



ENHANCING HEALTH AND FUNCTION
THROUGH EDUCATION AND RESEARCH IN
THE FIELD OF PHYSICAL MEDICINE AND
REHABILITATION

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President's Message

Dear Colleagues,

As I write my final President's Message for the FSPMR newsletter, I find myself reflecting with tremendous gratitude on the past two years. Serving as President of the Florida Society of Physical Medicine & Rehabilitation has been an incredible honor and one of the most rewarding experiences of my professional career.

When I began this journey, I hoped that we could continue strengthening our society, increasing engagement, and creating more opportunities for physiatrists across Florida to connect, learn, and advocate together. Looking back, I am proud of how far we have come—and I know that our greatest accomplishments have always been the result of people working together toward a shared vision.

I would like to begin by expressing my sincere gratitude to **Lorry Davis**, who served as the Executive Director of FSPMR for many years. Lorry dedicated an extraordinary amount of time and energy to our society and played an important role in building the foundation upon which we continue to grow today. Although she transitioned out of the Executive Director role last year, her contributions and commitment to FSPMR will always be part of our history. Thank you, Lorry, for everything you have done for our society.

I also want to recognize **Tania Jones**, our current Executive Director, whose energy, organization, and dedication have helped transform and advance FSPMR. Tania has brought new ideas, new momentum, and a renewed focus on growing our membership and strengthening our presence. I am incredibly grateful for all of her hard work and for everything she continues to do behind the scenes to move our society forward.

And finally, I am very excited to welcome our incoming President, **Dr. Marc Gerber**. I have every confidence that Marc will continue to build upon the progress we have made and bring his own vision and leadership to FSPMR. I look forward to supporting him and watching the society continue to flourish under his leadership.



Diana A. Hussain, M.D.

A Society That Continues to Grow

Over these past two years, FSPMR has continued to grow—not only in membership, but also in visibility, engagement, and purpose. One of the accomplishments that makes me particularly proud is that we have taken an important step forward by establishing our **own independent FSPMR Annual Meeting**.

This represents an important milestone for our society. Having a stand-alone meeting gives us the opportunity to create an educational program specifically designed around the broad and evolving needs of Florida psychiatrists. It also provides us with a place to bring together residents, fellows, early-career physicians, and experienced leaders while strengthening the identity and voice of PM&R in our state.

I strongly encourage those who have not yet registered for the upcoming **FSPMR Annual Meeting** to do so. We have worked hard to create an excellent program, and I am excited to see our members come together. I hope to see many of you there—not only for the outstanding educational content, but also to reconnect with colleagues, meet the next generation of psychiatrists, and celebrate what we have accomplished together.

Our Strength Is in Our Numbers

As I step away from the presidency, there is one message I hope to leave with every psychiatrist practicing in Florida :
Please get involved in FSPMR.

If you are not yet a member, I encourage you to join. If you are already a member, I encourage you to become more involved.

Our profession is stronger when we are organized and when we speak with a collective voice. Whether the issue involves legislation, reimbursement, scope of practice, education, advocacy, or the future direction of our specialty, our ability to influence these conversations depends on our participation.

There are many ways to contribute. Attend our meetings. Join a committee. Mentor a resident. Participate in advocacy. Share your ideas. Encourage your colleagues to join.

You do not have to take on a leadership position to make a difference. **Every member adds strength to our collective voice.**

I would love to see the day when every PM&R physician in Florida recognizes FSPMR as their professional home and understands the value of being part of a strong, organized state society.

Thank You

To our Board of Directors, committee members, volunteers, residents, fellows, and every member who has supported FSPMR—thank you.

Thank you for trusting me to serve as your President. Thank you for your ideas, your encouragement, your constructive feedback, and most importantly, your willingness to participate. The progress we have made belongs to all of us.

continued next page

I leave the presidency with tremendous optimism about the future of FSPMR. We have built momentum, strengthened our membership, established our independent annual meeting, and created a stronger foundation for the leaders who come next.

Although this is my final President's Message, it is certainly not goodbye. I will remain a proud member of FSPMR and look forward to continuing to support our society and our specialty in whatever ways I can.

Thank you for allowing me the privilege of serving as your President. It has truly been an honor.

I hope to see all of you at our Annual Meeting. Let's continue to grow, participate, advocate, and make our voices heard—**together**.

Warmest regards,

Diana Hussain, MD

President

Florida Society of Physical Medicine & Rehabilitation (FSPMR)



Disclaimer

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FSPMR MEETING 2026

FLORIDA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION

INNOVATIONS IN PM&R

OCTOBER 9-10, 2026

LAKE NONA WAVE HOTEL
ORLANDO, FL



[Conference
REGISTRATION](#)

[Conference
AGENDA](#)

[Join or Renew
Your FSPMR
Membership](#)

Reasons why you don't want to miss this year's conference!

- **FSPMR focused!**
- **Speakers that you don't want to miss**
- **Exhibitor time extended from previous years**
- **Networking with your peers**
- **Recruitment opportunities**

This year's lineup is worth your attention!

**This year's agenda is on the following two pages
and, on our [FSPMR.org/Events](https://www.fspmr.org/Events) webpage**

1st Annual FSPMR Focused Meeting: Agenda At-A-Glance

October 9–10, 2026 | The Wave Hotel Lake Nona



FRIDAY, OCTOBER 9, 2026 (General Session: Wave Ballroom B & C)

- 3:00 – 3:05 PM **Welcome & Introductions**
Program Chair: Marc Gerber, MD
- 3:05–3:25 PM **Epidurals and/or Mid-Column Pain**
Ben Westerhaus, MD
Interventional Spine & Pain Management Cantor Spine Center at Paley Orthopedic & Spine Institute
West Palm Beach, Florida
- 3:25 – 3:35 PM Q&A
- 3:35–4:05 PM Poster Presentations
- 4:05–4:40 PM **Keynote Presentation**
Greg Chaires, Esq.
Board Certified Healthcare Attorney, Chaires, Brooderson & Guerrero | Orlando, Florida
- 4:40–4:50 PM Q&A

Exhibit Hall (Wave Ballroom A)

- 3:35–4:05 PM Break with Exhibitors
- 5:00–5:30 PM **Meet & Greet** BOD, Fellows & Students, Program Director & Residents
Invitation Only – Social
- 5:00–5:30 PM RR – Grab Your Spouse/Family & Head to the Exhibit Hall
- 5:15–6:45 PM Reception with Exhibitors

6:45–9:00 PM

Friday Night Dinner & Membership
Meeting on the Reflection Lawn

Guest and Vendor Tickets Available

SATURDAY, OCTOBER 10, 2026

- 7:30–8:00 AM Breakfast with Exhibitors Location: Wave Ballroom A
- 7:30–8:00 AM Poster Presentations Location: Wave Ballroom B & C
- 8:00–8:05 AM Welcome & Introductions Program Chair: Marc Gerber, MD Location: General Session/Ballroom B & C
- 8:05–9:30 AM **5 RESIDENT PRESENTATIONS** Expert Panel: Diana Hussain, MD; Craig Lichtblau, MD; Andrew Dubin, MD
- 8:05–8:20 AM (#1) **5 Neuro Deficits After Roux-en-Y: A DX Challenge Presenting as a Stroke-Like Episode**
Arinze Ochuba, MD; Adrian Ybanez, DO | University of Central Florida/HCA FL West Hospital
- 8:20–8:35 AM (#2) **Current Evidence on Tennis Equipment and Upper Extremity Injury Risk: A Scoping Review**
Apollo Tran, DO | USF Morsani College of Medicine/HCA Blake Medical Center, Bradenton
- 8:35–8:50 AM (#3) **Atraumatic Central Cord Syndrome**
Elisa Chaparro, MD; Sophia Draughon | Larkin Community Hospital
- 8:50–9:05 AM (#4) **Malignancy Beyond the Mass: A Case of Paraneoplastic Dermatomyositis, Dysphagia, & Functional Freefall**
Sydney Woods, MD | Mayo Clinic Jax/Brook
- 9:05–9:20 AM (#5) **Botulinum Toxin Type A Chemodenervation for Iliopsoas Tendinopathy Post Anterior Total Hip Arthroplasty**
H. Nugnala | Larkin Community Hospital
- 9:20–9:30 AM Q&A

9:30–9:50 AM	Keynote Part 1: His Story Munjed Al Muderis, MD, Professor/Orthopaedic Surgeon, Paley Orthopedic & Spine Institute, West Palm Beach, Florida
9:50–10:20 AM	Poster Presentations Location: General Session
10:20–10:40 AM	Keynote Part 2: Osseointegration Munjed Al Muderis, MD, Professor/Orthopaedic Surgeon Paley Orthopedic & Spine Institute, West Palm Beach, Florida
10:40–10:50 AM	Q&A
10:50–11:10 AM	EMG in Orthopedics: Navigating Overcalls and Undercalls Rebecca McConnell, DO Board-Certified Physiatrist Rothman Institute Orlando, Florida
11:10–11:20 AM	Q&A
11:20 AM–12:00 PM	Keynote: Federal/Legal Avoid Black & White Stripes Jennifer Bolen, JD
12:00–12:10 PM	Q&A
1:15–1:35 PM	Neuromuscular – Mimics and Masqueraders Andrew Dubin, MD, Chair, Department of PM&R, Clinical Professor of PM&R, University of Florida, Gainesville, Florida
1:35–1:45 PM	Q&A
1:45–2:05 PM	Latest Evidence on Transcutaneous Spinal Cord Stimulation Kenneth Ngo, MD, Medical Director, Brooks Rehabilitation Hospital, Jacksonville, Florida
2:05–2:15 PM	Q&A
2:15–2:35 PM	AP Spine: Studying Anterior versus Posterior Column Low Back Pain Brian Goldberg, MD, Physician Associate, Rothman Orthopaedic Institute, Orlando, Florida
2:35–2:45 PM	Q&A
2:45–3:05 PM	Exercise and Rehabilitation in Bone Metastases: Restoring Function Safely Diana Molinares, MD, Associate Professor; Director of Oncology Rehabilitation Medicine, SCCC, Program Director, Physical Medicine and Rehabilitation Residency, Department of Physical Medicine and Rehabilitation, University of Miami Miller School of Medicine, Miami, Florida
3:05–3:15 PM	Q&A
3:15–3:35 PM	Regenerative Medicine in PM&R: Separating Science from Hype—Evidence, Mechanisms, & Clinical Reality Diana Hussain, MD, Founder and CEO, Florida Wellness and Regenerative Medicine, Orlando, Florida
3:35–3:45 PM	Q&A
3:45–4:00 PM	RR & Beverage Break and PSA Announcement: Marc Gerber, MD, Board-Certified Physiatrist and Owner, MRG Rehabilitation & Pain Management, Orlando, FL
4:00–4:20 PM	Resident Awards Presentations & Photos Expert Panel: Diana Hussain, MD; Craig Lichtblau, MD; Andrew Dubin, MD
4:20–4:40 PM	Unlocking the Hip: A Practical Approach to the Diagnosis and Management of Hip Pain Tunc Kiymaz, MD, Sports Medicine Physician, Rothman Orthopaedics Institute, Orlando, Florida
4:40–4:50 PM	Q&A
5:00 PM	Adjourn

Updates from:



Board of Medicine approves NBPAS as a recognizing agency

*Mary Thomas, Esq.
Special to the FMA*

The Florida Board of Medicine took a significant step toward expanding recognized board certification options for Florida physicians at its Aug. 7 meeting.

The Board voted to grant a [petition for waiver filed by the National Board of Physicians and Surgeons \(NBPAS\)](#) from a provision of [Rule 64B8-11.001, Florida Administrative Code](#), Florida's physician advertising rule. Once the Board's final order is issued, NBPAS will qualify as a recognizing agency under the rule, allowing physicians certified by NBPAS to represent themselves as "board certified" in Florida.

The decision marks a significant development in a long debate over maintenance of certification (MOC) requirements. The American Board of Medical Specialties (ABMS) and its member boards have long served as the predominant pathway for physician board certification recognized under Florida's advertising rule. However, for years, physicians have raised concerns that ABMS' MOC requirements are costly, burdensome and unnecessarily onerous.

NBPAS was established as an alternative certification pathway and has sought recognition in Florida for several years. In 2021, NBPAS petitioned the Board to become a recognizing agency. The Board denied that application because the rule requires a recognizing agency to administer a comprehensive examination, and NBPAS does not itself administer such an examination.

This time, NBPAS took a different approach. Rather than asking the Board to reconsider whether it satisfied the actual requirements of the rule, NBPAS filed a petition seeking a waiver from the examination requirement.

Under Florida law, a variance or waiver may be granted when the purpose of the underlying statute has been or will be achieved by other means and strict application of the rule would create a substantial hardship or violate principles of fairness. NBPAS argued that both standards were met in this case.

In its petition, NBPAS argued that the purpose of the examination requirement is to ensure that a physician claiming board certification has demonstrated competency through a comprehensive specialty examination. NBPAS maintained that its physicians have already met that standard because NBPAS certification is available only to physicians who previously completed initial specialty board certification through the ABMS, which includes a required examination.

NBPAS also argued that strict application of the requirement created a substantial hardship for physicians who had already demonstrated their competency but chose not to maintain certification through an ABMS member board. According to the petition, lack of recognition in Florida could affect physicians' employment, hospital privileges, credentialing and their ability to advertise themselves as board certified.

ABMS also appeared at the meeting to voice opposition to NBPAS' petition. While ABMS and its member boards have made significant changes in recent years aimed at reducing some of the burdens associated with MOC, those efforts were not enough to prevent the Board from voting to grant the waiver in favor of NBPAS.

Once the final order is issued, physicians who hold qualifying NBPAS certification will be permitted to identify and advertise themselves as board certified in Florida.

Physicians should keep in mind, however, that recognition by the Board of Medicine for purposes of Florida's advertising rule does not necessarily mean that every hospital, health system, insurer or other credentialing organization will accept NBPAS certification for its own purposes. Although NBPAS reports growing acceptance among hospitals and health systems, individual organizations may maintain their own credentialing and privileging standards. Physicians considering a change in certification should therefore verify the requirements applicable to their employment, medical staff privileges, payer participation and other credentials before allowing an existing certification to lapse.

NBPAS is scheduled to appear before the Board of Osteopathic Medicine at its Aug. 21 meeting to seek a similar waiver under [Rule 64B15-14.001, F.A.C.](#), the Board of Osteopathic Medicine's advertising rule.

The FMA will continue to monitor implementation of the Board's decision and the issuance of the final order.

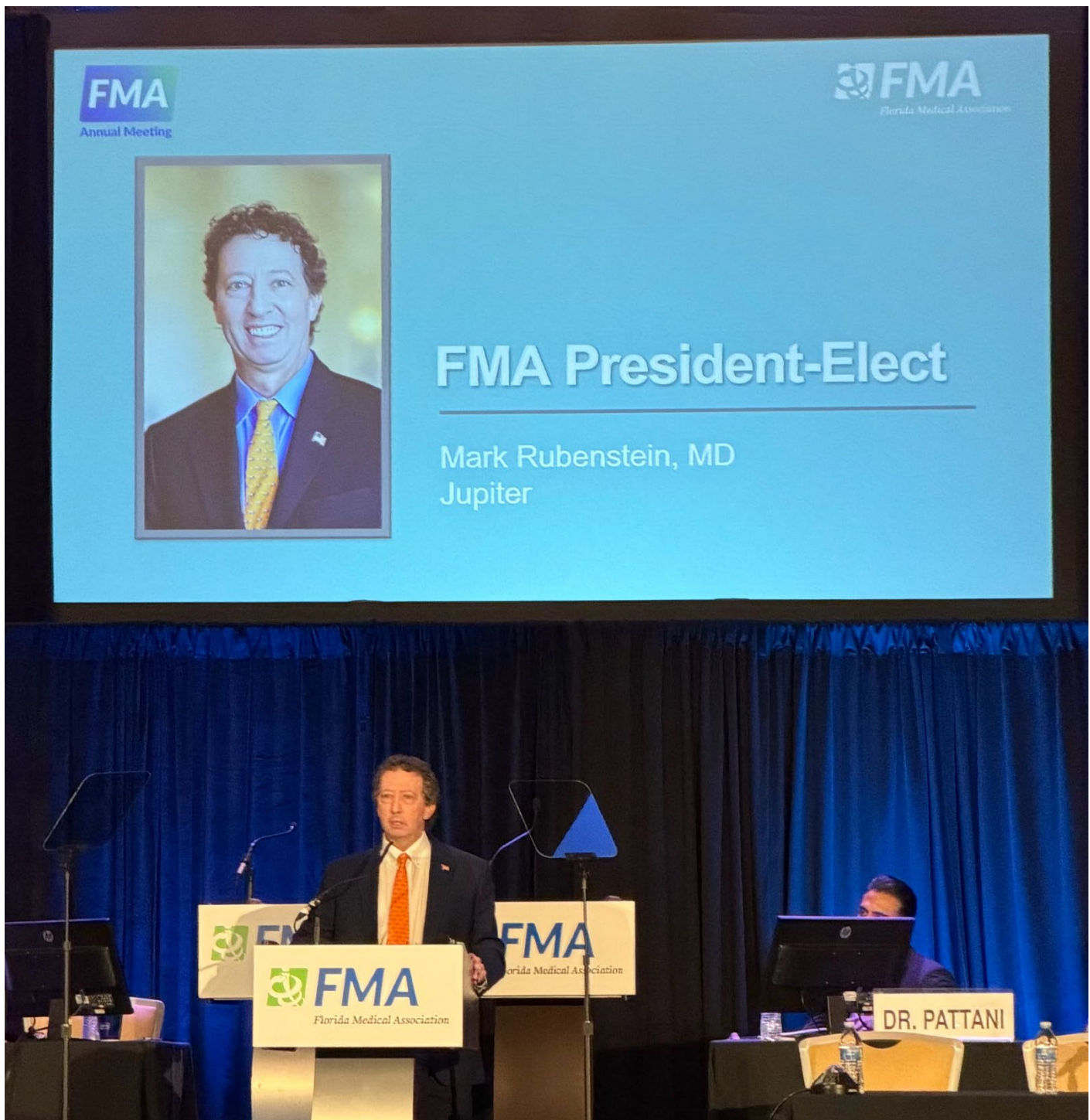
Mary Thomas, Esq., is Executive Director of the Council of Florida Medical School Deans. Previously, she served for over a decade as the Assistant General Counsel for the FMA. Ms. Thomas continues to represent the FMA in matters before the state's regulatory boards.

Also, find this article on the FMA website:

[Board of Medicine approves NBPAS as a recognizing agency](#)

Pictures from the FMA Meeting:

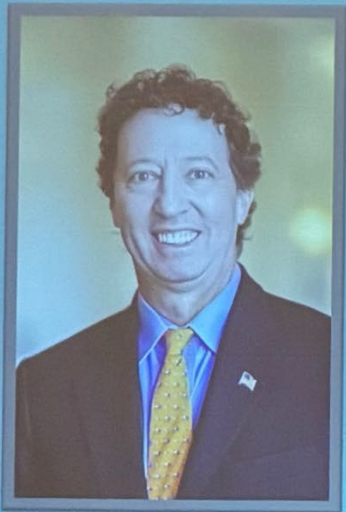




Pictured above: Mark Rubenstein, MD
Dr Rubenstein is also a FSPMR Past -President, and still a FSPMR member.



Pictured above: Congressman Byron Donalds and Dr. Marc Gerber at the FMA meeting



Speaker of the House

Mark Rubenstein, MD
Jupiter



Dr. Rubenstein is currently the FMA Speaker of the house.



Above are your FSPMR FMA representatives:
Left to Right: Mark Rubenstein, MD, Tania Jones, FSPMR Executive Director and
Dr. Marc Gerber at the FMA meeting

2026 Florida Medical Association (FMA) Annual Meeting

By Marc R. Gerber, M.D.

On July 31st-August 2nd, 2026, the FMA had its annual meeting at the Orlando Hilton. I was there as a delegate and our Executive Director Tania Jones was also in attendance. One of our other members, Mark Rubenstein, was also there in a much more important role. More on that in a moment. I'm sure most of you have heard of the FMA but for those who haven't, it is the largest organization of physicians in the state of Florida. The Florida Dept. of Health lists about 62,000 physicians in the state who are involved in direct patient care and the FMA has about 22,000 members. The FMA was founded in 1874 and is dedicated to the service and assistance of Doctors of Medicine and Doctors of Osteopathic Medicine. The FMA advocates on issues of legislation and regulatory affairs, medical economics and education, public health and ethical and legal issues.



This year Dr. Alma Little became the 150th FMA president and the first medical school dean to hold the FMA presidency. She is currently Dean at the Florida State University School of Medicine. Our own FSPMR member Dr. Mark Rubenstein just completed his term as Speaker of the House, which is an extremely important position within the FMA. He is now President Elect for the coming year and will serve a one-year term in that capacity. At next year's meeting Dr. Rubenstein will become the 151st President of the FMA. This is a tremendous honor and not an easy one to achieve. It takes years of dedication, volunteering and service as well as commanding the respect of the largest organization of physicians in the state. Just as important, this will be the first time a Physical Medicine and Rehabilitation Specialist will hold this position, which is a great milestone as many physicians still don't entirely understand what we do. Mark has served the FMA for many years in almost every capacity as one could imagine. I encourage our members to speak to him, ask questions, and listen to his experiences as he is a wealth of knowledge on legislative and practice issues.

I attended the last two meetings as a delegate for the FSPMR. Delegates have a say and vote on important issues at the House of Delegates session on Sunday. I also represented our society in the State Specialty Society session where we discuss numerous issues relevant to the various specialists in the state. I am just a rookie and learning the process. Appreciating how the FMA works is extremely impressive, interesting and rewarding. You get a chance to see how policy gets discussed and takes shape and you have a chance to make sure your interests as a physician are protected. I encourage any members, including residents and medical students to get involved. This year we had two House of Delegate positions for PM&R and I was the only delegate, as Diana was unable to attend. There is room for another member to participate and get involved and be a Delegate for next year. The delegate must be a physician and have an active membership with the FMA but there are plenty of medical students getting involved at an early stage of their career. Being a delegate is not a time-consuming position and just requires you to attend the annual meeting. For those who have an interest in leadership or getting more involved there are additional opportunities available. At our Annual Scientific and Educational Conference in October, Dr. Rubenstein will share some of his insights and more specifics on some of the resolutions. Just another reason to attend as you will find out more about what issues affect your patients, your practice and obviously your livelihood.

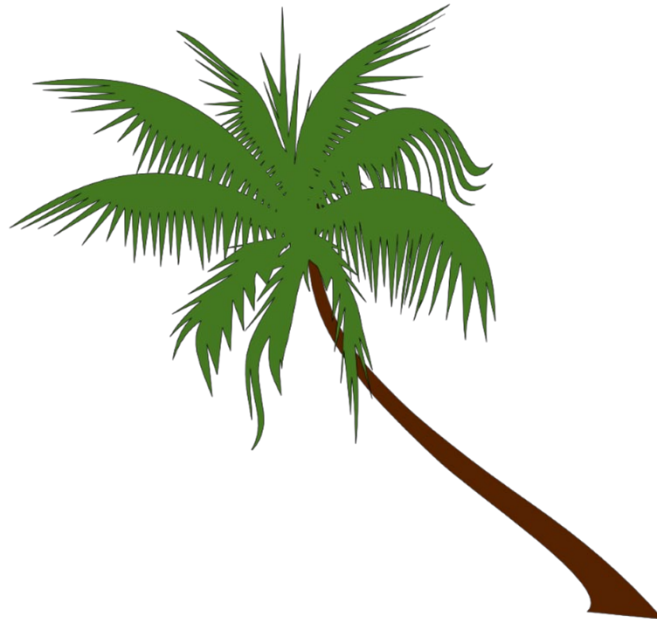
In addition to Mark showing me the ropes, I must also thank Tania Jones. Tania is also an unbelievable source of knowledge who has been involved with state specialty societies and organizations for greater

than 20 years. If you are hesitant or nervous about getting involved don't worry as Tania will walk you through the process. Last year I was lost and this year I felt a little more confident in terms of the process and how things are done. It is really "a very impressive meeting and you will learn a lot about organized medicine. Maybe in the future, one of our younger members or residents will become the second FSPMR member to be elected FMA President.

"IF YOU ARE NOT AT THE TABLE, YOU ARE ON THE MENU." I encourage all of our members to get involved first with our state society as well as the FMA. We need you and your voice matters! Next years FMA Meeting will be October 21-24,2027 at the Disney Yacht and Beach Club resort.

Marc Gerber, MD

Vice President, FSPMR



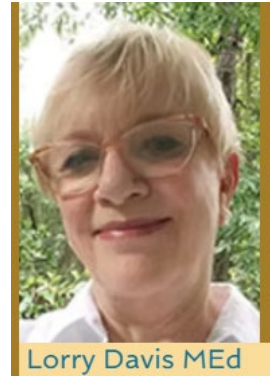
FSPMR Farewell and Hello Again!

Lorry S Davis, MEd, former Executive Director

“I forgot how good it feels to be in a room with just physiatrists!” This is what former FSPMR President Oregon Hunter MD told me at an event many years ago. It was one of a handful of times that FSPMR met on its own.

This year’s Annual Meeting, October 9/10, at the Lake Nona Wave Hotel, will give FSPMR another chance to experience being at an event of its own, the pleasure and comfort of community.

Dr Craig Lichtblau has graciously invited me to come back for this Annual Meeting’s Friday night dinner meeting. I look forward to seeing some old friends there.



A number of you attended my retirement celebration at last year’s annual meeting and heard my Fond Farewell to FSPMR. For those of you who were unable to attend, it is below. See you in Orlando!

Fond Farewell – September 6, 2025

It has been a privilege and a pleasure to serve the members of the Florida Society of Physical Medicine & Rehabilitation for over 35 years. Think about this: When I first started, there were NO PM&R residency programs in the State of Florida. Now there are 10!

As the residency programs grew, FSPMR created Resident Liaisons from each program. We started including each program’s update in our quarterly newsletter, and now – who doesn’t love the Residency Case Presentations Competition at the annual meetings?!!

FSPMR’s first newsletter was faxed, had a graphic of a page blowing a herald trumpet, and was entitled The PM&R Page.

I was FSPMR’s first Executive Director, serving 18 Presidents and Boards of Directors. The Presidents brought varying gifts to the table: we’ve heard tonight what Dr Mitch Freed and his two presidencies brought. We also heard from Dr Mark Rubenstein and recognize his leadership within organized medicine at the state level. Some other FSPMR Presidents come to mind:

It was under Dr Oscar DePaz’ presidency that FSPMR became incorporated as a nonprofit organization.

Dr Michael Creamer helped bridge the gap between allopathic and osteopathic physiatrists.

Dr Andrew Sherman brought academic leadership and gravitas.

And Dr Craig Lichtblau’s generosity much be recognized. He has helped to sustain this organization and keep it alive.

When I began managing physician specialty societies, FSPMR was my first, and now as I look toward retirement, FSPMR is my last. **Physiatrists have always been my favorite!**

What I see for FSPMR’s future: The specialty of Physical Medicine & Rehabilitation has proved itself to be very malleable, adaptable and versatile. This characteristic will allow the specialty to continue to grow, thrive, and create impact. As FSPMR reaches into the future, I am pleased Tania Jones has taken the Executive Director reins. She is smart, energetic, experienced, accomplished, and a good fit for FSPMR’s next leg of the journey.

(Note: At meeting setup, sunglasses were placed on the tables. At this time, attendees were asked to please put them on.)

In closing, let me say: **PM&R – your future is so bright! You’ve got to wear shades!**



Methodology for Projecting Future Medical Care Costs: Why Artificial Intelligence Cannot Replace Human Expertise for Individual Patients

Craig H. Lichtblau^{1,2*}, Bernard Pettingill³

¹Medical Director, Osseointegration Program, Physical Medicine and Rehabilitation Consultant to the Paley Orthopedic and Spine Institute at St. Mary's Medical Center, West Palm Beach, Florida, USA, ²Consultant to Children's Medical Services for the State of Florida, District 9, USA; ³Consulting Economist, LSU Medical Centre, New Orleans, LA 70112, United States

ABSTRACT

Artificial Intelligence (AI) is being increasingly applied across healthcare contexts. It has demonstrated value in reducing administrative burden by automating several tasks. However, while AI can augment healthcare delivery, it is fundamentally limited in its ability to replace the clinical judgment and uniquely human aspects of expertise in healthcare. These limitations are particularly important when projecting future medical care costs for individual patients, as this process requires direct, hands-on patient assessment, evidence-based clinical recommendations, and defensible expert judgment. Here, we discuss the specific limitations of AI in the context of predicting future medical costs for individual patients.

Keywords: AI (Artificial Intelligence); Physical medicine; Physical medicine and rehabilitation; cost; Catastrophic injury

INTRODUCTION

Artificial Intelligence (AI) is impacting every industry worldwide and is raising questions about the consequent evolution of work within those industries. Of particular interest is the specific role that AI may play in physical medicine versus the role of humans and how AI may eventually replace human functions over time [1]. While much of the research has been dedicated to investigating how AI can replace or augment clinical medicine, there is also interest amongst payers, insurers, and litigation specialists as to how AI may transform personal injury medicine, and in particular, how AI may impact the projection of lifetime medical costs of catastrophically injured patients [2-4].

Within the healthcare industry, experimentation with AI has shown that AI models do provide true clinical impact [5]. Nevertheless, sensationalized claims about how AI can outperform clinicians become less shocking once examined more deeply. Specifically, while AI can reduce burden and augment outcomes by performing automated tasks (often more efficiently and potentially more accurately than humans). AI is totally unequipped to render clinical judgments. Thus, experts

in AI agree that the future of AI in healthcare involves both human-AI collaboration, also known as Human-AI-Human (H-AI-H) decision-making, rather than a scenario in which AI completely replaces human expertise altogether [6,7].

Herein, we discuss the latest literature on the role of AI in physical medicine and rehabilitation healthcare and how its limitations in clinical care also render it incapable of ever fully replacing human expertise and judgment in projecting future medical care costs for individual patients.

AI may provide task-level automation in healthcare

AI is conducive to replacing effort on highly standardized, data-driven tasks because AI excels at retrieval and pattern recognition and can remember and process large amounts of data in a manner that human brains simply cannot [6,7]. As a result, AI is well positioned to support a range of healthcare functions, including:

Administrative work and documentation: AI can automate routine tasks like scheduling, data entry, and report generation, which can reduce the administrative burden on healthcare

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professionals, though human oversight remains necessary in order to verify accuracy [8].

Data analysis and predictive analytics: AI is proficient in synthesizing massive complex datasets to carry out tasks such as optimizing resource allocation, predicting rates of hospital admissions, and flagging patients at high risk for deterioration of their medical diagnoses [9].

Medical imaging and radiology: Perhaps the closest AI can come to "replacing" healthcare providers is in the context of medical imaging and radiology, as AI can interpret medical images and employ deep learning algorithms to accomplish tasks such as identifying certain lesions and extracting quantitative measurements. Performance in these tasks tends to meet or even exceed human performance in narrowly defined screening contexts [6,7]. Nonetheless, AI is not behaving as an autonomous agent that could replace radiologists and all of their expertise. Instead, certain discrete tasks that once fell under radiologists' purviews may now be offloaded to AI to enhance workflow efficiency, with radiologists still ultimately accountable for outcomes [7].

As scholars have noted while AI will likely increasingly be employed to replace effort on narrowly defined tasks above in order to augment healthcare delivery, the notion of AI replacing human physicians is a false dichotomy that relies on an oversimplified understanding of the practice of physical medicine and rehabilitation.

When it comes to the concept of projecting future healthcare costs, AI has been useful in forecasting costs at a population level [10]. While these advances have raised questions regarding whether AI could replace medical experts, including in the projection of lifetime medical costs for individual patients, AI lacks the nuanced clinical, contextual and individualized reasoning capabilities necessary for this type of prediction [6,11].

Several barriers prevent AI from replacing clinicians

Simply put, AI cannot replace clinicians, whether in the context of clinical or individualized healthcare costs projections, because AI is not a reasoning agent in the way a human is and in the way that effective clinical practice requires [12]. Specific deficiencies of AI that make this clear include that AI:

Lacks clinical judgment: While AI can perform well on standardized medical exams due to its sophisticated pattern matching, this skill is based on statistical correlations that prevent AI from properly evaluating atypical patient presentations, rare diseases, or outliers [12]. Human clinicians with clinical experience are able to seamlessly adapt to these scenarios [7].

Is unable to perform physical examinations: A critical limitation of AI in the clinical setting is its inability to perform a proper physical examination and/or patient observation. While AI has evolved to support surgical procedures, it lacks the complex sensorimotor capabilities and experience of tactile feedback that allows humans to adapt in real time to optimize patient care [6-7].

Is incapable of empathy: As a digital tool, AI cannot replace the emotional connection forged by human healthcare providers [13-15]. As a result, it has been argued that AI use in healthcare risks dehumanizing patients [6].

Misunderstands patient language: Most patients describe their symptoms in everyday language rather than in medical terminology. AI is often imprecise in translating the subjective experience of patients into interpretable clinical data [6].

Hallucinates: Without human oversight, the "hallucinations" that AI generates, whereby AI confidently but falsely provides medical information, diagnoses, or research citations which are fabricated. This places patient safety at risk [7-16].

Inherently lacks accountability: Given that AI is an assistive tool, it cannot be accountable for medical errors. Medicine requires that someone bears the moral and legal responsibilities for clinical decisions, which precludes AI from replacing healthcare providers in this context [7,8].

AI cannot replace humans in projecting future medical costs for individual patients

AI is being used more and more often to help forecast general healthcare spending, with algorithms frequently employed to predict future resource utilization or to classify patients at high risk [10]. However, there are fundamental reasons why AI cannot replace human medical experts in providing accurate projections of future medical costs for individual patients. These reasons operate at three distinct levels: Clinical, methodological, and epistemic to include:

The need for clinical assessment

Defining the cost of future medical care for individual patients requires comprehensive clinical and non-clinical evaluation that AI is structurally incapable of performing [17]. Medical professionals (such as physical medicine specialists) are needed to record patient histories, perform physical examinations and/or patient observation, and assess real-world patient functioning, and given that AI lacks this physical embodiment, it cannot perform these evaluations [6].

The methodology for defining the cost of future medical care requires the physician to collect and review medical records, physically examine and or observe the patient, formulate life expectancy and diagnostic conclusions, develop evidence-based recommendations for future care needs and conduct direct surveys accounting for treating physicians and vendors to obtain geographically specific retail cost data [17]. Each of these steps is grounded in direct patient contact and embodied clinical judgment, neither of which AI is capable of providing [6,7]. The physical examination and/or patient observation alone generates diagnostic information about a patient's real-world functioning, pain behavior, and capacity for activity that cannot be inferred from a claims database or medical review [7,11]. Conclusions, which if needed by other experts such as medical economists for legal resolutions, make it practical and reasonable in that setting.

The specific methodology for cost projections must also be defensible. Expert cost projections in personal injury litigation are subject to Daubert standards for scientific expertise, and the physician must be able to independently defend his/her conclusions under adversarial cross examination. No algorithmic system can be examined, cross-examined, or held professionally accountable for its conclusions. Just as non-physician practitioners who attempt to perform medical cost projections without formal clinical training may face important methodological limitations, AI is similarly limited when used in this context [17].

The algorithmic bias that leads to cost projection errors

AI relies on historical data to predict healthcare costs, which can lead to the conflation of lack of access to healthcare and ultimately the lack of need for healthcare [18]. The results are that those who have not accessed care will be deemed as not needing the extraordinary care. When lack of need results, this may not be the reason for low utilization. For instance, those without access to care will have low utilization but not necessarily low need.

This problem has been empirically documented. One study examined a widely deployed commercial algorithm and found that it systematically underestimated need in patients with equivalent illness burden, precisely because it used historical cost as the outcome measure rather than using a direct measure of the medical condition [18,19]. The algorithm was therefore not adequately capturing health status but instead was simply measuring what had previously been billed for care. For any given plaintiff, such a model cannot distinguish between a patient who needed less care and a patient who received less care when that distinction is warranted.

This type of error is predictable when applying population-level historical cost data to the individualized question of what a specific patient will need for the remainder of their lives.

The lack of transparency and adaptability of AI models

Much of the predictive modeling used by the private sector to forecast healthcare costs relies on proprietary algorithms, limiting the ability of clinicians and researchers to evaluate the assumptions and variables driving model outputs [18]. Consequently, it may be difficult to determine whether projected costs accurately reflect the individualized clinical trajectory and long-term medical needs of a specific patient. This lack of transparency poses a fundamental challenge in litigation, where expert opinions must be explainable, reproducible, and subject to adversarial scrutiny [11].

AI models also have limited ability to adapt and account for the evolving and highly individualized nature of long-term medical care, making them poorly suited for projecting lifetime healthcare costs for individual patients. Predictive models are typically trained on historical datasets and optimized to estimate expenditures over relatively short time horizons. As a result, a model designed to predict healthcare costs over

five years may not reliably forecast four decades of care for a patient injured in early adulthood [11,18-20].

Because future medical needs evolve over time and may be influenced by aging, emerging complications, and changes in standards of care, AI-generated projections fail to reflect the individualized clinical trajectory of a specific patient [11,18-21]. These limitations may be particularly consequential in catastrophically injured patients, whose long-term care needs are often highly dynamic and difficult to model reliably. By contrast, physician experts can apply longitudinal clinical judgment, prospectively evaluate changing clinical circumstances, and clearly explain and defend their reasoning before a court [1,11,18].

AI limitations may be the most detrimental when used with catastrophically injured patients

The limitations described above apply to any individual lifetime cost projection, but they converge with particular force in cases involving catastrophic injury. A patient who has sustained a severe spinal cord injury, a traumatic brain injury, or a catastrophic orthopedic injury presents a clinical picture that is simultaneously highly individualized, rapidly evolving, and profoundly difficult to characterize from population-level historical data [11,18-22].

AI performs well on typical cases that are abundantly represented in training data but fails when confronted with rare, atypical, or out-of-distribution presentations [7,12]. Catastrophically injured patients frequently fall into the latter category. Their future care needs may change substantially over time due to aging, delayed complications, evolving standards of care, and variable responses to treatment, limiting the reliability of algorithmic projections based primarily on historical utilization patterns [11,19,21,23].

In personal injury litigation, these projections directly influence the resources available to support an injured patient's future care [11]. Accepted methodology therefore requires qualified physician experts to perform comprehensive clinical rehabilitation evaluations and develop evidence-based recommendations regarding future medical needs, which may then be translated into economic estimates by medical economists [17]. Because this process depends on individualized clinical assessment, methodological transparency, and accountability, AI systems cannot independently replace physician expertise in projecting lifetime healthcare costs for those who have suffered catastrophic injuries [6,7,11].

CONCLUSION

AI is providing significant benefits in healthcare, and its role in medicine is likely to continue to expand. However, as we integrate AI into the healthcare industry, it is critical that we distinguish where AI can augment clinical care and the long-term protection of our patients and where it adds risk and compromises patient outcomes. When it comes to projecting lifetime medical costs for individual patients, AI may be capable of supporting certain fundamental tasks. However, because this type of projection requires clinical judgment and other human

capabilities that evade AI, AI cannot ever replace the clinical expert in this role.

CONFLICTS OF INTEREST

The authors declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

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Autonomic Dysreflexia

By Craig Lichtblau, M.D.

Introduction

Autonomic dysreflexia is a condition that emerges soon after a spinal cord injury at or above the T6 spinal level. The condition is generally defined as a syndrome in susceptible spinal cord injury patients, characterized by a sudden, exaggerated, inappropriate reflexive increase in blood pressure in response to a stimulus, usually bladder or bowel distension originating below the level of the neurological injury. This is usually manifested by severe headache, bradycardia, facial flushing, pallor, cold skin, and sweating in the lower part of the body.

Autonomic dysreflexia is significant because it is potentially a lethal disorder that occurs in about half or more of potentially susceptible individuals. Usually, symptoms can be alleviated by prompt recognition and relatively simple corrective procedures by caregivers.

Autonomic dysreflexia is also referred to as autonomic hyperreflexia, hypertensive autonomic crisis, sympathetic hyperreflexia, autonomic spasticity, paroxysmal hypertension, mass reflex, and viscer-autonomic stress syndrome.

Autonomic dysfunction, autonomic neuropathy, and dysautonomia describe general autonomic nervous system disorders and represent distinct clinical entities.

The higher the level of the spinal cord injury and its completeness, the greater the risk of developing autonomic dysreflexia. Up to 90% of patients with cervical or high-thoracic spinal cord injury are susceptible to the disorder. Dysregulation of the autonomic nervous system leads to an uncoordinated autonomic response that may result in a potentially life-threatening hypertensive episode when there is a noxious stimulus below the level of the spinal cord injury. In approximately 85% of cases, this stimulus is from a distended bladder, but a fecal impaction or other urological sources, such as a urinary tract infection, a distended bladder, or a clogged Foley catheter, may also cause the disorder. There is a clinically significant increased risk of stroke by 300% to 400%.

Autonomic dysreflexia can occur up to 40 times per day in susceptible individuals. Patients with traumatic spinal injuries who experience autonomic dysreflexia have a significantly higher death rate compared to individuals that do not the disorder.

The initial presenting symptom is an acute, severe headache, typically described as throbbing. Susceptible individuals, such as patients with spinal cord lesions at or above T6 or those with a history of autonomic dysreflexia, who complain of an acute, severe headache should immediately have their blood pressure checked. If the blood pressure is elevated, a presumptive diagnosis of autonomic dysreflexia can be made. Prompt recognition and treatment of the disorder, often by irrigating or changing the Foley catheter, can be immediately lifesaving.



Etiology

It must be realized that a variety of other stimuli, including pressure ulcers, skin infections, ingrown toenails, burns, bone fractures, tight clothing, significant temperature changes, certain medical and urological procedures, menstrual cramps, labor and delivery, hemorrhoids, anal fissures, digital rectal stimulation, sexual activity, and even tight shoelaces, can also provoke an episode of Autonomic dysreflexia.

Autonomic dysreflexia may also occur without any spinal cord injuries. In such cases, the underlying causes include stimulant drugs, such as cocaine and amphetamines; head trauma; subarachnoid hemorrhage; post-neurosurgical procedures; multiple sclerosis; brain and spinal cord tumors; Guillain-Barré syndrome, radiation myelopathy, post-cerebrovascular accident events, and cisplatin-induced polyneuropathy.

An episode of autonomic dysreflexia is objectively defined as an increase in systolic blood pressure of at least 20 mm Hg above baseline in adults and 15 mm Hg in children. A significant episode typically has a systolic blood pressure of at least 150 mm Hg or >40 mm Hg above the patient's baseline. The higher the injury level, the greater the severity of cardiovascular dysfunction.

Patients with a complete spinal cord injury are more than 3 times as likely to develop autonomic dysreflexia than those with an incomplete spinal cord injury.

Autonomic dysreflexia is uncommon during the first month following a spinal cord injury but has been reported as early as the fourth day post-injury. It generally does not develop until after the period of spinal shock resolves, typically within 1 year of the original injury. Approximately 92% of individuals who eventually develop autonomic dysreflexia experience their first episode within the first year following their spinal cord injury.

Pathophysiology

Strong cutaneous or visceral noxious stimulation below the level of the spinal injury, where the injury is above the splanchnic sympathetic outflow at T5-T6, initiates afferent impulses to the intermediolateral grey columns of the spinal cord that elicit abnormal reflex sympathetic nervous system activity from T6 to L2.

Involvement at or above the T6 spinal level is critical in the pathogenesis of autonomic dysreflexia. The greater splanchnic nerve is a sympathetic nerve trunk originating between T5 and T9, which modulates the body's largest circulatory fluid reserve. Spinal cord lesions at or above T6 cause intense sympathetic stimulation to constrict the splanchnic vasculature, resulting in the characteristic severe hypertension associated with autonomic dysreflexia.

The sympathetic response is exaggerated due to a lack of compensatory descending parasympathetic stimulation and intrinsic posttraumatic hypersensitivity. This exaggerated sympathetic response leads to diffuse vasoconstriction, typically to the lower two-thirds of the body, and a significant rise in blood pressure despite maximum parasympathetic vasodilatory efforts above the level of the spinal injury.

In an intact autonomic system, this increased blood pressure activates the carotid sinus and aortic arch baroreceptors, leading to a parasympathetic vasodilatory response to correct the increased sympathetic tone and reduce the blood pressure while slowing the heart rate through vagal nerve activity.

In the setting of a spinal cord injury, the normal corrective parasympathetic response from the medullary vasomotor center cannot travel below the level of the spinal injury, and the severe, generalized vasoconstriction affecting the splanchnic, muscular, vascular, and cutaneous arterial circulatory networks overwhelms the limited parasympathetic opposition and causes potentially lethal malignant hypertension. The compensatory vagal and parasympathetic stimulation leads to bradycardia and vasodilation, but only above the level of the spinal cord injury.

Sexual intercourse can be a stimulus for autonomic dysreflexia. Other potential triggering causes of autonomic dysreflexia include medical procedures; surgeries; constipation; gastric ulcers; fecal impaction; boils; fractures; dislocations; and infections, such as epididymitis, pancreatitis, and cholecystitis as well as labor and delivery. Pregnancy, in particular, becomes very complicated in patients with a history of autonomic dysreflexia.

Pharmacological causes of autonomic dysreflexia are rare; however, there have been reported cases with patients who were receiving combination therapy with duloxetine and amitriptyline.

History and Physical

Other clinical signs and symptoms of autonomic dysreflexia include:

- Anxiety, apprehension, or feelings of impending doom.
- Bradycardia.
- Cardiac arrhythmias (Atrial fibrillation, atrioventricular conduction abnormalities, and premature ventricular contractions).
- Cold, pale skin below the level of injury due to severe sympathetic-induced vasoconstriction.
- Confusion.
- Constricted pupils.
- Dizziness.
- Nasal stuffiness and congestion.
- Nausea and vomiting.
- Orthostatic hypotension.
- Piloerection below the level of the spinal injury.
- Profuse sweating and flushing above the level of the injury—typically involving the face, neck, and shoulders—due to compensatory parasympathetic vasodilation.
- Silent or asymptomatic autonomic dysreflexia.
- Thermoregulation.
- Visual disturbances, such as blurred vision or visual field defects.

Treatment/Management

Immediate evaluation and restoration of bladder drainage is recommended as the first and most likely potential triggering source to investigate. If there is any concern about Foley catheter function, it should be changed immediately. Avoid undue suprapubic pressing, tapping, or palpating the bladder, as this may exacerbate dysreflexia. If the patient does not have a Foley catheter, one should be placed immediately. Anesthetic gel should be administered directly into the urethra and left for at least 2 minutes before insertion, if possible.

Blood pressure should be monitored carefully during bladder drainage in patients with known bladder overdistension. Warmed normal saline should be used for catheter irrigation, as cold fluids could trigger further dysreflexia reactions.

If bladder leakage is seen around unobstructed catheters, it is often due to bladder spasms which may be associated with dysreflexia episodes. Overactive bladder medications such as Oxybutynin, Trospium, Vibegron, and Mirabegron can be used both therapeutically and prophylactically. Urinary tract infections may also cause bladder spasms in the absence of catheter blockage; however, these spasms are typically transient and resolve with successful treatment of the infection.

If the systolic blood pressure is >150 mm Hg or >40 mm Hg above the patient's baseline, pharmacological therapy should be initiated to reduce it before rectal examinations.

If neither bladder nor bowel problems appear to be the triggering stimulus, a systematic search for other causes should be undertaken. Common triggers include skin lesions; infected or ingrown toenails; infected decubitus ulcers; hip dislocations; fractures; venous thromboses; rectal fissures or abscesses; medication effects, such as nasal decongestants, sympathomimetic drugs, and misoprostol; gastric or bowel disorders; cholelithiasis; testicular problems, such as epididymitis or torsions; sunburn or insect bites; and previously unrecognized trauma, amongst other conditions.

Emergency Antihypertensive Pharmacological Treatment

If the triggering event cannot be identified and initial maneuvers do not improve the systolic blood pressure to <150 mm Hg or <40 mm Hg above the patient's usual baseline, emergency antihypertensive pharmacologic management should be initiated. Hypertension should be promptly corrected with agents that optimally have a rapid onset but short duration of action.

Nitrate-based medications should not be administered to patients who have taken sildenafil or similar medications within 24 hours (or within 48 hours of taking tadalafil) due to the potential for severe hypotension as they act synergistically.

Preferred initial pharmacological antihypertensive therapies for emergency use in autonomic dysreflexia include:

- Nitroglycerine 2% paste
 - Dosage: 1 to 2 inches placed on the non-hairy chest or elsewhere above the level of spinal injury.
 - Onset of activity: 3 to 5 minutes.
 - Duration of action: 8 hours.
 - Maximum dose: 5 inches.
- Nifedipine (bite-and-swallow method)
 - Dosage: 10 mg.
 - Onset of activity: 10 to 20 minutes.
 - Peak effect: 1 hour.
 - Repeat dose: May repeat every 20 to 30 minutes.
 - Duration of action: 4 hours.
 - Maximum dose: 40 mg/24 hours.
- Sublingual captopril
 - Dosage: 25 mg.
 - Onset of activity: 20 to 30 minutes.
 - Repeat dose: May repeat in 1 hour as needed.
 - Peak effect: 1 hour.
 - Duration of action: 4 hours.
 - Maximum dose: 50 mg.
- Sublingual clonidine
 - Dosage: 0.2 mg initially, followed by 0.1 mg hourly as needed.
 - Onset of activity: 10 to 20 minutes.
 - Peak effect: 1 hour.
 - Duration of action: 12 hours.
 - Maximum dose: 0.8 mg.

Summary of Emergency Management and Immediate First Steps

In the event of a suspected episode of autonomic dysreflexia, the following steps should be initiated immediately without delay:

- Sit the patient upright with their legs dangling and remove or release any tight clothing, shoes, belts, binders, or constrictive devices. Sitting up helps lower their blood pressure orthostatically by inducing blood pooling in the abdominal and lower extremity vessels and eliminating possible triggering stimuli.
- Vital signs should be closely monitored, such as every 2 to 3 minutes, until stable.
- If the blood pressure is over 150 mm Hg, a rapid-onset/short-duration pharmacological antihypertensive medication, such as 1 to 2 inches of 2% nitroglycerin paste, nifedipine 10 mg, sublingual clonidine 0.2 mg, or sublingual captopril 25 mg, should be administered.
 - Before administering a nitrate-based antihypertensive, determine whether the patient has recently taken a phosphodiesterase inhibitor, such as sildenafil, which can potentiate and exaggerate the hypotensive effect of nitrates.
- The triggering noxious stimuli should be identified and corrected as soon as possible.
- If the patient does not have an indwelling Foley, immediate catheterization of the bladder should be performed.
- If the patient has an indwelling Foley:
 - Check the catheter and tubing carefully for blockages, constrictions, folds, kinks, stones, or obstructions.
 - Make sure the catheter is placed correctly and positioned.
 - Gently irrigate the catheter with a small volume of sterile irrigation fluid, preferably at body temperature.
 - If the Foley catheter does not irrigate easily, change it immediately.
- When inserting or changing the Foley, inject urethral lidocaine gel and wait at least 2 or, optimally, up to 5 minutes, if possible.
- Intravesical instillation of at least 10 mL of 2% lidocaine about 5 minutes before scheduled Foley catheter exchanges diminishes episodes of autonomic dysreflexia. This precaution is typically only necessary in patients at very high risk.
- If there is a history of difficulty in Foley placement or insertion is difficult, use a coude catheter or council tip catheter and a guide wire to facilitate rapid and atraumatic placement.
- If the bladder is not distended and the Foley catheter is draining adequately, but the autonomic dysreflexia episode persists, a bowel issue, such as fecal impaction, is the most likely cause.
 - Relieving a fecal impaction is done manually, but lidocaine gel should be administered first and left in place for 3 to 5 minutes.
 - If this cannot be done, antihypertensive medication should be administered until the systolic blood pressure is <150 mm Hg before proceeding.

- The placement of an arterial line should be considered.
- Monitoring of the patient's blood pressure and vital signs should continue for at least 2 hours after the autonomic dysreflexia episode is resolved.
- Hospital admission is recommended if the patient responds poorly to the above therapeutic measures or the underlying precipitating cause cannot be determined.

Emergency Medical Kits

Susceptible patients—any patient with a spinal cord injury who has had at least 1 significant episode of autonomic dysreflexia—should always carry an emergency treatment kit or bag. This kit should include essential supplies such as:

- Extra Foley catheters (council catheters and coudé tipped are preferred).
- An automatic blood pressure cuff or monitor.
- Guidewires.
- Gloves.
- Sterile lubricant.
- A tube of 2% lidocaine anesthetic gel.
- Normal saline irrigation fluid.
- A catheter tip syringe for irrigation.
- 10 cc luer-lock syringes and sterile water to fill replacement catheter balloons.
- Emergency antihypertensive medications, such as 2% nitroglycerine paste and nifedipine 10 mg immediate release.
- Written instructions or information about autonomic dysreflexia, such as a summary of this review and simplified emergency management guidelines.

The emergency kit should include a medical information card containing the patient's identification information, address, emergency contacts, medical problems, allergies, usual medications, causes of prior episodes of autonomic dysreflexia, and baseline blood pressure.

A simplified summary of the management of autonomic dysreflexia should also be in the emergency kit to assist healthcare personnel, caregivers, or even bystanders unfamiliar with the problem in the event of an emergency.

Having such an emergency kit immediately available could be lifesaving.

The 6 B's that are the common causes of autonomic dysreflexia:

- Bladder (catheter blockage, distension, stones, infection, spasms).
- Boils (skin lesions, infected ulcers, decubiti).
- Bowel (constipation, impaction).
- Bones (fractures, dislocations).
- Back passage (hemorrhoids, rectal issues, anal abscess, fissure).
- Babies (pregnancy).

FASCIA IN PHYSIATRIC TRAINING AND PRACTICE: A TRIO OF VOICES

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THE ANATOMY PROFESSOR AND PRIMARY PHYSICIAN:

Medical education has undergone a profound shift over the past several decades. Across both MD and DO programs, curriculum hours dedicated to gross anatomy have drastically and steadily declined (1), with many institutions moving away from traditional cadaveric dissection entirely in favor of digital models and prosected specimens. While these modern modalities offer efficiency and accessibility, the reduction in tactile, hands-on anatomical training risks leaving a critical gap in preclinical preparation for clinical practice; resulting in less exposure to the humanity, teamwork and mortality important for professional identity formation.

Fascia has been particularly vulnerable to any curricular reductions. Historically, standard dissection methodologies treated fascia as little more than inert "packing material"—a fibrous web to be meticulously peeled away and discarded so that students could expose the larger named muscles, vessels, and nerves (2). In doing so, traditional training systematically taught generations of physicians to overlook the very matrix that binds the human body.

A growing body of research highlights fascia as a dynamic, highly innervated, and vascularized organ system essential to biomechanics, proprioception, force transmission, and chronic pain pathology. From myofascial pain syndromes and surgical adhesions to its role in oncology and inflammatory responses, fascia is proving to be a central player in patient outcomes.

From a basic science education perspective, we must bridge the gap between evolving scientific knowledge and contemporary training. If laboratory hours continue to be reduced while ignoring the continuous fascial network in our curricula, we risk graduating physicians ill-equipped to diagnose and treat complex connective tissue disorders. Reintegrating meaningful, fascia-based anatomical training into early medical education is no longer a preference—it is a necessity for the future of patient care.

THE PHYSIATRY RESIDENT AND OSTEOPATHIC PHYSICIAN:

In osteopathic medical education, fascia is not typically presented as a separate subject. Rather, it is encountered throughout anatomy, physical examination, and osteopathic manipulative medicine training as part of a broader effort to understand the relationship between form and function. This perspective encourages learners to think beyond individual muscles or joints and recognize the body's interconnected nature. As scientific interest in fascia has expanded, it has increasingly been recognized as a dynamic connective tissue network that contributes to movement and load transfer throughout the body.

This viewpoint resonates with many of the core principles of PM&R. A working knowledge of fascial anatomy can enrich clinical reasoning by encouraging consideration of how impairments in one area may influence performance elsewhere. In residency training, these ideas can naturally complement anatomy review, enhance interpretation of musculoskeletal ultrasound, and add context to conversations

surrounding myofascial pain. They may also offer a useful framework when assessing compensatory movement strategies after injury or exploring contributors to persistent symptoms that are not fully explained by imaging findings alone. As the field continues to evolve, fascial anatomy represents another avenue for linking foundational science with the functional goals that remain central to physiatric care.

THE PHYSIATRIST AND RESIDENCY PROGRAM DIRECTOR

Although fascia seems to be currently a trending topic, it is not a novelty in physiatry. In a 2014 narrative review, Kwong and Findley already recognized that physiatrists are well- positioned to advance the understanding of fascia in health and disease (3). They argue further that “studying fascia objectively at the basic science and clinical levels will provide important information that may change clinical practice.” Since then, research in the field has elucidated fascia structure and function, allowing us to understand the pathophysiology of chronic musculoskeletal and neuromuscular conditions. We have a fair evidence base demonstrating that myofascial therapy (4), acupuncture (5), and movement-based therapies (6), exert its therapeutic effects through the restoration of fascia. It plays an important role in proprioception and interoception in persons with hyper or hypomobility (7). With its acceptance and utilization for patient care, the next logical step is expanding the education of physicians in training and practice.

With this brief essay, we are putting out a call to physiatrists in practice and training to move this forward. At UF, Dr. Topping is building an online course that will satisfy the needs of learners at all levels, from undergraduate to postgraduate, with plans to scale up to an in-person experience including a cadaveric laboratory component and expanding to a physician CME activity. At the residency training level, Drs. Estores and Kwong are planning to collaborate on a needs assessment activity as the first step in curriculum development and integration into PM&R residency training. We want to hear your insights and your interest in being part of a core working group. Please contact any of us at ime@ufl.edu, ravis1997@ufl.edu, dtopping@ufl.edu.

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FSPMR Residency Programs

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For updates/edits on this page, please email FSPMR Executive Director [Tania Jones](#)
Liaisons' information and photos are also on the website FSPMR.org/Members/Board of Directors page.

Residency Updates



In This Issue:

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- ❖ UCF/HCA FL West
- ❖ Memorial Healthcare
- ❖ Broward
- ❖ U. Florida

UNIVERSITY OF MIAMI PM&R

September 2026 Edition

FSPM&R Colleagues,

We are honored to begin the 2026–2027 academic year as your new FSPM&R liaisons. The events in this edition highlight our program’s commitment to scholarship, service, wellness, and camaraderie. We look forward to supporting another year of growth and connection across our residency and fellowship community.

This issue highlights the graduating Class of 2026, resident and faculty award winners, Research Day, Miami World Cup volunteering, and the strong start to a new academic year at University of Miami / Jackson Health System PM&R.

Felix Zayas, MD & Zackary Park, MD | PGY-3 Residents

NEW FSPM&R LIAISONS

Felix Zayas, MD and
Zackary Park, MD
begin the academic
year as the new
resident liaisons.



Felix Zayas, MD



Zackary Park, MD



CELEBRATING THE CLASS OF 2026

Graduation at the Rusty Pelican



Residents, fellows, faculty, family, and friends gathered to celebrate the Class of 2026.



The graduating PM&R residents and fellows who completed their training at the University of Miami

Graduating PM&R Residents

- Mark Williams, MD
- Lance Reccoppa, MD
- Harika Valabhaneni, MD
- Felicia Watson, DO
- Reid McCollough, DO
- Matisison Alderman, MD
- Arielle Farhi, MD
- Azmeer Khamisani, MD

Graduating Fellows

- Nelson Castillo, MD – Cancer Rehabilitation
- Raymond Matthews, MD – Brain Injury Medicine
- Leyla Huyselini, MD – Spinal Cord Injury Medicine

Their contributions have left a lasting impact on our patients, trainees, and residency community. Once a Hurricane, always a Hurricane!

CELEBRATING EXCELLENCE

2025-2026 Residency Program Awards



The graduation celebration recognized outstanding achievements in academics, clinical care, teaching, research, and resident development.

Highest SAE Scores

Lance Reccoppa, MD; Sean Goldman, DO; Alexander Cristian, MD

Best Inpatient Resident

Felix Zayas Rodriguez, MD

Best Outpatient Resident

Mark Williams, MD

Best Ultrasound Course Instructors

Christian Diaz, MD; Zackary Park, MD; Daniel Wang, MD; Lance Reccoppa, MD

Lennar Foundation Resident Award

Felicia Watson, DO

Research Awards

Azmeer Khamisani, MD; Dylan Wood, MD; Nareka Trewick, MD; Felicia Watson, DO; Jonathan Paul, MD; Arielle Farhi, MD; Nazia Hossain, MD

Teacher of the Year

Kaivayla Deshpande, MD

Congratulations to all award recipients for their dedication to excellence in patient care, education, research, and mentorship. Their commitment continues to elevate the University of Miami PM&R program and inspire our entire department.



NEW CHIEF RESIDENTS

2026-2027 Chief Residents

INTRODUCING OUR SEASON 2026-2027 UMIAMI PM&R CHIEF RESIDENTS



Dylan Wood, MD



Jonathan Paul, MD

Dr. Jonathan Paul and Dr. Dylan Wood have begun their service as Chief Residents, helping guide resident education, communication, and program leadership in the year ahead.



UNIVERSITY OF MIAMI PM&R RESEARCH DAY

Celebrating innovation, mentorship, and scholarship

Research Day highlighted the scholarly accomplishments of our residency and fellowship programs. The event brought together residents, fellows, faculty mentors, and departmental leaders to share clinically relevant work and celebrate academic progress.

PGY-4 residents presented final results from their longitudinal projects, fellows shared work completed during subspecialty training, and PGY-3 residents provided updates on ongoing investigations.

Congratulations to Dr. Daniel Wang, recipient of the Gater Research Award, for the quality and impact of his scholarly work. We also thank Dr. Edward Tiozzo and every faculty mentor whose guidance helped trainees turn clinical questions into meaningful projects.



PGY-4 residents, Dr. Tiozzo, and Dr. Molinares gathered for University of Miami PM&R Research Day.



Congratulations to Dr. Daniel Wang, recipient of the 2026 Dr. David R. Gater Abstract Award.



A NEW ACADEMIC YEAR BEGINS

Welcoming new residents, fellows, and leadership



Residents gathered at Crandon Beach for volleyball, friendly competition, and a day of wellness and camaraderie.



A soccer-themed welcome event brought together residents, faculty, and staff as Miami celebrated World Cup season.



The new academic year began with opportunities for trainees across all classes to connect outside the hospital.

Incoming PGY-2 residents and fellows connected with colleagues through orientation, a soccer-themed welcome event, and a Crandon Beach social.



WORLD CUP VOLUNTEERING

Volunteering in the community



Dr. Dylan Wood and Dr. Nazia Hossain represented the program as volunteers during Miami's World Cup activities.



GROWTH, LEADERSHIP & EDUCATION

Program updates for 2026-2027

Expanding Our Faculty

We welcome Dr. Raymond Matthews, who joins after completing Brain Injury Medicine fellowship training with our program, and Dr. Ellen Tamboli, whose expertise strengthens interventional pain and spine education.

Introducing the New Pain/Spine Track

The new seven-week Pain/Spine Track combines focused clinics, diagnostic reasoning, hands-on learning, and exposure to image-guided procedures to prepare residents for careers in spine, pain medicine, and musculoskeletal rehabilitation. We look forward to another year of growth, collaboration, and excellence. Go Canes!



REPRESENTING THE U

UM PM&R Representation



Dr. Nareka Treweek had the opportunity to go to the Women Innovators in Pain Medicine (WIPM) conference in New Orleans, doing a case presentation and connecting with program alumni and mentors!

The American Medical Society for Sports Medicine (AMSSM) also received representation from the U! Our residents make us proud by presenting cases and doing podium presentations and networking, learning from leaders and reconnecting with faculty and residents from different programs.



Our residents also had the experience of participating at Xcel learning and apex biologics workshops on US guided procedures and regenerative medicine. In the picture Dr. Azmeer Khamasani and Dr. Nazia Hossain with Dr. Morgan, former UM resident.

Great teachers all around! Our amazing attending Dr. Jose Vives alongside our residents Dr. Sean Goldman and Dr. Christian Diaz got nominated for the UM school of medicine Excellence in Medical Student Teaching Awards!



An incredible weekend at the American Society of Pain and Neuroscience (ASPN) Annual Conference! Our residents had the opportunity to learn, connect, and proudly represent our program. A special congratulations to Dr. Igarashi and Dr. Nguyen on receiving the Top Abstract Award, an outstanding and well-deserved achievement!





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UCF / HCA Florida West Hospital – Pensacola Campus

Physical Medicine & Rehabilitation Residency Program

Resident Liaison: Arinze Ochuba, MD | Program Director: Susan Belcher, MD

Hello FSPMR family,



It is an honor to introduce myself as the new Resident Liaison for the University of Central Florida/HCA PM&R Residency. I am excited to represent our program and share highlights from Pensacola as our residency continues to grow, innovate, and contribute to the field of physiatry.

My name is Arinze Ochuba, and I was born in Lagos, Nigeria. I immigrated to the United States at the age of 17, where I worked while pursuing my education. I earned a bachelor's degree in neuroscience from Johns Hopkins University before receiving my medical degree from the Johns Hopkins University School of Medicine. I then completed a preliminary year in General Surgery at Temple University Hospital before beginning my Physical Medicine and Rehabilitation training at the University of

Central Florida/HCA Healthcare GME Consortium.

My passion for physiatry stems from a desire to restore function, improve quality of life, and build lasting relationships with patients throughout their recovery. I am particularly interested in interventional spine and pain medicine, where I hope to combine procedural innovation with comprehensive rehabilitation to help patients regain independence and return to the activities that matter most.

Outside of medicine, I enjoy physical training, art, traveling, and exploring new cultures. I am also passionate about mentorship, medical education, and organized medicine. I currently actively contribute to national organizations through committee service focused on diversity, equity, inclusion, and resident engagement. As Resident Liaison, I look forward to highlighting the accomplishments of our residents, fostering collaboration across programs, and showcasing the exciting work taking place within our residency.

Graduation Spotlight

This summer we proudly celebrated the graduation of our third PGY-4 class (Class of 2026):



From left to right.

- ★ Dr. Justin Buck, Pain Medicine Fellowship at the University of Florida in Gainesville, Florida
- ★ Dr. Megan Finch, Brain Injury Medicine Fellowship at Atrium Health Carolinas Medical Center in Charlotte, North Carolina
- ★ Dr. Zachary Lin, Pain Medicine Fellowship at the University of Texas Medical Branch in Galveston, Texas
- ★ Dr. Mathew McGillivray, PM&R Attending Physician

Pictures of more celebrations and an award ceremony.



Curriculum & Training Highlights

Our curriculum provides residents with a comprehensive, year-long educational experience designed to complement clinical training through a diverse mix of faculty-led instruction, resident teaching, interdisciplinary collaboration, and scholarly activities. Weekly sessions cover the full breadth of physical medicine and rehabilitation, including musculoskeletal medicine, spinal cord injury, brain injury, stroke, electrodiagnostic, pain management, prosthetics and orthotics, sports medicine, pediatric rehabilitation, spasticity management, cancer rehabilitation, cardiopulmonary rehabilitation, and ultrasound-guided procedures. The curriculum also incorporates interdisciplinary lectures from speech, occupational, and physical therapy professionals, orthopedic surgeons, pharmacy exchanges, journal clubs, case report presentations, and GME Grand Rounds to promote evidence-based practice and multidisciplinary care. Resident-led lectures provide opportunities to develop teaching and leadership skills while reinforcing core PM&R concepts. We also incorporate emerging topics, visiting speakers, board review, simulated interventional pain procedures in the operating room, and program-specific educational initiatives, ensuring the curriculum remains dynamic, relevant, and responsive to resident learning needs.



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Academics and Research

This year, our residency program performed a number of research projects.

These are some of the projects undergoing.

- **AAPM&R Annual Assembly Accepted Abstract:** Rehabilitation Challenges After Femoral Intramedullary Nailing (IMN) in a Patient with Diffuse Idiopathic Skeletal Hyperostosis (DISH) and Chronic Idiopathic Axonal Polyneuropathy (CIAP): A Case Report was accepted for poster presentation at the **American Academy of Physical Medicine and Rehabilitation (AAPM&R) Annual Assembly**. Authors: Arinze J. Ochuba, MD; Chigozie Igbonagwam, MD; Cheyenne Davis, PTA; Christopher Burton, MD. Department of Physical Medicine and Rehabilitation, University of Central Florida/HCA Florida West Hospital, Pensacola, FL. Category: General Rehabilitation.
- **FSPMR Annual Meeting Accepted Abstract for Podium Presentation:** *Neurologic Deficits After Roux-en-Y: A Diagnostic Challenge Presenting as a Stroke-Like Episode: A Case Report* was submitted for presentation at the **Florida Society of Physical Medicine & Rehabilitation (FSPMR) Annual Meeting**. Authors: Arinze Ochuba, MD; Adrian Ybanez, DO; Caroline Amerson, MD; Ryan Palmer, DO; Christopher Burton, MD; Marisa Terry, MD. Department of Physical Medicine and Rehabilitation, University of Central Florida/HCA Florida West Hospital, Pensacola, FL.

Our residents' intellectual curiosity reflects our commitment to advancing patient care through innovative thinking, scholarly inquiry, and the integration of evidence-based, standard-of-care practices. By pursuing novel solutions while maintaining the highest clinical standards, we strive to continually improve outcomes for the patients and communities we serve.

Conferences Attended: Women in Pain Management attended by our Chief Resident, Kristina Ledbetter, DO in New Orleans, June 2026



Education & Outreach

Hope and Health Clinic



Service to the community remains a cornerstone of the UCF/HCA PM&R Residency Program. Our residents proudly volunteer at the Hope and Health Clinic in Pensacola, providing compassionate care to underserved members of the community while gaining valuable experience in addressing diverse rehabilitation and musculoskeletal needs. Through this ongoing commitment, residents strengthen their clinical skills, deepen their understanding of healthcare disparities, and embody the spirit of service that defines our program. These volunteer efforts not only improve access to quality care but also reinforce our mission of developing compassionate physiatrists dedicated to serving patients both inside and outside the hospital.

Ice Flyers Team Physician Coverage

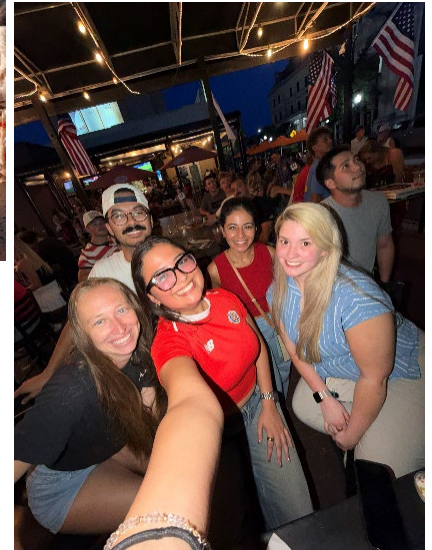
UCF/HCA PM&R residents have the unique opportunity to volunteer alongside the team physicians for the Pensacola Ice Flyers, gaining firsthand experience in sports medicine and event coverage. Working on the sidelines, residents assist with the evaluation and management of acute musculoskeletal injuries, contribute to return-to-play decisions, and collaborate with a multidisciplinary sports medicine team. This hands-on experience enhances clinical skills in injury assessment and rehabilitation while exposing residents to the fast-paced environment of athletic competition. Through these volunteer efforts, residents strengthen their expertise in sports medicine and reinforce our program's commitment to serving both athletes and the local community.

Rotating Medical Students

Education and mentorship are integral to the UCF/HCA PM&R Residency Program. Throughout the year, our residents work closely with medical students rotating at HCA Florida West Hospital's Inpatient Rehabilitation Unit, fostering a supportive learning environment through bedside teaching, case discussions, and hands-on clinical instruction. Residents serve as mentors by helping students develop their physical examination skills, clinical reasoning, and understanding of rehabilitation medicine while providing guidance on career development and residency training. These meaningful interactions not only enrich the educational experience of visiting students but also cultivate the teaching and leadership skills that are essential to becoming outstanding physiatrists.

Resident Life & Community

In June, we enthusiastically welcomed our incoming PGY-2 Advanced Program residents and PGY-1 Transitional Year residents. A welcome dinner and hospital-wide celebration kicked off the academic year, giving our newest residents the opportunity to connect with faculty and colleagues. Senior residents helped foster a culture of mentorship, camaraderie, and support, ensuring everyone felt at home as they began their PM&R journey.



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Resident Wellness

Resident wellness remains a cornerstone of our program. Recently, residents and faculty came together for a team-building outing at the local zoo, providing an opportunity to strengthen relationships, recharge outside the clinical environment, and foster the sense of camaraderie that defines our residency community.

Our resident mentorship program pairs each incoming PGY-2 with a PGY-3 mentor, fostering a supportive environment through shared clinical experiences, professional guidance, and social activities that strengthen camaraderie and ease the transition into residency.

The Residency Class at the zoo for Wellness.





Faculty Spotlight: Dr. Kendall Hulk, DO

Hometown: Glastonbury CT

Fellowship: Pediatric rehabilitation medicine Children's Specialized hospital, Rutgers New Jersey Medical School

About: pediatric and adult physical medicine and rehabilitation boarded physician with Nemours Children's in Pensacola.

Clinical interested: complex care, spasticity management, TBI, SCI

Fun fact: Minored in fine art, anatomy drawings published in medical journals and Nelson's Pediatric Textbook

Hobbies: Adventures with hubby, baby and two dogs, kayaking, paddle boarding, skiing, cooking, painting, gardening

Professional Leadership & Advocacy [WIP]

Physiatrist in Training (PHiT) Ambassadors: Dr. Chigozie and Dr. Anna Meganhardt serve as liaisons between UCF/HCA PM&R and AAPM&R.

AAPM&R Annual Assembly Participation: Dr. Caleb Leung and Dr. Arinze Ochuba will represent us.

Emerging Leaders in Spasticity Program: Dr. Arinze Ochuba and Dr. Ryan Palmer are completing this national leadership program. Dr Amerson and Dr Cordero are currently finishing up the program.

Functional Capacity Evaluation Training: Dr. Caroline Amerson will undergo advanced training in FCE.

Away Rotations: Residents are completing rotations in Pain Medicine, Brain Injury, and Sports Medicine.

Committee Involvement: Residents actively serve on Brain Injury, Spinal Cord Injury, Pain, DEI, NeuroRehab, Social Media, and Wellness committees.

Team Physician Coverage: Continuing sports medicine exposure through coverage of Pensacola Ice Flyers, Miracle League, and Soccer.

Resident Advisory Committee: Dr. Arinze Ochuba serves as our program liaison to UCFCOM GME

Resident as a Teacher Program: Dr. Arinze Ochuba completed this program to become effective teachers to others.

American Osteopathic College of Physical Medicine and Rehabilitation: Sports and Pain Committee. Dr. Chigozie Igbonagwam, and Dr. Arinze Ochuba.

Sports Team Physician Leaders: Dr. Chigozie Igbonagwam



Creativity Corner

When not caring for patients, our very own, Dr. Kris Sibaja, enjoys cultivating another passion—houseplants. Her growing indoor collection reflects the same patience, attention to detail, and dedication she brings to residency. From the lush trailing vines of Golden Pothos (*Epipremnum aureum*) to the elegant foliage of the Philodendron 'Pink Princess', each plant has its own personality and care routine.

The collection also includes a striking Fiddle-Leaf Fig (*Ficus lyrata*), known for its bold, violin-shaped leaves, and a charming Heartleaf Philodendron (*Philodendron hederaceum*), which happily climbs and trails throughout the home. Caring for these plants provides a welcome opportunity to unwind after long days in the hospital while creating a calming, green space to recharge.

Whether nurturing patients or plants, Dr. Kris Sibaja reminds us that growth happens with consistency, care, and a little bit of sunshine.



Social Media

Follow us on Instagram: [ucfhca_pmr](#) for more updates and content!

From the Gulf Coast to the statewide stage, UCF PM&R continues to build a culture of scholarship, innovation, leadership, and community.

Sincerely,

Arinze, Ochuba, MD

PGY-3 Resident Liaison University of Central Florida/HCA FL West Hospital PM&R Residency Program





PM&R Residency Program Update
Dr. Dev Patel MD (PGY-2) Resident Liaison
Dr. Jeremy Jacobs DO, Residency Program Director
Dr. Joanne Marie Delgado-Lebron MD, Associate Program Director

Hello FSPM&R Family!

Summer in South Florida brings two reliable things: afternoon thunderstorms, and a brand-new academic year. Since our last update, our program has graduated a class, welcomed another, celebrated a chief resident matching into fellowship, cheered a faculty member through board certification, and packed in a remarkable amount of learning between call shifts. Here is what the last few months looked like at Memorial.



Dev Patel, M.D

Passing the Torch: Farewell to Our PGY-4s

It was a heart-warming goodbye to our PGY-4s as they move on to the next chapter of their medical journeys and continue delivering the best possible care to their patients. To our graduates: thank you for being our role models, for the teaching you never billed us for, and for setting a standard on the floors and clinics that the rest of us are still chasing. We have very big shoes to fill.



The Memorial PM&R family celebrating our graduating class. Back row, wearing the graduation sashes, from left to right: Dr. Cody Barbari, Dr. Emma Adkins, Dr. Sri Moturu, and Dr. Jorge Bilbao.

A Chief Heads North: Dr. JP Mauriello Matches at Rochester

Congratulations to one of our chief residents, Dr. JP Mauriello, on matching into his number-one program: the NASS-accredited Interventional Spine and Musculoskeletal Medicine fellowship at the University of Rochester in New York.

For residents weighing their own fellowship plans, NASS-accredited programs are worth knowing about. Accreditation through the North American Spine Society signals a defined curriculum in image-guided spine intervention, musculoskeletal ultrasound, and — just as importantly — the clinical judgment of deciding who actually benefits from a procedure and who does not. Longtime readers may recognize Dr. Mauriello from our June update, where he presented at the American Medical Society for Sports Medicine annual meeting in Seattle. Rochester is getting a fantastic additional member to their team!



**Memorial
Healthcare System**
Graduate Medical Education

John Paul Mauriello, DO
Physical Medicine and
Rehabilitation Residency

Congratulations!

Matched Specialty:

**NASS Accredited
Interventional Spine and
Musculoskeletal Medicine
Fellowship**

**University of Rochester,
New York**

Dr. John Paul Mauriello, DO, chief resident, Memorial PM&R Residency.



Boards Behind Her: Dr. Holland Passes Electrodiagnostics

A very celebratory congratulations to our own stroke rehabilitation specialist, Dr. Breonna Holland, on passing her electrodiagnostic boards.

Electrodiagnostic medicine is one of the few corners of our specialty where the physician is simultaneously the clinician, the technician, and the instrument: you have to know peripheral neuroanatomy to localize a lesion to a specific segment, understand the physics and instrumentation well enough to know when a waveform is real and when it is artifact, and then integrate needle EMG and nerve conduction findings into an answer the referring physician can act on. Passing it is a genuine milestone, and our residents are lucky to learn this skill from someone as talented as Dr. Holland.



Dr. Breonna Holland, stroke rehabilitation specialist, Memorial Healthcare System.

Where Medicine Meets Business: The Boss Doctors Conference

Dr. Dev Patel (PGY-3) had the opportunity to join our sports medicine specialist Dr. Geden Franck at the annual Boss Doctors conference. Talented healthcare practitioners from across the United States came together to share what they have learned about building businesses and pursuing entrepreneurial ventures while still carrying a full clinical load.

It is a subject that most training programs do not formally cover. Residency teaches us how to read an MRI, run a spasticity clinic, and lead an interdisciplinary team — but very little about contract literacy, overhead, payer negotiation, or what it actually takes to open and sustain a practice. For physiatrists in particular, who so often build outpatient practices around procedures, that gap is worth closing early. Sessions ranged from practical financial literacy to candid conversations about burnout, autonomy, and the trade-offs between employment and ownership.



Dr. Dev Patel (PGY-3), left, and Dr. Geden Franck, sports medicine specialist, right.



Dr. Geden Franck delivering the opening welcome to a full house.



Dr. Geden Franck kicking off the conference.

ASPN 2026: Pain Medicine in Our Own Backyard

We hoped to have run into some of you at the 8th Annual Meeting of the American Society of Pain and Neuroscience (ASPN) this July at the Fontainebleau in Miami. Having a meeting of this caliber in our own backyard was a treat, and our residents took full advantage of it.

The program was a reminder of how quickly this field is moving. Sessions covered new advances in pain management and novel treatment modalities that take us one step closer to genuinely treating pain rather than simply managing it — a goal that sits squarely at the center of what physiatry does. Our incredible pain specialist Dr. Monika Patel had a busy meeting: she moderated a session on interventional oncology for pain physicians, served as a panelist on the management of facial pain and headache, and delivered a very informative talk on identifying the ideal practice setting for each individual pain specialist, whether academic, hospital-employed, or private practice.



From left to right: Dr. Luis Perez (PGY-3), Dr. Maggie Sweeney (PGY-3), Dr. Briana Alwawi (PGY-2), Dr. Monika Patel (attending, interventional pain), Dr. JP Mauriello (chief, PGY-4), and Dr. Dev Patel (PGY-3).

Of course, a conference at the Fontainebleau in July comes with certain obligations. Our residents made sure to enjoy the summery beach and pool vibes alongside another of our fantastic pain specialists, Dr. Reed Yaras.



Poolside at the Fontainebleau. Left to right: Dr. Maggie Sweeney (PGY-3), Nicholas Paolucci (MS-3), Dr. John Paul Mauriello (chief, PGY-4), Dr. Briana Alwawi (PGY-2), Dr. Reed Yaras (attending, interventional pain), and Dr. Dev Patel (PGY-3).

Spine and Shine Has Officially Kicked Off

Our annual Spine and Shine course is back, and it remains one of the most anticipated items on the residency calendar. The format pairs didactic teaching with hands-on procedural training so that residents can build interventional pain skills in a low-stakes setting before they ever step up to a live patient.

A huge shoutout to the minds behind it all: our interventional pain specialist Dr. Reed Yaras, and former chief turned UT San Antonio pain fellow Dr. Cody Barbari, who built this course specifically to help our residents sharpen their technique and walk into procedures with real confidence. This year residents worked through fluoroscopically guided transforaminal epidural steroid injections on phantom models — squaring the endplates, obliquing to find the classic "Scotty dog," working toward the safe triangle, and confirming appropriate contrast flow before anything else goes in. The repetitions matter. Procedural comfort is built long before the first patient is on the table, and a course like this is exactly where that happens.



Left: Dr. Christiania Edstrom (PGY-4) reviewing fluoroscopic imaging during the course. Right: Dr. Dev Patel (PGY-3) performing a transforaminal epidural steroid injection under fluoroscopic guidance.



Dr. Briana Alwawi (PGY-2) setting up for her turn at the table.

Until Next Time

And that is a wrap on our program's updates for this quarter! We have a new class settling in, a chief heading to Rochester, boards passed, a spine and shine course in full swing, and plenty more to come in the following months.

If you would like to stay more up to date with our residency program's activities, follow our Instagram page @mhs_pmr_residency. As always, we wish everyone a great close to the summer, and we look forward to hearing your updates and any exciting news.

Warmly,

Dev Patel, MD (PGY-3)

Resident Liaison, Memorial PM&R Residency Program





Greetings FSPM&R,

It has been an incredibly exciting and rewarding season for the residents and faculty of the Broward Health Physical Medicine & Rehabilitation Residency Program, and we are thrilled to share some of our recent highlights with the FSPMR Family.

We are so excited to welcome our newest class of PM&R residents! With the arrival of our new PGY-2s, our program is officially at full complement, and we could not be more excited to teach, learn, and grow alongside them throughout the year.

We kicked off the new academic year by celebrating our incoming residents at the Broward Health White Coat Ceremony, followed by a fun team outing at Topgolf. It was a great opportunity to welcome our newest members to the PM&R family and celebrate the start of their residency journey!



Arian Khoshgowari, DO



From Left to Right: Carol Siu (Program Manager), Dr. Jeremy Castro (PGY2), Ashin Chadha (PGY2), Dr. Amy Abdou (PGY2), Dr. Michael Argent (PGY2), and Dr. Meilani Mapa (Program Director)



From Left to Right: Dr. Jeremy Castro (PGY2), Ashin Chadha (PGY2), Dr. Amy Abdou (PGY2), Dr. Michael Argent (PGY2)



From Left to Right: Dr's Ashin Chadha (PGY2), George Beshara (PGY3), Michael Argent (PGY2), Sophie Risi (PGY3), JC Leach (PGY3), Amy Abdou (PGY2), Keith Myers (PGY4), Elham Younesian (PGY3), Jeremy Castro (PGY2), David Yusupov (PGY4)

Our new PGY-2s also jumped right into the heart of rehabilitation, getting the full patient experience alongside our incredible PT, OT, and SLP teams. From hands-on clinical learning to seeing the collaborative nature of interdisciplinary rehabilitation firsthand, our newest residents had a fantastic introduction to the world of PM&R. Here are a few highlights from their time working alongside our amazing therapists!



Dr. Amy Abdou (PGY2) test driving rehab equipment



Dr. Michael Argent (PGY2) undergoing FEES w SLP



While we welcomed our newest PGY-2s, we also celebrated our former PGY-2 class as they officially stepped into their PGY-3 year! Congratulations to our rising PGY-3s, we are excited to see all that you accomplish in this next chapter of residency!



From Left to Right: Dr's Sophie Risi (PGY3), Elham Younesian (PGY3), George Beshara (PGY3), JC Leach (PGY3)

As the new academic year gets underway, we are excited to continue our PM&R Ultrasound Didactic Series. We kicked things off with an introductory ultrasound course designed to orient our brand-new PGY-2s to the fundamentals of musculoskeletal ultrasound and get them comfortable with the equipment, techniques, and applications they will use throughout residency.

We can't wait to see what this new year brings and look forward to sharing more updates, accomplishments, and adventures with you all in our next newsletter!



From Left to Right: Dr's Arian Khoshgowari (PGY4),
Minh Quan Le (Associate Program Director) and
Amy Abdou (PGY2) reviewing ultrasound basics



University of Florida PM&R Residency Program

Amber Rampersaud DO, Resident Liaison

Irene Estores MD, Program Director

Cole McCarty, MD, Assistant Program Director

Greetings from Gainesville!

The past quarter was eventful and filled with bittersweet memories as we said goodbye to our PGY-4's as they embarked on the next step of their professional journeys. We are also excited for the start of the new academic year, and to welcome the new PGY-2 class.



Amber Rampersaud, DO

2026 Graduation Ceremony:

Congratulations to our graduating residents:

- Tobin Chakkala, DO
- Kyle Coffey, DO
- Daniel Kiehl, DO
- Joseph Rinaldi, MD

We are so proud of all your accomplishments, and grateful for the hard work, dedication, and resilience you have demonstrated throughout the past three years. We wish you all the best in your future endeavors.



Prosthetic and Orthotic Field Trip:



Our residents had the opportunity to take a field trip for didactics to Gainesville Prosthetics for an enriching and educational session. We explored key considerations in the clinical assessment and evaluation of prosthetic needs, while also gaining hands on experience with prosthetic scanning and casting techniques.

AAPM&R Resident Retreat:



Three of our now PGY-3 residents - Alyssa Axelrod, Ravi Ibrado, and Amber Rampersaud were selected to participate in the 2026 AAPM&R Resident Retreat in Chicago. They learned from national leaders in PM&R with hands on workshops and interactive case studies, while connecting with residents across the country.

First Day - Welcome PGY-2's:



A warm welcome to our new PGY-2 class, Ravi Shah, Sarah Sabol, Mary DesRosiers, and Lauren Taylor on their first day of inpatient rehab. We are excited for the new memories, adventures and experiences this year will bring!

Learning About Therapeutic Modalities:



Pictured are our PGY-2's - Ravi Shah, Mary DesRosiers, and Lauren Taylor demonstrating various therapeutic modalities including blood flow restriction, electrical stimulation and biofeedback. We are grateful to our therapists for taking the time to educate us on these tools.

Conferences:



Congratulations to PGY-3
Khash Rishsefid for
presenting his poster:
Temperament helps to
explain individual
differences in clinical pain,
sensory sensitivity, and
psychosocial functioning at
ASPN 2026!



ASPN 2026
Miami, FL



Meeting the Next Generation:



UF 2026 Career Fair

PGY-4 Eian Fariscal, Dr. Zadov, PGY-2's Ravi Shah, Mary DesRosiers, and Lauren Taylor volunteered to represent our program at the UF MD Class of 2030 Career Fair. They met with the next generation of physicians and answered their questions about the field of Physical Medicine and Rehabilitation.

UF College of Medicine
Department of Physical Medicine
and Rehabilitation
UNIVERSITY of FLORIDA



We are proud of the five first-year UF Medical Students: Animesh Borad, Noelle Dorvault, Robert Sedwick, Abdul-Jalil Dania and Zina Ahn for completing their 10-week summer research experience in the PM&R Department. They worked closely with the Research division team, faculty and residents which concluded with a presentation of their medical student research program (MSRP) experience.

The A Team:





Our PM&R residents and students are staying active this summer, OMS4 Alexander Mazzorana, PGY-4 Abe Amare, PGY-3's Alyssa Axelrod and Amber Rampersaud had some friendly competition on the court while playing pickleball.



@uf_pmr

Follow us on Instagram @uf_pmr for more updates and content!
https://www.instagram.com/uf_pmr/



UF | **College of Medicine**
 Department of Physical Medicine
 and Rehabilitation
UNIVERSITY of FLORIDA

PM&R Pioneers

Craig H Lichtblau MD

We help our early career psychiatrists by providing mentors for them. We call our mentors PM&R Pioneers. These mentors are for both practice management and clinical issues. They are listed below and early career members can contact them.

What makes a PM&R Pioneer? They have a minimum of 20 years of experience and want to share their knowledge, training and experience with new FSPMR members.

If you wish to serve in this capacity and you are not yet on the PM&R Pioneers list, please submit your name to Tania Jones, FSPMR Executive Director, tjones@meyerresources.com . Thank you for your consideration and if you'd like to discuss it further with me before deciding, please contact me at C.Lichtblau@chlmd.com.

Craig Lichtblau MD

Past President Director, FSPMR

Craig Lichtblau MD	(561) 842-3694
Michael Creamer DO	(407) 649-8707
Anthony Dorto MD	(305) 932-4797
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Thomas Rizzo Jr MD	(904) 953-2735
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Andrew Sherman MD	(305) 585-1332
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Angela McCloskey,
Concierge Physician
Relocation Specialist
407-616-3513



AngelaSellsSunshine@gmail.com
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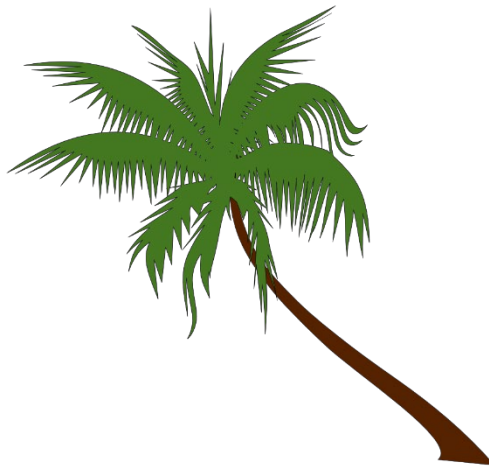
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**Professional Opportunities are FREE and
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Deadline for our next Issue is November 15, 2026

For our December 2026 Magazine

Guidelines for your articles are available on the website: <https://www.fspmrmagazine.org>

Here are some of the basic guidelines for your article submissions.

- Pictures: should be in .jpg or .gif format.
Include people's names in the pictures, if possible.
- All files must have minimum resolution of 72 dpi. (max. 300)
with a image size no larger than 1500 px x 900 px
- Documents should be submitted in electronic format (docx).
PDF's will not be accepted
- **FONT:** CAMBRIA pt 12

All articles will be approved by Newsletter editors.

FSPMR will retain full editorial rights to any submissions.

