2007 AAPM&R PRESIDENTIAL ADDRESS

Physiatrist 2007: Who Are We and Where Are We Going?

Joel Press, MD

ABSTRACT. Press J. Physiatrist 2007: who are we and where are we going? Arch Phys Med Rehabil 2008;89:1-3.

The field of physical medicine and rehabilitation has evolved greatly over the last half century. Although practice patterns continue to change, the unifying concepts of physiatry remain the same. Awareness of the unique aspects of physiatry is still not optimal. It is incumbent on the physiatric community to educate our colleagues, our patients, and the public about our unique field.

Key Words: Physical medicine; Rehabilitation.

AT FIRST, I WAS NOT really sure what the topic of my presidential address would be. Then, I did the only thing I know how to do anymore (besides ride a bicycle), and that was to go see some patients and see what topics came up. Invariably, I found myself, as always, explaining to another new patient exactly what kind of doctor I am, after explaining that, indeed, I am a doctor. After 20 years in practice, it made me wonder whether anyone really knows who we are and what it is that we do. My pessimistic side said, "This is ridiculous"; my half-full side said, "What a great opportunity." So many people to educate, so little time. . . .

So I thought I would discuss not only who we are, but also why it is so important that everyone else should know who we are and specifically what we do. As I reflect on those questions, I will try to indicate where I think we are going as a specialty, because it relates to a number of challenges that we need to confront today.

To the first question—Who are we? Let me begin by dealing with the name. Fizz-eye-a-trist? Fizz-ee-at-trist? Which are we? Why all the confusion? I suppose we can blame some of our founding fathers, who never really made it clear what we should call ourselves. How did we get this name? I cannot imagine what Drs. Krusen and Kottke where thinking when it was decided that we needed a name for a doctor of physical medicine and rehabilitation (PM&R). There they were, sitting around saying, "Let's come up with a name that no one will pronounce right, sounds just like psychiatrists (whose function in many cases we provide to our patients), and will torment our future Academy members until the end of time. Well, look at the bright side: they won't be able to come up with anything better." Well, I think they were probably right.

Dorland's Illustrated Medical Dictionary defines a physiatrist (fiz′e-at′rist) as a "physician who specializes in physiatrics."[1(p1385)] *Physiatrics*—from the Greek, *physio* (meaning nature) + *iatrke* (meaning surgery, medicine, or a physician)—is that branch of medicine that deals with the diagnosis, treatment, and prevention of diseases with the aid of physical agents, such as light, heat, cold, water, and electricity, or with mechanical apparatus (ie, physical medicine).[1(p1385)] That definition could probably use some major upgrading. I can only imagine the National Spelling Bee in the year 1948.

Such confusion. The curse of the name. We have been complaining about it for years. "We need to change our name." "We need to market the name more." It just does not roll off your tongue like otolaryngologist or obstetrician and gynecologist. The Physiatric Association of Spine, Sports and Occupational Rehabilitation, in its first few years, commissioned some "naming experts" to help come up with a better name for physiatrists who primarily do musculoskeletal medicine. Here are some of the top names we paid over $5000 to contemplate. Now remember, the target characteristics they were looking for included being more descriptive than the current name—more marketable, usable, consumer-friendly, professional, and physician-medically related; it should imply a specialist; and it should be short, memorable, and intriguing: *myoneurobiologist*, *neuromuscular orthopedist*, *regenerist*, *orthomyologist*, and *strategic medicine specialist*. Seriously, we paid people money to come up with these names. To round out the top 10: *neurosynergist*, *physiomed*, *flexicologist*, *biomedist*, and the *externist* (not to be confused with the *exorcist*). I guess they got the intriguing part right. Physiatrist never sounded so good!

The point here is that we are who we are. Market research has shown that we may have only a 2% or 3% market penetration of the name, yet when we explain to people what we do and what we have to offer, over 80% want to see *that* type of doctor. When riding 3800 miles this past summer, I had the opportunity to talk to lots of people in lots of towns across the United States. I would ask people who they saw for their back pain or who they would see if a family member had a stroke. The answer was usually their primary care doctor, then a possible referral to an orthopedic surgeon or neurologist. I can only remember 1 person, a young man in Lima, OH, who knew what a physiatrist was. I was astounded, actually. He had seen a physiatrist at Ohio State University for back pain a few years before. No, it was not Ernie Johnston. Yet as the market research confirmed, and I learned first hand, every one of them had something they wanted me to look at after I told them what I did. The problem is not the name; it is our poor ability to get the word out about what we do and what is unique about what we do. Getting the word out does not mean spending $1 million on an awareness campaign and thinking that will cause patients to flock to our offices. It means making sure that we allocate 30 to 60 seconds of every interaction we have with a new patient, and maybe the existing ones, to explain what we do. Think of the opportunities. If every physiatrist spent a minute or less explaining to their patients what they, as physiatrists, do, no matter what practice setting, there would be roughly 15 to 20 million patients a year who would know what physiatrists are. That would cost a lot less than $1 million and have dramatically more impact. The bottom line is that we are physiatrists

From the Rehabilitation Institute of Chicago, Chicago, IL.

Presented as the presidential address to the American Academy of Physical Medicine and Rehabilitation, September 28, 2007, Boston, MA.

No commercial party having a direct financial interest in the results of the research supporting this article has or will confer a benefit upon the author(s) or upon any organization with which the author(s) is/are associated.

Correspondence to Joel Press, MD, Rehabilitation Institute of Chicago, 345 E Superior St, Chicago, IL 60611. Reprints are not available from the author.

0003-9993/08/8901-00741$34.00/0
doi:10.1016/j.apmr.2007.10.013

(or fizz-ee-a-trists). Deal with it. Live with it. Flourish with it. It does not matter which term we use as long as we explain what it is that we do and how that distinguishes us. If rehabilitation medicine physician, as has been suggested by the Academy Marketing Committee, works better for you, so be it.

Now, let us return to who we are. We are a diverse group of physicians with a multitude of practice settings. We are a young field, relatively speaking. It does disturb me a bit that I am on the older half of the mean now. Our field, as has all of medicine, has shifted from an inpatient-based world to an outpatient world. More of our trainees are pursuing musculoskeletal practices as more opportunities emerge. It still appears, though, that a significant percentage of our members have practices that combine musculoskeletal and neuromuscular practices. Our philosophic approach to PM&R is not inpatient or outpatient centered or only musculoskeletal or neurologic in origin. Many of our patients have disabling conditions with multiple diagnoses. Our specific area of specialization is not as critical to the future of physiatry as is the approach we each take to improving patient ability to function. Regardless of our practice setting differences, we need to always think of ourselves as physiatrists first, and then, oftentimes, with specific areas of interest or specialization.

Why is it important who we are and what we call ourselves? As I stated, maybe the specific name is not important as long as we distinguish what it is that we do and how that physiatric approach is unique in caring for patients. However, without a specific identity and a distinguishing quality to our practices and patient approach, our future as a specialty will be quite bleak. Market research conducted for the Academy by the Chandler Chicco Agency, which ran 2 focus group sessions of primary care physicians in Chicago, IL, and Westchester, NY, showed that there were significant gaps in the primary care physician's level of understanding about the varied conditions physiatrists can treat and the treatment modalities used. Most felt that physiatrists are not well known and not networking in the "community" sufficiently. There was an impression that the physiatrist is an unnecessary "layer" in the treatment plan and was perceived interchangeability with physical therapists. Patients want, and need, a reason to specifically see a physiatrist for their disabling conditions, be it low back pain or their stroke or spinal cord injury. Anyone can be taught to do an epidural injection. Not everyone can care for a patient by doing an epidural injection as part of a more comprehensive treatment program that may include therapy, exercises, bracing, medication management, psychologic counseling, or referral—actually managing the patient. Not everyone can manage the stroke beyond writing "refer to therapies" and hope that the therapists know what they are doing. We need to give the referring doctors, insurance companies, and patients a reason to refer to us. Our specialty is unique in emphasizing improvement of function and improving mobility and activity, not just mentioning it as an additional line on the prescription pad. We sell *function* in everything we do. As a physician in a musculoskeletal practice, what makes me unique and sought after, and referred to, is not that I give nonsteriodal anti-inflammatory drugs better than the primary care doctor, or that I can administer an injection, or prescribe therapy—anyone can do that. What makes us unique is the approach we take to patient care. It is managing the patient with a physiatric approach that truly distinguishes us. We need to emphasize to patients and referring physicians, insurance companies, and government payers our uniqueness and that what we do adds value to patient care. If we want to exist and flourish as a specialty, we need to provide evidence of our worth. There are fundamental differences between PM&R fellowships in stroke rehabilitation and neurology fellowships and between pain fellowships in PM&R and anesthesia fellowships in pain. One may emphasize where the needle goes; ours emphasizes in whom to put the needle, when to administer it, where to do it, and most importantly what else to do to help the patient. If we continue to underemphasize our physiatric training, we will be marginalized in the medical community. We will not be necessary to manage any patients. Neurology or primary care could take over all inpatient rehabilitation of neuromuscular disorders. Orthopedic surgery, emergency department physicians, pediatricians, or any of a number of specialties could be asked to care for all musculoskeletal problems if we do nothing more than they do in managing our patients.

Calling ourselves physiatrists who specialize in pain management is very different from calling ourselves pain management doctors and hiding from what makes us unique in our approach. I had the uncomfortable experience of participating in a discussion group one afternoon at the North American Spine Society's annual meeting about nonoperative treatment for low back pain. The room was filled with surgeons and nonsurgeons. One physiatrist chimed in that he was an "interventional" physiatrist and wanted to know what he should do with his patient after he had "done all the diagnostic and therapeutic injections he could think of and the patient was no better." Where could he send that patient? Obviously, this was not a banner day for the specialty, as I tried to explain that most physiatrists would take a more comprehensive approach to the treatment of this type of patient.

So, that is who we are, what we are called, and why patients, insurers, referrers, et cetera need to be made aware of what we do and why what we do is unique, but how do we actually increase that awareness? Awareness is much more than our typical thoughts about public relations and marketing. We build our awareness by what we do and what we stand for, more so than "marketing" a message.

First, what is the Academy doing to put and keep us on the map? As one of the primary specialties that make up organized medicine, the Academy is representing each one of us in many national arenas that all build awareness for us as a specialty. There are numerous organizations, councils, committee partnerships, and committees on which Academy members serve that are in the background, unbeknown to most of us, that are having a huge impact on the awareness of PM&R. We have representatives on the Council of Medical Specialties Societies, a group of 30 societies representing U.S. medical specialties that represent diplomats certified by the American Board of Medical Specialties who address issues of national interest and mutual concern. We have representatives in the American Medical Association (AMA), including the specialty and service society, the resident fellows section, the young physician section, and Women's Physician Leadership Council. Academy members are actively involved representing our specialty for reimbursement and new technology at the AMA Current Procedural Terminology (CPT) Advisory Committee, the CPT codes for pain of the Pain Care Coding Partnership, and on the Relative Value Scale Update Committee. We have Academy members representing us on scope of practice issues with the AMA Scope of Practice Partnership. Maybe of greatest importance with respect to defining the future of medicine and potentially redefining specialty medicine is our involvement with the AMA Physician Consortium for Performance Improvement; the Academy is one of the lead organizations on the workgroup on degenerative lumbar spinal stenosis, and the Academy is also very active in the workgroups in geriatrics, osteoarthritis, osteoporosis, and stroke and stroke rehabilitation. Members of the Academy also represent the specialty at

other primary national quality initiatives, including the Ambulatory Quality Alliance, which is a broad-based collaborative of physicians, consumers, purchasers, health insurance plans, and others to improve health care quality and patient safety, and the National Quality Forum, a not-for-profit created to develop and implement a national strategy for health care quality measurement and reporting, which we are joining in 2008. There are also numerous coalitions and liaisons in which Academy members and staff are involved, including the National Institutes of Health (NIH)–National Center for Medical Rehabilitation Research (NCMRR) coalition, an effort to elevate the NCMRR at NIH to the status of an independent institute or center; the Commission for Motion Laboratory Accreditation; membership in the Decade of Bone and Joint Disease; and liaisons to the American Geriatric Society, National Osteoporosis Foundation, Coalition to Preserve Rehabilitation, American Institute of Ultrasound Medicine, Commission on Accreditation Rehabilitation Facilities, 75% Rule Coalition, and the American Heart Association Section for Long-Term Care and Rehabilitation, just to name a few. If we are not involved, we will never be part of the solutions to the many problems facing health care today. Some new initiatives include increasing awareness and understanding of PM&R directly with payers through the National Medical Specialty Society Insurance Coalition, a group of 20 national specialty societies that works with the private sector health plans to provide administrative simplification to the practicing physician, and the American's Health Insurance Plans (AHIP), a national association designed to serve member organizations and to inform policy-makers and the public about health care financing and delivery. AHIP represents nearly 1300 members who provide health care for more than 200 million Americans. Our involvement in all these organizations is a great step toward increasing awareness of our specialty; however, the ultimate test comes by our actions in our day-to-day practices.

So what can we do as individuals to improve our own exposure and ultimately awareness of our field? A good start would be to get the word out. Make sure all of your existing patients know that you are a physiatrist, a rehabilitation medicine physician, or whatever name works (remember, it is very unlikely that we will have a new name any time soon), and what it is that we do that is unique. Some of us may need to start by educating our family members a little better. To paraphrase the old commercial for Smith Barney investments, we will need to do it "one patient at a time."

We need to get involved in teaching at the medical schools—be it in an anatomy class, a physical exam course, a pathophysiology lecture, or a direct rotation—exposure of our field to the next generation of physicians will accomplish 2 important goals. First, if we are truly role models whom they would like to emulate, we will recruit the best and brightest from the medical schools. Association of American Medical Colleges data show that we are not necessarily attracting the most accomplished medical students into our field. Even if we do not recruit them to our field, if we are doing a good job, we can expose them to the meaning of physiatry and what it is that we do that is distinctive and helpful to their patients. Call it premarketing of our field. They are the future physicians and the future referrers of patients—show them what makes us different.

We all need to be physiatrists (or fiz-ee-a-trists) first. We need to emphasize and live our distinguishing features, not just talk about them. We need to walk the proverbial walk. Our actions are always unambiguous. If we can be physiatrists in our actions, our futures, and the quality of care we can provide for our patients, will be great.

Reference

1. Dorland's illustrated medical dictionary. 29th ed. Philadelphia: WB Saunders; 2000.