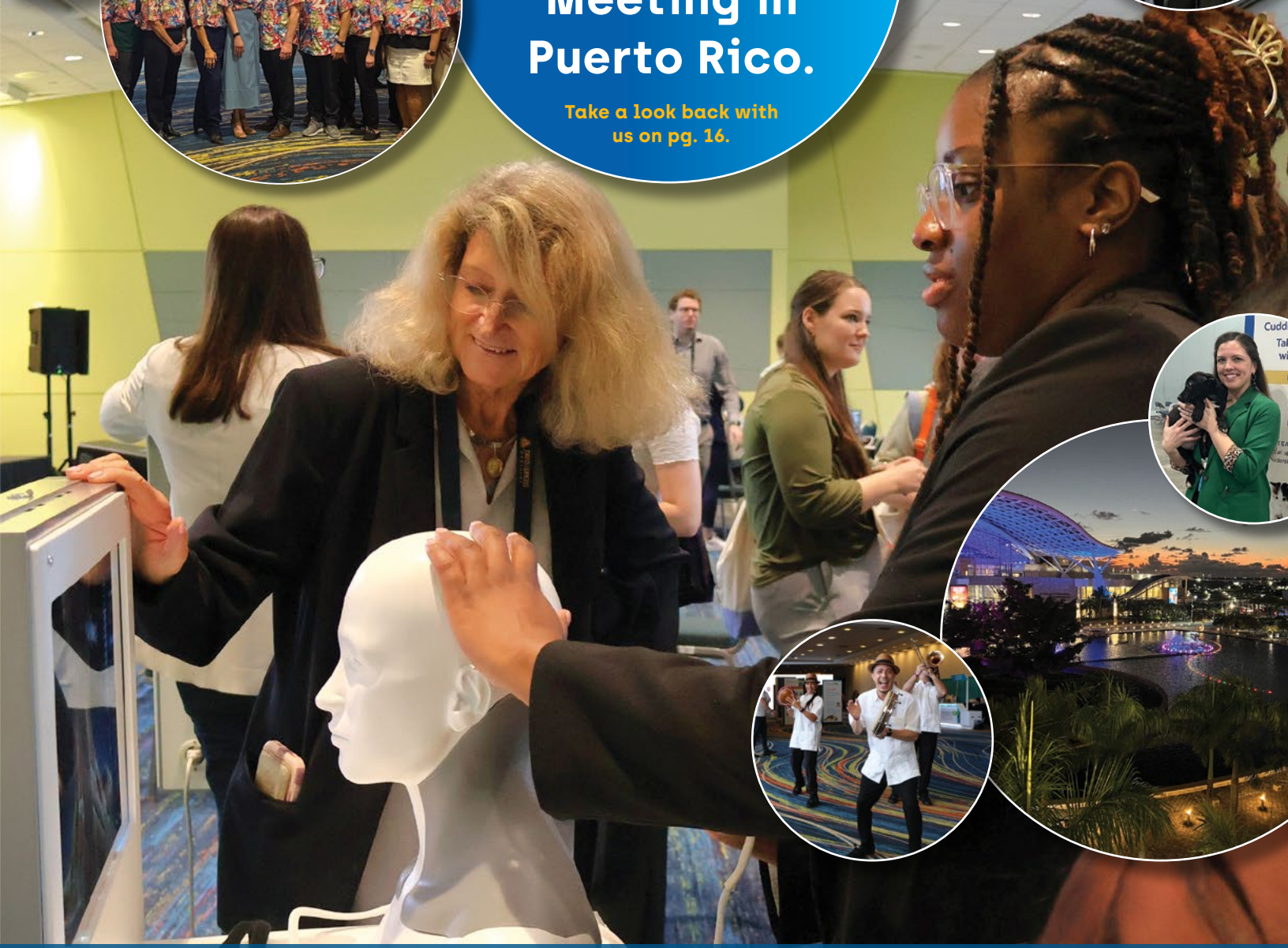
Physiatry FORWARD

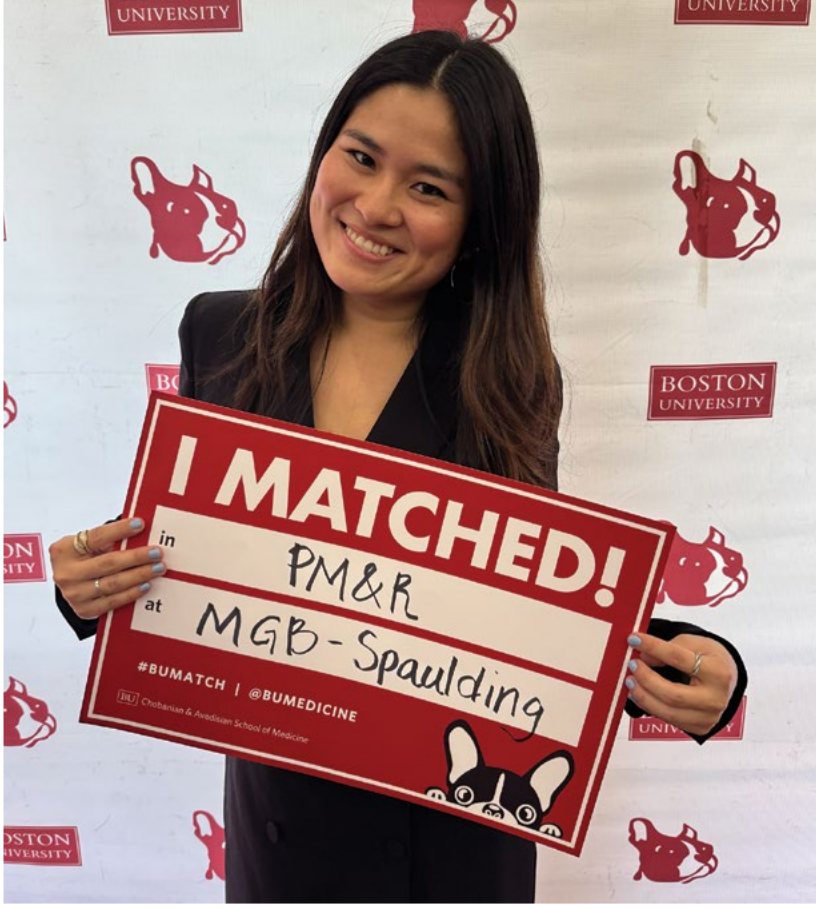
SPRING 2026 | AAP'S MEMBER MAGAZINE

Association of Academic Physiatrists

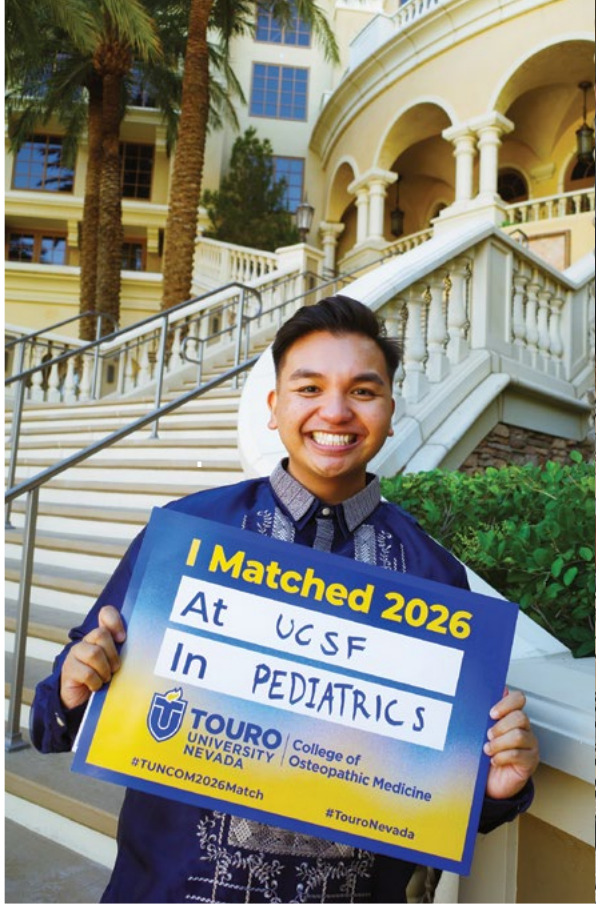
Some of the best moments from our 2026 Annual Meeting in Puerto Rico.

Take a look back with us on pg. 16.





PHYSIATRY POV



MATCH DAY HIGHLIGHTS

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

Spring has a way of clearing space, shifting perspective, and making room for what's next. It feels like a good moment to take stock of where physiatry is moving, and who is moving it forward.

Inside, you'll find a season's worth of progress: reflections from recent meetings, updates from our academic partners, and a mix of case studies and editorials that stretch from cryoneurolysis and hockey to concussions and TBI.

You'll also notice art, poetry, and feel-good stories woven throughout, reminding us that this field isn't just clinical, it's deeply human. Data matters, outcomes matter, but so does perspective, creativity, and the way we find meaning in recovery and change.

So consider this your spring reset: a chance to catch up, look ahead, and maybe see something familiar from a slightly different angle.

Liz Raubach
AAP Communications Manager
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physiatry.org/PhysiatryForward

Physiatry Forward is published twice 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.

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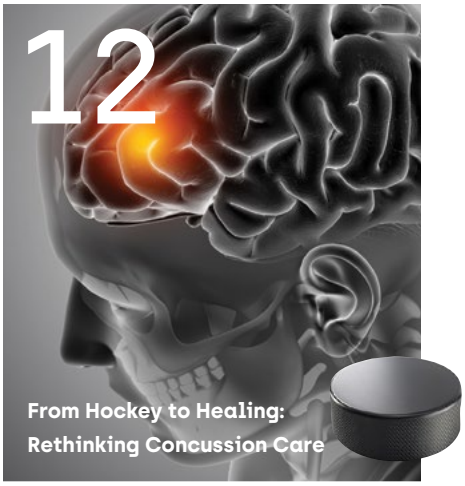
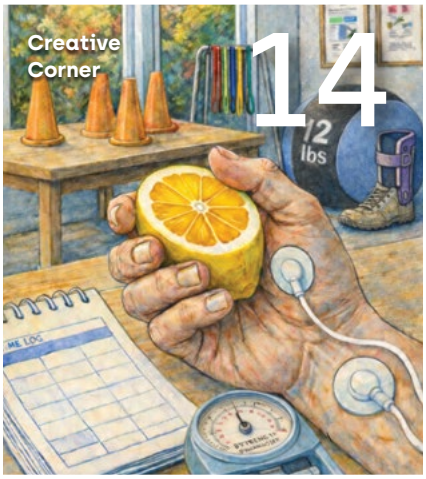




Contribute to *Physiatry Forward!*

Submit your work by visiting **physiatry.org/PhysiatryForward** and filling out the submission form.

SUBMIT

SAVE THE DATE | FEB 16 - 20, 2027

PHYSIATRY '27

THE FUTURE OF PHYSIATRY HAPPENS HERE

Make *waves* at the premier academic physiatry meeting in the world!

Members enjoy exclusive registration discounts to **all AAP events!**

Get ready for world-class education, meaningful networking, and a little fun in the sun with the leaders and rising stars of physiatry.

SEE YOU IN CALIFORNIA!

CROSS COUNTRY with our Academic Partners

From coast to coast, innovation doesn't sit still, and neither do the people driving it. In this edition of Cross Country, six of our Academic Partner institutions open a window into the work unfolding in their corners of the map, highlighting their communities, challenges, and ambitions. Together, their stories form a snapshot of a field in motion.

Mayo Clinic

For 90 years, Mayo Clinic Physical Medicine & Rehabilitation has combined deep clinical expertise with a patient-centered, multidisciplinary model to deliver comprehensive rehabilitation across the lifespan. Highlights from 2025 include:

- accredited adult and pediatric brain rehabilitation serving more than 1,300 patients annually
- specialized multidisciplinary clinics, including brachial plexus and upper-limb amputee care
- innovative thread carpal tunnel release and custom 3D-printed splints
- lymphedema/cancer rehabilitation for more than 3,000 patients annually

Together, we have the opportunity to build on this longstanding expertise, shape the future of rehabilitation medicine, and continue making a meaningful difference in the lives of our patients.

Penn State Health

Some recent highlights from the Department of PM&R at Penn State Health include:

1) **RESEARCH:** Our Annual Scientific Day with limb loss and sports rehabilitation theme, featuring adaptive athletes and disability advocates, Nicole VerKuilen and Kyle Stepp as keynote speakers representing the "So Every BODY Can Move" Initiative.

2) **EDUCATION:** Residency Program Director, Dr. Natasha Romanoski was awarded the 2026 Dean's Distinguished Educator Award, recognizing Penn State College of Medicine's faculty for outstanding teaching and contributions to medical and graduate education.

3) **CLINICAL:** Penn State Health Rehabilitation Hospital was recertified by the Commission on Accreditation of Rehabilitation Facilities, including addition of amputee rehabilitation certification.

Learn more about our Academic Partnership and its growing benefits at physiatry.org/AcademicPartners.

4) COMMUNITY OUTREACH: Adaptive Ski Day, where patients recovering from traumatic injuries experienced the slopes firsthand using specialized adaptive equipment.

Schwab Rehabilitation Hospital

At Schwab Rehab, our program is continually growing. We are proud that our Medical and Program Director, Dr. Michelle Gittler received the 2025 Distinguished Public Service, Health Equity, and Advocacy Award. Our scholarly activity also flourished with multiple poster presentations at AAPMR and AAP. We are thrilled our seniors matched into Pain fellowships nationwide, while another graduate begins a dedicated inpatient role in the Southwest. We eagerly welcome our new PGY2s, the 2027 class, and new attendings Drs. Brian Abarbanel (Stroke) and Tiffany Holland (SCI) as we advance rehabilitation medicine.

University of Alabama at Birmingham (UAB)

The UAB's Amputee Clinic at Spain Rehabilitation Center is the first in Alabama and among few nationally to offer 3D-printed prosthetic sockets, improving speed, cost, and precision. Led by Dr. Conley Carr, clinic medical director and Department of PM&R associate professor, the clinic uses digital scanning and printing to streamline production, allowing faster turnaround, and overnight manufacturing. Demand for prostheses is rising, with U.S. limb-loss cases expected to double by 2050. The technology enables consistent replicas and personalized fits, reducing discomfort and complications. Patients receive devices in days instead of weeks, accelerating rehabilitation. The system also supports customized orthotic braces, helping meet growing patient needs efficiently in modern healthcare settings.

UTHealth Houston

University of Pittsburgh Medical Center (UPMC)

This year, UPMC PM&R ranked #1 in NIH funding for rehabilitation research by the Blue Ridge Institute, allowing our team to continue their contributions to rehabilitation research. Congratulations to John Horton, MD, who was selected as a 2026 Fellow of the American Spinal Injury Association for his accomplishments in spinal cord injury research and clinical practice. Gwendolyn Sowa, MD, PhD and Nam Vo, PhD, received a five-year, $20 million NIH/NIAMS award to continue and expand a multidisciplinary investigation into the phenotype evolution and clinical trajectories of chronic low back pain. Twelve physiatrists were recognized as "Top Doctors" by Castle Connolly.

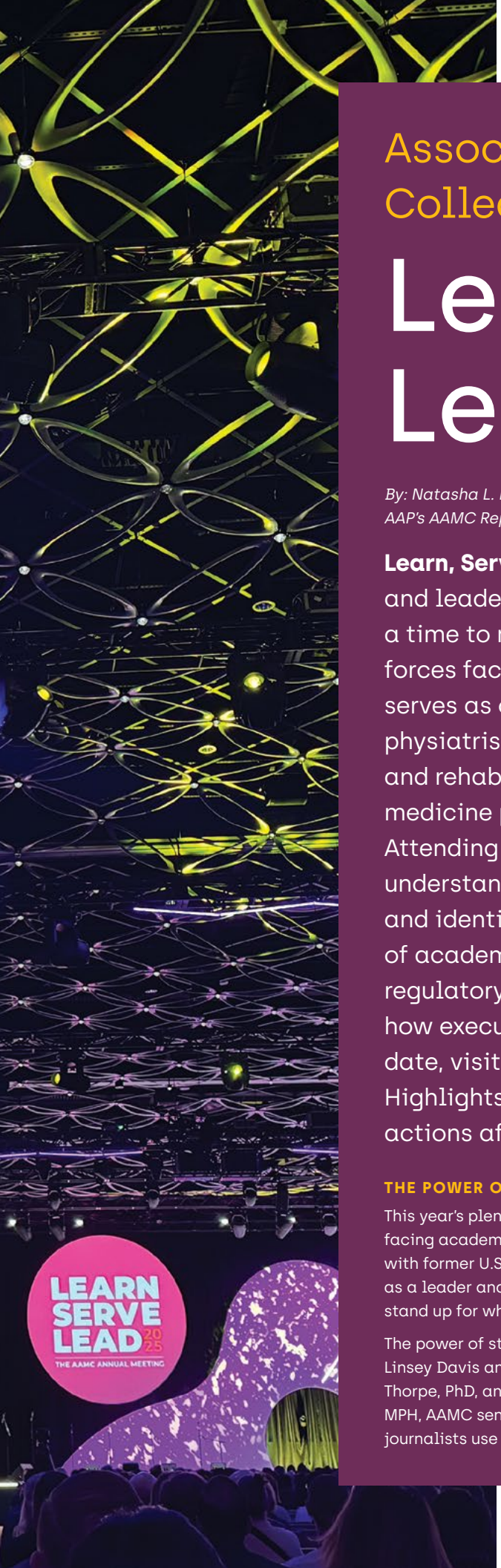
UTHealth Houston

Our department had a record number of faculty and resident participants at AAP '26 this year, including several resident-led podium presentations and AAP's expanding Spasticity Workshop. Our senior residents matched competitive fellowships in Pediatric Rehabilitation Medicine (University of Minnesota), Pain Medicine (Brigham & Women's Hospital), and Spinal Cord Injury Medicine (University of Utah). Chief resident Dr. Lauren Haney, alongside faculty mentor Dr. Isaac Hernandez, presented at ISCoS in Sweden on delivering gynecologic care to women with spinal cord injury. Associate professor Dr. Radhu Korupolu also received the ASCIP DiMarco Lecturer award in September. Congratulations!

UT Health San Antonio

It has been quite a year at UT San Antonio. In early 2025, we organized a T-shirt fundraiser and donated to flood relief efforts in the Texas Hill Country. We had residents contribute research locally and nationally: Dr. Shokraeifard won the 2025 Best Resident Case Presentation at Texas Pain Society! Finally, we celebrated our 6th Annual Research Day with Dr. Cheri Blauwet, a Gold-medal winning Paralympic athlete, Texas Parasports, and Kinetic Kids to discuss Adaptive and Para Sports Medicine and encourage our physiatrists to recommend recreational sports for patients with physical impairments. In 2027, we are excited for more growth!


VIVEK H. MURTHY
MD, MBA
19th and 21st Surgeon General of the United States
AAMC
LEARN
SERVE
LEAD
VIVEK H. MURTHY



Association of American Medical College's (AAMC) Annual Meeting:

Learn, Serve, Lead 2025

By: Natasha L. Romanoski, DO
AAP's AAMC Representative

Learn, Serve, Lead brings together thousands of learners and leaders in academic medicine. The conference is a time to network, reflect and understand the driving forces facing academic medicine today. Just as the AAP serves as our academic home in empowering academic physiatrists to advance the science of physical medicine and rehabilitation, the AAMC serves to support all academic medicine professionals at every stage of our careers. Attending the AAMC conference is an opportunity to understand the future of undergraduate medical education and identify how we as physiatrists can shape the future of academic medicine. The AAMC also partners with regulatory agencies within the federal government to track how executive actions may impact healthcare. To stay up to date, visit the AAMC website and subscribe to "Washington Highlights" a weekly newsletter highlighting legislative actions affecting medical schools and health systems.

THE POWER OF STORYTELLING

This year's plenaries focused on the use of storytelling to engage in difficult discussions facing academic medicine today. AAMC President and CEO David J. Skorton, MD, talked with former U.S. Surgeon General Vivek Murthy, MD, MBA, about the power of showing up as a leader and providing education within our own communities, stating "when we don't stand up for what we believe in, for our core principles, we lose something very important."

The power of storytelling continued with sessions moderated by ABC News journalist Linsey Davis and closed with a conversation between Science Editor-in-Chief Holden Thorpe, PhD, and Ashley Velie, a producer for "60 Minutes," moderated by Heather Pierce, JD, MPH, AAMC senior director for science policy and regulatory counsel. Velie highlighted how journalists use storytelling and encouraged those on the front lines to share their stories.

cont.

She discussed how interviews are typically grounded in specific talking points rather than led by passion and encouraged health systems and academic leaders to allow freedom of voice, "I beg of you, let your people talk. Let them share their truth."

Many other sessions used storytelling to embark on discussions actively affecting healthcare right now:

Outbreaks of measles are fueled by outbreaks of mistrust: Physicians are encouraged to reference the American Academy of Pediatrics toolkit for strategies in providing vaccine education in the clinical setting. Engaging and educating at a community level can leave a lasting impact.

Mass shootings: Doctors share lessons from the front lines: The lifelong emotional impact and realizations of strained resources were discussed by physicians on the front lines of past tragedies. Everyone in healthcare, every single employee, is encouraged to step in and help.

Doctors, beware: AI threatens to weaken your relationships with patients: With the acceleration of artificial intelligence (AI) in healthcare to advance efficiency and other metrics, we must balance the risk of losing the humanistic component of medicine. Sociologist at Johns Hopkins University, Allison Pugh, PhD, defined "connective labor" as "the forging of an emotional understanding of another person to create valuable outcomes." She expressed concern over the risk of losing connective labor with the rising use of AI and how it may depersonalize healthcare, and society.

AAMC ISSUES CALL TO ACTION TO STRENGTHEN NUTRITION TRAINING IN MEDICAL EDUCATION

An interactive session on the curricular integration of Nutrition served as a preview to a call to action which was released by the AAMC on Nov 6, 2025. The statement calls for U.S. medical schools and academic health systems to strengthen nutrition education. This came as a response to the U.S. Secretaries of Health and Human Services and Education who previously requested a commitment to strengthening nutrition education to reduce chronic disease mortality.

"Nutrition is central to preventing, managing, and treating many of the chronic diseases that continue to drive morbidity, mortality, and health care costs in the United States. [...] The AAMC strongly supports flexibility in the ability of its member medical schools to integrate comprehensive evidence-based curricular content on nutrition across all stages of medical education in alignment with their unique missions and accreditation standards," said AAMC President and CEO David J. Skorton, MD.

DISABILITY EDUCATION

Disability education continues to be well supported by the AAMC. Leslie Rydberg, MD, Physical Medicine and Rehabilitation at Northwestern University and current AAP Education Chair delivered a panel session on Advancing Disability Care and Inclusion in Medical Education. Examples of curriculum design and strategies to reduce bias and stigma were discussed to create a more inclusive learning environment.

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COMPETENCY BASED MEDICAL EDUCATION

The transition from UME to GME remains a topic of interest and innovation as schools work to integrate the foundational competences of medical education into curricula. Alongside this, the emerging use of competency-based education is shifting what we think we know about standard training pathways and redesigning how we instruct our learners, how we monitor their progress and how we assess competency to practice independently.

RESIDENCY RECRUITMENT

ERAS continues to work toward enhanced transparency in the application process. A new **ERAS Applicant and Application Volume Dashboard** was launched with monthly real time updates.

As of Nov 3, 2025:

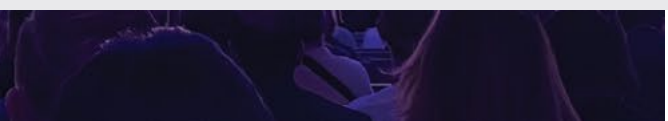
- 1,107 applicants have applied to PM&R
  - 422 MDs
  - 455 DOs
  - 185 IMGs
- For programs, a total of 46,775 **applications** have been received (this is the first time in the last 5 years that the field has seen a decline in overall applications)
  - The average number of applications received per program is 410.3
  - The median number of applications received per program is 402.5
- For **Geographic Preferences,** the majority of applicants chose **No Preference** or **Suburban or Urban.** A smaller number of applicants chose **Urban** and **Rural or Suburban.** No applicants chose **Rural.**
- The **% of Signals Received** to Total Applications Received per program for PM&R:
  - 1 program received 10-19% signals
  - 11 programs received 20-29% signals
  - 38 programs received 30-39% signals
  - 36 programs received 40-49% signals
  - 24 programs received 50-59% signals
  - 3 programs received 60-69% signals

Future ERAS enhancements to include:

- An enhanced **Letter Writer Portal** with direct links to letter writer emails and a dashboard for applicants to request and track letters
- **Publications** changing to **Scholarly Work** with additional customizations.
  - **Topic Groupings** will allow mapping of scholarship. E.g. If a case report was presented as a poster and then later published, they can be grouped together to show progression and commitment to the work.

REMINDER:

Opening Day for ERAS 2027 is Sept 23, 2026!



FROM HOCKEY TO

Rethinking Concussion Care

Written by medical students Sarah Allen, Cyrus Wania, and Chi Zhou

Growing up as an active young boy in Toronto, hockey quickly became the center of my life; but it also shaped how I understood injury. In the culture I grew up in, playing through pain was normalized, while concussions were poorly understood and rarely discussed. I played in the Greater Toronto Hockey League from 2010 to 2016. Most notably, I sustained at least three concussions in the 2014 to 2015 season. Unfortunately, I tried to play through the initial injury and after repeated concussions, I missed the rest of the season, required a medical leave of absence from school, and ultimately stepped away from competitive hockey in 2016.

At that time in Canada, there were not many resources and rules protecting patients from experiencing repeated head trauma and its associated sequelae. The league did not develop a formal league-wide concussion protocol until the 2016 to 2017 season. Rowan's Law in Ontario was enacted in 2018 after a rugby player passed away from second impact syndrome. Parachute Canada's Guideline on Concussion in Sport, which contains comprehensive return to play, school, and work guidelines, was developed in 2017. The absence of these resources in 2014 certainly impacted my personal experience as a patient. While my family physician provided excellent symptomatic and emotional support, my return to play and school process was filled with uncertainty. The use of tools such as the SCAT5 to objectively quantify my symptoms and following an established return to activity guideline would have helped tremendously and perhaps prevented a premature exit from the sport that I love.

Currently, I am a third-year medical student at the Schulich School of Medicine in London, Ontario. Through rotations in family medicine and primary care sports medicine, I have encountered numerous patients suffering from concussions, including young children, university varsity athletes, and the elderly. We rely heavily on the SCAT tool and the Parachute Canada guidelines at each appointment, and I have seen the benefits firsthand. Clear, stepwise return to play instructions ensure patients are not rushed back to sport, and the evidence-based nature of these guidelines allows us to counsel and educate patients with more confidence.

Despite the availability of evidence-based tools, concussion care remains vulnerable to misunderstanding. There still exist perceptions surrounding concussion care that are driven by myths from "tough guy" sports culture, the pressure to succeed, and the fear of reinjury. I have seen varsity athletes minimizing their symptoms to play in the big homecoming game, as well as parents who are reluctant to let their children participate in school recess weeks after the initial injury. The existence of guidelines alone is insufficient, and providers require the proper skills to show patients how to apply these guidelines to their own situation.

To address this translational knowledge gap, our team developed an educational tool in the form of a digestible one-page infographic to help the care providers that we know best: medical students. For many of us, the transition from classroom theory to clinical application can be challenging. We developed this tool to facilitate this transition. It provides clerks with high yield information to enhance their skills in patient counselling and education. This allows trainees to not only provide patients with educational pamphlets on return to play protocols but also have the confidence and expertise to explain each step in detail,

Looking back, I often wonder how my own trajectory might have differed if I had received clearer, more individualized guidance after that first concussion. Perhaps I still would have stepped away from competitive hockey, but the decision would have felt informed rather than uncertain.

HEALING:

CONCUSSIONS: MYTHS VS. TRUTHS

By: Sarah Allen, Cyrus Wania, and Chi Zhou

answer patient questions, and address common misconceptions. Rather than functioning as another checklist, the tool reframes common misconceptions that influence return to play, return to learn, and imaging decisions. The infographic will facilitate conversations that prioritize stepwise, and symptom guided progression, and the understanding that each patient recovers at different speeds.

The value of such a tool extends beyond medical trainees. While we initially envisioned it as a high yield resource for clerks navigating the transition from classroom knowledge to bedside counselling, the underlying goal is broader, to reinforce that concussion management is both objective and individualized. Tools such as symptom scoring systems and imaging rules provide measurable anchors, but recovery ultimately unfolds within a patient's unique academic, athletic, and psychosocial context. Effective care requires fluency in both domains.

Looking back, I often wonder how my own trajectory might have differed if I had received clearer, more individualized guidance after that first concussion. Perhaps I still would have stepped away from competitive hockey, but the decision would have felt informed rather than uncertain. Today, as a trainee learning to counsel patients through similar injuries, I am reminded that concussion care extends beyond symptom checklists and return to play timelines. It lives in the conversations we have, the myths we correct, and the confidence we instill. When education is delivered thoughtfully and tailored to the individual, it becomes not just information, but intervention.

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MYTHS	TRUTHS
Myth 1: Once symptoms improve, you can jump right back into full contact sport.	**Truth:** Return to play is gradual and stepwise, with medical clearance required before full contact.
Myth 2: You can tell how someone is doing by asking how they feel.	**Truth:** Use consistent symptom quantification (SCAT-5 or Rivermead) at each visit to track progression.
Myth 3: There is one standard recovery plan for everyone.	**Truth:** Concussion management must be individualized.
Myth 4: Head CT NEEDS to be done on everyone.	**Truth:** CT head rules (>16 years) and PECARN (≤16 years) are used to determine the need for CT imaging.
Myth 5: Patients automatically understand what to do next.	**Truth:** Patients benefit from education and follow-up using evidence-based guidance.

Link to additional resources

Creative Corner

Lemon and Limerence

Poem & artwork by Danyal Tahseen

I used to dream in ARAT scores, nine blocks stacked like a future I could hold. Now my occupational therapist says *good effort* when I manage three, and I know what that means: the gap between aspiration and anatomy is a room I live in now.

This is limerence: the way I still reach for doorknobs
with my right hand, the one that no longer opens anything
but old arguments with a higher power. The stroke took my dominant hand
and left me with a body that remembers the piano but can't
pour water without the cup becoming confession.

A yearning to find home in my own body again.

I am still in love with who I was before the CVA,
before the AFO, before the gait pattern that makes strangers look away.
The obsession sits under my sternum
like unmetabolized grief.

But the rehab gym smells like lemons, all disinfectant
and the bitter pragmatism of starting over. It's 10 a.m.
on a Tuesday and I'm relearning how to grip a toothbrush,
how to ask for help without breaking open.

My speech is slow now. Dysarthric.
Every consonant caught in honey, every word
a small rehabilitation of the mouth.
But listen: I have not run out of things to say.
My tongue is learning a new dialect of want.

Modified. That word is a lemon I've had to bite into,
seeds and all, the bitterness blooming in the back
of my throat like acceptance I'm not ready to name yet.

Some days my FIM score climbs. Some days I am but
a rehearsal of compensatory strategies, one-handed can openers
and accepting help in the cereal aisle without the apology I used to offer like penance.

The limerence whispers: *you should be further along by now. The lemon answers: you're here. The sun still rises. What now?*

I reached for my coffee this morning. Shoulder flexion to 127 degrees.
No spills. The occupational therapist clapped and I felt something dangerous flicker.
Not pride in who I was, but a glimpse of who I might be becoming.

My grip strength is 18 pounds and some mornings,
that's enough. Enough to hold something. Enough to say:
I am building a smaller life, yes.
A bitter one, yes.
But it's *mine.*
And there are still mornings when the light
comes through the kitchen window indifferent to what I've lost,
radiant despite it, and I think: maybe this is what hope looks like
after you've stopped asking it to be easy.

Limerence is the ache for the old blueprint.
Lemon is the house I'm building anyway,
one good hand and a heart that's learning to let go
without letting go of everything.

The mouth finds new shapes for yes. The hand releases what it cannot carry. The heart, stubborn muscle, slowest to retrain, it's learning how to beat again for a life I didn't choose but might, one day, if I'm honest, learn to love.

PHYSIATRY '26

The future of physiatry happens here.

Annual Meeting Recap

Physiatry '26 in San Juan brought the field together in a big way with equal parts learning, connection, and momentum. From the first sessions to the final send-offs, the focus was clear: practical education, real conversations, and time well spent with colleagues.

We welcomed **1,963** physiatry professionals from across the U.S. and around the world for education and training, new research, and a setting that made it easy to connect. The program delivered more than 80 sessions, spanning clinical care, medical education, research, and leadership, along with small-group meetups and early-career skill-building opportunities designed to be useful immediately.

The Poster Gallery featured over **1,000** presentations in a reception-style format, giving attendees the chance to engage directly with authors during live Q&A sessions, connect with peers and mentors, and move through the space at their own pace.

We're also grateful to the **70+** sponsors and exhibitors who added real value to the experience, from hands-on cadaver labs to breakfast and lunch symposiums, networking events, and an active exhibit hall.

Outside the sessions, attendees had plenty of opportunities to connect: at the President's Welcome Reception, Residents & Fellows Networking Night, Medical Student Quiz Bowl, and other gatherings throughout the week. Many also took advantage of the beautiful destination of Puerto Rico, exploring beaches, local neighborhoods, and restaurants with colleagues old and new.

Winner's Circle

2026 AAP AWARDS

The Annual AAP Awards Breakfast gives us an opportunity to recognize those who go above and beyond in the field of physiatry. These individuals have consistently made meaningful contributions through their work, leadership, and mentorship, and their impact reaches well beyond their immediate roles:

Distinguished Academician Award
Craig McDonald, MD*; UC Davis*

Early Career Academician Award
Dan Cushman, MD; *University of Utah*

Ryan Solinsky, MD; *Mayo Clinic*

McLean Outstanding Resident/Fellow Award
Colette Piasecki-Masters, MD; *Spaulding Rehabilitation Hospital/Harvard Medical School*

AAP Outstanding Service Award
Brad Dicianno, MD; *University of Pittsburgh Medical Center*

Prakash Jayabalan, MD, PhD; *Shirley Ryan AbilityLab*

Outstanding Mentor Award
Vu Nguyen, MD; *University of Alabama at Birmingham*

Outstanding Student Interest Group Award
Rocky Vista University College of Osteopathic Medicine
Student Chair: Holly Williamson
F*aculty Advisor:* Lauren Rudolph, MD

Innovation & Impact in Education Award
Daniel Daneshvar, MD, PhD; *Spaulding Rehabilitation Hospital/Harvard Medical School*

Leslie Rydberg, MD; *Shirley Ryan AbilityLab*

Carolyn Braddom Ritzler Research Award
David Morgenroth, MD; *University of Washington*

Distinguished Member Award
Larry Robinson, MD; *University of Toronto*

TOP POSTER AND PAPER AWARDS

Our Top Paper and Poster awards honor work that not only demonstrates scientific excellence, but also moves our field forward in meaningful, measurable ways. These projects reflect the innovation, precision, and passion that define our specialty at its best. We were proud to recognize the outstanding work that rose to the top:

FIRST PLACE:

Kimberly Waddell, PhD
Discrepancies in the Recommended versus Actual Discharge Disposition Following an Acute Stroke Hospitalization

SECOND PLACE

Isabel Gippo, MD
A Pilot Educational Intervention to Improve Diet-Related Self-Efficacy and Adherence: Knee Osteoarthritis Lifestyle Education (KALE) Study

HONORABLE MENTIONS

Prakash Jayabalan, MD, PhD
Personalized Medicine Approach to the Injections: The Injection Mechanisms Predicting Arthritic Clinical Treatment (IMPACT) Pilot Study

Priya Chandan, MD, PhD
Transforming Medical Education through Disability Curriculum: Outcomes from a National Initiative

Jeffrey Petigrow
Evaluation of Active Permeable Pressure Relieving Dynamic Seating System Prototypes in a Focus Group and Mechanical Testing

Chengchong Ai, MD
A Transcriptomic Analysis of Cartilage-Synovium Crosstalk in the Transition from Hip Femoroacetabular Impingement to Osteoarthritis Highlights Neuroregulatory Pathways as Key Drivers of Hip Osteoarthritis Progression

Sera Yoo, MD
Tick Tock Tick Tock: How Insurance Authorization Delays May Impact 60-day PNS Outcomes

Matthew Sherrier, MD
Intercostal Nerve Grafting for Symptomatic Pseudohernia Following Rib Fracture: A Surgical Technique and Case Report

The AAP meeting is always my favorite meeting of the year—a time to connect with like-minded academic physiatrists across the country.

MEETING HIGHLIGHTS

2nd Annual Pickleball Championship Games

The competition was fierce this year at our 2nd Annual Physiatry Foundation Pickleball Tournament. Congratulations to our top two teams on a great last game:

FIRST PLACE: TEAM PERFECT MATCH
Annelise Summers (ACOM) and Amit Bhargava, MD (Advanced Interventional Pain & Sports Medicine Center)

SECOND PLACE: TEAM VA CARIBBEAN
Anna Blanco, MD and Asdrubal Rivera, MD

It's not too early to grab a partner and start practicing for the next round of games in Long Beach!

New Preconference Workshops

This year's preconference lineup expanded to include several new workshops, all of which were well attended and received strong engagement. The highlight was the first Annual **Pediatric Rehabilitation Symposium,** which drew a full audience and marked an important addition to our yearly program.

Career Fair Table Decorating Contest

Our Career Fair brought the energy this year with packed booths, thoughtful conversations, and real opportunities taking shape in real time. Our winner, **Texas Rehab Hospital,** had a standout presence from start to finish, drawing attendees in with a Puerto Rican street party theme.

Also worthy of a shoutout were: UTHealth Houston, University of Arkansas, and UPMC.

Congrats to our winner and on another successful Career Fair in the books!

PAL: 20th Anniversary

We raised a toast to 20 incredible years of the **Program for Academic Leadership (PAL).** The energy in the room was contagious as members old and new celebrated two decades of innovation, collaboration, and impact. Here's to the next 20!

RECAP VIDEO
See if you can spot yourself. Scan the QR code to watch a video recap of the conference.

I left completely, professionally, reenergized!

A must for academic physiatrists!

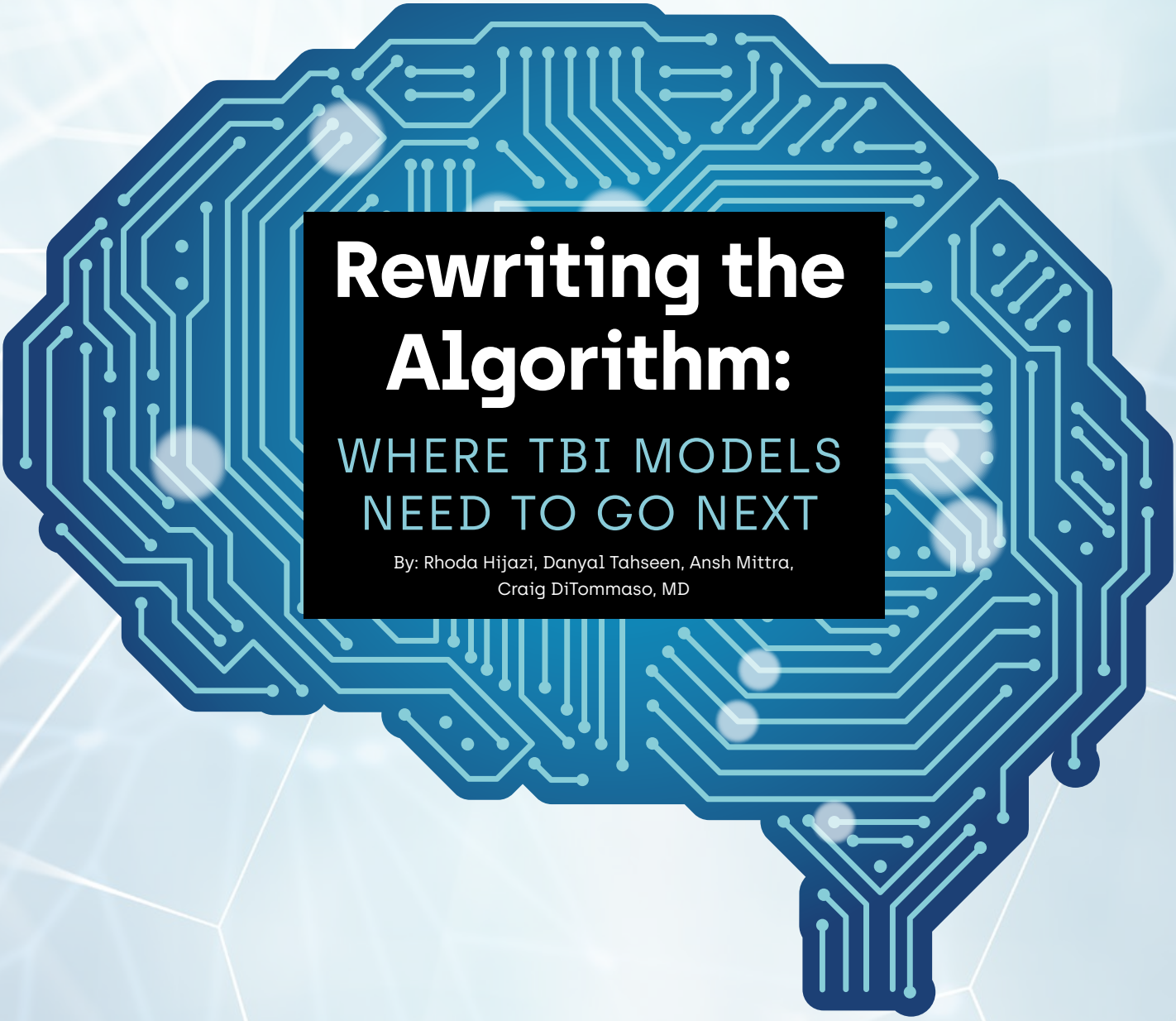
"AAP is a great way to stay connected with a great network of physiatrists. The learning opportunities and discussions are always beneficial to professional growth and keep my practice relevant. The ability to connect with learners from all over also helps those of us in education remember why we love academic medicine!"

"AAP provides the academic brain trust network I need to continue to improve in my everyday practices."

Attending the AAP Annual Meeting was an incredibly rewarding experience, both professionally and personally...The meeting created a powerful platform to reconnect with peers, build new collaborations, and collectively explore innovations that move our field forward.

It was a wonderful experience meeting colleagues and learning ways to improve my clinical care. Seeing how others approach things helped me find simple strategies to make my work easier and more efficient.

We can't wait to see you next year!



Rewriting the Algorithm:

WHERE TBI MODELS NEED TO GO NEXT

By: Rhoda Hijazi, Danyal Tahseen, Ansh Mittra, Craig DiTommaso, MD

Traumatic brain injury (TBI) rehabilitation is a critical component of recovery, aimed at restoring function, autonomy, and quality of life. Despite its importance, access to high-quality rehabilitation remains inequitable. Patients with limited financial resources, unstable housing, or inadequate insurance often face delays in care, limited therapy access, and inconsistent follow-up. These social determinants of health (SDoH) are strongly associated with worse outcomes, including lower functional recovery, higher therapy nonadherence, and increased hospital readmission.

Artificial intelligence, particularly machine learning (ML), has emerged as a promising tool to enhance rehabilitation planning by predicting outcomes and identifying high-risk patients. ML models can process clinical data to generate forecasts that inform discharge decisions, resource allocation, and post-acute care. However, most models rely on clinical variables such as age, injury severity, or imaging results. Without incorporating socioeconomic inputs, these tools miss the broader context influencing rehabilitation success. To realize their potential, predictive models must reflect both the medical and social realities patients face.

Artificial intelligence, particularly machine learning (ML), has emerged as a promising tool to enhance rehabilitation planning by predicting outcomes and identifying high-risk patients.

CURRENT GAPS IN PREDICTIVE MODELING

Predictive ML models show strong potential in forecasting TBI rehabilitation outcomes. For example, models using variables such as age, Glasgow Coma Scale (GCS) score, and comorbidities can predict functional independence, often defined as a modified Rankin Scale (mRS ≤ 2), with accuracy nearing 90 percent. However, several limitations remain:

- Overreliance on clinical data: Most models rely on biomedical inputs and omit key socioeconomic indicators that significantly affect recovery.
- Reduced real-world accuracy: Omitting variables like housing stability, caregiver support, and transportation access limits the ability to account for non-clinical barriers.
- Equity and bias concerns: Models trained on biased datasets risk reinforcing disparities, especially for marginalized patients.
- Incomplete risk profiling: Studies suggest that combining clinical and socioeconomic variables explains significantly more outcome variance. One analysis found that together they accounted for up to 34% of recovery variability.
- Lack of trust and clinical relevance: Tools that ignore social context may seem unrealistic, lowering adoption by clinicians and patients.

PROPOSED MODEL

To address these gaps, we propose the SES-Aware Functional Recovery Predictor (SAFR-P), a machine learning–based decision support tool that incorporates both clinical and socioeconomic features to improve accuracy, fairness, and utility in TBI rehabilitation planning.

Model Components

- Inputs would combine clinical indicators (such as GCS score, injury mechanism, neuroimaging findings, and comorbidities) and rehabilitation parameters (time to rehab and therapy intensity), alongside socioeconomic variables (insurance type, education, Area Deprivation Index, housing status, caregiver availability, transportation access). When direct data is unavailable, proxy indicators such as ZIP code, appointment adherence, or contact delays can be used to infer social risk.
- Architecture would use a gradient boosting or ensemble framework that handles mixed data types and missingness. Explainability modules would enhance transparency and support clinician interpretation at the point of care.
- Outputs would include individualized probabilities of functional improvement (e.g., projected Glasgow Outcome Scale–Extended scores), readmission risk, therapy nonadherence, and care suggestions tailored to the patient's risk profile. Stratification would segment outputs by socioeconomic quartiles and validate across demographic subgroups to ensure equity and avoid differential accuracy.
- Integration into EHR systems would enable SAFR-P to provide real-time support during discharge planning. Automated risk alerts could prompt case management consults, social work involvement, or enhanced outpatient follow-up planning.

Implementation and Scale

SAFR-P could first be piloted across a network of inpatient rehabilitation centers, randomizing patients to standard versus SES-informed discharge planning. Primary outcomes would include readmission rates, recovery scores, and economic metrics such as cost per quality-adjusted life year (QALY) gained or cost per readmission avoided.

Over time, SAFR-P could inform policy-level decisions. Aggregated data could be used to identify areas of concentrated social risk, guide resource deployment (e.g., mobile rehab units, telehealth), and support health equity initiatives. The model would also assist hospitals align with value-based care requirements by enabling more accurate benchmarking, especially for institutions serving high-risk populations.

PLEASE NOTE: *This project was inspired by a patient whose TBI recovery was modeled using machine learning and the Section GG Self-Care Scale. While the model predicted steady progress, financial and care access barriers limited her outcome, highlighting a gap that led to this work.*

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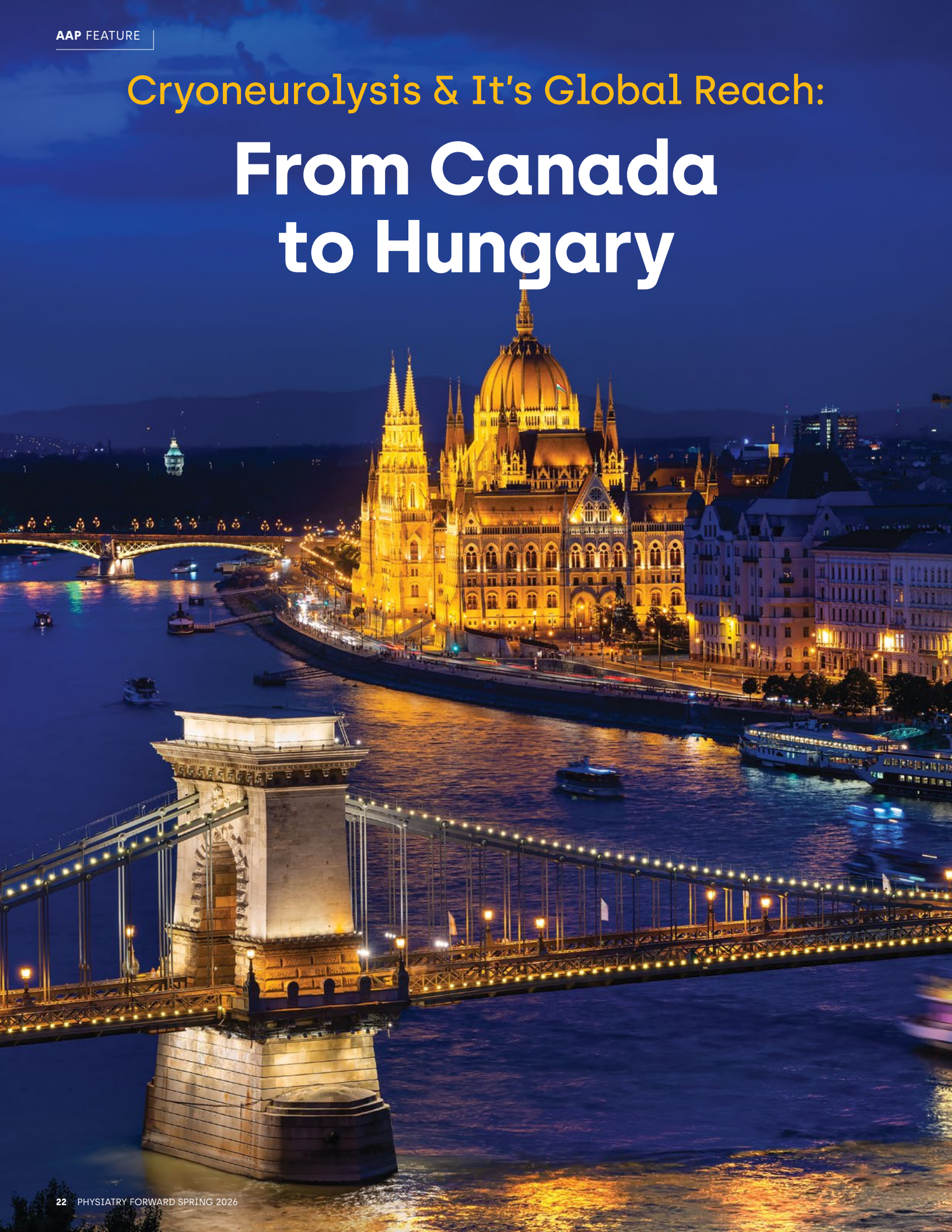
Cryoneurolysis & It's Global Reach:

From Canada to Hungary



LEFT TO RIGHT:

Stunning Budapest at night

Dr Zelenai treating our six year old, lent me his pediatric team scrubs

By Dr. Paul Winston

I received a LinkedIn message on July 1, 2025—Canada Day—from Budapest. Dr. Ferenc Zelenai, an anesthesiologist at the National Institute of Oncology in Hungary, had been using our diagnostic nerve blocks, cryoneurolysis, and pain techniques from my posts, along with our Atlas of Ultrasound Nerve Targeted Procedures for Spasticity. He had a question.

His patients, many post-mastectomy, were living with pain and reduced range of motion after surgery and reconstruction. He referenced the ViVe (Victoria–Verona) algorithm for acute hemiplegic shoulder pain, which I developed with Alessandro Picelli. It considers multiple etiologies. Could a similar approach work here?

I was immediately intrigued. This is a population where pathology is often addressed far too late. As a physiatrist on Canada's West Coast, in the grip of an ongoing opioid crisis, the push toward opioid-sparing pain management only adds urgency.

Shoulder and chest wall pain in cancer patients has many drivers: primary thoracic and rib pain post-surgery, adhesive capsulitis, post-surgical complex regional pain syndrome, and—most commonly—muscle shortening after surgery, often compounded by radiation and chemotherapy. Reconstruction adds another layer. Fibrosis leads to shortening, but aberrant reinnervation after a flap is also significant. The latissimus dorsi is denervated before transfer, yet excessive reinnervation can result in constant, unwanted contractions.

There are few guidelines. Many clinicians use botulinum toxin off-label. On a personal note, my mother developed pain and loss of range of motion after her mastectomy in Florida. I suggested toxin injections to her care team, but no one would proceed. I ultimately arranged treatment myself during a visit. One injection of Xeomin resolved it within a week. There is no central spasticity to drive recurrence.

Surgeons often reach out for "compassionate" stock for post-surgical cancer patients, as we typically have supply to share. That reality sharpened when a colleague in Texas treated a post-mastectomy patient successfully, only to later learn the patient had been charged $9,000 cash. Like me, she would have used compassionate supply in her previous hospital.

At the same time, I had been contacted by a mother in Budapest seeking treatment for her six-year-old daughter with cerebral palsy due to microcephaly. When I teach in Europe, patients often travel for care.

Dr. Zelenai was eager to expand into cryoneurolysis for spasticity and assured me his institution, one of the largest thoracic surgery centers in Europe, had a dedicated pediatric anesthesia team ready to assist. The family was thrilled to receive care at home, at no cost.

Our international pediatric cryoneurolysis program continues to grow. In the U.S., Atlanta's Children's Hospital is leading the way, with Stanford, Shriners California, and Rady Children's all developing programs this year.

Cryoneurolysis is more common in Eastern Europe; the largest equipment manufacturer in Europe is based in Poland. For me, there was also a personal pull. I trained in character dance, Hungarian Czardas among them, and the Danube, the music, the architecture all called. I began touring as a dancer internationally as a teenager, and I still mark each destination with a small, eccentric choreography of my own.

Dr. Zelenai, along with anesthesiologists Dr. Petra Juhasz and Dr. Akos Both, physiotherapist Helka Rancz, and

LEFT TO RIGHT

Planning our pediatric case

Dr Petra Juhasz and her team preparing for a cancer patient's treatment

neurologist Dr. Andreea Dumele, form the institute's pain team. Established decades ago, the program still carries the burden of proving its necessity. I always want to understand where I am working, and Dr. Zelenai spent a day guiding me through Budapest, its history, and the evolving tensions within Hungary's public–private healthcare system.

The clinical days were dense. Patients ranged from a highly functional yoga instructor unable to achieve basic poses, to those with advanced metastatic disease and severe pain. The anesthesiologists were quick, precise learners.

The key is careful assessment: where is the pain—and the restriction—coming from? Using ultrasound and palpation, we identified whether limitations stemmed from the pectorals, latissimus dorsi, or what I've described in publications as the axillary triad (latissimus dorsi, teres major, subscapularis). The rhomboids and trapezii also contribute.

We began with diagnostic lidocaine blocks to isolate the primary culprits. Many patients also had capsular stiffness; for these, we performed anterior shoulder hydrodilation using 3 cc of lidocaine and 10 cc of saline. The response was often immediate: restored or significantly improved range of motion, and with it, visible relief.

For deeper chest wall pain, diagnostic intercostal nerve blocks were used. The team was already experienced with cryoneurolysis at multiple levels for these cases.

Learning about Budapest with Dr. Zelenai

We called the approach ViBuNet, or Victoria–Budapest Network. Unlike classic spasticity, some patients improved significantly with blocks and hydrodilation alone. With Helka, we developed a stretching protocol to maintain gains, adding cryoneurolysis or botulinum toxin when needed. Several patients required cryoneurolysis, which we arranged immediately.

Many of these women carry significant trauma from repeated or unsuccessful surgeries. The anesthesiology team was prepared with propofol and sedation for those apprehensive about new procedures. I'll admit, I envied the immediate access to that level of support.

The procedures themselves were executed with precision. These were largely new anatomical targets for the team, so we reviewed each approach in detail beforehand. Dr. Juhasz, in particular, showed strong interest in building a spasticity program.

That afternoon, we treated a GMFCS V adult with cerebral palsy, severe contractures, and spasticity in all four limbs. Using our textbook, ultrasound guidance, and their expertise in nerve blocks, we worked through each target. The results were immediate. The patient remained alert and comfortable; his parents, relieved.

It often feels like an audition, being handed the most complex, refractory cases without prior context. You learn quickly whether your approach translates.

The next day, we met the six-year-old. After multiple WhatsApp consultations with her mother and physiotherapist, we knew her history: prior toxin treatments and surgeries in Spain, with three refractory limbs remaining. The pediatric anesthesia team, led by Dr. Ildikó Madurka, was ready.

Dr. Zelenai treated even the smallest targets down to the toe flexors contributing to clawing. Over nearly two hours, 16 nerves were addressed. In recovery, as she began to move—testing her legs, her shoulder—the change was unmistakable, even without words. Follow-up confirmed significant gains in gait stability and range.

These training intensives are emotional. For patients, there is fear—this is unfamiliar territory, without the reassurance of seeing others move through it. For physicians, there is often an

Cryoneurolysis is more common in Eastern Europe; the largest equipment manufacturer in Europe is based in Poland. For me, there was also a personal pull. I trained in character dance, Hungarian Czardas among them, and the Danube, the music, the architecture all called. I began touring as a dancer internationally as a teenager, and I still mark each destination with a small, eccentric choreography of my own.

Scan the QR code to watch one of Dr. Winston's dance performances

expectation of overwhelming complexity, which quickly gives way to recognition: the anatomy is learnable, the techniques replicable.

By the final cases, I step back. The team begins to guide itself. That moment, watching the shift from observer to practitioner, is quietly euphoric.

The Hungarian team did not pause. Within days, I was receiving outcome videos, patient messages, and reports of new referrals. They had already begun collaborating with local PM&R physicians, treating patients with MS, cerebral palsy, and stroke.

To date, more than 70 centers are offering cryoneurolysis for spasticity, with many more in development. Equally important are hands-on workshops, step-by-step anatomical training and ultrasound scanning on volunteers. The AAP has been a consistent and valued supporter of this work.

Cryoneurolysis works through controlled, reversible axonal degeneration using nitrous oxide or carbon dioxide. While cancer treatment has long used colder cryoablation to destroy tissue, our approach preserves surrounding structures, targeting only the axon.

I am not formally trained in cancer rehabilitation and continue to learn from colleagues in the field. But physiatry has always asked a different question: not what is the diagnosis alone, but how can function and quality of life improve?

The immediacy of nerve blocks and cryoneurolysis opens new possibilities, altering pain signals, releasing contracted muscle, even influencing organ function through neural pathways. The implications are still unfolding.

Anesthesiologists, leaders in peripheral nerve blocks, have been extraordinary teachers. Dr. Daniel Vincent, in my home center, first suggested applying cryoneurolysis to spasticity after I asked him to teach me diagnostic blocks. Since then, we have treated over 1,000 patients locally, and that number is accelerating globally.

I am grateful to the Hungarian team for their openness and drive. They may not yet realize how exceptional their program is, or how far its impact will reach, but their passion will certainly alter patient care forever.

Dr. Agnes Stogicza a celebrity in Cryoneurolysis met up for dinner over music

BIO

Dr. Paul Winston is a Clinical Associate Professor with the University of British Columbia and the Island Medical Program. He previously served as President of the Canadian Association of Physical Medicine and Rehabilitation (CAPM&R) and is currently the Medical Director of Rehabilitation and Transitions for Island Health, as well as the Medical Lead of Rehabilitation Medicine at Victoria General Hospital.

His practice spans a broad range of physiatry, including hospital-based inpatient and outpatient neurorehabilitation, with a focus on spinal cord injury, brain injury, and spasticity management. He also maintains an outpatient EMG and musculoskeletal practice.

Deeply committed to education, Dr. Winston is actively involved in teaching medical students and residents and regularly lectures at the local, national, and international levels.

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 RECIPE

Oreo Dessert

ERIC NGUYEN, DO

I love Oreo desserts, but am always freaked out by how caloric and unhealthy a couple Oreos are. And it is difficult to eat less than 5-10 Oreos in a given sitting. So, this dessert kills two birds with one stone by satisfying my sweet tooth and ensuring a high-protein dessert. In addition, it is very easy and quick to make as it is no-bake. It's an excellent snack before, during, or after work, and very very easy to make.

Serving Size: 2
Prep: 10 min, 1 hr refrigeration

INGREDIENTS

- Plain nonfat Greek yogurt (1 cup)
- Non-fat or light cool whip (8 oz)
- Protein powder (1 scoop) - I use MusclePharm Combat Protein Powder Cookies 'N' Cream flavor (*Can use any vanilla or chocolate protein powder)
- Sugar-free Jello pudding mix (1 tablespoon) – I use cheesecake or vanilla flavor (*Can use chocolate or any other flavor you feel like)
- Oreos (as much as you'd like) (*Can use any other cookies you'd like)

COOKING INSTRUCTIONS

1. Mix together all the ingredients besides the Oreo cookies in a large bowl with a spatula or spoon.
2. Place and crush Oreos in a plastic bag.
3. Fold in the crushed Oreos, and/or add the crushed Oreos on top for a nice cookie coating.
4. Refrigerate this entire mixture in an airtight container for at least one hour before enjoying. This gives the mixture enough time to combine together, and ensures the best consistency and flavor before serving.
5. ENJOY!

Recipe Adaptations: Can use gluten free and/or dairy-free Oreos, Cool Whip, and/or pudding mix

NUTRITIONAL FACTS SERVING:

1/4 cup (71g)
Calories: 141kcal (7%)
Carbohydrates: 17g (6%)
Fat: 5g (8%)
Fiber: 0.3g (1%)
Sugar: 4.6g (5%)
Protein: 7g (14%)

Yummy!

WELLNESS EVENT

Wellness Event with Rush PM&R

ANTHONY REYES, MD

As part of our program's ongoing commitment to resident wellness, our department sponsors an annual weekend resident retreat designed to provide a meaningful opportunity to reset and recharge. During this time, residents are fully relieved of clinical duties, with coverage provided by attending physicians.

The retreat is planned by the Wellness Chief with activities designed to strengthen the bonds amongst the residents. Our residents are always more inspired to create program improvements, refreshed, and ready to attack the second half of the year following the retreat.

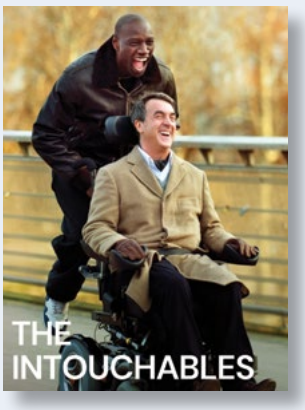
This past year, we took advantage of the beautiful late-summer weather at a lake house on Lake Michigan. We're beginning to plan for our next retreat in a few short months, and can't wait to welcome our incoming PGY-2 class by creating unforgettable memories!

MOVIE REVIEW

The Intouchables

REVIEWED BY: ALIZA PEREZ, DO

"Watching *The Intouchables* really felt like a reminder of why rehab medicine is so meaningful. Even though the film centers on a man living with quadriplegia, it is really about so much more than disability; it is about dignity, connection, joy, and finding ways to keep living fully despite major physical limitations. What makes it so powerful is how it shows that healing is not always about curing someone, but about helping them regain independence, purpose, and quality of life. It captures the heart of PM&R in such a human and emotional way."



CASE REPORT:

Troubleshooting Intrathecal Baclofen: Can MRIs Be a Powerful Tool?

Authors: Min Ju Kim, DO; Ricardo Fuentes-Saavedra, MD; Bryan Le, MD
Institution: Montefiore Medical Center, Bronx, NY

INTRATHECAL BACLOFEN (ITB) CAN BE USEFUL FOR PATIENTS WITH SEVERE SPASTICITY. HOWEVER, WORSENING SYMPTOMS OF SPASTICITY MAKE IT CHALLENGING TO DIFFERENTIATE BETWEEN DEVICE MALFUNCTION, CATHETER DISLODGEMENT, OR PROGRESSION OF PRIMARY PATHOLOGY. THIS CASE REPORT EXPLORES MRI AS A TOOL FOR IDENTIFYING TROUBLESHOOTING WITH CATHETER PLACEMENT OF AN ITB PUMP.

We present a 43-year-old man with a past medical history of multiple sclerosis (MS) complicated by severe spasticity, which was managed by ITB that was placed in 2018. The patient initially presented to the outpatient physiatry clinic after multiple mechanical falls. Notably, he fell on the right side of his abdomen where his ITB was located. He was admitted at that time after multiple falls, and was discharged to a freestanding acute inpatient rehabilitation center for multidimensional rehabilitation. There, the patient's ITB was uptitrated due to increase in spasticity and pain in lower extremities, with no significant relief. After 4 weeks of inpatient rehabilitation, the patient was deemed to have achieved fair improvement in his function and was discharged to a skilled nursing facility (SNF). Since his discharge to SNF, his ITB was further uptitrated again in June 2024, again with no improvement in spasticity and pain. The patient was also restarted on tizanidine without additional benefit.

Prior to the falls in April 2024, the patient ambulated with a cane, walker, and scooter. However, the patient's spasticity progressed over the next 3 months, and the patient was no longer ambulatory. In August 2024, the patient was readmitted to the hospital for evaluation for a possible MS flare as the etiology for his worsening spasticity. His physical exam during this admission revealed a Modified Ashworth Scale (MAS) of 4 in his left hip adductors and knee flexors and 3 in right hip adductors and knee flexors. MRI brain and spine were negative for MS flare. However, MRI spine revealed a ventral extra-axial fluid collection in the thoracolumbar spine from T1-L3 which was suspicious for dislodgement of the catheter (Figure 1). The patient was also given a 50 mcg bolus of intrathecal baclofen delivered through his existing baclofen pump with no improvement of spasticity. A catheter access port study under fluoroscopy revealed unobtainable CSF, confirming our suspicion of catheter dislodgement. Given his pump was near its elective replacement date, the patient's ITB catheter was ultimately replaced. Postoperatively, the patient's bilateral lower extremity tone significantly improved. He was discharged to an inpatient rehabilitation facility for uptitration of the baclofen pump for adequate control of spasticity and transfer training.

Intrathecal baclofen pumps can offer relief in patients with MS diagnosis requiring lower dosages compared to spasticity produced by stroke or traumatic brain injury. However, the chronic use of baclofen pumps requires an understanding of the possible malfunctions of the catheter delivery system and the pump itself. There are many signs and symptoms that can lead to considering

issues with the ITB, including rebound spasticity, diffuse pruritus, behavioral agitation, somnolence, and seizures in severe baclofen withdrawal cases. Currently, there are no universal guidelines to troubleshoot the intrathecal baclofen pump system, although experts have considered alternatives to the troubleshooting that include fluoroscopy-guided CT myelogram to identify the source of the problem, which is also intended to prove the integrity of communication of the pump with the intrathecal space. The study starts with the aspiration of CSF from the catheter access port. The inability to obtain fluid should raise the concern of patency of the catheter, such as catheter kinking, blockage from a tip granuloma, or dislodgement system, as happened in this case. Catheter malfunction is more common than pump malfunction, however there are multiple sites of possible discontinuity, which may be difficult to assess in one image. The current standard of care is to obtain dynamic imaging, such as a fluoroscopic dye study to assess the patency of the catheter.

Our case illustrates the possibility of using MRI as a more accessible modality to complement the evaluation of intrathecal baclofen pump troubleshooting. As the T2 images in MRI provide a great window to fluid collection, this imaging modality is able to capture fluid pockets that can reflect disruptions of the ITB catheter delivery system with adequate sensitivity. As the pump continues to deliver medication in a dislodged or kinked catheter, the fluid will slowly accumulate. This creates an important consideration as patients with medication not being properly delivered in the intrathecal space are at greater risk of withdrawal and death.

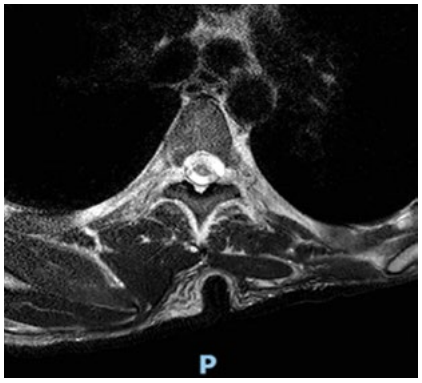


FIGURE 1:
Axial T2-weighted MRI at T5 demonstrating the intrathecal baclofen fluid collection in the epidural space.

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PHYSIATRY FOUNDATION

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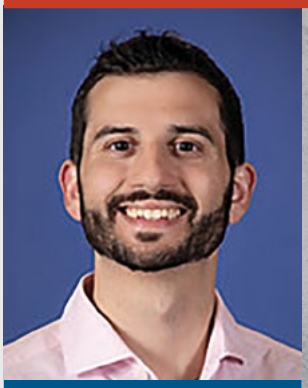
3. The grad gets recognized on **AAP's Wall of 'Grad'itude,** on social media posts, and in our magazine *Physiatry Forward.*
4. The grad or group of grads receive a note of appreciation.
5. 💥 Boom! Your donation gets you into our giving circles & supports the future of physiatry.

A Sense of Belongings: Shane Stone, MD



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

Dr. Shane Stone is a spinal cord injury (SCI) physiatrist with a particular interest in the management of spasticity and respiratory complications in SCI. He serves as an Assistant Professor and PM&R Director of SCI at UC Davis and is also a staff physician at the San Diego VA. Beyond clinical care, he is actively involved in resident and medical student education and mentorship. Within AAP, he serves as Chair of the Junior Faculty Council and is a member of both the Medical Student Educators Committee and the AAP Advisory Board. Outside of work, he is a husband and proud cat dad, trying to have a little fun every day.

1. **Helmet:** Since moving to California, I've been commuting to work by bike. As a PM&R doc, it would feel irresponsible not to wear a helmet. I enjoy the exercise and fresh air in the morning, and on the way home it's a great way to decompress.
2. **Headphones:** During fellowship, I had an hour-long commute that felt like wasted time. I started listening to podcasts on leadership, medical education, and PM&R. On the way home, I'd switch to audiobooks—always fiction, and usually something I've already read. That tradition stuck. I'm also big on music in the workroom—each day has a theme, a habit I started in residency.
3. **Sandwich Defender:** A gift from my wife to protect my most treasured possession: my daily peanut butter and jelly sandwich. The ingredients have evolved over the years, but the magic stays the same.
4. **Kindle:** I love to read. We spend most of our days living nonfiction, so I like to unwind with fiction. You'll usually find me reading authors like Brandon Sanderson or Brent Weeks.
5. **Patient Items:** As an SCI physician, one of the most rewarding parts of my work is the continuity I have with patients. After navigating the medical complexities of injury, my favorite part is helping them get back to living their lives. When patients share their successes—whether it's artwork created with an eye gaze device, a book, or a manuscript they've been working on—I treasure those items. I keep them on my desk as reminders of what's possible.
6. **Boomerang:** Australia holds a special place in my heart. I originally went there on a path toward becoming a marine biologist—clearly that didn't pan out. It was actually in Australia that I had my "aha" moment that medicine was the right path for me. It also taught me that there's more to life than just work, a perspective I still try to hold onto.
7. **Final Four:** I went to Duke for undergrad and was lucky enough to attend the Final Four in Indianapolis when they won it all in 2015.
8. **Sunscreen:** Since moving to San Diego, I've been spending more time outside. I keep sunscreen on my desk as a reminder to reapply before heading out for lunch or taking a quick walk with colleagues to reset during the day.

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