THE UNIVERSITY OF ARIZONA
College of Medicine
Phoenix

SPECIALTY REPORT

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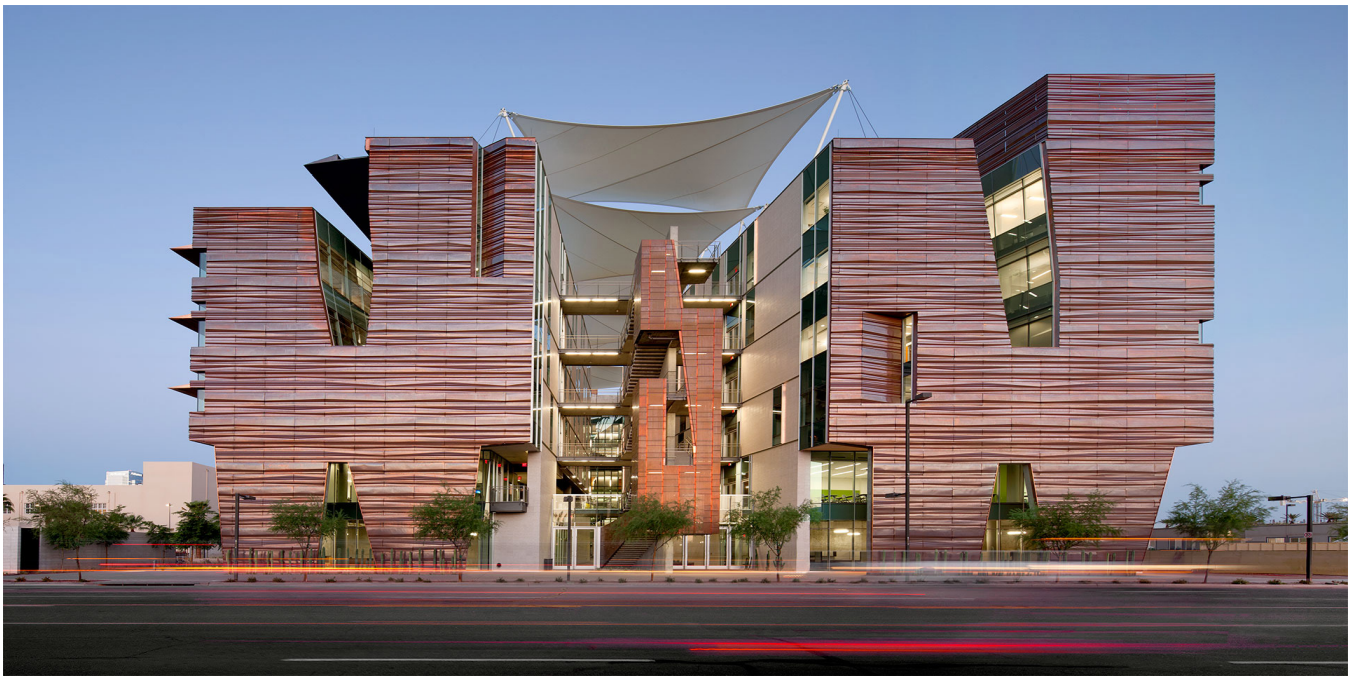

Program Director of Honor Health PM&R Residency Program & Staff Physiatrist at Phoenix VA Medical Center: Nandita Keole, MD

Dr. Keole is a physiatrist (Physical Medicine & Rehabilitation) and is the Program Director of the newly accredited Honor Health PM&R residency program. Dr. Keole completed her medical training at Seth G.S. Medical College in India and residency at the Rehabilitation Institution of Michigan/Wayne State University. She completed a fellowship in spine care and pain management at the University of Florida. Dr. Keole is board certified in electrodiagnostic medicine. She has been in practice since 2006 and moved to the Valley in 2012. Since 2014 she has been a staff physiatrist at the Phoenix VA Medical Center and is also a capstones preceptor for our medical students.

Can you tell me about your path to medicine and ultimately choosing PM&R?

I was always interested in helping people and getting them better. My pediatrician was a big role model for me and fueled my interest in medicine. My medical education was in India and I was not exposed to the field of physical medicine and rehabilitation during medical school. I was introduced to that field by my husband's relative who is a physiatrist. Seeing the breadth of that field is what drew me to the specialty. Helping patients get back on their feet and improve their quality of life was appealing to me.

The Honor Health PM&R residency program is the first of its kind in the Valley. What are your goals and vision for this program? What can medical professionals and students look forward to from it?

Our mission as we developed this program is to fulfill the needs of this community. We are striving to educate the residents in all aspects of the field, so they graduate as competent physiatrists. The residency will include inpatient rotations at the Honor Health Rehabilitation Hospital as well as outpatient rotations at the Carl T. Hayden VA Medical Center and Phoenix Children's Hospital. The residents will have exposure to procedures, including ultrasound guided and fluoroscopy guided procedures.

What excites you most about PM&R and the patient population you have the opportunity to work with?

Seeing patients who improve their functional independence and get back to doing what they love is what I love most about the field. In PM&R we do not own any organ system - we treat the whole person.

Can you describe your duties as Program Director for the PM&R residency program? How do you balance your duties there with your other commitments?

As a Program Director, I aim to be a role model of professionalism. With the help of the Designated Institutional Official (DIO) and my faculty I have developed a program that is consistent with the needs of the community and mission of Honor Health. In my role as a Program Director, I oversee

residency education (didactic content as well as rotations), faculty development and the well-being of both the residents and my faculty.

How has the field changed throughout your career? What do you think is in store for the future of PM&R?

PM&R has become more diverse- the involvement of physiatrists in outpatient musculoskeletal care (pain management and sports medicine) has increased. More post-acute care is transitioning to skilled nursing facilities. Cancer rehabilitation has developed as a new area of practice.

What advice do you have for students who are interested in PM&R?

Get some experience by scheduling rotations in the field so you can solidify your interest. Consider research. PM&R has a wide scope so make sure the rotation gives exposure to all facets of the field.

What are some of your hobbies when you have time away from your practice?

My favorite way to spend spare time is running. Other hobbies include reading and hiking.

—Hong Chen MS1

Educational Pathway for PM&R Residency

Most PM&R residencies are **3-year** programs and offer positions starting at the PGY2 level, which means that the medical student must seek a transitional/preliminary year in addition to an advanced residency spot. Some residencies offer a 4-year program, which integrates the first year of basic clinical training into their curriculum.

PATH 1: *Advanced* – PGY-2-4
Years 2-4 of PM&R at the advanced match site, and Year 1 done either as a preliminary or transitional year. The majority of programs offer this path.

PATH 2: *Categorical* – PGY-1-4
Programs begin in the PGY-1 year and provide the full training required for specialty board certification.

Preliminary Year – PGY-1
Specialty one-year programs in the PGY-1 year that provide prerequisite training for an advanced program such as PM&R. This can be Preliminary Internal Medicine or Surgery.

Transitional Year – PGY-1
A flexible internship in which an intern in the PGY-1 year is exposed to many fields. These individuals rotate through different hospital departments every few months. Historically, these programs are more competitive than preliminary programs to get into.

PGY stands for postgraduate year (after medical school).

Staff Physiatrist at Banner University Medical Center Phoenix & Faculty at University of Arizona College of Medicine-Phoenix: Paul Geimer, DO

Dr. Paul Geimer recently retired after over 40 years of practicing as a physiatrist. His undergraduate degree was from The Johns Hopkins University, which was followed by medical education at Midwestern University in Chicago. Dr. Geimer began his residency in physical medicine and rehabilitation at Midwestern and completed it at Good Samaritan Hospital, now Banner University Medical Center-Phoenix. After residency, he worked in private practice for 36 years, before returning to BUMC-Phoenix for his final 3 years of practice. He continues to serve as faculty at the University of Arizona College of Medicine-Phoenix.

How did you get into PM&R?

I went to medical school at what is now Midwestern University in Chicago, and one of the rotations that we were offered was at the Rehab Institute of Chicago. A doctor there became my mentor. He introduced the service to me saying, "a physiatrist is basically a specialist for the disabled", and that idea appealed to me. He also said that unlike most of medicine where you are directing people to do things, in rehab people really have to do something themselves. I was in the midst of internal medicine at that point. You would walk in and see a patient, and start filling out a list of all these tests. The patient did not know what you were doing and half the time you did not know what you were doing. I liked the idea of prescribing something the patient had to do. It is a completely different orientation. Rehab really doesn't work if the patients don't participate.

I also liked the collaborative aspect of the field. The therapists we work with offer a very functional perspective which can often supplement and transform a physician's more textbook approach. The field is very team oriented which was a relatively unusual approach in medicine in the 1970's, although is more common now. I also liked the psychosocial aspects of rehab. What you may have already realized is that as medicine has evolved, more and more of what we do is kind of prescribed in advance: a person has this, this is what we do. Every interaction we have with patients is based upon a psychological relationship of some sort and as you go along in medicine, you become more and more appreciative of this. A doctor's success or failure in treating a patient is in large part due to the quality of the interaction with them. Two different physicians with completely different approaches and personalities, can both get through to and connect with patients, but each must be sensitive to the quality of the interactions.

Nonverbal communication from the patient may often lead a physician to more successful treatment. You have to know if and how that person is absorbing what you are saying, and to what extent. With our stroke patients, you are dealing with people who often are not absorbing information very well. When I retired recently, a couple of people came up to me and said that I saved their lives, or their loved one's life. To be honest, I have never seen my activities as being life saving in any way, but I must have communicated something to them that assisted them in their recovery.

What does being a physiatrist encompass?

We really work in three areas -neurology, orthopedics, and internal medicine- and focus on how the three of those interact in physical recovery. One thing I would emphasize to my former orthopedic residents was the importance of a neurologic exam. Neurologic problems are common, and you have to know something about neurologic diseases in any field of medicine. The physiatrist has to know some orthopedics, especially as it relates to musculoskeletal function. And then, of course internal medicine which all doctors must know. In the hospital, you have to know a little bit about everything; how the neurosurgeon, the neurologist and orthopedist view a problem; as well as other specialties who treat our patients.

"Two different physicians with completely different approaches, can both get through to and connect with patients, but each must be sensitive to the quality of the interactions. It's this awareness of how you're coming across to a patient that is critical."

When I began my training at Good Samaritan Hospital, it was one of seven designated spinal cord injury centers in the country. We would have an entire floor full of 25 spinal cord injury patients. Thanks to seat belts and airbags we see fewer of these patients now although we continue to treat this category of patient. The second area that evolved over time is head injury, because as our treatment of it has improved, we have saved many more people. The issue then becomes, what happens to those patients? Stroke has always been a big part of a rehab medicine practice. So those three areas-spinal cord injury, stroke, and head injury- were the initial foundation of the practice of rehab medicine. The other big category we picked up was amputation, making four main categories of diseases in which the physiatrist is involved in the hospital today.

A 5th area, sports related musculoskeletal injuries also involves our doctors. Physiatrists, at least by training, have a better understanding of the interactions between muscles, ligaments, nerves.

What challenges do you see in the future of physiatry or medicine in general?

We need to approach pain differently. Pain is a symptom, not a disease. And often it has no simple cause, which is something that people in my field should be more sensitive to. A big part of our training is the use of physical modalities for the treatment of pain and discomfort. The promotion of narcotics and opioids became more prevalent in the late 80s/early 90s, and it was based upon a sound belief, that we do not want to undertreat pain. Humans will always have the desire to feel no pain or less pain, and our ability to treat pain with narcotics is one of the most important tools that physicians have. Then there is the issue of treating people who come into the hospital who are already addicted and have a new problem, trauma or illness. We have our devices, we have pain pumps, but if they are in rehab, three weeks later complaining of 10/10 pain, what do we do with that? It is a huge dilemma and I don't have a good answer. You are going to see a lot of that, because pain is one of the cardinal reasons that people come to the hospital. I hope the next generation of physicians will be much better trained in how to handle these issues.

—Jessica Callan, MS1

Neurophysiatrist and Back Pain Specialist at Barrow Neurological Institute: Scott Kreiner, MD

Dr. Kreiner graduated from the University of Arizona with a Bachelor of Science in Mechanical Engineering. He attended medical school at the University of Arizona in Tucson, where he completed a Preliminary Medicine Internship before completing a Physical Medicine and Rehabilitation Residency at the University of Texas at Southwestern in Dallas, Texas. He is the Director of Interventional Spine and Sports Medicine and Director of the Sports and Interventional Spine Fellowship at Barrow Brain and Spine.

What drew you to PM&R?

My background. I was a mechanical engineering major, so I was interested in musculoskeletal medicine. My advisor at the University of Arizona Tucson's Medical School suggested that I check it out. I met a PM&R physician in Tucson when I was down there, and they talked to me about the field and what it was. That piqued my interest and it went from there.

My residency was at Parkland Hospital, which is the largest county hospital in the country, so it was a very busy place to work; which, when you're a resident, is ideal. You get to see just about everything. It was a great learning experience. For just about any specialty, the more variety you see, the better it is. That was definitely a plus of being there.

What is your favorite part about your practice? What about your role in academic medicine?

My practice is all outpatient musculoskeletal medicine; probably 80% of the patients I see are patients with back or leg pain. The best part about it is making people better and having them come in to say, "Thank you." I work with a fair number of athletes, so being able to get them back on the field and performing is also rewarding. I like teaching and training. I've had 13 fellows. Most of my teaching is post-graduate/post-residency training. Recently, I've been invited to teach advanced courses and give talks on spine procedures around the world, which is a lot of fun. The international travel and speaking is new to me. In the last year and half I've been privileged to travel to Singapore, China, Dubai, Oman, Saudi Arabia and Columbia, educating and training spine physicians, and it's been a lot of fun. Right now, that's very exciting.

Can you talk about your role and duties as the Director of the Interventional Spine and Sports Medicine at Barrow?

Previously, I was a partner and ran a private practice called Ahwatukee Sports and Spine, which was here in the Valley for 18 years. It was me, a partner, a couple associates, a couple PAs, and some physical therapists. Last year, our group merged with Barrow Brain and Spine, which is one of the largest neurosurgical groups in the country. I took over as the Director of the non-surgical spine practice for the group. Currently, we have 7 non-surgical providers and we're expanding. My role is growing that line of healthcare and overseeing the standards and working with surgeons and non-surgeons to integrate spine care through the group.

What are you looking forward to from the next generation of physicians?

The eagerness the young mind brings is great. One of the things we start to see as we've been practicing for a while is that people can get stuck in a rut and curiosity starts to wane. You develop a monotony of doing things over and over again. Newer physicians look at things from a new angle and are able to figure out new ways of doing things that we haven't done before. I think that ingenuity brings a lot to any field and in particular, the fields of sports medicine and spine care.

What advice or tips do you have for students?

Stay involved and active in healthcare. Do your best not to get stuck in the role of taking care of your patients and coming home. Try to avoid the monotony I talked about previously. It's helpful to keep things new and keep whatever field you go into interesting and exciting. That would be my advice to everybody: stay involved with healthcare.

You're quite involved in the North American Spine Society and the Spine Intervention Society. Can you talk a little bit about your involvement?

When I was finishing my residency, there was not a lot of training in interventional procedures; we had to be self-trained, or trained by mentors, or through courses. Now, everyone with an interest in interventional spine procedures needs to go through fellowship training. Back 20 years ago, fellowships were nonexistent. I ended up being trained through courses offered through the Spine Intervention Society, and another organization, PASSOR, the Physiatric Association of Sports, Spine, and Occupational Rehabilitation. I learned a lot of my interventional skills through those organizations, and the rest from mentors in the field. I felt like these associations offered a lot to the medical community, so I became involved as I began practicing. I decided that was a good way to give back and to work with colleagues around the country who are leaders in the field. Currently, in NASS and SIS I'm working with spine care leaders from universities and practices all over the world, many of whom are publishing research. It's a great way to stay on top of everything in the field and stay at the cutting edge of what the practice has to offer. In spine care, as with other fields of medicine, I think we're starting to see more of a bridge between the surgical and non-surgical fields. The vast majority of stuff I do is with a needle, though we're starting to see some newer procedures that are blurring the lines between surgery and non-surgery, similar to the fields of cardiology and interventional neurology and vascular interventions. We're seeing that a little more in spine. We're seeing some newer techniques as technology advances. We're doing things through smaller and smaller openings, through a needle or portal to access and treat injured areas.

"It's a specialty most people don't get any exposure to at all during medical school. If they have an interest in musculoskeletal medicine, orthopedics, or neurology, then they should investigate PM&R."

Anything else you'd like to share?

I would encourage people to check out PM&R. It's a specialty most people don't get any exposure to at all during medical school. If they have an interest in musculoskeletal medicine, orthopedics, or neurology, then they should investigate PM&R. Check it out and see what it's about.

—Casey Sedillo, MS1

Alumnus: Brent Page, MD

Dr. Brent Page graduated from the University of Arizona College of Medicine-Phoenix in 2017. He completed his transitional year residency at Intermountain Healthcare in Salt Lake City, Utah prior to starting his PM&R residency this year at the University of Texas- Southwestern in Dallas, Texas. Prior to entering medical school, he worked as a physical therapy assistant which helped pique his interest in pursuing PM&R.

What drew you to PM&R?

I was initially drawn to PM&R because I am interested in musculoskeletal conditions. I started by considering orthopedics, sports medicine, and for a more primary care track- family medicine and internal medicine. I also had heard about PM&R but did not know much about it. The more I read, the more I was intrigued, because not only can physiatrists focus on musculoskeletal conditions but also PM&R is such a broad field that you can make it whatever you want. There are physiatrists who do EMGs, nerve conjunction studies, and focus on the neuromuscular junction level and there are those that work with spinal cord injuries or traumatic brain injuries and still others that deal with sports injuries and athletes. It is such a broad field in terms of types of patients and different practice environments.

What advice would you give an MS1 or MS2 who is interested in going into PM&R?

I would say that it is important to do a lot of your own research and reading about what the field is, as we do not get a lot of exposure to it while in medical school. I think it is important to do your own investigative work to see more about how broad the field of PM&R can be. Within the Phoenix community, there are tons of great PM&R doctors who would love to serve as mentors. Once you know a little about what the field entails, reaching out to these doctors could help you get a better feel for what PM&R is and give you more of a chance to learn about it. The main thing is to get some experience in PM&R. As there was not a formal program in Phoenix when I applied, it was important to me to look into away rotations early. Honor Health has now opened a PM&R residency in Phoenix this year but there weren't many opportunities to get these experiences in Arizona when I was going through school. If you are interested in PM&R, you will need to be proactive in searching out opportunities to gain experience in PM&R.

What did you look for in a residency program?

It was important to me to go to a residency program that offered exposure to a wide variety of clinical environments. I think that seeing different environments sets you up to better understand what environment you may want to practice in long term. My program allows me to rotate at a county hospital, seeing disadvantaged and underserved patients, and at private hospitals, a children's hospital, and a VA hospital. I think having access to all of these environments, and completely different patient populations, is really important as it helps you to understand what patient population appeals to you most. Some programs only place students in a single privately funded rehab hospital for their whole residency and that just gives you a small snapshot of the patients out there. I was

looking for a program that would give good exposure to different situations as it helps give you a better understanding of yourself and environment you are looking for.

What does a PM&R residency look like and how has your experience been so far?

In PM&R, you do an initial entry year and then start the specialty in your second year. I am in my first true year of PM&R now after an intern year. In the first year, you can do internal medicine or surgery, or do a transitional year like me. A transitional year is a combination of everything with rotations in internal medicine, surgery, and in the ER. It is like the 3rd year of medical school over again. During my transitional year, I learned to take care of all patients, including those post-surgery and with complex medical problems. Since PM&R is so broad, it makes it important to have a strong intern year as it makes you competent in both medical and surgical management of patients. In my first year in PM&R I have spent most of my time in the inpatient setting, learning to take care of patients with spinal cord injuries and traumatic brain injuries, along with stroke patients, organ transplants patients, orthopedic surgery patients, and complex medical patients. I enjoy the variety and taking care of all types of patients. I think my transitional year allowed me to have a strong start for this first year of PM&R.

What have you learned now about PM&R that you didn't know before?

What surprised me most about PM&R was being able to take care of stroke and traumatic brain injury patients and getting to see how much they improve over the course of several weeks. I think PM&R physicians get to see that more than anyone else. While the neurology service may see these patients acutely, they then discharge them home or to an inpatient care unit. They do not get to see their progress over days to weeks. In PM&R, we get to see people recover. It is amazing to see someone right after a TBI who is still having amnesia and who cannot remember how to tie their shoes later be able to shake your hand. It is amazing to be able to watch other patients in rehab go home with their families. I think that is meaningful for PM&R doctors as you get to see all parts of recovery.

" If you don't like a shadowing experience, try it again. If you do like a shadowing experience, still try it again. It will help you get a better feel for what a specialty really is, what the training is like, and what the specialty actually involves."

What qualities do you think make a good physiatrist?

I think to be a physiatrist you need to have a positive outlook. Many of the patients are chronically ill and have been this way a long time. It is important to bring optimism and hope to patients and help keep them oriented on the goal. You have to have patience as a lot of these patients have the potential for extraordinary recovery but this takes place over longer periods of time. You need to be able to see down the road and help engage the patient that there is hope and emphasize what they have to look forward to through their hard work.

Any words of advice?

If someone is interested in PM&R or any other specialty, I think it is important to get multiple experiences shadowing. I remember when I was in medical school, students in my year or in the year below who would say things like "I was interested in PM&R but then I shadowed a doctor and all they did was EMGs all day. Now I don't want to

go into PM&R." I think it is important to remember how broad these specialties can be. Physiatrists can do EMGs all day or run a rehab unit or take care of patients with organ transplants. If you are to shadow someone and you do not like it, do not let it rule out a specialty. It is also important to remember that shadowing a single person will not show you what a specialty will look like. PM&R training will encompass multiple aspects. You will not just be doing musculoskeletal medicine all day or treating athletes in a clinic. You will be learning to take care of patients in a variety of different situations and manage chronic illnesses.

—C. Maryssa Spires, MS1

Alumnus: Irvin Quezon, MD, PT

Dr. Irvin Quezon was born and raised in the Philippines, where he graduated with a BS in Physical Therapy from the University of Santo Tomas College of Rehabilitation Sciences. He moved to the US and practiced as a Physical Therapist in San Diego, California for a number of years before pursuing medicine to follow in his late father's footsteps. He earned his MD from The University of Arizona College of Medicine-Phoenix in 2018. He is currently an intern in General Surgery at Banner University Medical Center and is slated to begin his PGY-2 year at Baylor College of Medicine Physical Medicine & Rehabilitation Residency Program in Houston, Texas. Dr. Quezon is interested in Neurorehabilitation, Stroke, TBI, and Spasticity. He is an amateur chef and an avid collector of recipes.

What drew you to PM&R as a medical student?

My interest in PM&R pre-dates my life as a medical student. Prior to going into medical school, I was a staff Physical Therapist at a long-term acute care hospital in California for over 8 years. I was trained as a Physical Therapist at the University of Santo Tomas in the Philippines with plans on pursuing a medical career there. Unfortunately, my father passed away and with little money I decided to immigrate to the US to start practicing as a PT in San Diego to help support my mother and sisters. Once my family was together again in the US and financially stable, I was able to pursue medicine again and was lucky enough to come to the UA College of Medicine-Phoenix.

The reason I chose rehabilitation medicine may seem evident given my prior career, but the reason why I love it is a little more than that. Physiatry is a wonderful combination of non-operative musculoskeletal and orthopedic medicine, functional neurology, exercise physiology, kinesiology and practical applications in the form of physical modalities. There really isn't any other specialty like it: instead of focusing on a medical "cure," the goals of the physiatrist are to maximize patients' independence in activities of daily living and improve the quality of their lives. Rehabilitation medicine aims to enhance and restore functional ability and quality of life to patients with physical impairments or disabilities affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. Physiatrists are experts in designing comprehensive,

patient-centered treatment plans, and are integral members of the care team, which includes physical therapists, occupational therapists, speech and language pathologists, rehab nurses, pharmacists, social workers and case managers.

Rehabilitation medicine gets to the core of what I want in becoming a physician. Leadership, working as a team, collaborating with not just colleagues, but the patients themselves and ultimately helping fix a person, not just anatomically or physiologically by repairing all the moving parts, but in the way that matters the most to many people – Functionally: being able to do the things they want to do again, being able to go to the places they want to go, being able to be themselves again after a debilitating injury.

What advice do you have for medical students who may (or may not) be interested in PM&R?

"Rehabilitation medicine gets to the core of what I want in becoming a physician. Leadership, working as a team, collaborating with not just colleagues, but the patients themselves…"

My advice is, first and foremost, familiarize yourself with the specialty, learn what it's all about, its history and what sets it apart and what it's like practicing as a physiatrist. Get involved in this wonderful community of physicians who are involved in rehabilitation medicine by reaching out to mentors. Join one of the professional organizations; the AAPM&R (American Academy of Physical Medicine and Rehabilitation) and the AAP (Association of Academic Physiatrists) are great resources to have for establishing contacts and getting involved in research and internship opportunities, and they have great conferences that you can attend to present posters and meet new friends and future colleagues.

Don't be afraid to explore, especially in your 3rd and 4th year. I was interested in surgery at one point, and I hadn't been in a rehabilitation setting since I stopped working to go to medical school. There weren't that many available rotations for PM&R locally, but after a year or so of trying, I finally got to do a PM&R rotation. And I loved every minute of it. It took me 3 months to even start to consider having a dalliance with surgery, but it only took a week to fall in love with physiatry again.

It's not one of the more well-known specialties in medicine and there were not a lot of opportunities available for a medical student interested in Physiatry in Arizona, where there are limited PM&R programs. So, I created opportunities for myself and any of my classmates who might have an interest in rehabilitation medicine. With the help of my classmates and UA faculty and administration, we established the PM&R specialty interest group, making contacts with physiatrists from around the valley, facilitating events and workshops on campus to educate students regarding PM&R, helping foster interdisciplinary familiarity and cooperation between MD and PT & OT students.

What misconceptions do people have about PM&R?

When students, residents and physicians asked me what I wanted to specialize in and I said Physiatry, I usually got the same response: "Wow! Nice. I've heard good things about that…" followed by a puzzled look that presages their next query, "So… what do you do in PM&R?" It's a relatively little known specialty, which is ironic because it's essential to one of the facets of healthcare that affects so many patients in very significant

ways – the road to recovery and returning to functional independence. Every time I'm faced with that question, I try my best to educate and inform people about my chosen field and the whole array of specialists in the rehabilitation team that add so much value to patient care during the acute phase, the recovery phase and beyond.

I've heard people jokingly refer to it as "Plenty of Money & Relaxation." It of course, is not (sadly). It takes a lot of work and a significant amount of resilience to be in rehabilitation, but it is extremely gratifying to see your patients improve under your care. Becoming and being a physiatrist is no small task. In stroke rehab, you're not just dealing with the neurovascular system, you're dealing with all the sequelae that come as a consequence of it as well. It requires you to be an expert in musculoskeletal, neurology, and neuropharmacology in the setting of life-altering disease processes that affect multiple systems and aspects of your patient's life.

"It takes a lot of work and a significant amount of resilience to be in rehabilitation but it is extremely gratifying to see your patients improve under your care."

It used to be that people thought that PM&R was one of the easier residencies to match into. That may have been true in the past, with PM&R having relatively fewer programs and a small, but very active community of physiatrists, but it is becoming more and more competitive as more medical students are getting familiar with the specialty and the great breadth of opportunities that it offers in terms of really molding your practice into what you want it to be. From inpatient acute neurorehabilitation, to procedure based pain medicine, to outpatient sports medicine, to academic rehabilitation research, you really have a lot of opportunities to pursue what you have a passion for and it's becoming a more and more attractive specialty to a lot of physicians-to-be.

How do you find UA College of Medicine-Phoenix prepared you well for residency and beyond?

I feel that the school prepared me well and offered me great opportunities to be able to prepare myself for residency. Having NAU-PT and OT schools on the same campus gave me a chance to collaborate with the students and faculty on research projects. The faculty and mentors were all very encouraging and eager to provide advice, resources and contacts in PM&R in Phoenix and beyond and helped guide me towards successfully matching into my chosen programs.

Anything else you would like to impart?

My father was a small town doctor in the Philippines where I grew up and the best advice he ever gave to me was that, "Medicine is not easy, it takes hard work and a lot of sacrifice. Make sure you do it because you love it and make sure to do your best. In the end, when you see your patients get better because of what you did, it will all be worth it…"

—Conner Clay, MS1

Physical Medicine & Rehabilitation Interest Group at UACOM-P

Leadership Co-Chairs

Chair:
Melanie Schroeder, MS1
melmschr@email.arizona.edu

Faculty Advisor:
Dr. Denise Campagnolo

Mission Statement

The Physical Medicine & Rehabilitation Interest Group is dedicated to providing education and exposure to the students of UA-COM Phoenix regarding the field of Physical Medicine & Rehabilitation. Our aim is to provide students with the information, opportunities and tools necessary to explore PM&R as a career in medicine by facilitating seminars, activities, talks and practical clinics on the various facets of Physical Medicine. Our goal is to inform, inspire and enhance medical student interest in PM&R and allow future doctors the chance to be exposed to this rapidly evolving specialty.

Specialty Report Newsletter Editors: Jessica Pirkle Callan, Hong Chen, Conner Clay, Monica Sadhu, Casey Sedillo, Corinne Maryssa Spires, Sokena Zaidi

Faculty Advisor: Lisa Shah-Patel, MD

If you have any suggestions for articles of interest, corrections, or comments for how we could enhance the newsletter, please do not hesitate to contact us at *lshahpatel@email.arizona.edu* and *comphx-specialtyinfo.email.arizona.edu*

STATS TO KNOW

Physical Medicine and Rehabilitation Match Summary, 2018

No. of Programs	Positions Offered	Unfilled Programs	No. of Applicants	No. of Matches US Seniors : Total	% Filled US Seniors : Total	Ranked Positions US Seniors : Total
35	133	0	525	76 : 133	57.1:100	1,236 : 2,061

Positions Offered in the Matching Program, 2014-2018

2018		2017		2016		2015		2014	
No.	%	No.	%	No.	%	No.	%	No.	%
133	0.4	119	0.4	112	0.4	107	0.4	96	0.4

Summary Statistics on US Allopathic Seniors, 2018

Measure	Matched (n=228)	Unmatched (n=31)
Mean number contiguous ranks	13.1	6.4
Mean number distinct specialties ranked	1.6	2.0
Mean USMLE Step 1 score	225	215
Mean USMLE Step 2 score	239	229
Mean number of research experiences	2.9	2.9
Mean number of abstracts, presentations, and publications	4.2	3.4
Mean number of work experiences	3.4	2.5
Mean number of volunteer experiences	7.8	6.6
Percentage who are AOA members	5.3	0
Percentage who graduated from one of the 40 US medical schools with the highest NIH funding	24.1	25.8
Percentage who have a Ph.D degree	2.4	0
Percentage who have another graduate degree	14.8	17.2