Physiatrist's Voice

NEWSLETTER September 2019

Enhancing Health And Function Through Education And Research In The Field Of Physical Medicine And Rehabilitation

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PRESIDENT'S MESSAGE

Presidentôs Message

by Craig Lichtblau MD

Fall is in the air! Kids are back in school and a fresh academic year is upon us. Football season is here, and for many of us Floridians, that means weekend and social activities conform around our favorite college (Florida Gators, Florida State Seminoles, South Florida Bulls, Miami Hurricanes, UCF Knights) and professional teams (Jacksonville Jaguars, Miami Dolphins, Tampa Bay Buccaneers).

We hope everyone had a wonderful summer. One highlight of summer was FSPMRôs Annual Meeting in July at The Diplomat Beach Resort in Hollywood. We met in conjunction with FSIPP, and we plan to meet with them again next summer, July 16 ï 19, 2020, same location. FSPMRôs successful day-long scientific and educational breakout session included talks by Dr Randall Braddom on chronic and complex regional pain syndromes, talks by Attorney Jennifer Bolen and former DEA Rick Tucker on non-compliant, abusive patients and risk mitigation successes and failures, and resident case presentations from UMiami, USouth Florida, and Nova/Larkin Hospital PM&R residency programs. We hope to have the new Ft Lauderdale Memorial Regional PM&R Residency program involved by next year.

We received some constructive feedback for next yearôs breakout session: table with mics for panels, mic in middle of floor for Q&A from audience, more diversity of topics and shorter presentation times. *We want to hear from you, FSPMR Members, and especially the PM&R Residents – what topics do you want to hear about next year?* We want to find expertise to present next yearôs topics from within our own membershipé .it is an honor to be asked to speak. Regarding the meeting as a whole, it was suggested that the FSPMR Board join the FSIPP Board in one eveningôs Resident/Fellow special dessert event.

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PRESIDENTôS MESSAGE CONTINUED FROM PAGE ONE.

FSPMRôs Annual Business Meeting that Saturday evening also turned out very well. Many residents attended and we awarded three True Florida PM&R Pioneer awards to former FSPMR Presidents Drs Justine Vaughen, Rodolfo Eichberg, and Anthony Dorto. Drs Dorto and Eichberg have appeared in Member Spotlights in the two previous issues of this newsletter (http://www.fspmr.org/newsletters.html). Dr Vaughenôs Member Spotlight this issue is actually the speech that Dr Oscar Depaz gave when presenting her with the award. It is inspirational, why we love this specialty, and brings us back to ñthe virtue of what we can do and do for our patients.ò

Not only did PM&R Residents turn out in number, they also spoke up at the business meeting and represented themselves well. Two topics of import brought by residents:

1. Mentorship ï this gave me the opportunity to tout FSPMRôs PM&R Pioneer program which is exactly that, mentors for young physiatrists. Youôll find a short article in this issue about our Mentors/PM&R Pioneers, along with a listing with contact information of FSPMR members who have stepped up (thank you!) to this opportunity. This newsletter goes to FSPMR Members each quarter as well as to the PM&R Residents.
2. Voice with the Board of Directors ï a motion was made and carried to have the Resident Liaisons from each PM&R residency program attend telephonic board meetings, and join other board e-communications. The Liaisons will not have a vote, but will be able to give input from their programs and carry information back to their programs. A win-win!

By the time you read this, I will have returned from abroad. I went to Liverpool, England, beginning August 23, for a week long meeting and to present ñRotationplasty for Severe Congenital Femoral Deficiencyò at the Fourth Combined Congress of the Association for the Study and Application of the Method of Ilizarov, and the International Limb Lengthening and Reconstruction Society. After Liverpool, I traveled on to Warsau, Poland, where I was a surgical assistant for extremity reconstruction to Dr Dror Paley. I returned to this country on September 7.

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Yes, happy to be back home, and we wish everyone an energetic and productive Fall 2019. Remember, *we want to hear from you, FSPMR Members, and especially the PM&R Residents – what topics do you want in 2020's FSPMR Annual Meeting and Educational Breakout Session?* Please send your responses to me at c.lichtblau@chlmd.com, or Executive Director Lorry Davis, lorry4@earthlink.net.

As always, thank you, FSPMR Members. It is an honor and privilege to serve you.

Natasha Jadinovskiah, President Dr Craig Lichtblau, Executive Director Lorry Davis

Thank You to Medtronic

for Sponsoring the 2019 Annual Meeting and Reception

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AVASCULAR NECROSIS

Avascular necrosis (AVN) also known as osteonecrosis or bone infarction is death of bone tissue due to interruption of the blood supply. Early on there may be no symptoms, gradually joint pain may develop which may limit the ability to move. Complications may include collapse of the bone or nearby joint surface. Risk factors include bone fractures, joint dislocations, alcoholism and the use of high-dose steroids. The condition may also occur without any clear reason. The most commonly affected bone is the femur. Other relatively common sites include the proximal humerus, knee, shoulder and ankle.

Diagnosis is typically made by medical imaging such as x-rays, CT scans or MRI. Early on biopsy is used. Treatments may include medication, not walking on the affected leg, stretching and surgery.

Most of the time surgery is eventually required and may include a core decompression, osteotomy, bone grafts or joint replacement. About 15,000 cases occur every year in the United States. People 30 to 50 years of age are most commonly affected. Males are more commonly affected than female.

Signs and Symptoms:

In many cases there is pain and discomfort in a joint which increases over time. While it can affect any bone, about half of the cases show multiple sites of damage. Avascular necrosis primarily affects the shoulder, knee and hip joints. Classic sites are head of the femur, neck at the talus and waist of the scaphoid.

Avascular necrosis commonly affects the ends of long bones such as the femur. Other common sites include the humerus, knee, shoulders, ankles and jaw.

Causes:

The main risk factors are bone fractures, joint dislocations, alcoholism and the use of high-dose steroids. Other factors include radiation therapy, chemotherapy and organ transplantation. Osteonecrosis is also associated with cancer, lupus, Sickle Cell disease, HIV infection, Gaucherôs disease and Caisson disease. The condition may also occur without any clear reason.

Biphosphonates are associated with osteonecrosis of the mandible. Prolonged or repeat exposure to high pressures (such as experienced by commercial and military divers), has been linked to AVN, though the relationship is not well understood.

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Avascular Necrosis
continued

Pathophysiology:
The hematopoietic cells are most sensitive to low oxygen and are the first to die after reduction or removal of the blood supply, usually within 12 hours. Experimental evidence suggests that bone cells (osteocytes, osteoclass, osteoblasts), die within 12-48 hours and that bone marrow fat cells die within five days.

Upon reperfusion repair of bone occurs in two phases. First there is angiogenesis and movement of undifferentiated mesenchymal cells from adjacent living bone tissue that grow into the dead marrow spaces as well as entry of macrophages that degrade dead cellular and fat debris.

Secondly there is cellular differentiation of mesenchymal cells into osteoblasts or fibroblasts. Under favorable conditions the remaining inorganic mineral volume forms a frame work of establishment of new fully functional bone tissue.

In the early states, a bone scan and MRI are the preferred diagnostic tools. X-ray images of avascular necrosis in the early stages usually appear normal and in later stages appears relatively more radiopaque due to the nearby living bone becoming resorbed secondary to reactive hyperemia. The necrotic bone itself does not show increased radiographic opacity. As dead bone cannot undergo bone resorption which is carried out by living osteoblasts. Later the radiographic signs include a radiolucency area following the collapse of subchondral bone (crescent sign) and ring region of radiodensity resulting from saponification and calcification of marrow fat following medullary infarct types.

When avascular necrosis affects the scaphoid bone it is known as Preiser disease. When AVN affects the navicular bone of the foot it is known as Kohler disease which is primarily in children.

Treatment:
A variety of methods may be used to treat, the most common being total hip replacement; however, total hip replacements have a number of down-size including long recovery times and short life spans (of the hip joints themselves). Total hip replacements are an effective means of treatment in the older population; however, in younger people, they may wear out before the end of the person's life and they may have to be revised.

Biphosphonates which reduce the rate of bone breakdown may prevent collapse, specifically of the hip due to avascular necrosis.

Avascular Necrosis
continued

Other treatments include core decompression where internal bone pressure is relieved by drilling a hole into the bone and a living bone chip and an electrical device to stimulate new vascular growth are implanted and the free vascularized fIbular graft (FVFG) in which a portion of the fibula along with the patientôs blood supply is removed and transplanted into the femoral head.

A 2016 Cochran Review found no clear improvement between people who have had hip core decompression and participate in physical therapy versus physical therapy along. Additionally, there is no strong research on the effectiveness of hip core decompression for people with Sickle Cell disease.

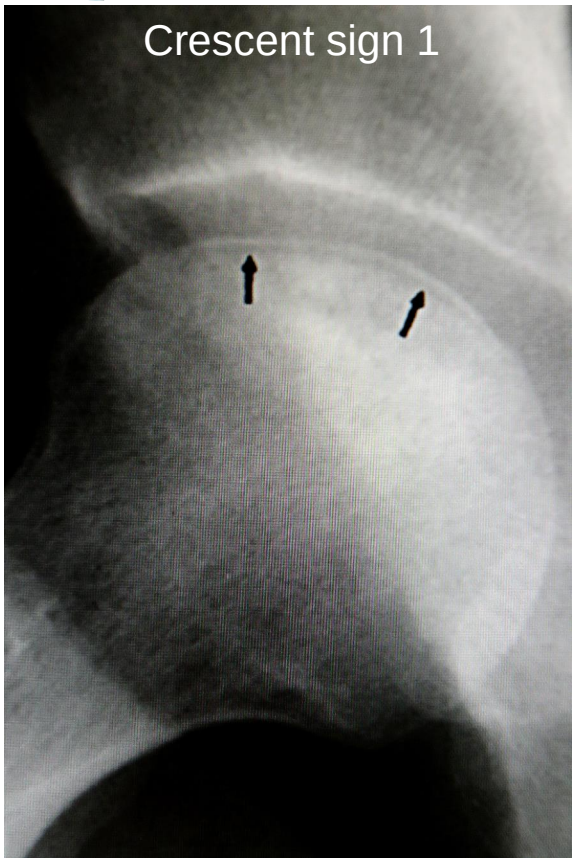
Progression of the disease could possibly be halted by transplanting nucleated cells or bone marrow into avascular necrosis lesions after core decompression although much further research is needed to establish this technique.

Prognosis:
The amount of disability that results from avascular necrosis depends on what part of the bone is affected, how large an area is involved and how effectively the bone rebuilds itself. The process of bone rebuilding takes place after injury as well as during normal growth.

Normally, bone continuously breaks down and rebuilds. Old bone is reabsorbed and replaced with new bone. The process keeps the skeleton strong and helps to maintain the balance of minerals.

In the course of avascular necrosis; however, the healing process is usually ineffective and the bone tissues break down faster than the body can repair them. If left untreated, the disease progresses and the bone collapses and the joint surface breaks down leading to pain and arthritis.

Epidemyology:
Avascular necrosis usually affects people between 30 and 50 years of age. About 10,000 to 20,000 people develop avascular necrosis at the head of the femur each year. Necrosing children at the femoral head is known as Legg-CalveôPerthes syndrome.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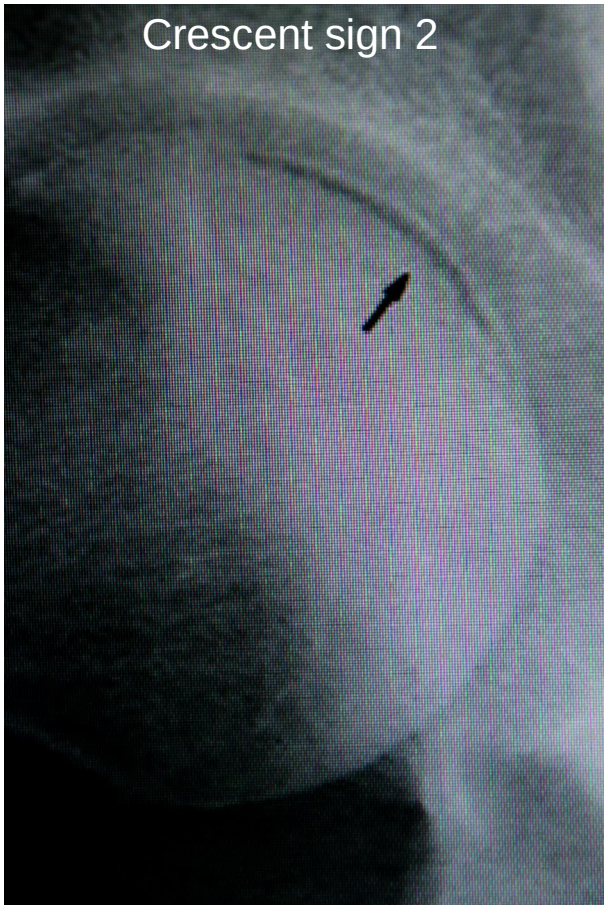
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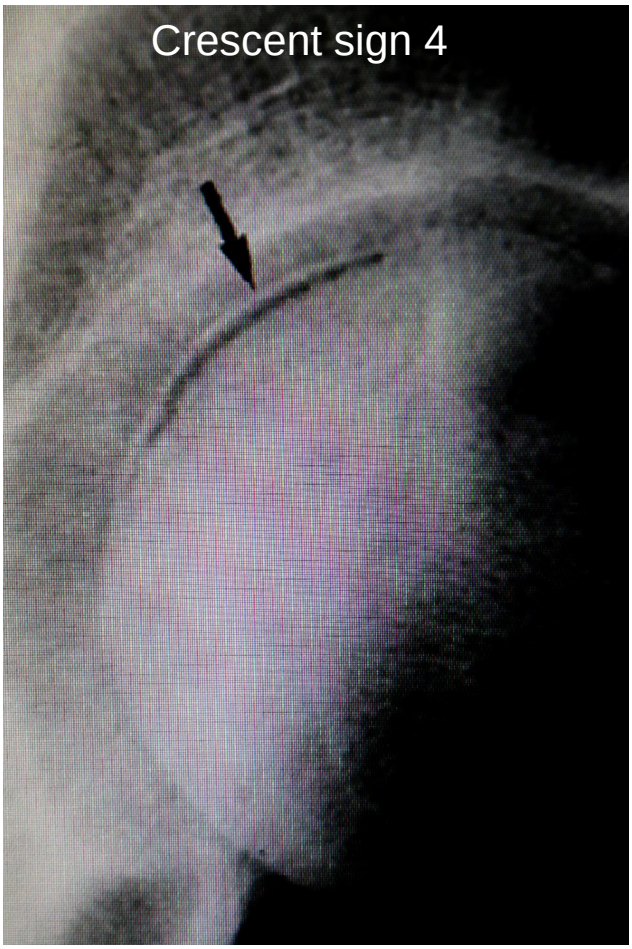
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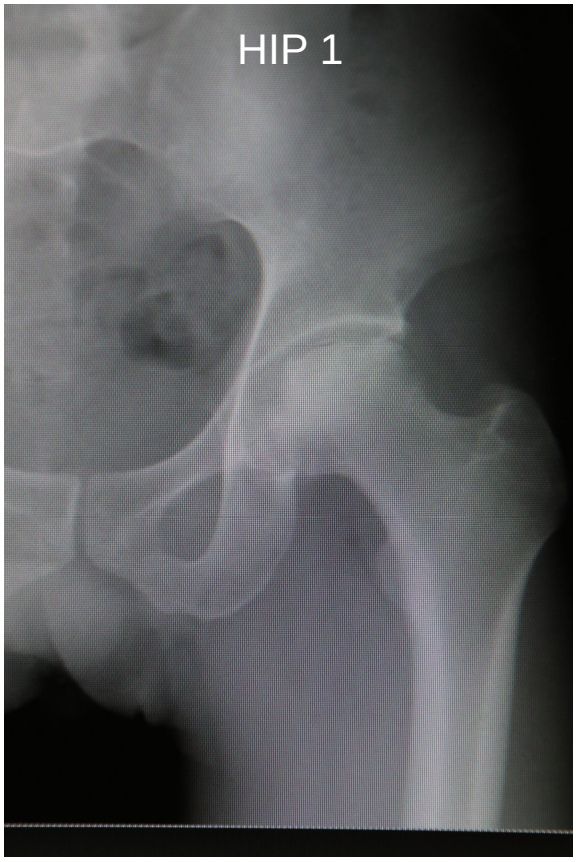
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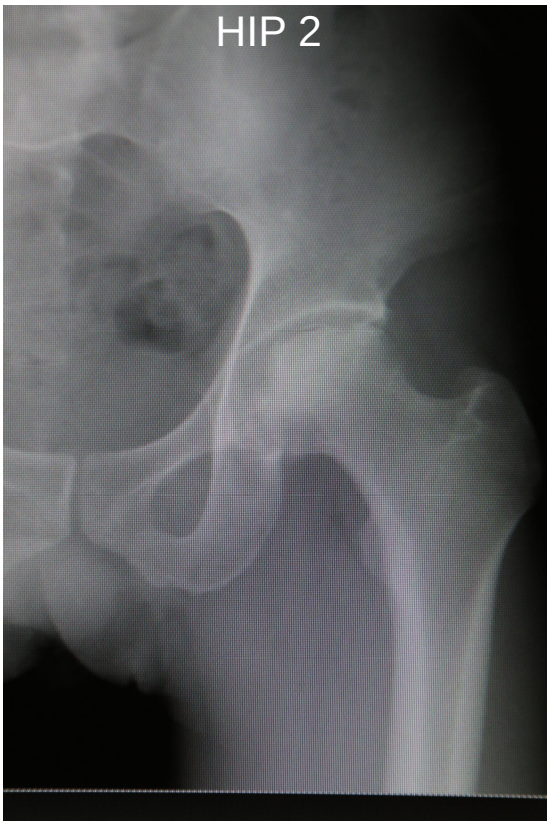
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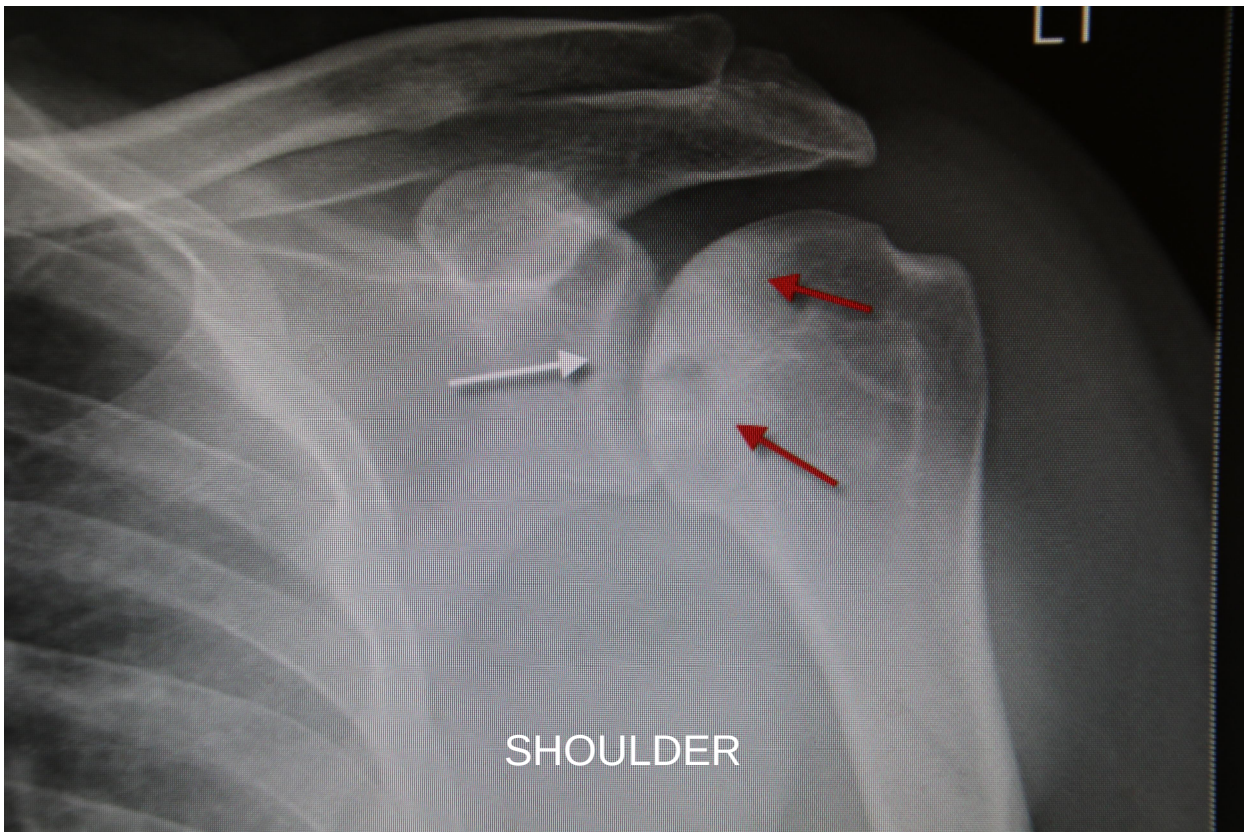

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Commentary Open Access

Costs of Future Medical Care in the United States: The Unique Contribution of the Physiatrist

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Commentary

In 2018 the United States (US) healthcare costs exceeded $3.65 trillion. This figure is expected to increase by more than 5% annually due, in large part, to increases in health care services and pharmaceutical. Both of these inverse costs are associated with incidence and prevalence of chronic diseases. The Centre for Medicare and Medicaid Services estimates that the US spent more than $10,739 per person on healthcare in 2017 [1]. This alarming figure is two to three times higher than what is spent in most developed countries including Sweden, France and the United Kingdom. Despite these astronomic costs, in comparison to other developed countries, the US has experienced steadily increasing morbidity, declining health outcomes and comparatively lower life expectancies [2-4]. In addition, disease processes often seen in rehabilitation practices, notably Musculoskeletal, neurologic and transport-related injuries, are associated with increased spending in keeping with the 5% annual average increase, with the second largest increase in annual spending due to low back and neck pain, conditions commonly involved in personal injury litigation [5].

When a patient sustains an injury resulting in a personal injury claim, it is critical to ensure that accurate and effective evidence and testimony is provided in court, in order to secure that claim and provide for the patient's optimal future needs and potential recovery. The standards for assessment and diagnostic formulation in medicolegal work must meet current consensus practice or Daubert standards [6,7]. In our recent peer journal, it was asserted that physiatrists are the most qualified physicians to render competent opinions as part of a Comprehensive Rehabilitation Evaluation (CRE) [8]. By definition, a CRE is a forensic medical report that uses knowledge, training, clinical practice experience, and peer reviewed literature to define impairment, disability, costs of future medical care and life expectancy [8].

In this article, we expand the conclusions, outline the methodology and elements of an effective CRE. We also address the unique contributions of physiatrists in estimating, and possibly curtailing, the escalating costs of healthcare in the US.

The heart of personal injury litigation rests with assessment of catastrophic and non-catastrophic disabling impairments, which physiatrists are most qualified to complete [9,10]. Physiatrists have specific education and training that uniquely qualifies them to provide thorough and accurate CREs [11]. Physiatrists must, out of necessity, have an extensive working knowledge of the CRE; which includes a Continuation of Care Plan (CCP). The accumulation of data needs to support the retail costs of the patient's future medical care and continuation of treatment.

According to Gonzales and Zotovas (185-186), the accepted methodology to define the cost for future medical care includes three stages:

(1) Collecting and reviewing medical records as well as interviewing and/or physically examining subjects. In this stage, the physiatrist considers evidence (including medical record data and diagnostic studies, plus the physician's own clinical examination findings) and the subsequent impact on the subject's current and future health function;

(2) Formulating life expectancy and diagnostic conclusions; developing opinions regarding and impairment, disability, comorbidities; and providing evidence-based recommendations for future medical needs. Examples of future care categories include physicians' services, diagnostic tests, medications, rehabilitation services, durable medical equipment and supplies, nursing and attendant care, environmental modifications, household services and acute care services; and

(3) Conducting extensive treating physician and vendor surveys to obtain retail cost data for future care recommendations, and using that data to perform cost calculations in order to draw quantitative conclusions. Utilizing sample data from sources that are geographically near to the subject's primary residence or location of care and the lowest procured estimates are most beneficial [11].

The costs associated with the patient's medical treatment procedures, support care and durable medical products should be unreduced retail costs. This is in keeping with a long-standing evidentiary rule known as the collateral source rule, which prevents an injured person's damages from being reduced by payments from their own medical insurance, workman's compensation, or other third-party sources. The collateral source rule further prohibits the admission of evidence that the plaintiff/patient has received compensation from some source other than the damages sought from the defendant in a personal injury case. While several states have altered or partially abrogated the rule by statute, it is still a widely-followed federal doctrine [12].

Additionally, collateral sources such as Medicare, Medicaid, marketplace insurance offered under the Affordable Care Act, and managed care insurance company plans often do not cover services or

reimburse at the rate whereby a physician's services, support care, and durable medical products can be obtained. The healthcare insurance system and government entitlement programs are subject to political influences and change related to the current political landscape. Thus, the only way to guarantee that a patient will have sufficient funding to obtain quality healthcare for optimized recovery is to assume that each patient will be required to obtain care at retail rates. Insurance coverage for certain treatment may or may not become available, but cannot be relied upon when forecasting the funds needed to obtain care.

Contacting individual physicians, support care, and durable medical providers directly and utilizing retail prices in the patient's home territory will greater guarantee the availability of funds to obtain support services and durable medical products. This is of paramount importance for a patient who has suffered a catastrophic or non-catastrophic injury, as medical care in the United States is more expensive than in any other developed country in the world, yet continues to rank extremely low in terms of access and service delivery [13]. In many instances, it is only through appropriate legal channels that healthcare, support services and durable medical products can be obtained. Creation of a reliable and valid CCP includes contacting as many treating physicians and vendors as possible to confirm procedures, protocols and pricing in the geographic location in which the patient resides or is going to reside for continued treatment.

As noted previously, the spirit and intent of the CCP is to decrease the patient's morbidity by decreasing his/her pain to the fullest extent practicable and to mitigate against increased pain as the patient progresses through the aging process. Chronic pain (to which patients usually become less tolerant over time), often leads too much greater disability [8]. The CCP addresses the three components of chronic pain, including the specific physical component, increased suffering over time, and the subsequent depression that frequently arises. A physiatrist's clinical experience provides the skills to craft a CCP which addresses all three components.

It should be noted that non-physiatrist treating physicians may be unfamiliar with the appropriate methodology to construct a CCP or to credibly defend it in court [6,10,11]. This can be devastating to the patient because the relevant information which affects the formulation of appropriate diagnostic and rehabilitation conclusions constitutes the proper foundation for future medical care and rehabilitation needs [11]. In contrast, physiatrists are taught during residency training a comprehensive approach to the assessment of medical and rehabilitation needs. Thus, physiatrists receive the best training to determine what medical conditions remain relevant to the patient's future care considerations [8,11].

According to Gunn (in Weed and Debra, 2010, 793-797), "It is the role of the physician to establish the existence of physical and mental impairment and it is inappropriate for a rehabilitation consultant to present opinion testimony as the existence of a medical condition or its likely progression." [14] The medical management of catastrophically and non-catastrophically injured patients must be the responsibility of the treating physician or disability evaluating physician. A non-physician life care planner is actually providing a disservice if he or she attempts to medically manage a patient's injury or disability, due to their lack of formal, structured medical education and real-world practice experience [10,11,14].

Physiatrists who treat patients and serve as expert witnesses possess extensive working knowledge of peer-reviewed published literature; they are able to apply accepted methodology to accurately complete the CRE. Further, they have extensive clinical experience in the chronic care of persons with a variety of disabilities, and are consequently able to accurately identify all of the patient's future needs [10]. Physiatrists already provide the services on a routine or frequent basis when taking care of their own patient population with equivalent diagnoses. As previously affirmed, a physiatrist's capacity to independently and credibly defend medical opinions, used as evidence in personal injury trials, is unsurpassed [11].

Physiatrists consider individual needs and the cost of providing services which have reasonable probability of restoring patient function, but must defer to a medical economist to provide sufficient scientific data to support a specific dollar loss [9]. After the physiatrist produces the CRE utilizing the appropriate methodology, it should then be presented to a qualified medical economist who is familiar with medical inflation and discount rates [8,9,15]. An economist has the education, experience and skills to translate those future medical care needs into present money value dollars, in order to determine the ultimate present value dollars needed to fund the costs requires by the patient. Failure to follow this prescribed methodology can lead to misleading testimony, resulting in underfunding requirements desperately needed by catastrophically and non-catastrophically injured patients, or worse, disqualification of the physiatrist as an expert by the court, for failing to satisfy the minimum qualifications identified in Daubert challenge for scientific expertise [7].

Conclusion

In summary, physiatrists are eminently qualified to identify and quantify a patient's rehabilitation needs following catastrophic and non-catastrophic injuries. It is also the natural domain of physiatry to complete a Comprehensive Rehabilitation Evaluation with a Continuation of Care Plan in support of the patient's rehabilitation needs, using appropriate methodologies under current consensus practice standards, and to credibly defend this evidence in a court of law. The most accepted methodology requires gathering and analysing objective medical data; formulating life expectancy and diagnostic conclusions and opinions — regarding impairment and disabilities; and presenting recommendations for future medical needs, with due consideration of the components of chronic pain. This is followed by directly contacting treating physicians, support care, and durable medical providers to research follow-up care and pharmaceutical costs and obtain geographically based, unreduced retail cost data for future' care recommendations, with quantitative conclusions supported by a qualified medical economist. These services are vital to patients in order to decrease their pain and maximize their function. With exploding healthcare costs and shifting political climates that may affect patient access to insurance and limit litigation remedies, it is incumbent upon physiatrists to create accurate and reliable CREs and testify on behalf of injured patients, thus fulfilling this role for which they are uniquely suited.

Disclosures

Dr. Lichtblau, Dr. Pettingill, Ms. Cardillo, Ms. Meli, and Mr. Warburton reported no disclosures.

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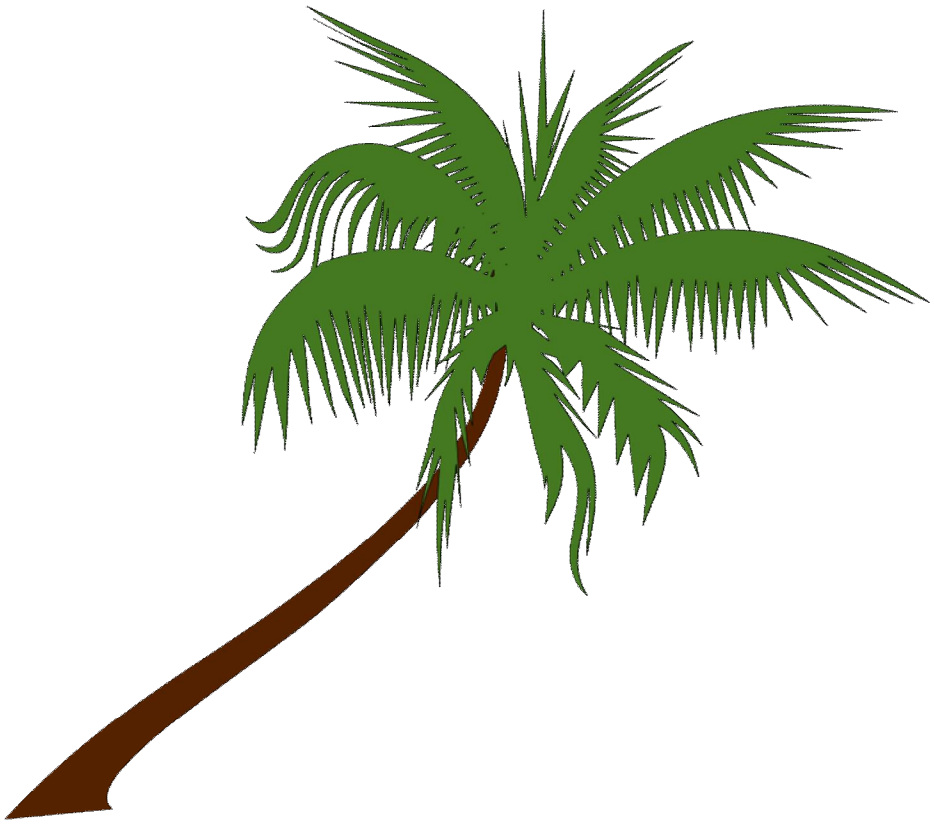

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UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE /
JACKSON MEMORIAL HOSPITAL PM&R RESIDENCY PROGRAM UPDATES

Greetings from the University of Miami Miller School of Medicine / Jackson Memorial Hospital PM&R Residency Program!

Residents Jorge Caceres, MD PGY4, Kazi Hassan, MD PGY4 and Rosa Rodriguez, MD PGY3 were honored to present on "Neuromodulation in Spinal Cord Injury" at this year's FSPMR annual meeting. It was an excellent opportunity to learn from so many Physiatrists throughout the state!

2019 FSPMR Conference (Left to Right): Lorry Davis, FSPMR Executive Director; Manoj Poudel, MD; Jorge Caceres, MD; Scott Klass, MD; Rosa Rodriguez, MD, MS; Craig Lichtblau, MD, FSPMR President; and Trisha Cardillo, MS4 at FAU.

We would like to welcome our new residents joining us in July:

Armando Alvarez, MD	Internship: University of Miami-JFK; Atlantis, FL
	Med School: University of Miami; Miami, FL
Michael Appeadu, MD	Internship: Kettering Medical Center; Dayton, OH
	Med School: Emory University; Atlanta, GA
Cristina Brea, MD	Internship: Jackson Memorial Hospital; Miami, FL
	Med School: Rutgers New Jersey; Newark, NJ
Minh (Quan) Le, MD	Internship: Florida Atlantic University; Boca Raton, FL
	Med School: Florida Atlantic University; Boca Raton, FL
Natalia Miranda, MD	Internship: Hospital Episcopal San Lucas; Ponce, PR
	Med School: Ponce Health Sciences University; PR
Richard Rosales, MD	Internship: Vanderbilt University; Indianapolis, IN
	Med School: Indiana University; Indianapolis, IN
Manoj Poudel, MD	PGY2: Kingsbrook Rehabilitation Institute; Brooklyn, NY
	Internship: Blake Medical Center; Bradenton, FL
	Med School: Tribhuvan University; Kathmandu, Nepal

UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE /
JACKSON MEMORIAL HOSPITAL PM&R RESIDENCY PROGRAM UPDATES

CONTINUED

We also would like to formally welcome Dr David Gater, MD, PhD, MS the new Chair for our Department of Physical Medicine and Rehabilitation. Dr Gater comes from Penn State Milton S. Hershey Medical Center and Penn State College of Medicine, where he has been the inaugural Rocco Ortenzio Chair of Physical Medicine and Rehabilitation since 2013. He earned an undergraduate degree in biology, a masterôs degree in exercise and sports science, PhD in Physiology and an MD at the University of Arizona, Tucson. He is board certified in Physical Medicine and Rehabilitation, Electrodiagnostic Medicine and Spinal Cord Injury Medicine.

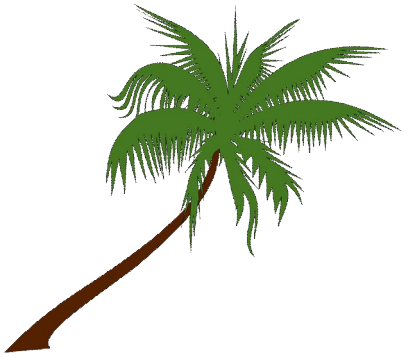
Additionally, this July, Martin Weaver, MD, our current Chief Resident, as well as Jesse Charnoff, MD, one of our 2019 graduates had their research published in the American Journal of Physical Medicine & Rehabilitation:

> Charnoff J, Naqvi U, Weaver M, Price C. Resident Education of Ultrasound Guided Procedures: A Homemade Practice Model Pilot Study. *Am J Phys Med Rehabil*. 2019; PMID 31268885.

Finally, our resident of the quarter award was presented to Jesse Charnoff, MD.

We are looking forward to an excellent academic year!

Rosa Rodriguez, MD, MS PGY3 FSPMR Resident Liaison	Andrew Sherman, MD, MS FSPMR Treasurer Residency Program Director University of Miami Miller School of Medicine



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USF PM&R welcomes Dr. Daniel Leary as the new Resident Liaison to FSPMR.

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Larkin Community Hospital PM&R Residency Update

Greetings from the Larkin Community Hospital PM&R Residency Program! We are thrilled to have kicked off this academic year with receiving our **OFFICIAL ACGME ACCREDITATION** and want to thank all of those involved who continue to make this program strong and successful!

We applaud our graduating seniors who have acted as our colleagues, mentors, and friends and wish them all the best in their various endeavors. They will be missed!

Graduated Seniors

We congratulate our new chief residents, Karen Rosen, DO, PGY4 and Ian Miller, DO PGY4 and welcome our new PGY2ôs into our Larkin PM&R family.

LCH PM&R residents with Dr. Braddom during the FSPMR/FSIPP Conference (2019)

Our residents, Vidur Ghantiwala, DO PGY2 and Trevor Persaud, DO PGY2 were honored to present ñA *Facet Joint Injection: The Good, The Bad, & The Ugly"* at the annual FSPMR/FSIPP conference held in Hollywood, FL this past July. This was a great learning experience for all those who had the opportunity to attend.

Congratulations to Andrew Hanna, DO PGY3 who has been honored to have multiple recent publications entitled: Lumbar Degenerative Disc Disease, Spondylolysis, Spinal Stenosis, and Cervical Myelopathy. All publications can be found through the National Center for Biotechnology Information (NCBI).

Larkin Community Hospital PM&R Residency Update

CONTINUED

Furthermore, we want to congratulate our resident Alan Nguyen, DO PGY2 for being selected to act as an advisory board member for the Society for Neurosports.

We are excited to catch up with our colleagues from various PM&R residency programs at the American Academy of Physical Medicine & Rehabilitation Annual Assembly in San Antonio, TX in November and wish you all the start to a wonderful academic year!

Kathryn Nelson, DO PGY3

Larkin Community Hospital

Department of PM&R

FSPMR Regional Liaison

Physiatrist's Voice
NEWSLETTER September 2019

A Tribute to Justine Vaughen MD

By Oscar Depaz MD

On the occasion of the FSPMR Annual Meeting, July 20, 2019, The Diplomat Beach Resort, Hollywood, Florida, when Dr Vaughen was presented with a True Florida PM&R Pioneer Award.

Eight years ago, I had the honor of presenting Dr Justine Vaughen with a Lifetime Achievement Award from the Florida Society of Physical Medicine and Rehabilitation. Today again I have the privilege of standing in front of my friends, my peers, and presenting Justine with a True Florida PM&R Pioneer Award. To tell you the truth, this should be the Justine Vaughen Award.

Dr Justine Vaughen is presented with a True Florida PM&R Pioneer Award by Dr Oscar Depaz.

With no disrespect to Dr Rodolfo Eichberg or Dr Anthony Dorto who just received similar awards, when Justine was trailblazing through Florida, you two had not started yet. When I was younger, Justine was my mentor, and now it is my turn to mentor. When I had one of my younger associates meet Justine for the first time, my associate called me afterwards and said, "I am star struck!" And I responded, "As you should be."

Allow me to give you some perspective. When Dr Vaughen received her MD diploma, less than 10% of the graduates were women. Now it is almost 50/50.

At the time Justine and Dick (her late husband who was also my mentor) moved to Gainesville, there were no physiatrists north of Orlando. She not only had to educate the whole medical community in north central Florida about the benefits and purposes of our specialty, but she had to do so while being a female physician in a male-dominated profession. Justine did this as a true trailblazer, never asking for special treatment, hand-me-downs, or favors. And she also never asked for permission.

One of my biggest lessons from Justine was when some big shots from Washington DC came to help design a new rehab wing at the Veterans Administration Medical Center in Gainesville. One of the young, confident administrators looked at Justine before the meeting began and asked, "So how should I address you?" Before we went any further she answered, "You can call me Dr Vaughen or Mam." After she took complete control of the meeting, stating exactly where she wanted the walls, the rooms, and the bathrooms to be placed, she looked directly into the eyes of the young administrator and asked, "Do you have any questions?" He responded, "No, Mam." Then Justine turned to me and said, "Let's go, Oscar."

When asked by an interviewer how she would describe herself, she said, "I am a physician." We are all doctors in medicine. We earn our diplomas by studying and passing grades. But not all MDs/DOs are physicians. To be a physician involves a level of commitment to our patients, love, respect, empathy, and connection which defines who Justine is. And those qualities, those gifts transcend her medical practice and filter into everything else she does or touches.

As a teacher, she became a mother. As a mother, she became a teacher. She is a leader, a complete role model.

Physiatrist's Voice
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A Tribute to Justine Vaughen MD

By Oscar Depaz MD

continued

As I observed her life and her career evolve, I saw the love and devotion she put into every step.

When the post-polio diagnosis became a major area of concern for all of those who had suffered this terrible disease years earlier, Justine was in front of this wave and developed a post-polio clinic. She made it a point to educate the public about this condition.

When it became evident that there was a need in our community for the daytime care of disabled adults with varied diagnoses, allowing them to remain in their homes with their families, Justine spearheaded the creation of Altrusa House in Gainesville which has now served many through the years. She served as President of the Altrusa House Board from 1998 – 2007, and she has been a Board Member from 1991 to the present.

While opening the future for all of us in the specialty of physical medicine and rehabilitation, Justine continued preaching the virtue of what we can do and do for our patients. She was a wonderful wife to Dr Fry for 58 years, a mother of two wonderful daughters, Martha and Mindy. And now she is a grandmother to their five children.

So it is with great honor and gratitude that I present this award to my mentor and professional mother, Dr Justine Vaughen.

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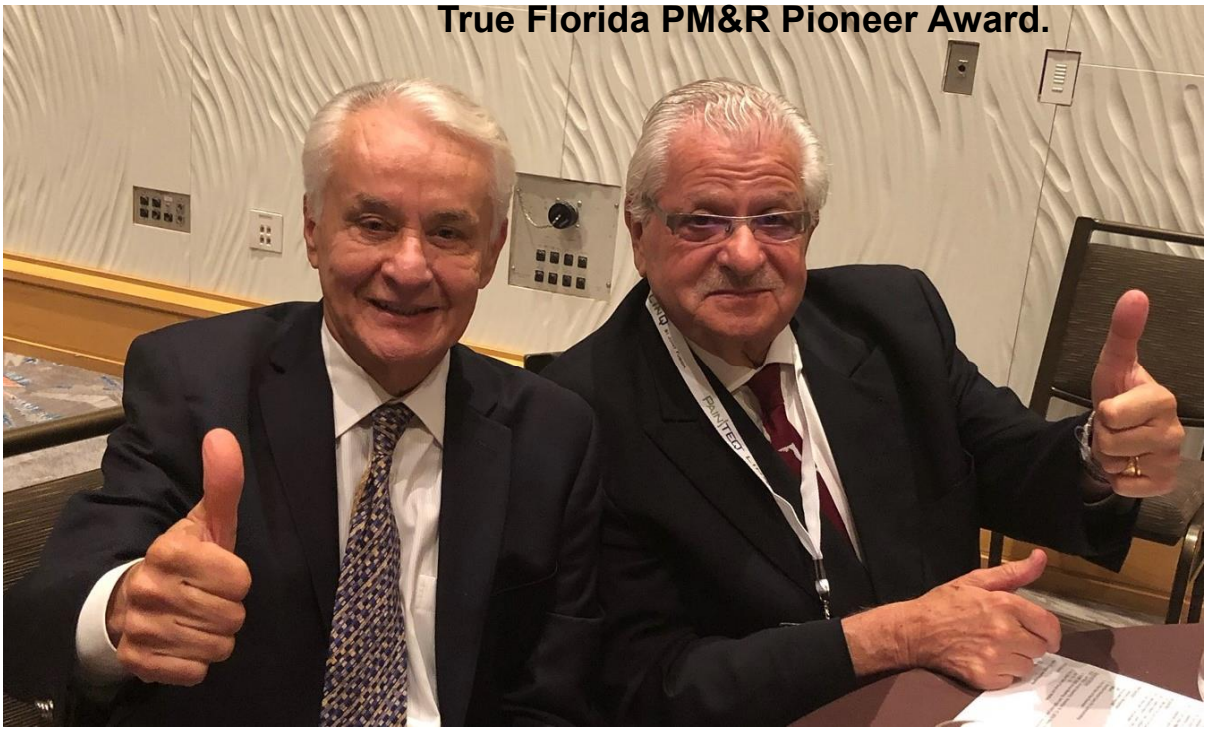
Drs Rodolfo Eichberg and Jairo Parada celebrate after Dr Parada presented Dr Eichberg with a True Florida PM&R Pioneer Award.



Physiatrist's Voice
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Dr Matthew Imfeld and
Dr Justine Vaughen

Some of the gang from Annual Meeting 2019:

Seated L to R: Jean Dorto, Natasha Jadinovskiah, Drs Craig Lichtblau and Jay Mendelsohn; Standing L to R: Drs Rigoberto Puente, Oscar Depaz, Justine Vaughen, Michael Creamer, Matthew Imfeld, Tony Dorto, Yvette Eichberg, Dr Rodolfo Eichberg, Executive Director Lorry Davis, Dr Colleen Zittel, and Jane Imfeld.

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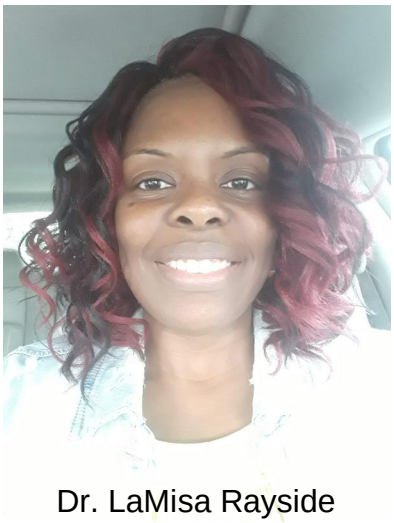
Allied Health Update



Dr. LaMisa Rayside

FSPMR Member Dr. LaMisa Rayside is our regular contributor to the Allied Health Update. She is not only a Board Certified Acute Care Nurse Practitioner, she is now a Doctor of Nursing Practice. Congratulations, Dr Rayside, well done!

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Dr Anthony Dorto is presented a True Florida PM&R Pioneer Award by Dr Craig Lichtblau.

Dr Tony and Mrs Jean Dorto

Job Opportunities

Job Opportunities are free and are posted as a service to FSPMR members

Send your job ads to FSPMR Executive Director, lorry4@earthlink.net.

Thank you.