Physiatry FORWARD

SUMMER 2025 | AAP'S MEMBER MAGAZINE

Association *of* Academic Physiatrists

Advocacy!

Learn more about our cover photo on page 4.


MCW PM&R Outing


UofL Residency Grads


Kessler Foundation on the Impossible Dream

UNC Team Discharges 1000th Patient

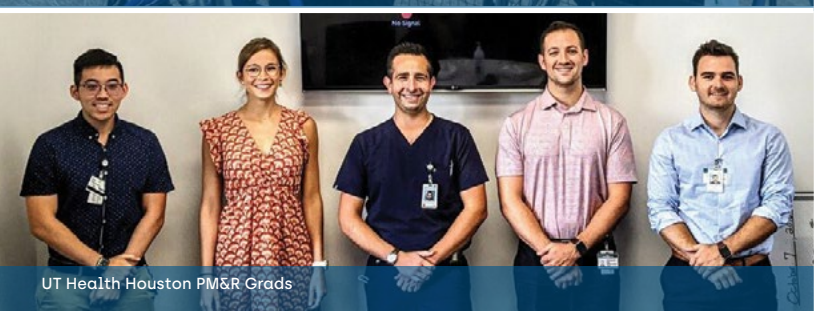

Neilsen Rehab Kayak Camp

Physiatry POV


New U of Minn Residents


Mayo Clinic


Incoming UNC Sports Med Fellows


UT Health Houston PM&R Grads


UCDavis Grads

Kessler Foundation

Mary Free Bed Hosts Adaptive Sailing Clinic


Mayo PM&R Grads

UT Health Houston Represents at SNOV


Mount Sinai Rehab Fun, Run, Walk & Roll


MossRehab Grads


New UNC Residents

UT Health San Antonio - FacultyResident Retreat


Yale PM&R Works with High School Athletes


UAB Grads


New Residents of UofL

VUMC and a Furry Visitor


UT Health San Antonio - Class of '27

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ON THE COVER

Members from our various councils and committees headed to Washington D.C. last fall to advocate for physician and patient rights.

***Physiatry Forward*, AAP's member magazine**

This season, we're focusing on a theme that doesn't take a vacation: advocacy. Big or small, public or behind the scenes, advocacy is at the heart of physiatry and the reason that we've come so far in rehabilitation medicine.

Inside, you'll find members voicing their concerns, inspiring others, and making waves. We hope these pages inspire you to keep pushing forward, using your voice and actions to shape a better future for physicians and patients alike.

Liz Raubach
AAP Communications Manager
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physiatry.org/PhysiatryForward

Physiatry Forward is published four times a year by the Association of Academic Physiatrists (AAP). With a circulation of 3,000, *Physiatry Forward* is sent to active members of the AAP. To view past issues, visit physiatry.org/PhysiatryForward.

Contribute to our Fall issue of *Physiatry Forward!*

Submit your photos, content, ideas, and more by visiting **physiatry.org/PhysiatryForward** and filling out a submission form.

FROM THE PRESIDENT

Dear AAP community,

Christopher J. Visco, MD

As I write we have just begun a brand-new academic year for the latest batch of physiatrists in training, who bring all the hope and enthusiasm we are fortunately accustomed to in our incredible field. At the same time medicine faces recent perils; measles case numbers have just reached an all-time high in recent history and a bill was signed into law that is projected to have devastating effects on Medicaid services particularly for patients with disabilities. It is dizzying.

This year I opened our training with a reaffirmation of the values that drive our core mission and keep us anchored during stressful times. For me, these are: 1. lead with kindness, 2. think of others before you think of yourself, 3. give grace. We reflect on these often in the course of clinical, professional, and personal activities. Do you also have personal and professional values that you would like to revisit? I'd love to hear about them.

Let me invite you to join the AAP in advocating for our shared academic mission, for physiatry, and most importantly for our patients. Advocacy is already at the core of who you are and the essential bedrock of what you do; advocating for your patients in the course of clinical care. Bring your values with you as we tackle the challenges ahead. In this issue of Physiatry Forward we can read on multiple topics of advocacy. As you explore please consider how you might lend your voice. After all, the professional legacy we all leave will be defined by our actions.

Christopher J. Visco, MD

Ursula Corning Associate Professor of Rehabilitation Medicine
Vice Chair, Department of Rehabilitation and Regenerative Medicine
Columbia University Vagelos College of Physicians and Surgeons

Director of Residency Training in Physical Medicine and Rehabilitation
Associate Director of Fellowship Training in Sports Medicine
NewYork-Presbyterian Hospital, Columbia and Cornell

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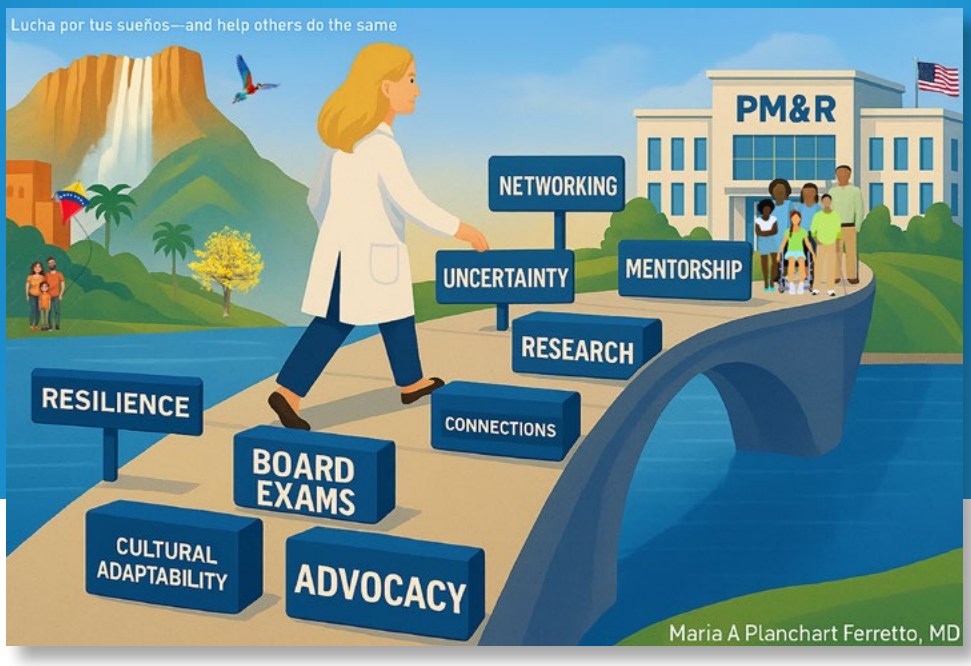
AUG 21-23 2025

CHICAGO

Advocating for the Advocate:

THE IMG PATH TO PM&R

By Maria Planchart Ferretto, MD



As a physician from Venezuela preparing to apply for residency in Physical Medicine and Rehabilitation (PM&R) in the United States, I've learned that advocacy isn't just about fixing broken systems. Sometimes, it begins with the courage to tell our own story.

For international medical graduates (IMGs), the path to practicing medicine in the U.S. is often long, challenging, uncertain, and invisible to those outside it. It involves navigating complex immigration requirements, breaking language and gender barriers, succeeding in national board exams, and embracing cultural change while staying clinically sharp in a constantly evolving field. However, for me, these obstacles served as a powerful motivation to become an advocate for myself, my colleagues, and the patients I hope to care for.

Advocacy has been part of my identity long before I learned the word for it. I am the daughter of a Chilean immigrant and breast cancer survivor and of a father who survived a heart attack in his thirties. From a young age, I witnessed how sickness could disrupt a family's life and how resilience and compassion could help rebuild a sense of dignity. As a student, I volunteered in nursing homes, distributed essential supplies to families in need, and organized medical brigades in rural communities. Those experiences exposed me to the painful reality that care is not always equitable, especially for people with disabilities. They inspired me to learn sign language so I could better connect with patients who too often go unseen.

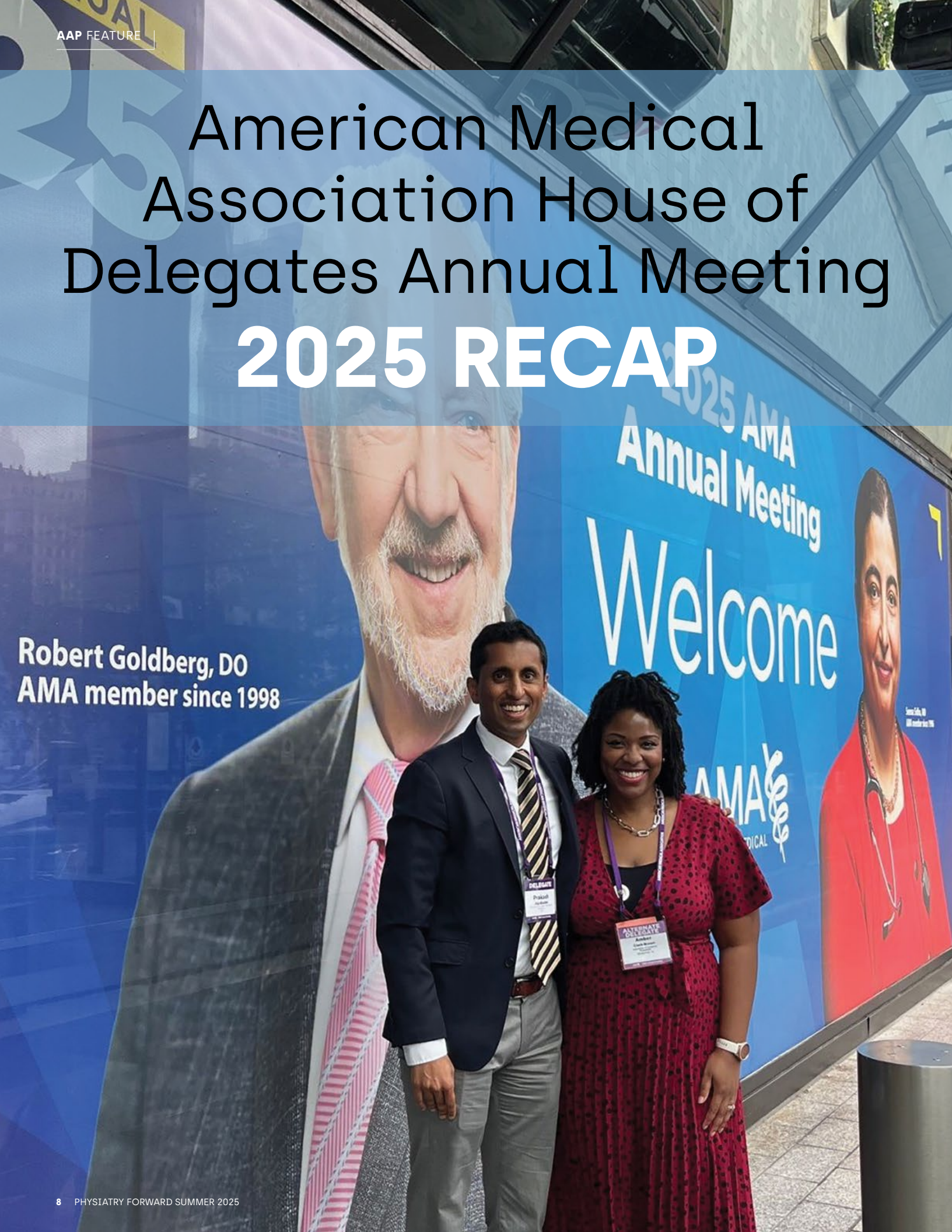
As the first doctor in my family, I have come to see advocacy as an action and a way of seeing the world. It means listening, adapting, and leading with empathy, even when resources are limited. Coming from a healthcare system in crisis, I carry a perspective shaped by resilience, creativity, and an unwavering commitment to ensuring that rehabilitation is recognized as a fundamental human right. I have witnessed how patients endure without access to rehabilitation and how communities fill the gaps left by fragmented systems.

I advocate not only for patients but also for other IMGs like me. We are not just applicants but future leaders, culture bearers, and bridge builders. We bring global insight, adaptability, and cultural humility to a specialty that thrives on empathy and whole-person care. Though I have not yet matched into residency, I have already begun mentoring other IMGs through this process by guiding study plans, assisting through documentation processes, connecting them to research opportunities, and, most importantly, reminding them that they are not alone.

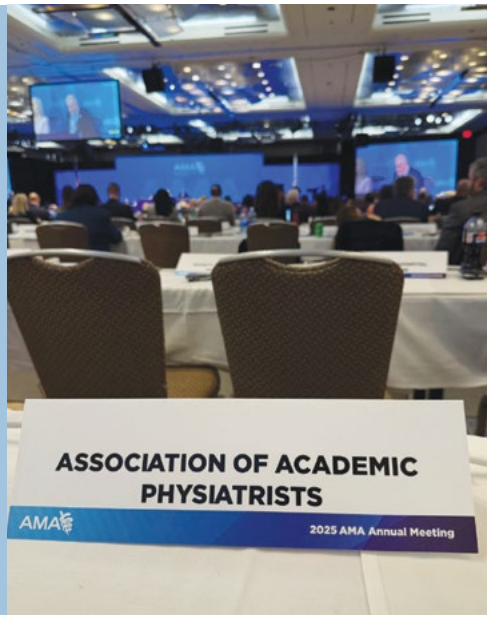
As a bilingual physician, I hope to advocate for multilingual and immigrant patients in the United States—people who, despite living in a country with greater resources, still face delays in care due to language barriers, limited access to transportation, lack of interpreter services, or fear related to immigration status. These realities will continue to shape my research, clinical focus, and advocacy throughout residency and beyond. I'm not just applying to PM&R; I'm pursuing a mission to build a future where rehabilitation is accessible, care is human-centered, every language is heard, and no one walks the path alone.

American Medical Association House of Delegates Annual Meeting

2025 RECAP



The House of Delegates (HOD) is the legislative and policy-making body of the American Medical Association (AMA). State medical associations and national medical specialty societies are represented in the HOD along with AMA sections. As the Delegate to the AMA, together with my colleague Dr. Amber Clark-Brown (Alabama Department of Public Health, Alternate Delegate), we represent the AAP.



The AMA HOD meets twice a year to review and discuss hundreds of resolutions related to issues in health and medicine that affect physicians across the specialties, and they held their Annual Meeting in Chicago, IL, from June 6-11, 2025. During the meeting, we also attend the PM&R, Mobility, and Neuroscience caucuses and are also members of the Academic Physicians Section.

At this year's meeting, due to the recent proposed changes at the federal level in health care, there were many resolutions focused on maintaining NIH funding for research, protecting access to care for patients, and making sure physicians' voices were heard in congressional houses. Some policies that were of particular importance to AAP members included:

NIH FUNDING FOR MEDICAL RESEARCH

This resolution, which was strongly supported by the PM&R caucus, was approved by the AMA HOD. In this approved resolution, the AMA would work with the NIH and other governmental funding agencies to oppose caps on indirect costs, including facilities and administrative reimbursements, that would restrict critical early-stage and independent research as well as grant-funded training programs. The resolution would also advocate for the ability of research institutions to negotiate indirect cost rates to ensure researchers can recover the full cost of conducting federally funded research. In addition, the AMA will advocate for targeted reforms to streamline administrative and regulatory requirements to achieve sustainable cost reductions while preserving essential research infrastructure.

SUPPORT FOR CONTINUANCE OF MEDICAID WAIVERS

Protecting Medicaid for the health of millions of individuals, particularly for individuals with and without disabilities across the country, received strong support and was a focus of multiple resolutions. Specifically, resolutions were passed in which the AMA would advocate for the approval of the renewal of Medicaid waivers (section 1115) that will improve and preserve the Medicaid program as a critical safety net for patients. In addition, federal funding for Designated State Health Programs (DSHP) in Medicaid Section waivers should also be continued. There was also a resolution passed in which the AMA would advocate for the inclusion, renewal, and expansion of food and nutritional services in Medicaid Section waivers, as a strategy to reduce food insecurity and improve health outcomes among Medicaid beneficiaries.

EMERGENCY RESOLUTION REGARDING THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES

While the Annual HOD Meeting was occurring, separately, the 17 members of the CDC's Advisory Committee for Immunization Practices (ACIP) were removed by the Department of Health and Human Services (HHS). ACIP makes recommendations on the safety, efficacy, and clinical need of vaccines. ACIP decisions have typically been evidence-based and informed by input from stakeholders and subject matter experts. In response, an emergency resolution was introduced by multiple specialty organizations, including the American College of Physicians, on the floor of the AMA HOD, to address this matter. The resolution would direct the AMA to sustain public support for the current ACIP structure, and also encourage both the Secretary of HHS (Secretary Kennedy) and the appropriate Senate Committees to reconsider the changes that were implemented. This resolution received very support and testimony was ultimately passed by the HOD.

WHY SHOULD YOU JOIN THE AMA?

For the AAP to be a member and participate in the AMA, the AAP must maintain a certain number of AMA members. The AAP needs to have a voice! Please consider joining the AMA so that the AAP can continue to represent you and the field of physiatry. For more information on AMA membership, go to: www.ama-assn.org/membership.

Prakash Jayabalan MD, PhD *(Shirley Ryan AbilityLab)*
Delegate to the AMA HOD for the AAP

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Association canadienne de médecine physique et de réadaptation

Bridging Mind & Motion:

A Physiatrist-Led Call to Integrate Mental-Health Care in Puerto Rico

By: Israel A. Mojica, MD

Research indicates that co-morbid depression or post-traumatic stress disorder (PTSD) can significantly prolong inpatient rehabilitation stays by approximately 20–25% longer. For example, trauma patients who screened positive for in-hospital PTSD and/or depression experienced notably longer hospital stays compared to those without these conditions.[7] In stroke rehabilitation, a history of depression has likewise been associated with longer lengths of stay and less efficient functional gains.[4]

Even brief psychological interventions can yield measurable functional benefits during rehabilitation. Depressed patients tend to use rehabilitation services less efficiently—showing smaller Functional Independence Measure gains per day—so addressing mood symptoms early is crucial.[4]

Nearly half of Puerto Rican stroke survivors suffer from depression. One study reported that 49% of stroke survivors of Puerto Rican origin had post-stroke depression, compared to about 32% among other Latino groups.[3]

A 2022 report noted that 32 out of 78 municipalities in Puerto Rico had no psychiatrist at all, and the territory now has the lowest per-capita availability of mental health professionals of any U.S. state or territory.[1]

Recent data demonstrate a dramatic expansion of telehealth use among Spanish-first speakers. The COVID-19 pandemic catalyzed a more than 12,000% surge in Medicare telehealth visits in 2020 as services shifted to remote delivery.[2]

Providing care in the patient's primary language leads to better engagement and outcomes. Studies find that Spanish-speaking patients seeing Spanish-speaking providers have improved follow-up adherence and reduced no-show rates.[6]

Unaddressed mental health needs can contribute to medical complications and readmissions. Hospital readmissions after stroke cost on average $15,000–$20,000 per event. Reducing avoidable readmissions—by treating depression or anxiety that hinders recovery—can save tens of thousands of dollars per patient.[8]

Integrating behavioral health early in the rehabilitation process is not only clinically effective but also cost-effective. Proactive mental health screening and consultation services for hospitalized patients lead to shorter lengths of stay, and savings from reduced complications and days in hospital often outweigh program costs.[5]

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MEDICAID IS A LIFELINE FOR OUR PATIENTS WITH DISABILITIES. WE MUST PROTECT IT.

By: Therese Derovanessian, MD

Mr. Johnson arrived on the inpatient rehabilitation floor unable to move the left side of his body, barely able to speak after a massive stroke. Day by day, with intensive therapy, he began to regain his speech and mobility.

Ms. Tammy, who lives with cerebral palsy, came in with her caregiver to replace her broken wheelchair after years of use. Her replacement allowed her to maintain her independence.

What both patients had in common, and the only reason they could access this essential care, was that they, like 43% of all non-elderly disabled adults, were covered by Medicaid.

Physiatrists have seen what happens when patients are denied medically necessary rehabilitation—not because it is not indicated, but because of insurance coverage. The proposed "One Big, Beautiful Bill" Act threatens to restrict essential access to rehabilitation services further. The bill would slash $700 billion from Medicaid over the next decade through eligibility restrictions, benefit reductions, and privatization.[1] According to the Congressional Budget Office, nearly 11 million Americans could lose coverage entirely.[2] This is particularly alarming for the disability community, who account for 72% of all Medicaid expenditures[3] and account for 15 million people.[4]

For our patients, Medicaid isn't a safety net—it's the foundation for survival.[5] The consequences of gutting Medicaid go far beyond numbers on a spreadsheet—they are felt most acutely by people with disabilities. The House's 2025 budget proposal would slash over $2 trillion in programs serving low- and moderate-income Americans, with Medicaid bearing a major brunt. For people with disabilities, this could mean losing access to home care, personal attendants, assistive equipment, or even institutional care—services that are often life-sustaining. According to the Center on Budget and Policy Priorities,[6] many of the proposed changes are not designed with the unique realities of disability in mind: they ignore that many disabled individuals cannot meet work-reporting requirements and already face extensive administrative hurdles.

Disability rights activist Julie Farrar recently said in an interview,[7] "I was born missing 12 vertebrae, and every six months, I have to prove I'm still disabled enough to qualify."

The disability community is already subject to exhausting eligibility reviews and coverage instability. Further cuts will only deepen this issue, isolating people from the care that supports their survival, independence, and dignity.

FOR OUR PATIENTS, MEDICAID ISN'T A SAFETY NET—IT'S THE FOUNDATION FOR SURVIVAL.[5] THE CONSEQUENCES OF GUTTING MEDICAID GO FAR BEYOND NUMBERS ON A SPREADSHEET—THEY ARE FELT MOST ACUTELY BY PEOPLE WITH DISABILITIES.

We must reject this direction.

Physiatrists are at the frontlines. We understand the value of function, the cost of losing it, and our patients' long, non-linear journeys. We cannot stay silent as access to that care is eroded.

While we defend Medicaid, we must also look forward. A well-designed single-payer system—such as that proposed by Physicians for a National Health Program (PNHP)— would ensure continuity, equity, and dignity. Critically, it would include:

- Home and Community-Based Services (HCBS)
- Inpatient rehabilitation and long-term post-acute care
- Durable Medical Equipment (wheelchairs, ventilators, communication devices)
- Personal care attendants and in-home nursing
- The urgency is real. In May 2025, ADAPT activists were arrested at the Capitol, demanding the protection of Medicaid and the civil rights of disabled Americans. This is not a theoretical debate—it is unfolding now at the intersection of medicine, policy, and survival.

As physicians and physiatrists, we must:

- Refuse to normalize exclusion from rehabilitation and lifesaving services
- Advocate for payment models that center human dignity—not just cost-efficiency
- Bring disabled voices into PNHP, medical education, and every space where care systems are designed

Physiatry was built to restore function and preserve independence. We must use that expertise to build a system that includes everyone—not just those who can afford to fight for it.

Therese Derovanessian, MD is an Armenian-American from Seattle, Washington who recently graduated from medical school in New York and is now an incoming preliminary medicine resident at NYU Langone Long Island. She will continue her advanced PM&R training at Johns Hopkins.

Therese is passionate about disability justice, health policy, and advancing global rehabilitation care. She actively advocates for legislation impacting her patients' lives and believes physician voices are essential at the policy table. Clinically, Therese gravitates toward interventional pain management, especially for oncological and medically complex patients. However, she remains open-minded and curious, finding nearly every subspecialty within physiatry engaging and full of possibility.

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Association *of* Academic Physiatrists

APPL 2025 REPORT

ADVOCACY & PUBLIC POLICY LEADERSHIP PROGRAM

The first cohort of the new AAP Advocacy and Public Policy Leadership Program (APPL) attended a pre-conference workshop on Legislative topics at Physiatry '25. The three-year program, led by Chloe Slocum, MD, MPH, Spaulding Rehabilitation, and Greg Worsowicz, MD, MBA, Mayo Clinic, provides background knowledge and experiences in legislative and regulatory policy to Physiatric academic faculty.

LEGISLATIVE WORKSHOP TOPICS

Health Policy & Physiatry; Thriving as a Physician Advocate: Developing Your Skills; The Basics of the Legislative & Budgeting Processes; Building Strategic Coalitions in Rehab; Do's and Don'ts of Lobbying: Preparing to Speak to Legislators

PARTICIPANT INSTITUTIONS

- Burke Rehabilitation Institute, NY
- East Carolina Brody School of Medicine, NC
- Northwell Health, NY
- Sidney Kimmel Medical College at Thomas Jefferson University, PA
- University of Missouri, MO
- University of Utah Health, UT

EXPERT FACULTY

- Kate Beller, JD; *AMRPA*
- Elissa Charbonneau, DO, MS; *Encompass Health*
- Bruce Gans, MD; *Powers Pyles Sutter & Verville PC*
- Prakash Jayabalan, MD, PhD; *Northwestern/Shirley Ryan AbilityLab*
- Mooyeon Oh-Park, MD; *Burke Rehabilitation Hospital*
- Danielle Perret Karimi, MD; *UCI School of Medicine*
- Danielle Powell, MD; *University of Alabama at Birmingham*
- Chris Rorick; *Polsinelli*
- Felicia Skelton, MD, MS; B*aylor College of Medicine*
- Chloe Slocum, MD, MPH; *Spaulding Rehabilitation/Harvard Medical School*
- Ross Zafonte, DO; *University of Missouri*

APPLICATIONS FOR 2026 ARE NOW OPEN!

Upcoming workshops will cover topics based on themes of Patient Impact and Administration / Regulatory topics.

APPLY BY SEPTEMBER 1st

More information is available at **physiatry.org/APPL**

PHYSIATRY FOUNDATION

Summer Wrap-Up

Hats off to the grads!

We're cheering on all the new physiatrists as they take their next big step—congrats on your incredible achievement! Shine bright and lead the way!

Thank you to our residency programs!

This summer, programs across the country honored their graduating physiatrists through special tributes. Your generosity supports scholarships for PAL, RMSTP, and APPL, fuels Mission Innovation, and advances programs for medical students. We're grateful for your partnership—and we hope to celebrate together again in 2026!

Mission Innovation has launched!

We received a wave of bold proposals aimed at advancing wellness, education, global outreach, and DEI in physiatry. Thank you to everyone who submitted their vision—we're excited to announce awardees in the coming months!

What's Coming This Fall

Medical Student Annual Meeting Scholarships

Starting this September, the Physiatry Foundation will offer scholarships for medical students to attend the AAP Annual Meeting—helping future leaders experience the energy, inspiration, and community of AAP.

2nd Annual Pickleball Championship @ Physiatry '26

Team registration opens this fall for our second Pickleball showdown! Who will challenge our reigning champs from Shirley Ryan AbilityLab? Start planning your all-star teams now—game on!

End-of-Year Giving

We're already 70% of the way to our $100,000 goal for 2025! With your continued support, we'll hit our target—and unlock a matching gift from AAP, doubling your impact. Thank you for helping us shape the future of physiatry.

CELEBRATE A GRAD 2025

*Congratulations **UT Southwestern** graduates on achieving this amazing milestone in your journey! Y'all have demonstrated such growth and development during residency. We are incredibly proud of each and every one of you!*

*On behalf of the entire **UPMC Department of Physical Medicine and Rehabilitation,** we extend our heartfelt congratulations to each of you on reaching this incredible milestone. Your dedication, resilience, and unwavering commitment to patient care, research, and the advancement of physical medicine and rehabilitation have been genuinely inspiring. Throughout your journey, you each have demonstrated the spirit of teamwork, leadership, and compassion that defines the very best of our field. You've left a lasting impact on our department, the faculty and staff, and the patients you've served — and we are proud to have been part of your story. The Future of PM&R is brighter because of you.*

***The University of Alabama at Birmingham (UAB) Department of PM&R** would like to congratulate our 2025 graduating residents — Dr. Cynthia Francis, Dr. Viny Memula, Dr. Darien McNeill, and Dr. Jason Schroeder! We are so proud of you and look forward to the many wonderful contributions you will make to the field of physiatry.*

Big Congratulations to Burke Graduates

Drs. Ricky Ju, Kenia Maldonado-Vergara, Brandon Roberson, Tiffany Ezepue, Atinder Nijjar, and Lili Wang!

*On behalf of the faculty and staff from **Northwell's Department of PM&R,** it is my great pleasure to extend my heartfelt congratulations to Dr. Marielle Araujo, Dr. Elizabeth Cipparrone, Dr. David Popok, Dr. Eli Sepkowitz, and Dr. Darcey Hull on reaching this significant milestone in their medical journeys. Today marks the culmination of years of dedication, sacrifice, and perseverance. You have not only met the high standards of this residency program, but you have also grown into compassionate, skilled, and resilient physicians. All the best!*

Join the Movement & Celebrate Your Favorite Grads

Disruptive Innovation in Physical Medicine and Rehabilitation

By: Dan Pierce, MD

Our field's continued relevance in healthcare will not be preserved by drifting further into high-margin activities, but by maintaining our identity as leaders in function and complex recovery across all levels of care.

Disruptive innovation,[1] a term coined by Harvard professor Clayton Christensen, describes how simpler, more accessible business models can overtake more established ones — not by outperforming them, but by serving the needs that incumbents have previously ignored. Initially dismissed as less sophisticated or niche, these innovations grow by appealing to underserved populations or by solving less complex problems — areas often overlooked by incumbents focused on high-margin, more specialized services. A classic example is the personal computer: initially dismissed as underpowered substitute to mainframe computers, it ultimately redefined the market by meeting users' evolving needs. Given the financial pressures reshaping today's healthcare landscape, this concept should give the PM&R community pause. Could our specialty ever experience the same fate as the mainframe computer?

Since its formal organization nearly a century ago, physiatry has worked hard to gain recognition within healthcare. We are currently seeing increased interest in our field but is this enough to sustain our specialty's place in healthcare? The same structural threats to our specialty noted by Gans[2] in 2006 persist: blurred specialty lines, decreased interest in post-acute rehabilitation, and increased competition from other clinicians for rehabilitation-related services. Our specialty has been historically rooted in the coordination of multidisciplinary rehabilitation care across the healthcare continuum. With time, however, our field seems to be transitioning towards higher sophistication (and higher margin) interventions, often involving new diagnostic technology or more profitable procedures. While these developments reflect legitimate clinical advancement, they also signal a potential migration away from the core of our specialty and vulnerability to a future disruptive entity.

Take direct access to physical therapy, a potential disruptor. Nebraska was the first state to permit direct therapy access in 1957, and now all fifty states allow some form of direct access.[3] The healthcare delivery model of direct access to therapy could be viewed as a cheaper and more convenient, albeit less sophisticated, model than one requiring physician oversight. As these care delivery models continue to evolve, including those employing expanded PT scope for imaging orders and limited medication prescribing,

physiatrists risk being circumvented from the very care processes they once led. If physiatry continues to trend "upmarket" by focusing on more sophisticated interventions while delegating core rehabilitation decision-making, we risk being quietly bypassed. When PM&R referrals to therapy simply read "eval and treat," we inadvertently reinforce this disruption by delegating our traditional role as leaders of the rehabilitation team.

At the same time, the broader healthcare system is undergoing a shift away from fee-for-service reimbursement and toward value-based care. This transformation, while not an example of disruptive innovation itself, shifts incentive structures by rewarding outcomes over volume. While disruptive innovations often succeed by undercutting incumbents on cost or convenience, value-based care creates an opportunity for PM&R to reassert its relevance by demonstrating how traditional physician-led rehabilitation models can improve function, reduce complications, and lower total cost of care.

As academic physiatrists, we are stewards of the specialty's identity and future. Our role is not only to train the next generation of clinicians but to help shape the systems in which they will practice. That means developing care models that highlight our field's unique strengths and ensuring trainees become true experts in both physical medicine and rehabilitation medicine.

Disruptive innovation rarely arrives with fanfare. It chips away at the margins until the status quo no longer holds. The risk for physiatry-led rehabilitation care models is not replacement by superior care, but marginalization by models that are simpler, faster, and easier to access. Our field's continued relevance in healthcare will not be preserved by drifting further into high-margin activities, but by maintaining our identity as leaders in function and complex recovery across all levels of care.

Dan Pierce, MD, is an early-career general physiatrist interested in healthcare delivery, quality, and policy. He is an Assistant Professor at University of Nebraska Medical Center and has clinical appointments at Nebraska Medical Center, Omaha VA Medical Center, and Madonna Rehabilitation Hospital.

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SPOTLIGHT: INTERNATIONAL PHYSIATRY PHILIPPINES

Curious about how the field of Physiatry is practiced around different parts of the world? Join us for this edition of the AAP Junior Faculty Council's—International Physiatry Column—where we interview Physiatrists who have had experiences practicing around the globe. In this edition we speak with Dr.Reynaldo R. Rey-Matias. MD, FPARM, PTRP, MSHMS, DPBPM. Dr. Rey-Matias is a professor and chair of Physical Medicine & Rehabilitation at St. Luke's Medical Center in the Philippines

Written By: Faheem Mahomed, MD - Assistant Professor, Pediatric Rehabilitation, Dell Children's Medical Center, University of Texas (UT) - Austin

Q: Hello Dr. Rey-Matias! Thanks so much for joining us for this discussion!

A: My Pleasure! I am happy to share my experience working in the Philippines!

Q: Can you tell us a little background about your education/training/work history?

A: I graduated with a Bachelors of Science in Physical Therapy from the University of Santo Tomas (UST) College of Rehabilitation Sciences. I received my medical degree from UST Faculty of Medicine and Surgery. My residency in Rehabilitation Medicine was completed at the University of the Philippines - Philippine General Hospital. I've served as the Past President of the ASEAN Rehabilitation Medicine Association, Asian Oceanian Society of Physical Rehabilitation Medicine and am the Current Secretary of the International Society of Physical and Rehabilitation Medicine (ISPRM).

Q: How did you come across the opportunity to work in rehabilitation in the Philippines?

A: I became interested in PM&R during medical school, where I was drawn to the holistic and functional approach of the specialty—focusing not just on treating disease but on restoring quality of life. The opportunity to practice in the Philippines came naturally after I trained there (as I was originally from the Philippines). Many tertiary hospitals in the country have PM&R departments, and there's a growing need for rehabilitation services due to the aging population and the high burden of conditions like stroke, musculoskeletal disorders, and traumatic injuries.

Q: Is it a field that is well established there, or did you have to lay some of the groundwork for your practice?

A: PM&R is a recognized and established specialty in the Philippines, with residency programs accredited by the Philippine Board of Rehabilitation Medicine (PBRM). However, while it's well established in academic and urban medical centers, there are still gaps in awareness, accessibility, and infrastructure, especially in rural areas. So, depending on where I chose to practice, I may have had to do some groundwork—educating other medical professionals, building interdisciplinary teams, or even advocating for better rehabilitation facilities.

Q: Did you explore other opportuni0es outside the Philippines before choosing to work there?

A: Yes, I considered opportunities abroad—particularly in countries like the U.S., Canada, or Australia, where PM&R is highly specialized and better resourced. However, I ultimately decided to stay in the Philippines for several reasons: a strong connection to the local community, the opportunity to contribute to a growing field, and the chance to make a more immediate impact in a setting where rehabilitation services are still developing. It felt like a space where I could be both a clinician and a change-maker.

Q: Are there opportunities for U.S. or foreign-trained physicians to work in Physiatry in the Philippines?

A: Yes, there are opportunities, but with caveats. Foreign-trained physiatrists can potentially work in the Philippines, especially in academic, research, or volunteer capacities. However, clinical practice rights are more restricted and tightly regulated, particularly for non-citizens.

Q: How does getting your medical license in the Philippines work if you're foreign-trained?

A: Under current Philippine law, only Filipino citizens can be fully licensed to practice medicine (including PM&R) in the Philippines; If you're a dual citizen (e.g., U.S.-Philippine), you can sit for the Philippine Physician Licensure Examination (PLE), administered by the Professional Regulation Commission (PRC); If you're not a Filipino citizen, you typically cannot practice independently unless you're involved in temporary humanitarian work or international medical missions and/or you've secured special permits from the PRC and/or Department of Health (DOH).

Q: Do you have to take any additional exams to be allowed to work there if foreign-trained?

A: Yes—if you want to legally practice medicine in the Philippines, you must pass

the Physicians Licensure Examination regardless of where you trained (unless you're only participating in short-term programs or under very specific foreign-expert arrangements).

Q: Is there any supervisory period required if you trained elsewhere?

A: For those who completed residency abroad, local board certification is still typically required to be recognized as a specialist. This is assessed case-by-case by the Philippine Academy of Rehabilitation Medicine (PARM) or the PBRM.

Q: Are there language fluency requirements?

A: English is the primary language used in medical education and hospital settings in the Philippines. No formal language test is required if you're fluent in English.

Q: Tell us about your practice in the Philippines. What is your setup like?

A: I work in a hybrid setup that includes both inpatient and outpatient rehabilitation. My main base is a tertiary hospital in Metro Manila where I see a wide range of cases—from stroke, spinal cord injury, and TBI to musculoskeletal pain and post- surgical rehab. I also have a small private clinic practice, and I do some academic work part-time, mentoring residents and contributing to research. Many rehab physicians here practice across multiple facilities—government hospitals, private hospitals, and outpatient centers. That's quite common due to the structure of healthcare and demand for services.

Q: Do you mostly do inpatient or outpatient work?

A: I'd say about 60% outpatient, 40% inpatient.

- Outpatient: I see patients with chronic pain, sports injuries, amputations, pediatric disabilities, and post-stroke follow-ups;
- Inpatient: We manage rehab programs for patients recovering from neurologic events, orthopedic surgeries, and ICU-acquired weakness. Rehab teams are usually multidisciplinary—physiatrists, PTs, OTs, speech therapists, and rehab nurses.

Q: How many patients do you see each day? How many days a week are you working? What are your hours like?

A: Outpatient clinics: Around 15–25 patients/day, depending on the complexity; Inpatient rounds: I follow 10–20 patients, either as the consulting physiatrist in most of the cases. I typically work 5.5-6 days per week, which is pretty standard here; Monday to Friday: 8:00 AM – 5:00 PM, Saturday (half-day): 8:00 AM – 12:00 PM; I also handle administrative work and teaching in between clinical hours.

Q: What is call like? Is it similar to the US?

A: Call is much lighter compared to other specialties. Rehab is generally a consultative service, so we're not usually on-call for emergencies, but we are available for urgent inpatient issues—like changes in functional status or spasticity management. In private practice, you may be on informal call for your patients (e.g., follow-up issues via mobile). The call system isn't as formalized or burdensome as in U.S. hospitals. Most rehab physicians in the Philippines do not have overnight in-house call.

Q: What does your patient population in the Philippines consist of?

A: The patient population is quite diverse, but some diagnoses are very common due to the country's epidemiological profile and health system characteristics. For example, there are a lot of stroke/CVA cases and TBI especially due to motor vehicle accidents as well as acute/chronic pain and sport injuries. There is very limited access to pediatric rehabilitation, so I do take on cases of cerebral palsy and developmental delay.

Q: Do you see patients from outside the Philippines?

A: Occasionally, yes—especially in private hospitals like St Luke's Medical center. Medical tourists or expats from neighboring countries (e.g., Indonesia, Papua New Guinea, Pacific Islands) sometimes come for care in post-stroke rehab, prosthetic fitting/training, and specialist consultations in spasticity management. Some are OFWs (Overseas Filipino Workers) who come home after an injury or illness abroad and seek comprehensive rehabilitation here.

Q: What is the general awareness of PM&R as a specialty like in the Philippines? Is it a well-known specialty among physician/patients there?

A: PM&R is a recognized and board-certified specialty in the Philippines, but its visibility and perceived value vary significantly depending on the setting and the specialty of the referring physician.

In urban areas and tertiary hospitals, there's growing awareness of what physiatrists do—especially among stroke patients, orthopedic patients, and families with children with developmental conditions – however, in more rural or underserved areas, many still don't know what a "rehab doctor" is until they're referred. Some think we're just physical therapists or confuse us with orthopedic surgeons.

Among physicians in tertiary hospitals and academic centers, PM&R is fairly well known, especially in departments like Neurology, Orthopedics, Pediatrics, and Internal Medicine. Younger physicians and medical students tend to have better exposure to PM&R now, thanks to stronger residency programs and inclusion in clinical rotations.

Q: Are Families and Patients Appreciative of the Care?

A: Yes—very much so. Once they understand what PM&R involves, families are incredibly grateful. There's often a sense that rehab is where healing continues—especially after the "main" medical crisis is over. We help bridge that gap, and patients pick up on that. There are some cultural factors at play though as many Filipino families are deeply involved in caregiving. This means we often spend as much time educating and supporting the family members as we do the patients. There's sometimes a reluctance to accept long-term disability or chronic conditions, especially in younger patients, so counseling and psychosocial support are critical parts of what we do.

Q: How do other specialists view PM&R there? Do other physicians know when and what to refer to you for?

A: It's generally a respectful but mixed perception depending on their experience working with physiatrists. Neurologists

and orthopedic surgeons who've collaborated with us on stroke rehab, SCI, or post-op recovery usually have high regard for our role. Some surgeons and internists, especially those unfamiliar with rehabilitation medicine, may under-appreciate our scope, seeing us mainly as referring to therapy rather than leading interdisciplinary rehab.

There's a growing recognition that PM&R bridges gaps in care, especially for chronic disability, function loss, and long-term recovery—things not typically addressed in acute specialties. In larger hospitals or academic settings, yes—referrals are appropriate and often timely. In smaller hospitals or private practice, it's hit-or-miss. Some refer too late (e.g., months after a stroke), or only when "all else fails." Others may not refer at all, simply prescribing therapy themselves without involving a physiatrist.

Q: Is there a big need for PM&R in the Philippines?

A: Without a doubt. The demand far exceeds the current capacity of the healthcare system to deliver comprehensive rehabilitation services. There is a high burden of disability-related conditions, gaps in access to rehabilitation services, and a shortage of physiatrists, especially outside of major urban areas. Many provinces and smaller islands have no dedicated rehab physicians, therapists, or equipment. Rehabilitation is often underfunded, and public hospitals may lack comprehensive multidisciplinary teams or assistive technology.

However, there seems to be growing awareness and recognition as more Filipinos survive strokes, cancer, and ICU stays. Families are now looking for ways to optimize recovery and long-term function, which is exactly where PM&R comes in. There's increasing demand for pediatric rehab and early intervention services as autism and developmental delays become more widely recognized and diagnosed.

Q: Is there demand for PM&R in the region (Southeast Asia) in general?

A: Yes—across Southeast Asia, the situation is similar. Many countries in the region face aging populations, high trauma burdens (from road traffic accidents), and rising NCDs. Health systems have historically focused on acute care and are now catching up in building post-acute and rehabilitative care infrastructure. The WHO Rehabilitation 2030 initiative has highlighted the need to scale up rehab services globally, and many ASEAN countries, including the Philippines, are now beginning to respond to that call.

Q: What are some of the big differences between working in the Philippines' health system vs. other countries?

A: In the Philippines, especially in public hospitals, limited resources are a major constraint. There are fewer rehab physicians per capita, scarce access to assistive devices (wheelchairs, prosthetics, orthotics), and often outdated or unavailable therapy equipment. In the Philippines, access to PM&R varies dramatically by geography and income. Urban centers (like Metro Manila) have decent access, but many rural or island communities have no rehab services at all.

Although there is PhilHealth (the national health insurance program), rehab services—especially outpatient care, prosthetics, and home modifications—are often paid out-of-pocket. A family might delay rehab because they can't afford transportation or therapy fees.

Filipino families are deeply involved in caregiving, often providing full-time support at home after discharge. There is a strong sense of family obligation, which helps in rehab adherence, but sometimes leads to overprotection or delay in seeking professional help.

Multidisciplinary rehab teams are growing but still uneven. Many centers lack speech therapists, rehab nurses, or psychologists.

Q: What are some of the positive aspects of working in the Philippines?

A: Patients and families are genuinely appreciative of the care we provide. The relationships feel personal, and you often see firsthand how your interventions improve lives. You can have a huge effect on quality of life, especially where rehab resources are limited. Working in your own culture adds emotional depth to your work. There's a communal atmosphere among staff and parents that fosters collaboration and loyalty.

Q: What are some of the negative aspects?

A: Many hospitals lack equipment, assistive devices, therapy staff, or updated technology. You often have to get creative with low-cost solutions or improvise to meet parents' needs. Many patients pay out-of-pocket for therapy, medications, and mobility aids. Some skip rehab altogether due to cost, even when it's urgently needed. You know what could help, but you have to work within what they can afford. Bureaucracy can be frustrating—delayed referrals, insurance issues, and slow hospital processes are common. Administrative burdens often fall on physicians due to understaffing. Outside major cities, there's often no access to rehab medicine at all. This leads to delayed care, worsened outcomes, and referrals that come far too late.

Q: What advice would you give to someone interested in working abroad, and in the Philippines specifically?

A:

- **Do Your Homework on Licensing and Regulations** - If you're foreign-trained, you'll need to pass the Philippine Physician Licensure Exam (or meet specific equivalency requirements). Start the licensing process early—it can take months or even years. Understand visa and work permit requirements as well.
- **Understand the Healthcare System and Practice Environment** - Be ready to work in settings with limited equipment and variable multidisciplinary support. Familiarize yourself with the cultural norms around healthcare and family involvement.
- **Build Cultural Competence and Language Skills** - While English is widely spoken, fluency in Filipino/Tagalog or regional languages will enhance communication and patient rapport. Learn about local health beliefs, family dynamics, and social structures.
- **Be Flexible, Resourceful, and Patient** - Expect to adapt your clinical practice to the resources at hand, and be creative with treatment plans and rehabilitation strategies. Patience is key—progress may be slower due to system constraints or socioeconomic factors.

- **Engage in Networking and Mentorship** - Networking with other mentors that have experience working in the Philippines helps with job opportunities, professional growth, and understanding local nuances.
- **Prepare for a Deeply Fulfilling Experience** - Working in the Philippines offers the chance to make meaningful, visible impacts on patients' lives. The work is rewarding but challenging, requiring resilience and compassion.
- **Consider Your Personal Support and Lifestyle** - Reflect on your own emotional and social support systems—working abroad can be isolating at times. Keep open communication with family and friends back home, and consider living conditions, cost of living, and lifestyle adjustments.
- **Be Ready to Advocate and Educate** - PM&R is still growing in the Philippines, so you'll likely spend time educating colleagues, patients, and families about the specialty. Advocacy for better rehab services is part of the job.

Q: Do you feel that you are well compensated? How do compensation and benefits in the Philippines compare to other countries?

A: In general, physiatry salaries in the Philippines are lower than what you'd expect in higher-income countries like the U.S., Canada, or Australia. However, the cost of living is also lower, which somewhat balances the difference. Many physiatrists working in private practice or in well-established tertiary hospitals may earn better than those in public or rural settings. Benefits like health insurance, retirement plans, paid vacation, and sick leave vary by employer. Government hospitals may have standardized benefits but lower pay. Private hospitals or clinics often offer better compensation packages. Compared to other countries, vacation Eme may be shorter, and work-life balance can vary.

Q: What are your favorite things about living in the Philippines? Do you see yourself staying long term or exploring opportunities elsewhere?

A: The Philippines is stunningly beautiful—from tropical beaches and islands to lush mountains and vibrant cities. I love the warm climate and being close to nature, which offers a great balance to the demands of medical practice.

Filipino culture is warm, hospitable. It is community-oriented with a large variety of flavors in food, festive celebrations, and deep family traditions that bring people together. The close-knit family ties and community spirit create a support system that's hard to find elsewhere. There's a genuine sense of belonging and connection in both professional and personal life.

Being able to contribute to a growing specialty like PM&R in a developing health system gives me a sense of purpose and fulfillment. I enjoy the collaborative spirit among colleagues and the gratitude from patients.

Q: What were your expectations about working as a PM&R physician in the Philippines, and how did those expectations compare to your actual experience?

A: I anticipated some challenges with limited equipment and infrastructure, especially compared to more developed countries, but it was often greater than I had imagined – this often required even more creativity and advocacy.

I expected that I'd have to be resourceful and flexible in managing patients. I knew that families would be highly involved in patient care and rehabilitation, and that cultural values would influence how rehab is approached. The depth of family commitment was inspiring, but at times, lack of formal home care support put heavy burdens on caregivers. Balancing family expectations with realistic rehab goals required ongoing communication. I understood that PM&R was still a developing field in the Philippines, with growing awareness but also some gaps in understanding among other healthcare providers. I expected to find meaningful work in helping underserved populations and contributing to building a newer specialty.

I also realized that many physicians and even some patients had limited knowledge about what PM&R can offer. A significant part of my role became educating colleagues and patients about the specialty. Despite challenges, the opportunity to directly improve patients' quality of life made the work deeply rewarding. Being part of a growing field and seeing tangible progress in patients' recovery exceeded my expectations.

Q: What are some steps people can take to secure a position in Physiatry in the Philippines?

A: Connect with practicing physiatrists and faculty in the Philippines through PARM or hospital affiliations; Join online groups or social media communities related to PM&R in the Philippines to stay informed and connected. Foreign-trained physicians should prepare to take the Philippine Physician Licensure Exam. Gather and verify all your medical credentials early, as this process can take time. Research the visa process for foreign medical professionals and begin conversations with potential employers about sponsorship. Engage with the Philippine Academy of Rehabilitation Medicine (PARM) for job postings, mentorship, and networking. If possible, arrange short-term observerships or volunteer roles in Philippine rehab centers to gain local experience.

Q: Thank you so much for your time and sharing your experiences in the Philippines, this was some great information that I'm sure many people interested in working abroad will appreciate this!

A: No problem! Thanks so much for having me!

If you or anyone you know is interested in sharing their experience practicing Physiatry abroad and would like to be featured in the next edition of our International Physiatry column please reach out to Faheem Mahomed, MD, via email at: fmahomed2892@gmail.com

WORDS OF WELLNESS

Welcome to your quarterly Words of Wellness, a column dedicated to giving you resources and inspiration to intentionally practice wellness and encourage your peers. These features are brought to you by the AAP's Resident/ Fellow Council (RFC) Well-being Subcommittee.

FEATURED WORKOUT

Making it Easier to Take Care of Myself: YouTube + Visual Cues

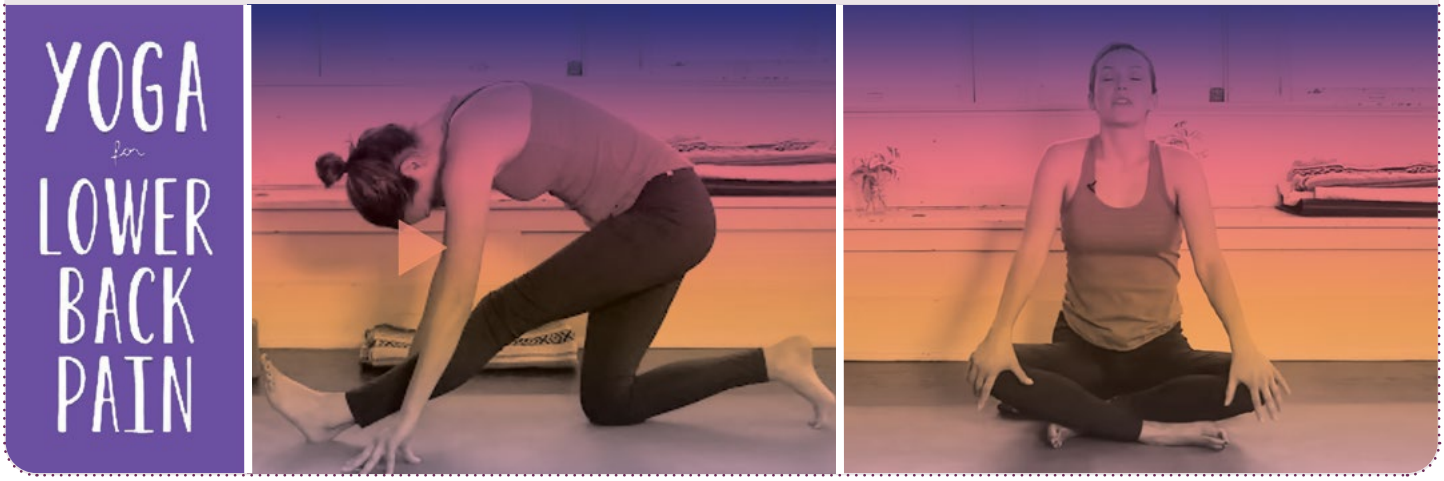
AUTHOR: CATHERINE KINGRY, MD

Over the past year of residency, I have struggled with lower back pain flares. Whether it's getting on the ground and crawling after kiddos in Pediatric PM&R clinic, standing for hours with a lead vest on during Pain Management procedure days, or sitting too long at the computer on inpatient rotations, I've learned that I have to take care of my back…or else it's harder for me to take care of my patients. Using exercise videos, specifically back pain videos by **Yoga with Adriene on YouTube,** has been one of the most straightforward ways for me to focus on my back while navigating an ever-changing schedule during residency. It's free, it's always available, I can repeat the video as many times as I want, or I can try something else with several other back-specific videos. If I don't like a video, or if there are certain poses or movements that don't work for me, I can find something else! Searching 'yoga for back pain' on YouTube brings up many videos by different channels, and they are usually slower paced than a traditional Vinyasa flow yoga class.

I strategically placed my yoga mat right next to my bed, so when I wake up and roll out of bed every morning, my mat is there as a visual reminder that I should take 15-30 minutes to take care of my back before I start my day. Do I usually drink a cup of coffee first? Yes. But then, I can find 15 minutes between my coffee and leaving home to do some stretching, spine articulation, and warming up my core. This is a lot easier for me to accomplish sometimes than going to a yoga or pilates class or paying for an online workout subscription.

What are the barriers keeping you from exercising the way you want to or need to, and what can you do to remove those barriers? It's amazing to me that simply seeing my yoga mat when I get out of bed reminds me to take care of myself more than anything else has.

yogawithadriene.com/yoga-lower-back-pain/



REFLECTION

Self Reflection

AUTHOR: MELINA LANDRY, DO

As physiatrists, we guide patients toward well-being. Yet, our own journeys often mirror theirs. For years, my definition of wellness was focused on the pursuit of perfection: only eating the healthiest foods, doing intense workouts, and optimizing sleep. Each day a push to outperform the last. This ideal consumed me, perhaps shaped by my background as a dancer and yoga instructor, where discipline and pushing limits were the norm.

Then came medical school and intern year. The relentless pressure and exhaustion shattered my all-or-nothing approach. When I couldn't hit those self-imposed goals, I spiraled, feeling utterly depleted with zero reserves to handle any stress. My pursuit of an ideal had, ironically, left me empty.

Now, reflecting at the end of PGY-2, my understanding of wellness has profoundly shifted. I've worked to find contentment in "smaller stakes" self-care, and the pressure for a perfect routine has faded. Today, wellness for me isn't about grand gestures; it's about presence and small acts of self-kindness. It might be a brief walk or simply taking time to do my makeup because it makes me feel good. It's consciously choosing to do one little thing for myself, free from judgment or the expectation of achieving some ultimate "perfect" well-being.

I don't know if this flexible approach is universally "right," but in this demanding phase of my life, it's absolutely working for me. It's building resilience, allowing me to find peace, one small act at a time. Perhaps, that's the most profound kind of wellness there is.

I hope this brief glimpse into my journey resonates with you and highlights that **wellness is multidimensional and ever-changing.** May you continue to find the wellness that fits your schedule, remembering that it looks different for everyone, and even from day to day.

FEATURED RECIPE

High-Protein Greek Yogurt Bagels

Easy 4-ingredient bagels with a high-protein, low-carb option

Yum

INGREDIENTS

- 2 cups flour
  - Option 1: All-purpose flour
  - Option 2: King Arthur Keto Wheat Flour
- ¼ tsp salt
- 2 tsp baking powder
- 1.75 cups Fage lactose-free 0% Greek yogurt
- 1 egg (for egg wash)
- Everything bagel seasoning

INSTRUCTIONS

1. Preheat oven to 375°F.
2. Mix flour, salt, and baking powder in a bowl.
3. Add Greek yogurt and stir until a dough forms.
4. Divide and shape into 6 bagels.
5. Brush with egg wash and add toppings if desired.
6. Bake for 25 minutes or until golden brown.

Estimated Macros per Bagel:
(makes 6)
Using 2 cups flour +
1.75 cups Fage 0% lactose-free Greek yogurt

All-Purpose Flour:
- 170 calories
- 1g protein
- 28g carbs
- 1g fat

King Arthur Keto Wheat Flour:
- 135 calories
- 17g protein
- 5g carbs
- 4g fat

MEDICAL STUDENT EDUCATOR'S COUNCIL (MSEC)

physiatry.org/MSEC

Leslie Rydberg, MD – *Chair*

The Medical Student Educator's Council is actively supporting several initiatives to enhance medical student advising and education in PM&R. A new PM&R Rotation Guide for students is being created in collaboration with the Medical Student Council. The 2025 Road to Residency program is progressing well, featuring new sessions and a feedback survey. Updates to the AAP Advising document are in progress to reflect recent changes in the residency application process. The Disability Education Network is being migrated to the AAP Virtual Campus, and volunteers are welcome to assist. The 2025 Virtual Intro to PM&R program is set to run in June, offering multiple weekly sessions for U.S. and international students.

RESIDENTS AND FELLOWS COUNCIL (RFC)

physiatry.org/RFC

Eric Jones, MD – *Chair*

The AAP Resident/Fellow Council recently appointed members of the Well-Being, Research, Tech, and Social Media subcommittees. We look forward to how our subcommittees will help drive future initiatives and support ongoing growth within physiatry.

Educational programming continues to flourish. The Road to Residency Series has already covered sessions on personal statements, meaningful experiences, program signaling, and post-match insights, while the Q&A Fellowship Series has covered Pediatrics, TBI, Sports/Sports and Spine, and Spasticity/Neuromuscular, with upcoming sessions on Cancer Rehabilitation, SCI, Pain Medicine, and more. Webinar partnerships with sub-speciality societies have been a recent addition, with recent sessions collaborating with AMSSM and ASRA.

Physiatry '25 debuted "Reflections: Exploring Identity after Illness or Injury," 54 art pieces by 40 artists around the globe—patients, clinicians, and families—curated by Dr. Colette Piasecki-Masters and the RFC Well-Being Committee.

To advance DEI efforts, the "Can We Talk?" program continues to offer mentorship and resources for URiM medical students. Interested individuals can reach out to Dr. Lucila Beuses.

Publication efforts remain strong, with the Spring issue of Physiatry Forward out now and Physiatry in Motion now accepting Summer issue submissions (due August 1).

Our social media presence continues to grow—now with over 2,800 followers on X and 6,400 on Instagram. Keep an eye out for all upcoming initiatives!

Finally, abstracts for Physiatry '26 in Puerto Rico are due September 10. We look forward to seeing you there!

PROGRAM COORDINATORS COUNCIL

physiatry.org/ProgCoordinators

Aimee Brough, MS, C-TAGME – *Chair*

To all our fellow coordinators, hello from your AAP Coordinator Council! As many of you know, we have been working hard to be a valuable resource to you and represent all of you on a national level. As you know, this year was an election year for us, so we have some new faces on the Council. Aimee Brough moved into the role of Chair, Lucretia Wilson was elected to the role of Vice-Chair and Maria Hamud was elected to the role of Secretary. We're very excited to work together to bring exciting new ideas to the Council in 2026.

AAP Coordinator's Manual:

One of the biggest accomplishments from last year is the complete overhaul and publication of the AAP Coordinator's Manual. This living document hosts a wealth of knowledge that has been compiled into an easy guide to help understand all things PM&R, with emphasis on the importance of coordinators in ACGME, and will continue to be updated on a yearly basis when needed. This can be found on AAP's Coordinator's page.

Physiatry Connect:

A big update this year is the retirement of the Listserv and the move to Physiatry Connect! Physiatry Connect works in a way like many social media platforms. You can build your profile and adjust your privacy and subscription settings. In the Program Coordinators Community, you can find many different discussions and connect with members from all over. You can check out past posts and see the different replies as well. If you are a member of the Coordinator Community, you will receive an email letting you know that a new post or a reply has been made so you can always stay up to date.

Physiatry '26 Planning:

A big part of the council's duties is to plan the coordinator sessions for each AAP national conference. After Physiatry '25, we sent out a post-conference survey that gave attendees the opportunity to provide feedback on presentations, give recommendations / requests for future topics, and additional comments. Based on this, we have worked to update the coordinator sessions to reflect this and worked to find presenters and topics of interest.

Please remember: We Need Presenters!

The coordinator sessions rely heavily on coordinator participation, so if you have a topic, you feel confident in or want to share knowledge with your fellow PM&R coordinators, please reach out!

Thank you for being part of this wonderful community and sharing your wealth of knowledge with your fellow coordinators. We hope to see you in Puerto Rico at Physiatry '26!

MEDICAL STUDENT COUNCIL (MSC)

physiatry.org/MSC

Kayleigh Crane – *Chair*

Happy Summer! The Medical Student Council is off to a strong start for the 2025–2026 year following our leadership transition at Physiatry '25.

In March, we rolled out our essay contest, and in April, hosted a successful post-Match panel. May brought the inaugural meeting of the National Student Interest Group Registry, where members shared ideas and collaborated across institutions.

Our Research Subcommittee is preparing four excellent journal clubs, kicking off in July. Meanwhile, the Education & Wellness Subcommittee continues to produce "This is Physiatry" podcast episodes and is developing a tool to support students during clerkships.

The Membership Subcommittee is actively pairing Big and Little Buddies and invites all medical students interested in mentorship to apply.

Our Diversity Subcommittee continues to highlight voices from Underrepresented in Medicine and work diligently on other initiatives. Lastly, but certainly not least, our Social Media Subcommittee continues to design our wonderful graphics to keep everyone up to date.

We're ecstatic for the year ahead and honored to support medical students on their journey. If you have ideas, feedback, or questions, feel free to reach out to us at aapmedicalstudentcouncil@gmail.com.

Let's make it a great year together!

RESIDENCY AND FELLOWSHIP PROGRAM DIRECTORS COUNCIL (RFPD)

physiatry.org/RFPD

Tracy Friedlander, MD – *Vice Chair*

2025 YEAR IN REVIEW:

The Residency Fellowship Program Directors (RFPD) Council of the Association of Academic Physiatrists has had a productive and forward-thinking year, marked by collaboration, innovation, and a shared commitment to advancing physiatric education.

Shaping the Future of Accreditation:

This year saw significant developments in accreditation standards. The ACGME has been working on major revisions to program requirements, informed by extensive stakeholder engagement and scenario planning. These updates address key issues such as expanding categorical programs (integrating intern year) and adjusting requirements for subacute rehabilitation, elective time, and the continued use of case logs. A final draft is expected by summer 2025 (with an opportunity for comment), with implementation anticipated in the 2026–2027 academic cycle. The introduction of Clinician Educator Milestones has further emphasized the importance of faculty development and reflective practice.

Board Certification and Professional Development:

The American Board of Physical Medicine and Rehabilitation (ABPMR) reported strong pass rates for 2024—86% for Part I and 88% for Part II—and has announced exam dates through 2026. The board has broadened the scope of its Improving Health and Health Care (IHHC) initiative, now recognizing quality improvement articles and committee service as qualifying activities (including CCC and PEC). Enhanced exam performance reports and better alignment between the Part I exam and the Self-Assessment Exam (SAE) are also underway. To support faculty development, ABPMR has introduced Grand Rounds and a scholar program for early-career educators.

Innovating Resident Recruitment:

The RFPD Council has been actively exploring new approaches to resident recruitment. The RFPD with guidance for the Recruitment Subcouncil has officially launched the Standardized Letter of Evaluation (SLOE) as an alternative to traditional narrative letters. All applicants are expected to have at least one SLOE. We continue to encourage programs to provide feedback on its use. Additionally, program signals for 2025-2026 recruitment season have increased to 20. The council also examined the evolving landscape of virtual versus in-person interviews and discussed the implications of program signaling. Broader efforts have focused on increasing transparency, supporting diversity in recruitment and retention, and promoting the well-being of program directors in the recruitment process.

Physiatry '25 RFPD Workshop: Elevating Feedback and Evaluation:

The second day of the Physiatry '25 RFPD Workshop focused on transforming feedback into a more meaningful, learner-centered process. Participants explored models such as MICA, R2C2, and CARE, which emphasize relationship-building, self-assessment, and actionable coaching. These frameworks aim to shift

feedback from a one-way critique to a collaborative dialogue that supports growth and reflection. The session also addressed the limitations of traditional written feedback, which often lacks specificity and tends to focus only on the extremes of performance. In response, a pilot example of resident-led group feedback sessions was shared, where trained senior residents facilitate discussions and compile feedback for faculty. These sessions are brief, structured, and supported by tools like the Narrative Evaluation Quality Instrument (NEQI) to ensure both quality and consistency.

The workshop also highlighted the value of second-hand feedback and the use of Objective Structured Teaching Exercises (OSTEs) with simulated learners to normalize expectations and improve inclusion. Participants were encouraged to view feedback as a bidirectional conversation grounded in trust and shared goals. The RFPD council would love to hear about updates or other strategies used by programs to enhance the evaluation and feedback experience. Please reach out.

Looking Ahead:

Planning is already underway for the coming year. The recruitment subcouncil will continue to refine the SLOE process, explore recruitment strategies. Future workshops may feature panels on timely topics such as unionization, disability in training, and trends in inpatient rehabilitation. There is also growing interest in examining the broader direction of the PM&R field and how educational programs can adapt to meet emerging needs.

As always, the RFPD Council remains committed to fostering excellence in physiatric education and supporting the next generation of leaders in academic medicine.

ADMINISTRATIVE DIRECTORS COUNCIL

physiatry.org/AdminDirectors

Zachary Bechtle, MHA – *Chair*

Hello colleagues! It was excellent seeing so many of you at the last conference. We had record administrative director attendance in Phoenix and continue to build momentum. We have welcomed Aaron Olsen to the Administrative Director Council (ADC) Cabinet as Secretary and thank Yelena Sionova, our outgoing Chair, for her contributions and ongoing engagement.

This year we have introduced our first mid-year content in the form of the Quarterly ADC call. The purpose of this virtual meeting is to stay up to date on developments in the specialty and leverage our collective experience to help one another problem solve. All Administrative Directors are welcome. Our first call took place in June and we will reconvene in September. The June meeting covered topics such as benchmarking, service lines, structures, and external partnerships. The high-level meeting summary was shared through Physiatry Connect for those unable to attend (thank you Catherine!).

Last but not least, we are currently finalizing our ADC program for Physiatry '26. After listening to member feedback, we plan to return to a primarily 1-day ADC block for the majority of business director content to aid with travel arrangements and maximize session attendance.

The Enduring Power of **Compassion in Rehabilitation**

By: Dr. Alice Kam and Dr. Cynthia Hung

Compassion for others— the original reason many of us chose medicine— can often be overshadowed by the pressure of productivity metrics. Yet it is something we must not forget. Compassion helps us be empathetic and strengthens our connections with patients, ultimately enhancing the quality of care. Even small gestures— a few extra minutes with a patient or a kind of exchange with a colleague— can profoundly transform the clinical environment. This is especially true in rehabilitation, a field grounded in interdisciplinary collaboration and a focus on functional recovery.

As rehabilitation professionals, we encounter countless opportunities to express compassion. Larger gestures, such as offering more frequent follow-ups, often yield clear and immediate benefits. But smaller acts—bringing a patient a glass of water or helping them change the television channel—are equally meaningful. These actions not only comfort the patient but can also ease the burden on nursing staff, reinforcing a culture of support and shared responsibility.

Our field presents unique opportunities for compassionate advocacy, particularly in navigating healthcare systems that may undervalue the non-emergent, functional care we provide. Insurance barriers are common, but a compassionate mindset can inspire persistence and creativity. For example, an acute care consultant who took the time to walk a patient to the bathroom gained a deeper understanding of the patient's functional limitations—insight that ultimately strengthened the case for acute inpatient rehabilitation. Similarly, in the outpatient setting, taking the time to fully grasp how pain or weakness affects daily function can result in more effective compassion support.

Compassion extends beyond patients to include our inter-professional colleagues. Social workers, nurses, and therapists are integral to rehabilitation care. Understanding and supporting them—especially junior staff or those navigating complex family dynamics—fosters a collaborative, trusting workplace culture. When we take the time to educate, clarify processes, or simply listen, we build stronger teams and better care pathways.

In today's performance-driven, technologically augmented healthcare system, compassion also plays a protective role. The burden of electronic medical records and relentless administrative demands can lead to fatigue and burnout. Amid transitions to AI-integrated workflows, acts of compassion—such as recognizing colleagues' stress, encouraging time off, or supporting diverse workforce needs—create space for well-being and balance. These human-centered practices model a healthier work culture for the next generation.

Compassionate leadership represents a shift toward adaptive, integrated, and collaborative practices. Accelerated by the digital transformation of the COVID-19 era, compassionate leadership transcends local boundaries, enabling meaningful global connections. It encourages open communication, radical candor, and shared growth. Rather than enforcing top-down control, compassionate leaders invest in their team's development, empowering the team to act and fostering trust and psychological safety.

Ultimately, compassion is not only beneficial to individuals—it strengthens our entire healthcare system. It enriches person-centered care, enhances advocacy, and creates a workplace where people feel valued and empowered. In an era focused on volume and efficiency, compassion remains a quiet, powerful, human tailored force that enables us to truly care.

This article was authored by Dr. Alice Kam, a physiatrist and Assistant Professor at the University of Toronto, and Dr. Cynthia Hung, consulting physiatrist at Montefiore Medical Center and assistant professor at Albert Einstein College of Medicine. Dr. Kam is also an Affiliate Scientist at the KITE Research Institute, Toronto Rehabilitation Institute – University Health Network, and her research focuses on integrating compassionate care and AI-enabled assessment in rehabilitation education. Together, they explore the vital role of compassion in physiatric practice and propose actionable insights for fostering a more humane healthcare system.

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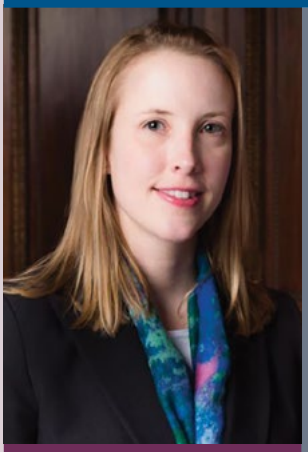
A Sense of Belongings: Chloe Slocum, MD, MPH



A behind-the-scenes look at the treasured belongings of one featured member

Chloe is a PM&R physician and spinal cord injury specialist who serves as Associate Chair for Quality and Assistant Professor at Harvard Medical School, and Director of Health Policy at Mass General Brigham-Spaulding Rehabilitation. She leads the Spaulding New England Regional Spinal Cord Injury Center (SNERSCIC) and is a national expert in health policy and systems of care. Her work focuses on improving long-term outcomes for people with spinal cord injury, expanding access to quality care for individuals with disabilities, and enhancing rehabilitation delivery. Dr. Slocum has published and presented widely on SCI outcomes, health policy, and clinician well-being.

1. **"Thank You" letters:** Two of my favorite "Thank You" letters are from the ABPMR for serving as an oral boards examiner—which I love doing and have participated since 2021—and from the family of a particularly challenging patient I care for early on as an attending. It was the most touching, heartfelt letter and is a reminder to me that great things can come out of conflict and that just "being there" can make a big difference. Also, that there is always a benefit to remaining calm under pressure, even if things seem very chaotic in-the-moment.
2. **My file cabinet:** My proton mug reminds me to stay positive and my Beyonce sign is a reminder to approach things creatively and strategically. I am both a big science and music nerd, as my family will confirm.
3. **Kids artwork:** I have two toddlers and being around them is just incredibly joy-filled and sometimes silly. They helped me decorate parts of my office and it is inarguably better for it.
4. **Tea mug:** I drink a lot of tea! I am also a professionally certified well-being coach and have served as a faculty coach for physicians at Mass General Brigham since 2023. This mug reminds me to "Enjoy the Journey" and center myself in the present moment, which is useful when I'm in clinic.
5. **Legislative testimony and visitor tags:** One of my proudest achievements is testifying before Joint Sessions of the Massachusetts House and Senate and advocating for access to PM&R and rehabilitation services with our elected officials. It requires a different sort of communication, but has the opportunity to be deeply impactful in terms of changing policy and public discourse about the care we provide as physiatrists.
6. **Slocum's Toyland from Dorchester, MA:** This was given to me by a patient and was a toy store that existed for nearly 100 years in the historic Boston neighborhood of Dorchester. There's no relation to me, but it was a lovely gesture and speaks to my passion to help those I serve thrive, engage, and live fully in their communities, not just simply managing their health conditions or body systems.

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