fasting causes an inability to be compliant with oral meds, resulting in a longer time to recover from injury and thus delayed return to work. In that scenario, is it the responsibility of Worker's Compensation to pay this patient/employee's salary for those work days that were missed due to religiously-based deviation from the recommended treatment plan?

When patients tell me, as many have, that God has brought them to me for treatment, what is the culturally-appropriate response? Should I dodge the issue and say nothing? Should I engage in acceptance (that God brought the patient here) via culturally-inquisitive questions such as asking whether the god they are talking about is Yahweh vs. Jesus vs. Allah? Or would that just show my culturally-biased upbringing in one of these Abrahamic monotheistic religions, when really the person may be referring to Zeus, or Thor, or the 'Flying Spaghetti Monster' deity, or perhaps they are just referring to a "higher power"? Would it be culturally open-minded of me to ask which god (since they brought god into the discussion), or would it be offensive since my questioning would imply that there could be other god(s) besides theirs? If I just dodge the issue, does that fail to embrace the cultural-diversity that the patient brought into the medical interaction?

When patients tell me, as many have, that God is acting through me (as their physician), in my expertise in treating their coccydynia, how should I reply? Should I politely agree that God (whichever god they mean) is acting through me, which might imply that I am a supernaturally-empowered healer (and which could raise questions as to why I need the needles, the injectible steroids, and the fluoroscopy machine to do my magic).

When patients tell me, as many have, that "I thank God for having you choose to treat this condition," how should I respond? Should I say that I believe in 'free will' and that I freely chose this niche area myself (without divine command, at least that I know of), or might saying this offend their assertion that their God chose this for me, or at least directed me to this?

When a patient told me that she believed in astrology (that daily lives of individual humans are affected by the positions of the stars/planets in the solar system at the time the person was born), how should I have reacted? Next, she was insistent that I reveal to her my birth date (so that she could understand me via my zodiac sign)? Should I be respectful and embrace the diversity of a viewpoint different than mine, or should I diplomatically decline to reveal my personal, semi-private information? When I arranged to have a covering colleague see her for one of her follow-up visits while I was away one week, she insisted on knowing the birthdates of my colleagues so she could determine which one (based on their Zodiac

signs) she would see in my absence. Should I have embraced her belief system, or should I have respected my colleagues' personal privacy? What if the patient's zodiac-based preference was at odds with the covering doctor that I would recommend based on differences in my colleagues' professional medical skills?

When a patient or medical student sneezes... should I say "God bless you"? Does that imply that I think they should be intervened upon by a singular (monotheistic) god (rather than embracing polytheism, e.g. "may the gods bless you")? Or is it just a quaint saying devoid of true religious meaning (in which case perhaps I would be using God's name in vain, thus violating one of the Judeo-Christian Ten Commandments)?

One day in clinic when I wrote something in red ink, a team member told me not to use red ink because Jesus had written his parts of the Bible using red ink. (Some versions of the New Testament use red ink for quotes attributed to Jesus.) Her implication was that only Jesus should be allowed to use red ink (but apparently no one told the pen manufacturers). Should I point out that the New Testament was written many decades after Jesus' death and no Bible scholars say Jesus himself wrote any of it at all? Would I be showing sensitivity by embracing open discussion about her religious viewpoint, or would I be offending her by pointing out that almost no one in her own faith believes what she is asserting? Should I stop using my red pen, to comply with her religious views? (What if next week she wanted me to stop using ALL pens?)

When patients wish me a Merry Christmas, should I say the same back to them? What if the medical student in the room with me is Muslim, atheist, Wiccan, etc., and the student might feel excluded? Should I ask the student what would be okay, or is that invading his/her privacy? What if the patient is darker-skinned than me: should I wish them a Happy Kwanzaa? Would that be culturally sensitive of me to acknowledge they might be celebrating that holiday (just as when someone finds it natural to wish me a 'Merry Christmas'), or would the "Happy Kwanzaa" be a presumptuous example of racial profiling?

Should I just wish everyone a happy 'winter solstice', since that is a common unifying event (i.e., regardless of ethnic/religious/cultural background we all share the same planet, the same sun, and thus we all experience that the daylight lengthens beginning in late December) or would this imply acceptance/endorsement of the ancient, pre-Christian belief in that December 25th was the birth of their pre-Christian god: the sun?

Should I just say "Happy Holidays", or is it offensive to not explicitly name the Christian holiday (as Bill O'Reilly suggests)? Since I am employed by a state-owned University (UMDNJ), if I do wish a patient a "Merry Christmas", while I am interacting with them in my official professional capacity

as a government employee, am I violating the First Amendment of the United States Constitution by portraying government endorsement of one particular religion (i.e., violating the "separation of church and state")? Is saying "Happy Holidays" in December an offensively tardy greeting to Muslims who had their Ramadan holy days more than 3 months before Christmas this year? Should I hang a secular-ish Santa decoration in my office waiting room, or does that offend the Westboro Baptists who say Santa is taking our kids to Hell?

To avoid the whole mess, I usually say nothing unless a patient wishes me something, then I say "Thank you... and a Happy New Year". (Or am I being biased to think that they go by the Gregorian calendar rather than the Chinese calendar, Mayan calendar, etc.?) Perhaps I should just wish them "Good will toward men"... (oops, that fails to mention women...).

Overall, you can see there are a multitude of questions that arise, just from this sampling.

While we respect each human and his/her rights to believe/practice their various traditions, there are times when we may question whether we can in good conscience respect the beliefs themselves. Particularly challenging are beliefs that contradict or impede what science tells us to be good medical care.

In conclusion, I wish you Peace, Health and Happiness, and a wonderful whatever holiday you are (or are not) celebrating.



### **Nine Steps for Success**

1. Always maintain the highest ethical standard.
2. Check your ego at the door and stay humble.
3. There is no substitute for hard work.
4. Treat everyone with respect—not just your boss.
5. Build your teams around nice people, and remove the jerks.
6. Make tough decisions sooner—do not wait.
7. Stay calm and thoughtful under stress.
8. Measure everything—you can't manage what you don't measure.
9. Develop five year plans.

### ***Quotes and Quotables***

“When you lose, don't lose the lesson.”

“Follow the three R's:

- Respect for self
- Respect for others
- Responsibility for all your actions”

“Share your knowledge. It is a way to achieve immortality.”

“Be gentle with the Earth.”



### Philosophical Sayings

*People may doubt what you say, but will believe what you do*

*Never explain—your friends do not need it, and your enemies will not believe it.*

*Time you enjoyed wasting was not wasted.*

*Courage is not a lack of fear, but the ability to act while facing fear.*

*If you're heading in the wrong direction, you are allowed a U-turn.*

*You've got to do your own growing, no matter how tall your father was.*

*The best way to predict your future is to create it.*

*Don't look where you fell, but where you slipped.*

*Look at life through the windshield, not the rearview mirror.*



*“Good fortune comes to those who write the fortunes,” read the tiny slip of paper. At year's end, the time is ripe for making fortune cookies. Here's your chance to predict the future, reveal a secret, or hint at something*

*really juicy. Just for the fun of it, instead of the traditional fortune cookie shape, these delicate, orange-scented cookies are rolled, cigarette-style. So, after you've written your prophetic message, just roll it up and tuck it into the cookie's hollow center.*

### Next Year's Fortune Cookies

*Makes 12 to 16 cookies*

- 1/2 cup all-purpose flour
- 1 tablespoon cornstarch
- 1/4 cup granulated sugar
- Pinch of salt
- 1/4 cup vegetable oil
- 2 egg whites, at room temperature
- 1 tablespoon plus 1 teaspoon Grand Marnier or other orange-flavored liqueur
- 1 teaspoon pure vanilla extract
- 1/2 teaspoon grated orange zest (about 1/2 medium orange)



1. Preheat the oven to 325°F. Line a baking sheet with a reusable nonstick sheet liner or parchment paper and set aside.
2. In a medium bowl, whisk together the flour, cornstarch, sugar, and salt until well blended. Add the oil, egg whites, liqueur, vanilla, and orange zest. Beat at high speed until smooth.
3. Start with just 2 cookies at a time, dropping the batter by level tablespoons about 3 inches apart of the baking sheet. Using the back of a spoon, spread each portion into a 4-inch diameter cookie. Bakes until the edges start to brown, 8 to 10 minutes.
4. Using a wide, thin, flexible spatula, lift each cookie off the baking sheet. (If it begins to bunch or tear, let it cool for another 15 to 20 seconds. Or if it cools too much on the pan, return the pan to the oven to resoften for about 1 minute.) Using your fingers, roll the hot cookie into a cylinder. Have a bowl of ice water close by to keep your fingertips cool. Place seam side down on a rack to cool completely. Repeat with the remaining batter. Before serving, slip a fortune into the hollow center of each cookie.

*Courtesy of Sara Perry, “Holiday Baking”*

### For the pooch in your family



#### Have any leftover turkey?

#### Turkey Bake Tempter

Makes 10-12  
Prep time: 10 min  
Cooking time: 40-45 min



- 1 lb minced turkey
- 5 oz dried breadcrumbs
- 1 egg, beaten
- 1 sweet potato, cooked and mashed
- 5 oz carrots, thinly sliced
- 3½ oz green beans, thinly sliced
- 1 tablespoon chopped sage
- 3 tablespoons homemade chicken stock or water
- 1 tablespoon brewer's yeast

1. Mix all the ingredients in a large mixing bowl until well combined. Transfer the mixture to a deep 10 x 12-inch ovenproof dish and level out with the back of a spoon. Bake in a preheated oven, 350° for 40-45 minutes until firm. Remove from the oven and leave to cool.
2. Cut the turkey bake into 2-inch squares and store for up to 5 days in an airtight container in the refrigerator. Serve cool or cold as your dog cannot digest hot food and it can cause damage to the lining of his stomach.

*Taken from PUPSNACKS*

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