

MINNESOTA MEDICINE

MAR/APR 2023 • \$9.99

When the news is bad

Many physicians fear—and often fumble—discussing death and dying with patients and families

PAGE 12

ALSO

Health commissioner **COVID CRITIQUE** PAGE 28

Is **SCIENCE** slowing down? PAGE 7

CYTOMEGALOVIRUS screening PAGE 10



MINNESOTA
MEDICAL
ASSOCIATION

Great News for Your Patients!
Expert skincare from the comfort and safety of their own home.

Your patients can visit personally, with Dr. Crutchfield, a board certified dermatologist and Mayo Clinic Medical School Graduate with 25 years of clinical experience.

We specialize in the treatment of acne, psoriasis, vitiligo, eczema/rashes, and all other skin concerns. We also have regular clinic hours for patients who need in-person appointments.



CRUTCHFIELD DERMATOLOGY

Experience counts. Quality matters.

Your patients can schedule an appointment using Zoom, Skype, Facetime, Google Duo, Cell Phone and even land lines!



Fast, Easy, Fun and now covered by most insurance plans!
Have them Call 651.209.3600 or email us at
Appointments@CrutchfieldDermatology.com and we'll take it from there!



Discover CE Courses That Just Click



RELEVANT

Commercial tobacco topics and trends



QUICK

Free and easy online courses



ENGAGING

Interactive and pausable modules

Created with busy healthcare professionals in mind, each free, engaging, accredited course covers a commercial tobacco-related topic that commonly arises in a clinical setting. See how we can help you provide the best care for your patients.

Quick CE Courses

- Connecting the harms of commercial tobacco to chronic health conditions
- Cessation for behavioral health populations
- Vaping and e-cigarettes
- Quitline programs for specific populations (American Indian, youth, behavioral health, pregnancy)
- Minnesota Quitline 101
- Pharmacist prescriptive authority for nicotine replacement medications
- Ask, advise, connect

Explore these quick, relevant and free courses on
CoursesThatClickMN.com

CONTENTS

Mar/Apr 2023 | VOLUME 106 | ISSUE 2

IN THIS ISSUE

Every patient eventually dies—some 90% from chronic illness. Despite time to prepare for the end, many physicians communicate poorly with their dying patients and their families. How can they do better?



12

death and dying

12 When the news is bad

Many physicians fear—and often fumble—discussing death and dying with patients and families.

BY SUZY FRISCH

28 Looking back and ahead

Jan Malcolm, whose service as state health commissioner made her the public messenger of COVID-19, warns we're not ready for another pandemic. Meanwhile, Ruth Martinez reflects on 35 years as head of the state Board of Medical Practice.



CORRECTION

An article in the January–February issue about Project ECHO misspelled the name of Brian Graham, MD, PhD, addiction medicine physician and director of Hennepin Healthcare's opioid-related Project ECHO initiatives. It also failed to acknowledge Cuong Pham, MD, and Cedric Weatherspoon as co-directors of the Race Equity and Opioid Use ECHO. There are multiple ECHOs at Hennepin Healthcare; this article is specifically related to opioid-related programming. The project occasionally introduces community members to discussions with physicians and other healthcare providers to inform practice changes. *Minnesota Medicine* regrets these errors.

DEPARTMENTS

4 EDITOR'S NOTE

6 SCIENCE

University of Minnesota research suggests how physicians might get more of their patients vaccinated against Covid-19.

BY GREG BREINING

7 SCIENCE

Those ground-breaking advances in science are oh-so 20th century.

BY GREG BREINING

8 COMMENTARY

Don't let ideology stand in the way of more efficient healthcare.

BY MARK BRAKKE, MD

10 GOOD PRACTICE

Newborn screening begins for the most common cause of infectious birth defects.

BY BETH-ANN BLOOM

27 ARTS AND MEDICINE

Our last visit.

BY JUSTIN YAMANUHA, MD

34 THE PHYSICIAN ADVOCATE

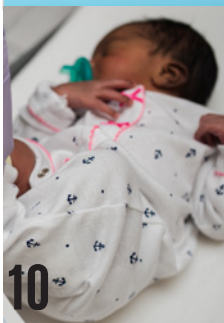
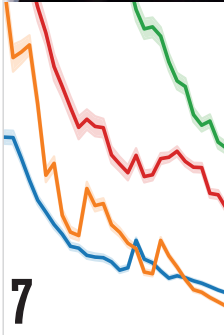
Lessons learned in *Smits v. Park Nicollet Health Services* case. Speakers selected for Project ECHO Transition Summit. MMA president weighs in on recreational cannabis. U of M, CentraCare discuss medical school for rural health. CMS releases new Medicare physician payment rates. X-Waiver no longer required to treat opioid use disorder. Provider tax to be reduced in 2023. New conditions added to medical cannabis program.

40 MMA ANNUAL REPORT 2022

52 ON CALL

Amy Gilbert, MD, MPH

Minnesota Medicine is intended to serve as a credible forum for presenting information and ideas affecting Minnesota physicians and their practices. The content of articles and the opinions expressed in *Minnesota Medicine* do not represent the official policy of the Minnesota Medical Association unless this is specified. The publication of an advertisement does not imply MMA endorsement or sponsorship.



CONTACT US

Minnesota Medicine

3433 Broadway Street NE, Suite 187
Minneapolis, Minnesota 55413-2199

PHONE: 612-378-1875 or 800-DIAL-MMA

EMAIL: mm@mnmed.org

WEB AND DIGITAL EDITION: mnmed.org

OWNER AND PUBLISHER

Minnesota Medical Association

EDITOR

Greg Breining

DIRECTOR OF COMMUNICATIONS

Dan Hauser

ART DIRECTOR

Kathryn Forss

CIRCULATION/WEB CONTENT

Mary Canada

MEDICAL EDITORS

Rahel Nardos, MD
Christopher Wenner, MD
Colin West, MD, PhD

ADVISORY COMMITTEE

Veda Bellamkonda, MD
Grant Botker, MD
Devon Callahan, MD
Derrick Lewis
Charles Meyer, MD

COPYRIGHT AND POST OFFICE ENTRY

Minnesota Medicine (ISSN 0026-556X) is published bi-monthly by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 187; Minneapolis, Minnesota 55413-2199. Copyright 2023. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Periodicals postage paid at St. Paul, Minnesota, and additional mailing offices. POSTMASTER: send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 187; Minneapolis, Minnesota 55413-2199.

SUBSCRIPTIONS

Annual subscription: \$45 (U.S.) and \$80 (all international)

MISSING ISSUES AND BACK ISSUES

Missing issues will be replaced for paid subscribers at no additional charge if notification is received within six months of the publication date. Replacement of any issues more than six months old will be charged the appropriate single back issue price. Single back issues of *Minnesota Medicine* can be purchased for \$25 (U.S.) and \$30 (Canada, Mexico, and other international). Send a copy of your mailing label and orders to Mary Canada, 3433 Broadway Street NE, Suite 187; Minneapolis, Minnesota 55413-2199 or fax it to 612-378-3875.

To submit an article

Contact the editor at mm@mnmed.org.

The editors reserve the right to reject editorial, scientific or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors or any of its constituents.

Like us on Facebook

Follow us on Twitter @MNMedMag

TO ADVERTISE

Contact Dom Weyker

PHONE: 651-288-3435 | EMAIL: domw@ewald.com



MINNESOTA
MEDICAL
ASSOCIATION

PRESIDENT

Will Nicholson, MD

PRESIDENT-ELECT

Laurel Ries, MD

CHAIR, BOARD OF TRUSTEES

Edwin Bogonko, MD, MBA

SECRETARY/TREASURER

Kimberly Tjaden, MD

PAST PRESIDENT

Randy Rice, MD

CHIEF EXECUTIVE OFFICER

Janet Silversmith



Chris Wenner, MD

Medicine has been and still is an expedition of audacity and endurance

Physicians continue to endure the assaults from science deniers that our profession is part of a government (or pharmaceutical) cabal. We endure shifting, yet enduring, obstacles to deliver equitable care. We endure diminution of our value as judged by third-party payers and corporate medicine. Our endurance is regularly tested as are the patient bonds that make our profession so unique, so special. Yet, we sally forth.

In 1914 polar explorer Ernest Shackleton set forth in an attempt to traverse the continent of Antarctica. Those familiar with the story are aware that his appropriately named schooner, *Endurance*, became trapped in sea ice and ultimately sank. The entire crew of 28 survived a year and a half of frequent gale force winds, frost-bite, severe malnutrition, and an 800-mile row across the Weddell Sea in a 21-foot lifeboat. Recently, the *Endurance* was discovered two miles below the surface of the ocean, remarkably intact.

The proposed expedition was chided by Shackleton's detractors as "audacious." Once underway, the voyage quickly changed from exploration to preservation, which Shackleton accepted and embraced.

The practice of medicine at times can be likened to the predicament of Shackleton and crew. We often are constrained by overwhelming external forces and must adapt and adopt. We have not been forced to subsist on seal blubber—but we have been fed plenty of administrative and legislative pablum.

Medicine requires audacity *and* endurance.

The MMA is putting forth the audacious legislative proposal of developing a statewide registry for POLST (Provider Orders for Life-Sustaining Treatment) documents. Detractors of the POLST form have not called it audacious (to my knowledge), yet they have attached it to the euthanasia debate, and some religious leaders have encouraged followers not to complete the form. Despite these objections founded on thin ice, the MMA understands that end-of-life care is best promulgated when discussed, documented, and disseminated *before* the end of life. This incredibly commonsense proposal will facilitate this process and support all four pillars of medical

ethics. From a standpoint of nonmalfeasance, we all know what happens in ERs and ICUs to dying people without clear advanced directives. More medicine is not always better medicine: *aegrescit medendo*.

Physicians continue to endure the assaults from science deniers that our profession is part of a government (or pharmaceutical) cabal. We endure shifting, yet enduring, obstacles to deliver equitable care. We endure diminution of our value as judged by third-party payers and corporate medicine. Our endurance is regularly tested as are the patient bonds that make our profession so unique, so special. Yet, we sally forth.

In the same month that Shackleton set sail, the lead story of *The Boston Medical and Surgical Journal* (now known as *The New England Journal of Medicine*) pertained to the treatment of tuberculous adenitis. Clearly, the endurance and audacity of our medical forebears has made this topic a nonissue for most physicians in Minnesota. What medical topics will future generations of physicians read about and ponder upon that our cohort treated with audacity and endurance?

Once stranded in the sea ice, Shackleton's task became singular: return the entirety of his crew to their families. Our purpose as physicians is similarly singular: the health and well-being of our patients and communities. Emulating the remarkable attributes demonstrated by those intrepid souls over a century ago, we maintain our steadfast course, knowing the ice will ultimately thaw, the winds will abate, and the skies will clear—revealing our accomplishments and the ever-present challenges of tomorrow.

Christopher J. Wenner, MD, is the founder of Christopher J. Wenner, MD, PA, an independent family medicine practice in Cold Spring. He is one of three medical editors for *Minnesota Medicine*.

1,000 TO 28,000 SQUARE FEET

MEDICAL SPACE FOR LEASE



West Health Campus - Plymouth
RARE OPPORTUNITY TO BE ON CAMPUS

- Turnkey suites available
- Custom design/build your new space
- Space to accommodate large users
- Competitive rental rates
- Generous tenant improvement allowance



Southdale Medical Campus - Edina
BE PART OF A MEDICAL NEIGHBORHOOD



Midtown Medical Buildings - Minneapolis
ON ABBOTT NORTHWESTERN HOSPITAL CAMPUS

Discover opportunities to relocate or expand your practice.



MedCraft[®]
Healthcare Real Estate

MIKE FLEETHAM
(952) 767-2842
MFleetham@MedCraft.com

JOLENE LUDVIGSEN
(952) 838-7126
JLudvigsen@MedCraft.com

medcraft.com/leasing

Vaccine hesitancy

CHANGING THE DEBATE

BY GREG BREINING

Rather than asking if patients want a COVID vaccine, physicians would do better to ask what kind of vaccine patients prefer. By doing so, they could significantly boost acceptance even among hardcore skeptics predisposed to reject vaccination, according to new research.

If the practice became widespread, 5 million more Americans could be protected from COVID, according to Akshay Rao, professor and General Mills Chair in Marketing, and colleagues at the University of Minnesota Carlson School of Marketing and the University of Wisconsin—La Crosse. Their study appeared in *Vaccine*.

“If you get people to stop thinking about whether they should do something and think about which one of two or three or five options they should select, the probability of selecting an option increases,” Rao says.

“I’ll give you an analogy. If you have children, particularly if they are little, asking them whether they would like to go to bed is asking for a fight. Whereas asking them if they would like to fly in or jump in is OK,” he says. “The underlying neuroscience is that the brain concludes that the decision to go to bed—whether—has already been made. Now it’s a question of which way should I choose.”

Asking about vaccines is no different. Presented with a choice, the brain generates counterarguments. “If you allow people to think about *whether* to get vaccinated, you can develop arguments pro and con,” says Rao. “Getting vaccinated is a good thing because I’ll be protected. I’ll protect others. Getting vaccinated is a bad

thing because those guys are implanting microchips.”

Rao and colleagues tested their idea by recruiting and surveying more than 1,700 respondents online. Half were asked if they were willing to get vaccinated. The

rest were asked which COVID vaccine—Moderna, Pfizer, or Johnson & Johnson—they preferred. (The second group also got an “I don’t want a vaccine” option.)

The comparative approach (“*which* vaccine”) produced a 6% reduction in vaccine hesitancy. Among conservatives

most likely to oppose vaccinations, it did even better—a 10% reduction.

Why more effective with those most likely to refuse? Because that’s where there’s the greatest opportunity for improvement. But there’s a second reason, says Rao. Conservative populist voters, according to previous research, tend more than other groups to employ “heuristic processing”—taking mental shortcuts in analysis rather than laying out long lists of objective pros and cons.

The comparative ask shifts the internal debate to something like this: “Well, I hear that the Moderna—you know those guys have never taken a product to market before. And J&J is a reputable company. And Pfizer has a weird spelling thing going on there. So let me take J&J,” says Rao.

“They are still counterarguing, which is a natural human instinct,” he says. But “it will result in one winner at the end of the day.”

Such persuasive sleight-of-hand is common in marketing, whether the comparison is Coke versus Pepsi, or Pop Secret over Orville Redenbacher’s. But with the



Akshay Rao



advent of COVID, Rao had begun thinking about the need for persuasion in medicine. “At conferences, through our multiple layers of masks, we talk to each other about this. How could we use the principles of our discipline to change the way people behave?”

Already, public health officials had been trying to encourage vaccination with lotteries and prizes and mandates. But many approaches seemed to fall flat or even backfire. Meanwhile, vaccination hit a wall. At the time of Rao’s study, about 32% of the U.S. population remained less than fully vaccinated.

“So,” says Rao, “this seemed to be a ready setting in which to apply it and make a difference.”

Rao is looking for physicians and clinics willing to participate in a new round of research. Rao says the conditions and treatment might run the gamut, though he admits he’s particularly interested in trying to improve the rate of childhood vaccination.

“The issue of childhood COVID vaccines is to me, just as a human being, concerning. I’m seeing so much resistance of people to getting their children vaccinated,” he says. “This would be a good way to test it. Would you like your child vaccinated? Or, which vaccine would you like your child to have?”

Greg Breining is editor of *Minnesota Medicine*.

Disruptive Research

NOT SO MUCH ANYMORE

BY GREG BREINING

Even as the number of published scientific papers has ballooned to more than a million a year, the proportion that upend our understanding of a subject has steadily and dramatically declined—and that’s true across all fields, including the life sciences and biomedicine, according to a new study in *Nature*.

“I think it’s a concern,” says co-author Russell J. Funk, associate professor at the University of Minnesota’s Carlson School of Management. “I think disruptive discoveries are important for pushing science forward.”

“Overall, our results suggest that slowing rates of disruption may reflect a fundamental shift in the nature of science and technology,” according to the study. “The decline represents a substantive shift in science and technology, one that reinforces concerns about slowing innovative activity.”

To bring objective rigor to the study, Funk and colleagues analyzed 45 million scientific papers and nearly 4 million patents with computers ranging from their desktop models to mammoth machines at the Minnesota Supercomputing Institute.

Their criteria for ranking disruption was a “CD index” the authors developed based on citation patterns. They reasoned

that a revolutionary paper would cite earlier work but that after publication subsequent studies would cite the new work and ignore the old.

A classic example is James Watson’s and Francis Crick’s discovery of the double helix structure of DNA, announced in a paper in *Nature* in 1953. “There were some other speculative theories about the structure of DNA before that, and they cited those papers that were contributing to that conversation,” says Funk. “But then they got it right. So no one cites that old stuff anymore. They cite Watson and Crick. Our metric just tries to quantify those patterns.”

By this measure, since the mid-20th century, the ratio of earth-shaking discoveries to ho-hum science has fallen off a cliff. The average CD index dropped more than 90%.

Why? And should we be worried?

The most obvious explanation Funk calls the “low-hanging fruit” hypothesis. All the big stuff has been discovered. Since the theories of relativity in physics, evolution in biology, and plate tectonics in geology, the rest is exposition. Similarly, some have argued that as science has matured, it has resolved many of the big mysteries and is now doing work to develop and expand those discoveries.

But Funk is skeptical. “In my mind, if it’s all about low-hanging fruit, I would expect that the decline would be much more correlated with the age of the field,” he says. “We’ve explored 5% of the oceans. We’ve explored one planet in the solar system. There’s just so much out there that we’re just constantly finding new phenomena that need explanation that challenges our existing theories.”

Instead, Funk feels that much of the decline comes down to “the social organization of science—how science is done, and things like the incentives that researchers have to pursue different types of projects.

What kind of projects are going to get funded? What kinds of things do you need to do to get tenure? How many papers do you need to publish? It’s a lot easier to publish stuff that builds on and extends existing things rather than tries to overturn them. Funding agencies are wanting to make sure that every dollar gets spent well, and usually the very disruptive stuff is higher risk,” he says.

To explain whatever is causing the decline of disruption in all fields “has to be affecting a lot of scientific fields at the same time,” Funk says. Unfortunately, he says, that explanation suggests no quick fixes.

Nonetheless, Funk says, reaction to his paper “has been way too dramatic, like this is the end of science. That’s way too negative.”

Funk says two things are important to remember. First, disruption refers to the effect on understanding in a field of science, not necessarily impact in society at large. “We’re not looking at whether these papers lead to new cancer treatments that saved this many lives or things like that. We’re looking at disruption internal to the system of science,” he says.

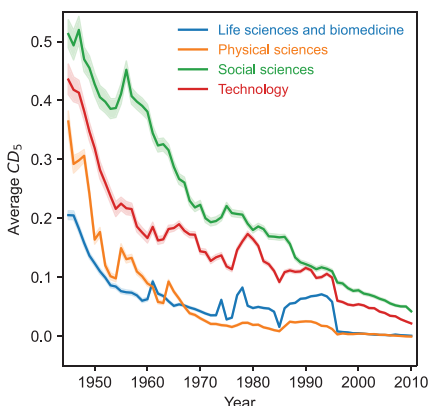
Second, the proportion of disruptive papers has declined, but the actual number has remained relatively constant, Funk says. But they are swamped by the rising tide of studies that are not disruptive.

Discoveries that are incremental or “developmental” are valuable in their own right, he says. “I think you need a really healthy mix.”

As for his paper, which has generated coverage and publicity beyond his expectations—is it disruptive?

“I don’t know,” says Funk. “I guess only time will tell.” MM

Greg Breining is editor of *Minnesota Medicine*



Decline in Disruptive Science. Across all fields of science, relatively fewer papers are overturning established understanding. Illustration credit: Michael Park, Erin Leahey, and Russell J. Funk.

Single-Payer Plans

Don't let ideology stand in the way of more efficient healthcare

BY MARK BRAKKE, MD

I agree with Robert Koshnick, MD, (“Empower-Patient Accounts,” January/February *Minnesota Medicine*) that healthcare finance has problems. But I do not think his proposed solution is practical, and it also does not address the major problems in U.S. healthcare finance.

Let us start with a brief look at problems.

The United States has the most expensive healthcare in the world—more than twice the cost of healthcare in Japan, Australia, the United Kingdom, Canada, Belgium, France, Sweden, and Austria, and \$4,000 more per person per year than that of the second-most expensive nation, Switzerland. Our prescription drug costs are more than double that of other prosperous countries.

Despite the expense, results are poor. According to the CIA’s *The World Factbook*, our life expectancy is 72nd in the world. Because of underinsurance or lack of insurance, medical debt is the biggest cause of personal bankruptcy in the United States. Inadequate insurance is a major cause of delayed or skipped medical care.

Administrative inefficiency is unavoidable in the current situation. We have

many insurance companies interacting with many hospitals, clinics, doctors, and others. There are many, many different contracts between insurers and providers. There are time-consuming preauthorizations. We hear lots of marketing to convince people that a particular insurance plan is the best when in reality it is essentially the same as the competitors’. It is estimated 30% of the U.S. healthcare dollar goes to administrative costs. Most other modern, prosperous nations are spending half that on administrative costs.

I think it is reasonable to ask: What is the opportunity cost to an American of our current dysfunctional healthcare finance? According to data from the Kaiser Family Foundation for 2019, U.S. healthcare cost per capita was \$11,945. The cost in Switzerland, the second-most expensive country, was \$7,138. Take the difference, \$4,807, invested yearly at a 6% return for 65 years and the result is more than \$3 million. Those are dollars that could be more wisely saved for retirement, used for better wages, or spent on housing or education.

Koshnick suggests Americans overuse healthcare. The studies of physician visits per person in other countries show

Americans actually see their physician less frequently than residents of other modern nations.

Koshnick also states that defined benefits in healthcare are inflationary. That assertion assumes Americans enjoy going to the doctor. Most Americans prefer to avoid the doctor when possible.


The solution Koshnick proposes, which he calls “empower-patient accounts,” is a type of health savings account (HSA). It is important to recall that the big medical expenses and the big inequities occur when people become seriously ill and need hospitalization or prolonged care. HSAs do not address the major expenses and dysfunctions in our healthcare situation.

There is a second problem with HSAs. This requires a bit of analysis.

The HSA subsidy should be risk-adjusted, that is, adjusted downward from the average subsidy for healthier-than-average citizens and upward for sicker-than-average citizens. The HSA program won’t work if we simply give the same subsidy to everyone. If everyone is given the same subsidy, healthier people will be given dollars they don’t need (which drives up total healthcare spending), and sicker



Some say they do not want the government in healthcare. That is just what the insurance and pharmaceutical industries want you to think. Those who are hesitant to fix the current U.S. healthcare mess should think about how well the current Social Security and Medicare operations work.



It is true Medicare needs some tweaks to make it better, but it has served millions of retirement-age Americans well.

Amount spent on medical care

Over/underpayment (assuming \$3,000 subsidy)

	MEDICAL BILLS	OVER/ UNDERPAYMENT
Healthiest individual	\$0	\$3,000
Next healthiest	\$0	\$3,000
Average health	\$2,000	\$1,000
Next-to-sickest	\$8,000	-\$5,000
Sickest individual	\$40,000	-\$37,000
Total bills for all five individuals: \$50,000		

people will have too few dollars to meet their medical needs.

The table illustrates why the subsidy must be risk-adjusted. It assumes, for simplicity, that five people live in the community to be served by the proposed HSA program. The average person's medical expense per year is \$10,000. And the usual 20/80 rule applies; that is, the sickest 20% generate 80% of total healthcare spending while the healthiest 80% generate only 20% of total spending. The left column shows the results of these assumptions: Total spending is \$50,000, and one person accounts for 80% of total spending while the other four account for the other 20%.

What happens if the government gives each of these five people a subsidy of the

same amount, say, \$3,000? One sees the results in the right column. The government overpays the healthiest individual by \$3,000, the second healthiest individual by \$3,000, and the third-healthiest by \$1,000. In sum, the overpayments to these three individuals have driven up total spending in our five-person society by \$7,000. Meanwhile, the government underpays the two sickest individuals.

One can conclude an HSA will not address the most serious problems in healthcare finance and is impractical to implement because of variable risk.

Koshnick also suggests direct primary care. The problem with direct primary care is an actuarial one. A physician who accepts a fixed payment from a group of patients is contracted to care for them regardless of their medical problems. The physician has essentially become an insurance company. The difficulty is an individual physician's risk pool is too small, and the cost of care in each physician's practice will vary widely depending on varying demographics.

What is the solution? Everyone should have insurance for major medical expenses. (Everyone is a slight exaggeration. The very rich like Warren Buffett do not need health insurance.) No one should

go bankrupt or suffer because of medical debt. We need administrative efficiency. We need effective drug price negotiation. We need effective planning for rural health. Minnesota Sen. John Marty has authored the Minnesota Health Plan legislation and has an explanatory book available on the web at MNHealthPlan.org. U.S. Rep. Pramila Jayapal has authored the Medicare for All Act. Either of these bills would fix the major financial problems in U.S. healthcare while leaving us in the care of the physicians and hospitals we prefer.

Some say they do not want the government in healthcare. That is just what the insurance and pharmaceutical industries want you to think. Those who are hesitant to fix the current U.S. healthcare mess should think about how well the current Social Security and Medicare operations work. It is true Medicare needs some tweaks to make it better, but it has served millions of retirement-age Americans well. Government programs can work well when designed well and given good oversight by the voters. When voters need the government to fix a problem, they should expect their elected officials to be responsive. Do not be trapped by cynicism. Do not let an ideological filter in your brain make you blind to a real fix. Make the country work for the average person as well as for big business.

I acknowledge that a single-payer healthcare system will be disruptive for some businesses. But the farmer did not avoid tractors to protect the horse breeders and harness makers. Computer makers did not avoid word processors to protect typewriter makers. The traditional model of health insurance in the U.S. is no longer the wise or efficient way to finance health insurance. The gains to the average U.S. resident brought on by healthcare finance reform will far outweigh the challenges of the transition. **MM**

Mark Brakke, MD, practiced family medicine in Minnesota for 41 years and served on the boards of two health maintenance organizations. After retirement, he became involved with Health Care for All Minnesota, advocating for affordable, equitable healthcare.

Congenital cytomegalovirus

NEWBORN SCREENING BEGINS FOR MOST COMMON INFECTIOUS CAUSE OF BIRTH DEFECTS

BY BETH-ANN BLOOM

Lesley Atwood, MD, FAAFP, shared a story that is all too familiar to those who deliver babies and care for children in Minnesota. Her patient had what appeared to be a normal pregnancy—no reports of illness, rash, or fever—until she had a type 3 fetal heart rate tracing when she was in labor at 36 weeks. The baby was in serious distress and needed to be delivered right away. The newborn's head was small, and an MRI showed calcifications and other signs of brain damage from congenital cytomegalovirus (cCMV).

Congenital CMV is the most common and underrecognized in utero infection that can cause long-term developmental harm. In many cases, as Atwood describes, the infection and the damage it causes aren't apparent during pregnancy—or even at delivery.

Now, thanks to a recent change to the Minnesota Department of Health's Newborn Screening Program, Minnesota is the first state in the nation to test all newborns to identify babies infected with cCMV, regardless of problems during pregnancy or symptoms at birth. The screening began Feb. 6.

About 1 in 200 babies are born with cCMV—in Minnesota that's about 300 newborns annually. About 80% are asymptomatic at birth and are never expected to develop neurodevelopmental complications. But the remainder may experience complications such as hearing loss, cerebral palsy, and vision problems—sometimes not until months, or even years, after birth.

Previous efforts to identify babies with congenital infection by testing newborns



MINNESOTA DEPARTMENT OF HEALTH

Testing at birth allows for timely consultation with pediatric infectious disease specialists who can help weigh the risks and benefits of antiviral drug treatment for newborns experiencing symptoms of disease. Furthermore, newborns without symptoms can be evaluated for hidden damage caused by the virus.

meeting specific clinical criteria (maternal signs of infection, failed newborn hearing screen, poor in utero growth) have been unsuccessful in identifying all cases.

Identifying cCMV as the cause of neonatal symptoms saves families the expense of

searching for other causes of the symptoms and the anxiety of not knowing. In addition to reducing the diagnostic odyssey, testing at birth allows for timely consultation with pediatric infectious disease specialists who can help weigh the risks and benefits of

antiviral drug treatment for newborns experiencing symptoms of disease. Furthermore, newborns without symptoms can be evaluated for hidden damage caused by the virus. Primary care providers can monitor the child's hearing and balance to remediate problems before language and social development are affected.

Newborn screening has been available through the MDH Public Health Laboratory for more than half a century. Almost every Minnesota baby benefits from screening for some 60 disorders. This screening includes checking for hearing loss and hypoxia associated with critical cardiac defects. Screening for cCMV was added to the panel of tests as a result of the state's Vivian Act in 2021, which directed the Minnesota Department of Health to provide education and awareness of cCMV, and to consider adding a test for cCMV to the newborn screening panel, which the commissioner of health recommended last year. Screening for cCMV will be the first test for a congenital infection incorporated into the panel.

Newborn screening specimens are collected, transported, and analyzed in St. Paul in the first week of life. Abnormal results are telephoned to the clinician caring for the baby by MDH genetic counselors who provide information about the result and the recommended next steps for follow-up. This same model will be used for cCMV screening.

"We will rely on primary care providers who know the families best to coordinate the clinical evaluations of newborns found to have CMV in their bloodspot collected shortly after delivery," says newborn screening manager Jill Simonetti. These evaluations will help those providing direct care distinguish between the majority of babies who are asymptomatic at birth and the small number of infants who may require intervention. In severe cases, the primary care provider may work with a pediatric infectious disease specialist to discuss benefits and risks of treatment options.

MDH is working with the CDC on a surveillance program to evaluate cCMV screening. Medical laboratories statewide will help newborn screening staff identify missed cases of cCMV. Surveillance will help determine if newborn screening improves outcomes for infants born with this disease. Minnesota's screening program will provide the first opportunity to evaluate variations in cCMV infection to see if there are demographic groups of children more likely to be burdened by sequelae of in utero infection.

MDH staff have already been contacted by advocates and newborn screening programs in other states for guidance in implementing laboratory-based screening programs for cCMV. Minnesota continues to be a leader in newborn screening and is expanding its long-term commitment to protecting the health of its youngest citizens. **MM**

Beth-Ann Bloom is a research scientist with the Minnesota Department of Health.

We are looking for a Family Medicine Physician in Southeastern Minnesota

Deliver exceptional patient care in Preston, MN!

About this position:

- Full-time or part-time
- \$30K sign-on bonus, stipend, and moving allowance
- Dynamic rural practice
- Build community relationships
- Provide care for all age groups

A competitive salary and comprehensive benefit package, including a \$30,000 sign-on bonus!

About Olmsted Medical Center

OMC has over 1,300 healthcare professionals serving at over 22 locations, including two multi-specialty clinics, a primary care/walk-in clinic, a Level IV trauma hospital with 24-hour emergency room, a Skyway Clinic in downtown Rochester, and 11 community branch clinics. OMC also offers walk-in FastCare and Acute Care clinics.



Why choose Preston?

OMC's clinic located in Preston is an established family practice that includes one other physician, an advanced practice clinician, and amazing support staff. Preston is a vibrant community in the heart of bluff country in southeastern Minnesota, just 35 miles from Rochester.

Preston offers a peaceful, small-town atmosphere with many activities, such as:

- Biking or hiking the Root River State Trail
- Camping, fishing, and golfing
- Exploring Mystery Cave State Park or Historic Forestville
- Enjoying a variety of restaurants, a winery, and a brewery
- Future location of the Preston Veterans Home

Interested? Provide your Cover Letter and CV of Interest to Deb Cardille: dcardille@olmmed.org or call **507.529.6748**.



Equal Opportunity Employer/Protected Veterans/Individuals with Disabilities.



When the news is bad

Many physicians fear—and often fumble—discussing death and dying with patients and families

BY SUZY FRISCH

Michael Pitt, MD, already understood the importance of clear, unambiguous communication when physicians talk to patients and their families at the end of someone's life. It's a major part of his research at the University of Minnesota Medical School. But its significance really hit home last year when Pitt received a call from the hospital team looking after his father.

"We lost your father," Pitt remembers the caller saying. Even with Pitt's medical knowledge and experience, and a full understanding that his dad was gravely ill, "I heard that, and my initial thought was, 'Gosh, he was mobile enough to get lost!' I took it as good news. He was able to get out of bed and get lost and he's doing a lot better—even though this was an unrealistic possibility."

Though the person meant to soften the bad news, the end result was confusion that made the situation even worse. It reinforced Pitt's view—and underscored the importance of his research—that physicians can do harm when they communicate poorly with patients and families about death and dying.

"I always say, you can be the smartest doctor in the world, but if your patient doesn't understand what you're saying, you're useless. The ultimate success in my career will be if doctors stop viewing being really smart and being really effective communicators as an either-or," says Pitt, an associate professor of pediatrics and a





death and dying

pediatric hospitalist at M Health Masonic Children's Hospital in Minneapolis. "They view the art and science of medicine as a dichotomy, but they should co-exist."

Yet one component of this art—communicating with patients and family members about death and dying—historically has been a skill that physicians gain in the field, not in the classroom. In a 2016 *BMC Medical Education* study, 54% of medical students reported having no classroom training on end-of-life care during medical school, and 88% of residents reported the same during residency. Still, half of residents said they frequently held such

conversations with patients, and 61.9% of the time they were unsupervised and had to go it alone.

Having discussions about death and dying is difficult for most people. In medicine, it's a topic that often gets danced around through euphemism and jargon. These talks are especially challenging for many physicians when they feel unprepared and lack confidence in their skills. But that discomfort can be ameliorated through education and training, says Amy Greminger, MD, a hospice physician and assistant professor at the University of Minnesota Medical School, Duluth cam-

pus, who teaches a first-year class called Art and Science at the End of Life.

Being a doctor involves relaying bad news, "and it hurts less if you know what's coming. Just like at the end of life, it's so anxiety-provoking to not know what's going to happen," Greminger says. "I believe in this [course] material because I think having doctors understand some of their pain points before they go on to the wards helps everyone be better supported. My hope is that in preparing people, they don't feel so alone when they are going through it—physician and patient."

All physicians should be trained in having end-of-life discussions, says Patrick Lalley, MD, a palliative medicine physician at CentraCare and medical director of the Quiet Oaks hospice house in St. Cloud. After all, only 10% of people die unexpectedly, while 90% will die from chronic or serious illness. Planning for death and discussing people's wishes with their family and medical team should occur long before there is a crisis.

"Start upstream and have a relationship with them," Lalley says. "Then when you get to the point of saying, 'You don't have much time,' they are accepting of that and trust you and the advice you have for them."

Delving into the delivery

In recent years, medical education began shifting to include more curriculum and

Having discussions about death and dying is difficult for most people. In medicine, it's a topic that often gets danced around through euphemism and jargon. These talks are especially challenging for many physicians when they feel unprepared and lack confidence in their skills.



Alex Ginsburg, MD



Amy Greminger, MD



Rajini Katipamula-Maliseti, MD



Patrick Lalley, MD



training to prepare future doctors for end-of-life conversations. At the Mayo Clinic Alix School of Medicine and on the university's Duluth campus, students engage with the topic through coursework and skills practice. Starting in summer 2023, the university will standardize its curriculum so that medical students on the Twin Cities campus will take the end-of-life course, too, says Johannah Scheurer, MD, a neonatologist and assistant professor of pediatrics.

Scheurer helped develop a workshop in pediatric end-of-life care skills for fellows in pediatric critical care, neonatal-perinatal medicine, hematology-oncology, and blood and marrow transplant. The half-day sessions, held at the university's M Simulation center since 2018, bring together inter-professional teams for education, practice with standardized patient family members, and opportunities for feedback, all with the goal of building competence and confidence. Such training is vital for pediatric specialists because patient death is far less common in pediatrics than other areas of medicine. This makes the see one, do one, teach one training model less effective, Scheurer says.

"The workshops were in response to a call-to-action from some of the trainees themselves, who were expected to help

take care of dying pediatric patients and work with their families but felt very unequipped to do so," Scheurer says. "For many trainees it's a really difficult, stressful area of care, and they asked for more education and practice before jumping in."

A key element of the workshop is learning how to provide clear communication to patients' families and practicing saying difficult things like "Your baby is dying" or "Your child is dying" before working with the role-playing patients who present trainees with various scenarios during simulations, Scheurer says. "Being able to say those words can be pretty uncomfortable to us, but it's what families want and need to hear. They don't want to be confused about what is actually going on. We talk about the back and forth of communication and how to elicit people's goals of care and work on shared decision-making."

When Greminger teaches the week-long course in Duluth, she covers a wide range of topics including the dying process, palliative care and hospice, ethics, the role of spirituality and religion, and providing culturally specific care. A core element of the course involves helping students refine their communication skills, with time to role-play giving bad news and getting feedback from clinicians.

When Alex Ginsburg, MD, attended medical school and completed his emergency medicine residency at Mayo, his training in end-of-life conversations began during basic and advanced doctoring courses. Students learned and practiced having difficult conversations, including those about death and dying, and observed other physicians during rotations in palliative medicine and hospice, says Ginsburg, who now works at Mayo in emergency medicine and palliative medicine.

In residency, Ginsburg dove deeper into communication training based on the VitalTalk framework, simulations focused on serious illness communication, and learning by doing, with guidance and feedback from other clinicians. Simulations focus on caring for patients who are critically ill and dying. They cover training physicians in best practices for sharing information, ensuring they understand the patient's values, and then providing care that matches those values.

"You get that repetition so that having these conversations is a little bit more second nature," Ginsburg says. "It's not always easy, but it's easier when you're not saying things for the first time. You've had practice saying it."

Providing that practice reflects a general change in approach to training physi-



Michael LuBrant, PhD



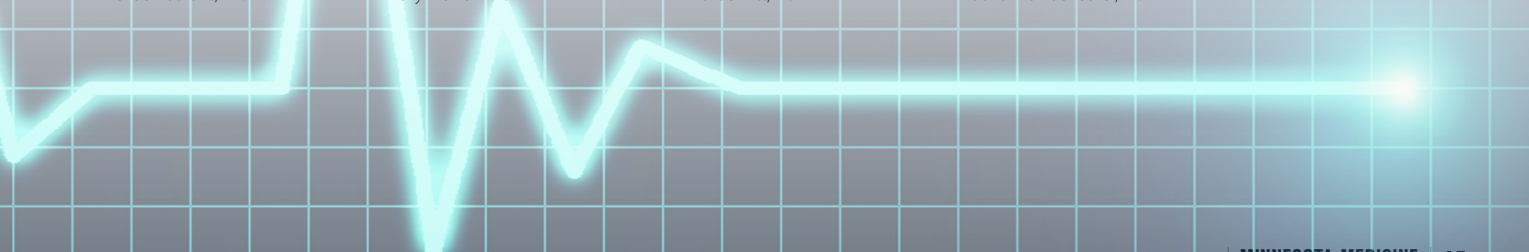
Kelly McManimon



Michael Pitt, MD



Johannah Scheurer, MD





TALKING ABOUT DEATH AND DYING

Rajini Katipamula-Malisetti, MD



Rajini Katipamula-Malisetti, MD

Rajini Katipamula-Malisetti, MD, is a medical oncologist and hematologist with Minnesota Oncology and director of quality. She sees patients in Coon Rapids at its clinic and Mercy Hospital.

How do you deliver news that a patient is dying?

Involving family is very, very important when you're having these conversations. I sometimes say that everybody is going to die. It's not knocking on my door now, but it is knocking on yours. And it's up to you whether you want to keep the door open and say, "I'm okay," or keep the door closed and be scared about it. You have your family and physicians with you to support you until the end. Then I usually ask them about their thoughts about dying. What is their biggest fear? Most of the time they are not scared for themselves, it's the fear of leaving their family and not being able to be there. "Will I be in pain?" Those are the biggest questions I get. Having family there to tell them it's okay, they will be okay—it releases them and takes that burden off their chest.

What has been your experience when you have these conversations?

I have patients from one spectrum to another. They are always going to be difficult conversations, no matter how easy or difficult the patient is. You cry more with the easier patients because they tell me, "Doc,

I know how hard your job is. It's okay to tell me I'm going to die." I must have seen thousands of patients by now, but with every patient you get so involved that you lose a part of yourself when that patient dies.

What advice do you have for clinicians?

Remember that every word you say will affect the patient in one way or the other. For 60–70% of time, when you walk in patients usually know that they are dying. Talk to them with compassion. It's about how we can find that peace and comfort for the patient and the family. Give them your time, no matter how busy you are. If they get angry or upset or are reacting in a way that you are not anticipating, remember that it's probably their own fears playing out—it's not about you.

Have you had any conversations that you especially remember?

I had a patient with advanced pancreatic cancer. He was an atheist, and he had a completely opposite view compared to other patients. For some patients you have that little anxiety going into their room and seeing how they will take this news. But with this patient, no matter what news I had I would always come out laughing because he used to make fun of his scans and diagnosis. He lived for three years, and I think his personality is what drove him to live that long. We went through four lines of treatment and as I walked in with the scans in my hand, he said, "I know that look on your face. I know I'm done." I told him that he made my job easier, and he said, "Then you have to give me half your paycheck because I did your job." He al-



ways believed that death is a normal process and not something to be scared about.

What makes discussions more difficult?

One patient I had today is very young and can't have any more chemotherapy. She's an immigrant and her husband is still in Africa, and she has her children with her. She is going to die, and she does not want to accept it. It is very hard for people to hear that finality and hear that there is no other option and medically we can't do anything more. We tell them we will do everything we can to keep them comfortable.

How do you help people when they are in denial?

It's not just a one-person discussion, it's a team discussion. It's me as an oncologist saying that more treatment is not a possibility—you are not improving. We have a palliative care team, and they are also saying that you can't get more treatment; how can we really make it possible for comfort to happen? Hearing that message from four or five people, like the nurse and social worker and palliative care team, it will sometimes be what changes the patient's opinion. There are a very few patients where we might not get to that point, and they end up dying in the hospital, which is unfortunate.

cians in end-of-life communication, at Mayo and elsewhere, Ginsburg says. It's no longer just a nice-to-have skill that can be studied and gained through experience. Instead, it's akin to mastering a procedure like placing a central line.

"The shift is that now we realize that communication during serious illness is also a procedure, and we all need to practice in order to become proficient," Ginsburg says. "We need to teach those particular skills, practice them, and help people put them together so that they can have an effective conversation. Having an effective conversation is making sure patients are getting the best care possible for their goals."

Best practices

And just how should physicians talk to patients who are dying? There are many strategies, but some critical stage-setting must come first. Lalley emphasizes being face-to-face with people, such as pulling up a chair next to hospitalized patients to avoid standing over them in bed.

"Slow down and allow the time to be fully present in these conversations. Sit with them at eye level and let them know, 'I'm here with you. Let's take as much time as you need to go over it,'" Lalley says. "If you invest the time, it helps you establish a relationship with the patient."

Rajini Katipamula-Malisetti, MD, a medical oncologist and hematologist with Minnesota Oncology, does this, too, whether she's seeing patients at the clinic or at Mercy Hospital in Coon Rapids. She

stresses the importance of making eye contact with patients when sharing news that they are dying. It's also essential to read the room to take note of personal and family dynamics. Be mindful of complexities like when the patient and family don't agree on care plans, or there is dissension among family members, Katipamula-Malisetti says.

Often, physicians have two parallel conversations, one with the patient and one with family members, each with different needs and considerations. Katipamula-Malisetti makes sure to take time to help both understand and process the bad news. "There is the patient, who is wondering, 'Am I going to die, and how am I going to deal with this?' and the family, who is going to lose that family member. Those memories may be painful for the rest of their life," Katipamula-Malisetti says. "It's a huge struggle between the two objectives."

Pitt calls it the flashbulb moment that indelibly sears a memory in someone's brain. "Doctors don't often realize that they are about to be part of someone's story forever. They hold the camera and are about to push the button when they deliver this news," he says. "We have to help doctors because people will remember it forever."

When teaching medical students and trainees, Greminger underscores not bursting out with news that a person is dying. "You should not and cannot deliver the news until you ask the patient how they want to hear it. Say, 'I have some

Only 10% of people die unexpectedly, while 90% will die from chronic or serious illness. Planning for death and discussing people's wishes with their family and medical team should occur long before there is a crisis.



TALKING ABOUT DEATH AND DYING

Patrick Lalley, MD



Patrick Lalley, MD

Patrick Lalley, MD, began his career in family medicine, becoming board certified in palliative medicine more than 20 years ago. Today, he is a palliative medicine physician at CentraCare and medical director of the Quiet Oaks hospice in St. Cloud.

How do you begin end-of-life conversations with patients?

I usually ask them what they understand about what the doctors have told them. Knowing their understanding is important because then if they give me permission,

I can explain more about the important things to think about going forward. Establish a relationship with the patient and ask how this illness is impacting them and what's important to them. What do you value the most? What support do you have? Get to know the person who has the illness better so that you can treat them better.

What has it been like for you to deliver bad news?

To be honest, before I had training, it was emotional and more difficult and not something I felt I was good at. I could get through it okay and I hoped everything went okay. But now it's different. I have experience in doing it a lot, and I have a road map of how you want to talk to someone about something really important. Having that training and technique makes you more comfortable in these situations. I know how to talk to patients and listen to them.

What do you try to avoid during these conversations?

You don't want to talk for five minutes. You want to give them bites of information. Don't use big medical terms—explain it as simply as you would to your kids, so to speak. Ask them, 'What did you understand about our conversation?' Some get it right away, and some do not get it at all. Some may have memory issues and might not absorb it. Then you try again.

Are there any conversations that really stick with you?

Unfortunately, as physicians we always have a library in our brains of times it didn't go as well as we wanted. You are in a sacred moment with patients, and for most

of us who go into medicine, there's not a better reward than that. There are so many examples. It involves touch, shaking hands, making eye contact, thank-yous—just a sense of appreciation from a patient that we are caring for them. I appreciate that they allow us to be with them on that journey.

Any advice for other physicians?

Never tell a patient specifically how much time they have, because you don't know, and they will hang on to that. If you say they have three weeks and they are here two months from now, they will be upset with you that you were way off. If you're in an exam room, get off the computer and look at the patient—look them in the eyes. If you are working on the computer, you are missing the emotions and the communication going on. You aren't developing a deep connection with that patient and showing that you are there with them.



things I want to share. Is this a good time? Do you want me to share them with you or share them with your family, too?” she adds. “Everybody has a different preference and you’re never going to make the right assumption.”

Greminger often draws on SPIKES, a framework for having difficult conversations developed at the University of Texas MD Anderson Cancer Center and the Toronto-Sunnybrook Regional Cancer Centre. It provides guidance to clinicians to meet patients where they are, provide just the right amount of information in the right way, and help them process the news. Then, they finish by talking about next steps and strategies for supporting the patient and family.

“When you use a process like that to deliver bad news, it’s more patient-centered,” Greminger says. “It’s a conversation that engages people and focuses on what the patient experiences. For me that’s been really helpful.”

Lalley uses SPIKES as well as an ask-tell-ask format. Here, physicians ask pa-

tients what they understand about their case and ask for permission to share what they know. Physicians then tell patients what they understand about the person’s condition based on their chart, tests, or scans, including that they are dying. Finally, physicians ask their patients to repeat back what they understood, to make sure they fully comprehend the news.

Ginsburg and some other providers at Mayo use the REMAP protocol for teaching trainees (reframe, expect emotion, map values, align, and plan). A key lesson is that physicians must provide a big-picture view about what is happening, Ginsburg says. It’s easy to get wrapped up in test results and other data and not convey the full weight of the situation.

For a dying patient with cancer, Ginsburg might say, “Your CT scan shows that despite the chemotherapy we tried, your cancer is still growing. Sadly, what that means is that you are dying,” he says. “We have to be that clear and use a word that makes sense like dying rather than using a euphemism and avoiding it.”

Physicians commonly use euphemisms, but this runs the risk of causing significant confusion, Pitt says. He points to 2018 research in *JAMA Network Open* that clinicians often avoid using terms like *die*, *death*, or *dying* in pediatric settings. In 92% of cases, physicians used phrases like “let her go,” “not live,” and “it may happen soon,” to convey a child’s impending death. To Pitt, that means “we have more work to do” to teach precise communication.

At the University of Minnesota Medical School Program of Mortuary Science, students learn how to help people plan for the end of their lives whether they are facing death sooner or later. The program covers communication similar to what future physicians and trainees learn, including the best ways to talk with people and their relatives when someone is dying, says program director Michael LuBrant, PhD.

Over the years as a mortician and educator, LuBrant has gleaned some ironclad dos and don’ts, including make no assumptions. “You just do not know what you don’t know. Just because they are members





TALKING ABOUT DEATH AND DYING

Johannah Scheurer, MD



Johannah Scheurer, MD

Johannah Scheurer, MD, is a neonatologist at M Health Fairview Masonic Children's Hospital and assistant professor of pediatrics at the University of Minnesota Medical School. She facilitates a workshop for pediatric fellows on end-of-life care skills.

What is the best advice you received about talking to families whose child is dying?

One of our chaplains would say, "A big part of our job is to meet families where they are and help them have the story that they are going to live with forever." It's clear in our minds that things won't be curative, but maybe they need another day or two to sit with that. We want to make sure the patient doesn't have undue suffering or pain. But we try to give families what they need to get to the place to have the story they live with forever about their loved one.

What is it like to do this work?

I find deep meaning in the work that I do in providing end-of-life care to patients and families. It doesn't mean that it's not sad or upsetting. But when we are able to work with a family and the team for the patient to have a good and comfortable death, that is just so important and meaningful to the family. I've had many families

come back to the NICU or send cards and express a lot of gratitude to our team for giving their baby the most peaceful and meaningful death possible.

What do you emphasize with trainees about end-of-life conversations?

Transitioning to end-of-life care isn't giving up. There's a lot of emphasis that it's not about stopping everything. It's about changing the treatments for the baby, toward treatments that are focused mainly on their comfort. A really big thing is helping a family not feel abandoned by the medical team. We remain very involved and on the journey with them.



of one religious tradition, they might not follow those traditions exactly. They might want some variation or to not follow them at all,” LuBrant says. “Ask open-ended questions and listen carefully. Provide them with agency to make decisions based on the information you provided.”

Voices of experience

Physicians who often deliver bad news likely can recall many times the discussions went poorly. There are plenty of occasions that went well, too. In either case, they learned lessons they carry forward to the next conversation.

People who have held these discussions, and those who have experienced them, can provide universal guidance. Kelly McManimon, who belongs to Scheurer’s workshop team that trains pediatric fellows, brings her perspective as a bereaved parent and medical social worker at United Hospital in St. Paul to help prepare trainees for end-of-life conversations.

McManimon’s daughter Charlotte (Charlie) died in 2011 from a heart defect, undergoing multiple heart and stomach surgeries and other procedures during her four months of life. McManimon experienced many conversations with physicians, mostly good but some that could have been better.

When she first learned of Charlie’s heart defect, three clinicians came to the room

to talk to her. That was a bad sign to McManimon, and she could tell that it was serious. The neonatologist said things like “this is a big diagnosis” and never stated that Charlie would be okay. This didn’t provide McManimon with false hope, which she appreciated and helped prepare her for the tough road ahead.

McManimon tells trainees “not to give false hope and be direct with their comments, even though it’s hard for the parent and hard for them. The more clearly they can say things the better,” she says. “Using words like *death* and *dying* are so important because your mind can work around anything else. You hear that they aren’t doing well and you think, ‘Well, but they will get better.’ If you don’t use significant words, it’s hard to grasp.”

Frequently, physicians seek to back up their diagnosis with data, but it’s better not to relay those details unless asked. “They want to share their knowledge,” Greminger says. “But a lot of times in these situations, we need to talk less and listen more and respond to the emotions. We need to give people time to process things rather than talk.”

McManimon appreciates words that workshop facilitator and neonatologist Heidi Kamrath, DO, shares with trainees. “When talking with patients and families, she will say, ‘This is what I’m concerned about, and this is what I hope for,’” Mc-

Manimon says. “That gives parents a clear understanding that we hope for this outcome, and this is the reality.”

By giving people clear information—even if it is heartbreaking—they are able to start processing and accepting the diagnosis, Greminger says. It’s also important to not use phrases like, “There’s nothing more we can do for you.” It’s devastating for patients to hear, and it’s not necessarily true,” she adds. “We may not be able to cure the disease process, but as physicians we can always be present. We can work on pain and symptoms, and we can provide knowledge so that people have less anxiety about the outcome.”

Helping patients and families through the stress and grief of impending death by breaking bad news in the right way is some of the most important work a physician can do. These vital conversations, with lifelong impacts on all involved, reverberate for patient, family, and physician. “It’s not what we say but how we present ourselves,” LuBrant says. “They will forget what you say, but they will never forget how they felt in your presence.”

Suzy Frisch is a Twin Cities freelance writer.



Kelly McManimon

“Using words like *death* and *dying* are so important because your mind can work around anything else. You hear that they aren’t doing well and you think, ‘Well, but they will get better.’ If you don’t use significant words, it’s hard to grasp.”

KELLY MCMANIMON, BEREAVED PARENT AND MEDICAL SOCIAL WORKER AT UNITED HOSPITAL IN ST. PAUL



TALKING ABOUT DEATH AND DYING

Amy Greminger, MD



Amy Greminger, MD

Amy Greminger, MD, is a hospice physician and assistant professor of family medicine and biobehavioral health at the University of Minnesota Medical School, Duluth campus, where she teaches the course Art and Science at the End of Life.

What do you focus on during conversations with patients and families about death and dying?

It's really important not to make any assumptions about what's hard and not hard. Sometimes death isn't the worst thing that

happens to people, and you never know where the patient or family is. Really take the time to be grounded and centered in the moment. Know where you are emotionally so that you can spend your currency supporting them. Sometimes we do need a debrief. Make sure you have the support of someone on your team who you can talk to. We need to be there for each other just like we need to be there for our patients.

What is the most valuable advice you received?

I remember vividly a chaplain that I worked with saying, "Sometimes I do get stuck and when I do, I take this phrase out of my back pocket: Tell me more." It's helped me so many times where you feel the need to respond and say something, but you don't know where that person is coming from. Taking the time to know more about where they are coming from is helpful. People have this amazing ability to be insightful about what they need.

Is there a situation that you still remember?

When I was a resident, I had a patient who was listed as full code [all resuscitation measures to keep them alive]. I went in with the perspective that based on his illness, he should be DNR/DNI, and that I should get him to change his code status. That's a mistake. Having had more experience, I know my job is to not get anything from patients. It's my job to help them clearly understand and express what they want. That conversation was not a good experience for this patient, and it was not a good experience for me. I was well-intentioned but it wasn't the care he wanted, and he was resolute in that. Ultimately, he remained full code. I learned a lot from

that, like needing to take more time to hear his perspective in the beginning and listen to where he was coming from. I have had many positive experiences since that conversation, but that experience impacted my career profoundly. It made me a better doctor, 100%.

What advice do you have for physicians who fear having these discussions?

It's really normal if you don't want to do it. For me, it's how you frame it. It's not, "Oh my gosh, I'm the person who has to do this to this person." Instead, it's, "I'm the person who gets to support this patient and their family through this process." The story you tell yourself can shape how you feel about it. Being the person who is trying to make this go as well as possible—and knowing we have the knowledge to do that—is part of creating a good story for people. I get to be there for that patient and family and that's really fulfilling work.



POLST: The right path to informed decisions

BY VIC SANDLER, MD

We doctors have historically done a poor job of explaining to patients their diagnosis, their prognosis, and their options. Consequently, many patients receive medical treatment that is not consistent with their wishes and values. Legally, we are required to do so. See the Minnesota Patient Bill of Rights. Ethically, we are also required to do so. See the ethical guidelines from the American Medical Association.

Why aren't we more clear with patients? We often justify our deficient communication by rationalizing that we don't want to deny the patient hope. But hope and truth do not have to be in conflict. As a hospice and palliative medicine physician, I say to my patient with metastatic cancer: "I hope you will be able to attend your granddaughter's wedding in six months, but let's make a plan so we can still honor your choices if you don't survive that long." Most patients, particularly if they are terminally ill, want clear information about their disease and prognosis. Even patients in hospice who fully understand that they are terminally ill, but don't desire more specific information about their prognosis, have without exception in my 16 years in this field given permission for me to discuss specifics about prognosis with their caregivers.

Do doctors have a gene that prevents them from being honest and direct with their patients? No. We simply weren't trained adequately or at all to prioritize these critical conversations. We also suffer from "heroic positivism" or what many call the "therapeutic imperative." We are trained to intervene and to battle illness. Whatever we do to combat the disease is heroic and positive—by definition.

But this is not true for the 90% of our patients who die of chronic illness. They

at some point in their disease course see the medical heroics not as positive but as negative. Instead, if given the information needed to make an informed decision, they would choose to avoid medical interventions that seek to prolong life in favor of a focus on quality of life. Ironically, many of these patients live longer because of their decision to focus on palliation and to avoid aggressive medical interventions.

Since doctors do not always have the time, training, or inclination to have the conversations that will lead to informed patient choices, the POLST Task Force, under the auspices of the Minnesota Medical Association, has developed a guide to support patients and their doctors. The POLST (Provider Orders for Life-Sustaining Treatment) is an advance care planning tool that allows patients to pick full aggressive treatment or limit that treatment consistent with their wishes and values. It has been endorsed by the MMA, the Minnesota Nursing Association, the state Emergency Medical Services Regulatory Board, and the Minnesota Board of Medical Practice.

The POLST can be downloaded at www.polstmn.org. It facilitates the incorporation of nurses and social workers into the advance care planning process. But it does this in a careful way by providing an excellent patient and family educational video as well as scripted conversations to ensure that patients and families get consistent and accurate information. For example, the likelihood of surviving out-patient CPR is only 7%. Only a provider (physician, advanced practice registered nurse, or physician's assistant) can sign a POLST, but utilizing the skills of nurses and social workers to provide education will facilitate patient choice.

Because the POLST is a provider order, it can and will be followed by emergency medical services and emergency department physicians.

Go to our website and learn how you and your health system can optimally use the POLST process to support the wishes and values of older patients and patients with serious illness.

The MMA is spearheading the passage of POLST registry legislation at the Legislature. This legislation would fund the creation of an online registry of all POLST documents created in Minnesota. It would allow emergency medical services to have real-time digital access to patients' choices regarding CPR and intubation.

Vic Sandler, MD, is a geriatrician, hospice and palliative medicine specialist.



Cultural considerations

BY SUZY FRISCH

Natalia Dorf Biderman, MD

Internal medicine physician and hospitalist at Park Nicollet Methodist Hospital in St. Louis Park. She grew up in Uruguay, where she attended medical school.

One of the big things I always think about when treating people with a Latinx background is that in general and historically, engagement with the healthcare team is much more paternalistic. That means the engagement is one of, “You tell me, and I will do.” Families are a lot more involved. Very frequently with aging parents, the children and the clinicians might discuss what is best for the patient. At times, the patient will say, “My son or my daughter and my doctor will decide for me.”

In the Latinx community, it’s not very usual to talk about death and dying. It might take a little more effort on our part. It is really important to be patient and understand that it might not be as straightforward as with patients from other backgrounds. Be open to ways of doing things differently.

In a busy healthcare system, we try to move very fast. When events of this magnitude happen in someone’s life, it’s much easier to engage with the patient individually and move on. While that might be appropriate for people from certain backgrounds, there are certain populations—particularly when we speak about the Latinx community—where a large group of people are involved. We move as a village.

In the rooms of Latinx patients, there is always someone. There might even be many family members at a time. Some people might see that as chaos, but I encourage them to embrace that sense of community. Sometimes I hear clinicians say, “You go in there, it’s a circus.” Or, “I just asked everybody to leave.” And it makes my heart sink.

If you go into a room and see five or six family members, they are supporting someone at the end of their life. Sometimes there might be more questions or there might be more confusion about what you are saying. But for the patient, it supports them when they are journeying into death, and it supports family members through some of the most difficult times in their lives.

Andrew Kiragu, MD

Pediatric critical care physician at Children’s Minnesota and an associate professor of pediatrics at the University of Minnesota Medical School. He grew up in Kenya and attended medical school in the United States.

Whatever assumptions or thoughts you had, that is not necessarily what is going on with each particular person. There is no prescription, like if someone is Somali or Hmong, they don’t talk about this or that. Even within cultures and backgrounds, there are many different perceptions about what death and dying means.

People are not monolithic. In Kenya, there are 40 plus languages spoken and in Nigeria there are hundreds of different languages spoken and different cultures. And of course, some people are Christian, and some are Muslim, and they draw on their lived experience and culture and family background. One has to get to know each patient and family and not think, oh, this patient is from East Africa, so this is how I should approach them.

With immigrants, it’s not uncommon that many people have significant deference to physicians, sometimes to their detriment. “The doctor said I have to do this, because in Kenya, when the doctor says you have to do this, you have to do it.” There is less questioning, and sometimes people do need to question.

In populations where there has been a history of systemic cultural racism—like Native American and African American—for many reasons there is some distrust of the healthcare system. Patience is sometimes required because there is a level of mistrust, particularly when it comes to end-of-life care: “Are you choosing to withdraw care from my child because she’s Black? What would you do if she was a white kid?” You have to be able to step back and remember where that particular family is coming from. You have to be thoughtful and respectful, especially around these issues.

Roli Dwivedi, MD

Family medicine physician, CEO and chief clinical officer of the Community-University Health Care Center in Minneapolis, and an associate professor of family medicine and community health at the University of Minnesota Medical School. Dwivedi is from northern India, where she attended medical school.

In my own culture, typically death is not a fearful thing for people. But then when you talk about dying it is fearful. In many parts of India, a lot of people strongly believe in reincarnation and that we basically never die. We have a soul that always lives. Our body is like a cog in a machine. When it stops functioning the soul leaves the body and finds another body to live in. After someone dies, there are a lot of rituals and ceremonies that go on for 13 days. It takes 13 days for the soul to find another body.

I see patients from many different cultures. One time there was a patient from Vietnam with a chronic disease, and I was bringing up the concept of an advanced directive. The patient was crying, and the family members were crying. I was in shock. I knew it was going to be a hard conversation but not to that extent. The daughter said, “We don’t talk about death. If we talk about death, it means that we will be dying soon.”

When I’m talking with a patient who is fighting a terminal illness or has a



chronic disease and comes from a different culture, I come to the conversation with curiosity and without judgment. Share your own experiences and your lack of knowledge of their culture, and engage people in conversation, empowering them to make decisions about their care. I'll ask them, "What do you think about an advanced directive? Is there anyone in your family you'd like included in the conversation?" We can work with the family in their own way about what is culturally acceptable to make decisions.

At the clinic, my patients will ask me everything [about traditions in India]. They feel they can relate to me, and I will share. That's where the cultural part is so interesting. I think as human beings, there are so many commonalities in different cultures, and we can operate on those commonalities. It's the way to go.

Friederike Froke, DO, MPH

Third-year emergency medicine resident at the Mayo Clinic. She recently rotated at a rural urgent care clinic for Indian Health Services, spending a month on the border of the Navajo Nation.

Based on my discussions with the staff, who were primarily Navajo, it seemed like death is a natural part of the process of life. There is a component of concern about omens of death, and Navajo people

may look for signs to avoid harm. For some, if they experience a coyote crossing the path of their car, they will not cross that area of the road and turn their vehicle around. They would then seek to cleanse themselves of bad energy.

It is essential not to use the word *death*, *dying*, or the terminology naming a severe illness because it insinuates that the provider may be wishing the ailment on the person. If giving a patient bad news, you could consider stating, "A person with a disease like your own may experience..." and so on. The culture has a matriarchal design, so if a family is involved with patient care, it is essential to address the matriarch and be attentive to her input.

On one of the first days on the rotation, I received an email from the medicine man welcoming me to the campus. The date and time were listed for a ceremony called smudging, which is offered to all new employees. Smudging is a ceremony where sacred herbs and medicines are burned as part of a ritual or for cleansing or health purposes. Indigenous peoples have their own terms and phrases for smudging. For example, *nookwez* is Ojibwe for "smudge medicinally."

Physicians should consider asking [Native] patients if they would like smudging during their time of need. In theory, a traditional medicine person

would be able to cleanse the patient spiritually, and they can provide their services without using smoke.

After a patient dies, do not mention the person's name or the loss. There are concerns that any verbalization regarding the person or their memory would interfere with their ability to navigate the afterlife.

Sara Sutherland, MD

Second-year emergency medicine resident at Mayo Clinic. She is a member of the Sault Tribe of Chippewa Indians and grew up in Munising, Michigan.

I didn't have a lot of experience with death and dying growing up. Recently my best friend's father died, and she is from the same tribe as me. I had the experience of going through a Native American funeral ceremony. In our culture, when someone dies, the family lights a sacred fire for four days to help their family member reach the spirit world. Someone is constantly there to tend the fire. Anyone who knew the person can visit the fire and put in the four medicines: sage, sweetgrass, cedar, and tobacco. They say prayers in each direction and help the person get to a good place. That's a unique experience and very special.

Each tribe can be so different, so have an open conversation with patients about what they want and how we can respect their wishes the best. Many hospitals have Native outreach people—we do at Mayo. I recently took care of an elderly patient from another tribe. They would place sage and tobacco packets by his bedside, near his head, and say prayers in their language. The Native coordinator helped with that.

With Native cultures or really any culture, be completely open and say, "I'm here for you and I want to respect your cultural practices and support you as best as I can as your physician. If there is anything we can do to support you, please tell us." The number one thing is to be extremely open and respectful with your patients.





Oblivious to jargon

BY SUZY FRISCH

Interviewing people at the Minnesota State Fair, researchers from the University of Minnesota Medical School wanted to know: Is it good or bad news if you have an impressive chest X-ray? If a cancer screening reveals positive lymph nodes, is that encouraging? Turns out, the majority of people surveyed understood the opposite of what physicians intended to communicate.

This research, published in *JAMA Network Open* in 2022, revealed that people regularly misunderstand some of the common phrases physicians use to relay medical information. Whether the clinician used jargon or highly technical information, the end result is confusion for patients and families.

Researcher Marissa Hendrickson, MD, a pediatric emergency medicine physician at M Health Fairview Masonic Children's Hospital and associate professor of pediatrics, explores how to improve communication with patients and families. Hendrickson and Michael Pitt, MD, an associate professor of pediatrics and a pediatric hospitalist at Masonic, teach an elective course to medical students about jargon and how to avoid its pitfalls.

"We had the idea to do this study at the state fair to find out what people do and don't understand," Hendrickson says. "We looked at phrases that might have one meaning in common usage and another in medicine. We wanted to find out how well people understand the medical phrases and then help clinicians be clearer."

Some of the survey findings include:

- 80% of participants understood that an unremarkable chest X-ray was good news, while only 21% comprehended

that an impressive X-ray was generally bad news.

- 79% understood that they received bad news when told that halfway through chemotherapy, their tumor was progressing; 67% knew that having positive lymph nodes also was bad news.
- Medicalized language was easily misunderstood, including 11% comprehending that needing to be NPO at 8 a.m. meant they should have nothing to eat or drink (Latin: nil per os—nothing by mouth), while only 2% understood the meaning of a potential occult infection. (No, it is not the work of Satan.)

Physicians are often unaware that they use incomprehensible language with patients and families. And that can have significant consequences. If patients don't understand the news physicians are sharing, "they might not understand what they need to do to treat their condition, or they might not believe that what we're prescribing is necessary. They might not trust us," Hendrickson says. "We need to work to help patients feel like full partners in the work we're doing together."



Marissa Hendrickson

These findings are part of a larger body of work by Pitt and Hendrickson related to the use of jargon. Coining the phrase "jargon oblivion," they published a report in the *Journal of General Internal Medicine* in 2019 that categorizes seven types of jargon. It includes acronyms, euphemisms, medical terminology like *afebrile* or *metastasis*, and technical terminology like telling a patient they have



cholecystitis instead of an inflamed gallbladder.

Often, physicians misjudge what their patients understand. Or physicians are so steeped in the medical world that they forget which terms are not common knowledge, Pitt says. Other times they might be trying to show off their expertise or ease the pain of bad news by couching their language.

"When you ask physicians and clinicians, they all say they don't want to use jargon with patients," Hendrickson says. "More often than not they don't realize they are using jargon and have lost sight of what people don't understand."

Hendrickson, Pitt, and their research team plan to continue their jargon studies, aiming to help physicians communicate more clearly with patients and families. Focus areas will cover what people understand about various medical specialties as well as judgmental jargon, such as stating that a patient "denies drinking alcohol" or "failed outpatient treatment."

"We're all interested in helping people get this right," Hendrickson says. "We think it's really important to be aware of what your patients are understanding, and we're excited to learn more about that." MM

Our Last Visit

BY JUSTIN YAMANUHA, MD

I saw my patient today outside of the clinic,
unencumbered by the formalities of a typical visit.

The invitation was extended to visit her familiar place
instead of her coming to see me at mine.

It was a unique situation that brought us together:
two souls connected as patient and doctor.

She told me about her recent decision to halt treatment
for the cancer which tried to capture her for over a decade.

Her doctors gave her options for another surgery
with odds not in her favor.

She no longer wanted to fight
the adversary that just would not relent.

She decided it was time to go home for hospice,
to be with her family rather than surrounded by strangers.

The freedom to choose the place to take her final breaths
made her content and gave her some control.

I didn't know what to say or do,
but she didn't seem to mind.

Instead of her looking to me for answers,
she held my hand and let me ask her questions.

I wondered if she felt scared or sad,
but she said only that she was tired.

Tired of fighting and tests and medicine that made her sick,
she was ready to be with her loved ones.

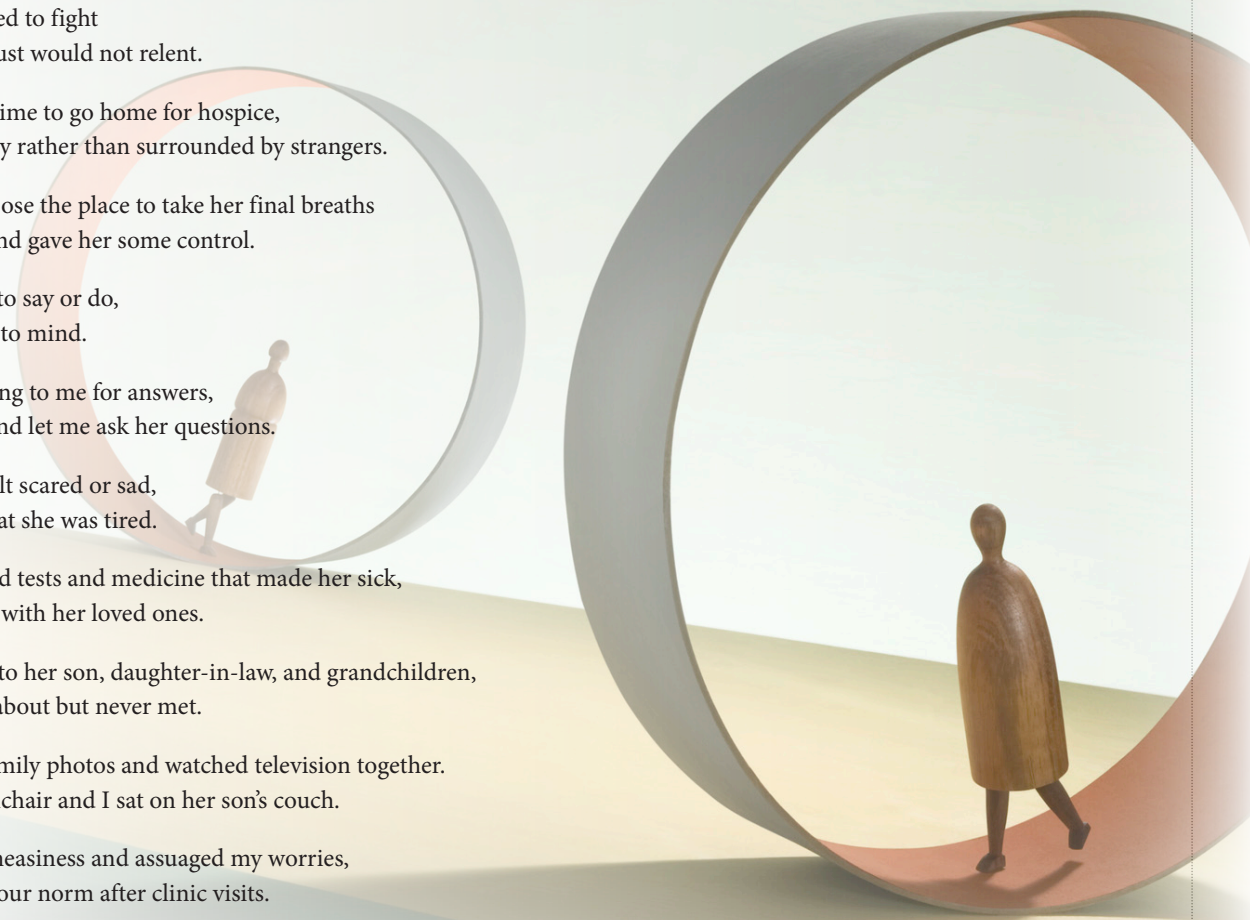
She introduced me to her son, daughter-in-law, and grandchildren,
whom I had heard about but never met.

We looked at old family photos and watched television together.
She sat in her wheelchair and I sat on her son's couch.

She doctored my uneasiness and assuaged my worries,
hugging me as was our norm after clinic visits.

I will miss her laugh and her familiar greeting, "There go my doctor!"
"There go my patient," I thought as I waved goodbye and drove away. MM

Justin Yamanuha, MD, is an assistant professor, Department of Ophthalmology and Visual
Neurosciences, University of Minnesota Medical School.



LOOKING ← BACK AND AHEAD →

Distrust of science frustrates retiring health commissioner

Jan Malcolm warns we're not ready for another pandemic

A long-term fixture on Minnesota's healthcare scene, Jan Malcolm first served as state health commissioner during 1999–2003 under Gov. Jesse Ventura, where she battled to protect smoking-prevention and health-training endowments funded by the state's tobacco lawsuit settlement.

After her term, she served as chief executive officer of Courage Center and vice-president of public affairs for Allina Health. But in 2018, Gov. Mark Dayton tapped her to serve again as health commissioner. She continued under Gov. Tim Walz, becoming the face of Minnesota's efforts to fight COVID-19. On a recent flight from California, another passenger told Malcolm, "You look like that woman on TV who couldn't stop talking about COVID."

Shortly after she retired as commissioner early this year, Malcolm spoke to *Minnesota Medicine* about highlights of her public career and challenges facing Minnesota's healthcare and public health systems. The interview has been edited for clarity and brevity.

Why did you choose to come back to government, to take the very position you had held before?

I just really loved public sector work. I found a lot of alignment with my policy interests, but also I always have been motivated by the bigger picture of all this healthcare stuff—what effect does this actually have on the health of the popula-



tion? That's sort of the core purpose of public health and governmental public health.

Let's leave the COVID era out of the discussion for the moment. What accomplishment pre-2020 will you value the most?

In Gov. Ventura's term, you may recall, in his very first budget we had the state's part of the proceeds from the tobacco lawsuit. Working with the governor and Finance Commissioner Pam Wheelock at the time we crafted some extraordinarily, I think, good uses of that tobacco settlement money and set up a really robust youth-oriented prevention campaign—and also a robust stream of money going to the University of Minnesota for health professions training. I was really, really proud of what we were able to do with those tobacco settlement dollars. The endowment vehicle was really smart as financial policy. It turned out to be very vulnerable politically, because it was the very first thing Gov. [Tim] Pawlenty eliminated with the stroke of a pen to cure a large part of the deficit in his first term.

Prevention never competes well for funding in the state or federal budget, because the payoff is typically not so immediate. The effects are sometimes invisible, especially when prevention works. No one even knows it's there. Maddening! So having this boatload of money coming into the state from the tobacco settlement continues to this day. But it goes right into the general fund.

The second thing I would say from that term, we started our statewide Eliminating Health Disparities Initiative back then. On average, Minnesota is great on so many health measures. But you look below the averages, we've got some of the worst disparities in the country. We had known that for awhile, from a health statistics perspective. But it was really in Gov. Ventura's term that we really elevated that to a statewide priority.

Another thing I would just mention—the reason that Gov. Dayton asked me to serve the last year was to work on some operational issues at the Health Depart-

ment related to regulation around nursing homes and other care facilities around elder care and elder issues. In Gov. Dayton's last year we didn't get the bill done. We got it done the next year under Gov. [Tim] Walz—a comprehensive assisted-living licensure bill coming out of all that, because we were one of the last states to actually have a regulatory framework for assisted living different from skilled nursing facilities.

Are there projects—again, before COVID—you didn't get to finish or that stymied your best efforts?

I think we had so many things that we wanted to really take to the next level before COVID hit. School health, mental health. A whole range of chronic condition issues, all of which have been badly exacerbated by the pandemic. Some of the health policy challenges that I have worked on my entire career—I was packing up my office and I came across some things that I had written much earlier in my career. It sort of made me want to bang my head on my table. I could have written them a month ago.

Let's move to COVID. I'd assume the pandemic was the most challenging aspect of your public health career.

No question. I think for all of us. It was a healthcare challenge the likes of which we have not seen, just given the global scale of it and the duration of it. I mean, we're really, really good in public health and in Minnesota in particular at emergency response to the more typical crises. We catch and contain outbreaks, whether that's food-borne disease or infectious disease, quicker than anybody. That's a point of pride for us in Minnesota. But this was of a scale that I think my dear friend [University of Minnesota public health professor] Mike Osterholm could envision, but most of the rest of us just couldn't imagine something that would be hitting the entire world at the same time and last for three years and counting and disrupt society so completely.

And then the politicization of it—how it became so ideological, so politicized

I think we had so many things that we wanted to really take to the next level before COVID hit. School health, mental health. A whole range of chronic condition issues, all of which have been badly exacerbated by the pandemic. Some of the health policy challenges that I have worked on my entire career—I was packing up my office and I came across some things that I had written much earlier in my career. It sort of made me want to bang my head on my table. I could have written them a month ago.

just made it infinitely harder. And I think that's one of our big challenges ongoing—what do we do about that? We have a real problem with public lack of trust in science and in expertise.

It was intellectually, physically, emotionally incredibly hard. And simultaneously, some of the most important work many of us will ever do.

You're on record recommending a longer mask mandate than Minnesota implemented—longer than Gov. Walz finally accepted. Talk about your thoughts at the time, and how you look back on it now.

From an evidence perspective, it's just so clear that masking works to reduce transmission and protect the vulnerable. So the reason for the mandates I think was quite clear, again, from an evidence perspective—trying to slow the spread and protect the vulnerable. That's a pretty darn good strategy. Certainly vaccination remains the most powerful tool, but masking is certainly one, and I think pretty preferable to closing things down.

Certainly there was a huge push-back against government mandates and rules. And clearly we got to the point—and I think the governor read it correctly—the mandates were not as useful because people were tired of it and they just weren't going to do it.

I think it's confusing for people. They're interpreting the fact that we've moved away from all the rules as a signal that it's over or that it's not that important. Whereas I would dearly love for people to just understand the risks and understand the mitigation measures and use them, especially in higher-risk situations.

How does public health thread that needle—to take off the mandates because they recognize people are fed up with them, but still encourage people to take voluntary precautions?

We talk about it till we're blue in the face. But it just isn't getting through. So what are the communication strategies that can break through the fatigue? It just gets tuned out now. Psychologically people are just so eager to be over it. I get that. We are, too.

We're being encouraged to return to normal. But it's a different story if you're immunocompromised, for the folks who

don't have the same kind of access to prevention or treatment for one reason or another. They can't move on! And they feel like the rest of us are putting them at greater risk by the fact that we're just sort of over it.

It's a vexing, vexing challenge. It's not for lack of putting messages out there. They're out there every day. But it's just not getting through. I don't know what it's going to take.

As you can tell, it gets me fairly agitated.

You became a target for people who opposed government mandates. That must have had you thinking, why did I come back to government service?

It made me very sad and angry. In person, people are invariably nice. And grateful. I've had so many people say to me thank you. Almost all of the really, really nasty stuff was anonymous on social media. And in the political realm, it sort of comes with the territory. But the intensity of it, and some of the accusations, as if we wake up in the morning with the desire to screw up people's lives. It's like, what do you think our motivation is? So, it was difficult.

I deserve neither the credit nor all the blame. But that's what happens when you're the visible one.

Florida Republican Gov. Ron DeSantis is getting a lot of mileage out of his claim that by imposing fewer restrictions during the pandemic, he allowed the economy to flourish and kids to do better in school. How would you compare Minnesota's approach? And which approach worked better?

Certainly we know that the impact on kids in not having in-person learning for a couple years was not good. There's no debate about that. We can and I'm sure will continue to debate why it was done and was it necessary and was it helpful.

There's no question that many of those broad community mitigation measures had negative consequences. They absolutely did. The cost-benefit calculation, though—I believe as the data continue to come in, Minnesota's approach, and many other states', to be more aggressive on miti-

gation did matter—a lot! It mattered in our fatality rate.

And on the economy—we encouraged in-person learning to resume earlier than many. I think the governor was always eager to lift the mitigation as soon as possible. People think we were so extreme in our mitigation. I think he struck a much more balanced approach. As you said, I was the one arguing for more mitigation.

One of the outcomes of the pandemic was the overarching skepticism if not outright hostility to scientists and science. How do we as a society repair that damage?

That is one of the big problems. Why was the public so vulnerable to that—to that disinformation, not just misinformation? Why did this sort of anti-science, anti-authority narrative have such appeal?

So who is in a position to rebuild that trust? We have to try, but we can't do it—we being government or authority figures—ourselves. I do think it needs a change in tone from our political leaders. And that's hard. If they're getting political mileage out of fueling the mistrust, then that's a terrible problem.

I really appreciated what former Gov. Pawlenty did around vaccination. He appeared a couple of times with Gov. Walz and he said, "I don't understand the anti-vaccination stuff. This is a victory for President Trump and Republicans. We should be claiming credit for this." That's what I wish there was more of.

How well prepared are Minnesota and the nation for another pandemic?

We won't be unless we really learn and apply some of the lessons. Yes, in some ways we've learned how to do things at a scale and a speed that would serve us well in future pandemics. We've learned how to stand up testing sites and vaccination sites. So we've gotten a play book, if you will, of how to build up the public sector response. But that takes a lot of money. We had an extraordinary amount of federal resources and some not trivial state resources put against it. There's not the money to keep doing that.

How do we build some surge capacity into the system, or systems plural? We've gone to just-in-time everything as an efficiency measure and to some good effect. We've been trying to make the system more efficient for decades, and can debate how well we've done on that measure. We certainly have squeezed all the excess—excess in air quotes—that we can out of capacity. Mental health is a great example of this. We've really tried to lessen the role of the institutions, but without necessarily adequately funding the community-based systems to replace them.

From a policy perspective, it's both a really interesting time to try to revisit some of these larger questions—through the lens of what we've just been through and what does that further illuminate about the gaps in our system, the discontinuities, the fragmentation? Some folks in Congress and in some of the agencies are calling for some of those bigger-picture serious discussions. The same is true here at the state level. But it's not a groundswell by any means. Let's have a big health policy congress! Well, there sure as hell should be, but who thinks that sounds like fun?

Future plans?

Like many of us, I'm pretty worn out at the moment and need some time to regain some health, some energy. I would love to be a part of some of these policy conversations and system rebuilding, but I don't really see that in a formal kind of job capacity. I'm not sending out my resume. Let's say that.

Interview by Greg Breining, editor of *Minnesota Medicine*.

LOOKING ← BACK AND AHEAD →

Minnesota maintains a high bar in medical performance

Ruth Martinez, retiring head of the state Board of Medical Practice, says recent programs have supported physicians under stress

Ruth Martinez did something that, these days, is unusual. Not long out of St. Catherine University, she took a job with the Minnesota Board of Medical Practice. And there she worked until early February, when she retired as executive director, more than 35 years later.

Over that time there have been changes—new programs, new issues—but the regulation of medical behavior and competence has continued to hew to the legislation that sets the standards.

Shortly before she retired, Martinez spoke to *Minnesota Medicine* about highlights of her career and changes in the board's work. The interview has been edited for clarity and brevity.

How has the job changed in that time? I'm thinking about the particulars of the Board of Medical Practice, working with physicians, ensuring that they're complying with ethical standards.

So much of the work of the board is prescribed in statute. Our regulatory work



doesn't have a whole lot of creativity or flexibility. We're really tied to the statutes that we enforce. So in some ways work is constant and unchanging. We always have and always will be evaluating the minimum qualifications to hold a medical license in the state of Minnesota.

Changes, though, sure have happened. For instance, programs like the Health Professional Services Program, which was implemented in the mid-'90s offering confidential monitoring opportunity for impaired professionals to enable them

COVID has affected the providers that we regulate more than anything. One of the things we've noted is that when providers were finding themselves really, really stressed and increasingly isolated because of the pandemic, that was not a good recipe for people and their own personal well-being. I don't have to tell you, there's just an extraordinary amount of burnout in the healthcare profession, and we worry for our regulated professionals.

to continue practicing to the best of their ability while maintaining public safety. That is one of the biggest and most important things that happened while I was at the board.

We've implemented a medical licensure compact that has really expanded portability across state lines. That is another huge event, I think, for access to healthcare and again protecting public safety, maintaining state sovereignty over that license.

Since the Minnesota Medical Association is an organization of physicians, let me ask this: What sorts of things most often get a physician appearing before the board?

You know, one of the big challenges for practitioners is just staying current on medications, current standards of care. I think at times we see physicians who just haven't stayed up to date on the latest and greatest prescribing practices. We see a lot of issues around prescribing, documentation, which I think has really become very challenging for practitioners with the electronic medical records. I probably don't have to say much more about that. Physicians will be happy to tell you how challenging it is.

It was supposed to make everything easier, wasn't it?

You know, it was designed for reimbursement. It was not designed for user-friendliness in the real world of documenting an interaction with a patient. I think that has challenged some physicians to document as well as they might or could or should.

We certainly have seen physicians struggling with illnesses, who have come before the board. We have seen boundary violations—boundaries, by the way, in many different ways—not just sexual relationships, or inappropriate relationships between professionals and patients, but also boundaries around prescribing. You know, treatment of a patient, letting patients get overly involved in directing their own course of treatment, that sort of thing.

Have those kinds of issues changed at all in 30 years?

Oh, I think for sure the issues around opioid prescribing. You know, this happens. You see something that looks like a great treatment and ultimately when we learn more and have more data, we realize something maybe isn't the magic bullet it was thought to be.

We certainly see more discussion of certain things that I think have been shrouded in secrecy for awhile, like sexual misconduct. We don't have a statute of limitations on investigating sexual misconduct, which really enables people to come forward at a time when they feel ready to talk more about their experience.

Medical practice is still that relationship between a provider and a patient. Minnesota is still a very high bar in provision of medical care. We are fortunate in the state of Minnesota to have truly high-quality healthcare.

Speaking of Minnesota, the Public Health Citizen's Research Group, in a 2021 report, puts Minnesota close to the bottom among states in terms of number of disciplinary actions for its population of physicians. The group concludes that "low rates of serious disciplinary actions suggest that medical boards are not adequately taking actions to discipline physicians responsible for negligent medical care or whose behavior is unacceptably dangerous to patients."

We've been at the bottom of that list for my entire time here at the board. I will say that this is a report without context, that a low number of disciplinary actions is not an adverse reflection on the state of Minnesota and our regulatory enforcement. It is a reflection of the high quality of healthcare in our state—the ability of us to have a program like the Health Professional Services Program that keeps people practicing under monitoring. That report with the numbers says nothing about the

actual healthcare delivery that goes on in this state.

How has COVID-19 affected work at the board? Or has it?

COVID has affected the providers that we regulate more than anything. One of the things we've noted is that when providers were finding themselves really, really stressed and increasingly isolated because of the pandemic, that was not a good recipe for people and their own personal well-being. I don't have to tell you, there's just an extraordinary amount of burnout in the healthcare profession, and we worry for our regulated professionals.

Did differences of opinion over COVID and vaccines—driven in part by politics—sometimes stray over into poor or irresponsible medical information and malpractice?

You know we've certainly had some complaints. The challenge for all of us was really in wrapping our heads around what was sort of a constantly evolving standard of care around COVID and vaccination and so forth because the guidelines were changing so frequently. We tried to work, and continue to try to work, to the best of our ability with what was known. When a complaint comes for us, of course, it's a complaint about something at a point in time. So we always have to be looking at what was the standard when that care was provided.

During this last election, the Board of Medical Practice became ensnared in politics in a way I hadn't heard of before. Scott Jensen, a physician and the Republican candidate for governor, acknowledged he had been investigated by the board several times and vowed that if elected, that "we'll take care of that juggernaut." I know you can't comment on that particular investigation, but wasn't this highly unusual, that the board would get targeted in a political campaign so prominently?

It's not the first time that the board has been a pawn in politics. It happens. What I can say is that the governor appoints the


board. The governor could not unseat a board without going through a significant administrative hearing process. When board members come up for appointment, whoever is the sitting governor has the opportunity to appoint individuals to the board. Governors always have that prerogative—to appoint anyone they find appropriate to sit on the board.

One of the things that seems to have come out of the politicization of COVID is that some people certainly have lost respect for our administrative agencies. Do you see it that way, and is it a problem?


Administrative agencies always have been and always will be easy targets. So I try not to lose too much sleep over that. We always wish that people had more respect for public servants, but the reality is we can and often are a target for people if it serves their personal agenda. You do your best to do your work properly, effectively, efficiently, and as I said at the start of our conversation, the work of the board is legislatively established through a series of statutes. We follow our regulatory statutes and we enforce the law as we are mandated to do. Anyone who chooses to be a public servant has to know that sometimes you're going to take it on the chin, and it's not personal.

I've said it before and I'll say it again—the Board of Medical Practice is one of the most highly functioning groups of people I've ever seen in my life. It's been a real sincere pleasure to serve them. MM

Interview by Greg Breining, editor of Minnesota Medicine.



ADVANCED
BRAIN + BODY
CLINIC



- Anxiety
- PTSD
- ADHD
- Depression
- Bipolar Disorder

Innovative psychiatric interventions including ketamine, Spravato, and TMS covered by most insurance providers.

Advanced Brain + Body Clinic
13911 Ridgedale Dr.
Minnetonka, MN 55305
612.682.4912
advancedbrainbody.com



Lessons learned in *Smits v. Park Nicollet Health Services* case

Last September, the Minnesota Supreme Court issued an opinion in the case of *Smits v. Park Nicollet Health Services* that could have negative impacts on mental health providers and the treatment they provide in Minnesota.

What happened in the case?

A patient was being seen for mental health services on an outpatient basis by Park Nicollet when he murdered his family before committing suicide. The patient's next of kin sued Park Nicollet and Health Partners, claiming that the patient's violent acts were foreseeable and more should have been done to prevent the patient's actions, even though the patient had no history of violence, made no threats of violence, and was not in the custody of Park Nicollet.

How was the MMA involved?

The MMA and the Minnesota Hospital Association, participating as amicus curiae, submitted a brief explaining how this significant expansion of liability would

negatively impact the mental health system in Minnesota.

What did the Minnesota Supreme Court decide?

First, that Park Nicollet and its physicians do have a duty to protect a patient from self-harm, even if the patient is not in their custody.

And second, that Park Nicollet physicians do not have a duty to protect a patient's family from the violent acts of a patient absent a custodial relationship, history of violence, or threats of violence.

In Minnesota, a physician owes a duty to avoid causing foreseeable harm to their patients and may owe a duty of care if there is a foreseeable risk of harm to others. In the case of a patient's self-harm or suicide, a physician owes a duty of care when that patient is in the custody of the physician (being treated as an inpatient). In this case, the patient was not in the physical custody of Park Nicollet but was being treated as an outpatient. However, the court found that Park Nicollet physi-

cians still owed a duty to the patient because they agreed to treat him.

As for a duty owed to the patient's family, a physician owes a duty to individuals for the acts of their patients if those acts are foreseeable. Foreseeability can be established by a history of violence or by explicit threats being made. In this case, none of the aforementioned factors exist, the court said. The court held that the harm committed by the patient against his family was outside the scope of what could have been foreseeable to Park Nicollet physicians and that "severe" depression on its own cannot make patient violence legally foreseeable."

Why is this case important for Minnesota physicians?

The portion of the opinion that found Park Nicollet physicians could be responsible for the self-harm of their patient puts Minnesota physicians in a difficult position when treating mental health conditions. The opinion encourages physicians to use more drastic treatments or to admit patients as opposed to treating them as outpatients because the physicians could still be held responsible for the patient's behavior.

On the other hand, the portion of the opinion that found Park Nicollet physicians did not have a duty to protect the patient's family from the unforeseeable violent actions of their patient will maintain the status quo and help to continue destigmatizing mental health diagnoses. The court itself acknowledged the harm that could occur if foreseeability of violence could be established by a diagnosis of depression alone when it stated, "holding that any patient with untreated depression and anxiety is a foreseeable murderer is not supportable and would certainly serve to stigmatize a population in need of further assistance." MM

Resource: *Smits as Trustee for Short v. Park Nicollet Health Services* (<https://caselaw.findlaw.com/mn-supreme-court/1911384.html>)

News Briefs



Speakers selected for Project ECHO Transition Summit

Local and national speakers will cover a variety of important topics on the transition of youth with medical complexity into adult care. The daylong summit takes place March 13 at 317 on Rice Park in St. Paul. You can attend either in-person or virtually. For the full agenda, faculty bios and to register, visit mnmed.org/education-and-events/project-echo/project-echo-transition-summit. The summit has been approved for CME credit. For more information, email cme@mnmed.org.

Board of Medical Practice gets new executive director

Elizabeth Huntley, JD, began her new role as the new executive director of the Minnesota Board of Medical Practice in early February. She replaced Ruth Martinez.

Huntley has been with the board for the past 17 years. Since 2018, she has served as deputy director. Before that she served as a supervisor in both the complaint review unit and the licensure unit. She received her JD from Mitchell Hamline School of Law in 2004. Before obtaining her law degree, Huntley worked as an investigator for the Minnesota attorney general's office.

New state health commissioner begins tenure

Brooke Cunningham, MD, PhD, became the new commissioner for the Minnesota Department of Health in January. She replaces Jan Malcolm, who has served in the position since 2018 and from 1999 to 2003. Most recently, Cunningham served as the assistant commissioner for the department's Health Equity Bureau. She has also served on the MMA's Health Disparities Work Group and Health Equity Advisory Group.

U of M, CentraCare discuss med school for rural health

The University of Minnesota and CentraCare are in discussions to create a new medical school that would focus on rural health.

The school, which would open in 2025, would be based in St. Cloud. The plan needs approval from the university's board of regents.

The partnership comes out of a desire to address the growing shortage of medical professionals in rural areas of the state. Rural patients have limited access to care and have reduced services at clinics and hospitals. They have to wait longer for appointments and travel farther for care.

The U of M opened its Duluth campus in 1972 to focus on rural health.

MMA president weighs in on recreational cannabis

In a January 11 opinion piece in the Minneapolis *Star Tribune*, MMA President Will Nicholson, MD, urged lawmakers to consider how legalizing cannabis will impact the health of Minnesotans.

"As physicians, we urge policymakers to be mindful of the harmful and difficult lessons learned with respect to alcohol and tobacco regulation," Nicholson writes. "These lessons, combined with the best available, albeit insufficient, evidence on the health effects of cannabis must inform any future Minnesota policy."

Nicholson then lists seven considerations that are taken from MMA policy on recreational cannabis. (You'll find the policy compendium under the Advocacy tab at www.mnmed.org. The policy 530.999 can be found at the top of page 132 of the PDF.)



CMS releases new Medicare physician payment rates

In early January, the Centers for Medicare and Medicaid Services (CMS) released the new Medicare physician payment files that include the 2023 conversion factor of \$33.8872, which is 2% lower than the 2022 conversion factor of \$34.6062. The new conversion factor reflects the year-end adjustments to Medicare payment rates adopted by Congress.

The 2023 conversion factor might have been reduced by an additional 2.5% except for pressure applied by the MMA and other organized medicine groups, led by the AMA.

"This cut comes at a time when physician practices remain stressed by COVID-19, seasonal infections, and many financial challenges," said MMA President Will Nicholson, MD. "Although the size of the cut is smaller than first proposed, I want to be clear, the MMA views any cut to Medicare physician payments as unacceptable."

The MMA denounced the cuts in a letter sent in December to Minnesota's congressional delegation. The MMA will continue to

advocate for updates to Medicare physician payments that better reflect the increasing costs of practicing medicine.

X-Waiver no longer required to treat opioid use disorder

With the signing in December of the Consolidated Appropriations Act of 2023, Congress eliminated the DATA-Waiver Program, also known as the X-Waiver. This means that an X-Waiver is no longer required to treat patients with buprenorphine for opioid use disorder.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Drug Enforcement Administration (DEA) issued guidance in January on the removal of the X-Waiver.

For many years, the X-Waiver has been a significant barrier to the treatment of opioid use disorder, and its requirements contributed to the stigma that surrounded the disease. Medication for opioid use disorder is a critical tool for those fighting to overcome the disorder in that it helps to sustain recovery and prevents overdoses. The move by SAMHSA and the DEA to eliminate the X-Waiver will increase access to buprenorphine for those who would benefit from its treatment the most.

According to the SAMHSA and DEA guidance, all DEA registrants should be aware of the following:

- A DATA-Waiver registration is no longer required to treat patients with buprenorphine for opioid use disorder.
- All prescriptions for buprenorphine now require only a standard DEA registration number. The previously used DATA-Waiver registration numbers are no longer needed for any prescription.
- There are no longer any limits on the number of patients a prescriber may treat for opioid use disorder with buprenorphine.
- The act does not affect existing state laws or regulations that may be applicable.

It is also important to note that the act also introduced new training requirements for all prescribers. These requirements will not go into effect until June 21. The DEA and SAMHSA are actively working to provide further guidance, and physicians should expect to hear from the DEA with additional information on these requirements soon.

Provider tax to be reduced in 2023

Minnesota's provider tax, based on a law passed in 2011, is assessed on the gross revenues received by physicians and other healthcare providers for patient services. The tax will be reduced by 11% for 2023—from 1.8% to 1.6%.

The provider tax is deposited into the Health Care Access Fund and is used to fund the MinnesotaCare program and other programs designed to ensure affordable access to healthcare services.

In 2011, the legislature passed a law that requires the commissioner of management and budget to determine the projected balance in the Health Care Access Fund each year. If the revenues are projected to exceed 125% of the needed expenditures, the commissioner must reduce the tax to reduce the structural balance in

the fund. The reduced rate is just for that calendar year. The rate change for 2023 is the first time this provision has been triggered.

The current surplus in the Health Care Access Fund was partly caused by increased federal payments for Medical Assistance and MinnesotaCare that reduced the state expenditures that were needed for these programs.

The provider tax was originally adopted by the Legislature in 1992 with the creation of the MinnesotaCare program. It was originally set at a rate of 2%. The tax was permanently reduced to 1.8% in 2019.



New conditions added to medical cannabis program

In late November, the Minnesota Department of Health announced that it will add irritable bowel syndrome and obsessive-compulsive disorder to the list of qualifying medical conditions for participation in Minnesota's Medical Cannabis Program.

The new qualifying conditions will take effect Aug. 1.

No petitions for new delivery methods were considered this year. Petitions for gastroparesis and opioid use disorder were not approved.

As in past years, the health department conducted a formal petitioning process to solicit public input on potential qualifying medical conditions and delivery methods for medicine. Minnesotans submitted petitions in June and July. Following that, the process moved into a public comment period and a review panel. Health department staff prepared reports that summarized research pertaining to the use of medical cannabis for each proposed condition.



FROM THE CEO

Farewell to three giants

As I write this column in early February, I am grateful to say farewell to the cold and snowy days of January. Yet, there are farewells of a more significant nature on my mind. In January we bid farewell to three giants—individuals who left indelible marks on Minnesota public health, medicine, and health policy.



On January 3, **Jan Malcolm** retired from her role as commissioner of the Minnesota Department of Health. She holds the unique distinction of

having served under three different governors—Gov. Jesse Ventura, Gov. Mark Dayton, and Gov. Tim Walz.

Few state agency commissioners achieve broad public name recognition. The COVID-19 pandemic changed that for Malcolm as she—and all public health professionals—were thrust into the public spotlight in ways not previously imaginable. She led the health department through arguably the most significant public health crisis in a century. Her commitment to science, best available evidence, transparency, and collaboration helped land Minnesota ninth among states in terms of COVID-19 state health system performance, according to The Commonwealth Fund's 2022 Scorecard on State Health System Performance.

In addition to her stellar public service, Malcolm had an impressive career in the private sector—working for Minnesota health plans, health systems, and the Robert Wood Johnson Foundation. In 2004–5, Malcolm partnered with the MMA in development of the MMA's influential Physicians' Plan for a Healthy Minnesota health system reform report. Hers is a retirement more than well deserved.



On January 31, former U.S. Sen. **David Durenberger** passed away. Durenberger represented Minnesota in the U.S. Senate from 1978 to

1995. He was an influential and impactful figure in national health policy, serving on various committees of jurisdiction, including the health subcommittee of the Senate Finance Committee. He sponsored the 1988 Medicare Comprehensive Coverage Act, the most significant expansion of Medicare benefits since 1965. (The law, however, was repealed a year later following public confusion and opposition.) He was also the original Senate sponsor of the Americans with Disabilities Act. Following his departure from the Senate, Durenberger chaired the National Institute of Health Policy at the University of St. Thomas, where he promoted health policy dialogue and leadership until 2014. Durenberger mentored countless future

health policy leaders and partnered frequently with the MMA to support health policy debate and education.



On January 14, **James Boulger**, PhD, passed away. Boulger was professor emeritus at the University of Minnesota Medical School, Duluth, where he

worked for nearly 50 years. Boulger created a training model that relied on community-based physicians—preceptors—to train students in rural communities. The program, the Rural Medical Scholars Program, remains a central part of the UMD medical school curriculum. His name is synonymous with rural primary care medical education. For the hundreds of physicians he trained and nurtured, his name is also synonymous with mentor, leader, and friend. For many rural communities in Minnesota, his legacy is a profound improvement in local healthcare access.

On behalf of the MMA, it is my honor to recognize and thank these three giants of Minnesota healthcare for their significant and memorable contributions.

Janet A. Silversmith

Janet Silversmith

JSilversmith@mnmed.org

VIEWPOINT

Fighting a pandemic pay cut

Physicians across Minnesota and the entire country have spent the last three grueling years fighting to keep their fellow Americans safe during the COVID-19 pandemic.

Many of us put our own lives, our families' lives, and our practices on the line as we relentlessly fought back against a global pandemic. We upheld the ethics and best practices of our nation's health systems, and we stood up to political attacks on science, facts, and common sense.

Despite this noble effort, Congress gave us a pay cut.

In early January, the Centers for Medicare and Medicaid Services released the new Medicare physician payment files that include the 2023 conversion factor—it's 2% lower than last year. This new conversion factor reflects the year-end adjustments to Medicare payment rates adopted by Congress.

And it was supposed to be worse.

We fought hard against their original plan, a 4.5% cut. The MMA joined the AMA and all 50 state medical societies and sent a letter to Congress in December stressing the depravity of cutting physicians' pay. We organized grassroots pressure and lobbied our local elected officials. As a result of these efforts, we were able to get the cut down to 2%.

Although this is a success of sorts, any cut to Medicare physician payments is unacceptable. This happens year after year. In fact, from 2001 to 2021, Medicare physician pay fell 22% after adjusting for inflation in practice costs.

We are challenging our elected officials to fix our flawed, unjust, unsustainable Medicare payment system in 2023.

No one is more committed to controlling the high cost of healthcare than physicians—we see the harm it causes our patients every day. Unfortunately, Congress didn't cut into anybody else's revenue to reduce costs—they focused their cuts on us. They didn't ask the industries that physicians depend on to lower their costs or to help us run our practices more efficiently. They didn't cut insurance company revenue—those companies are making tens of billions in profits. They didn't cut revenue for the device patent holders or the drug patent holders who also continue to see massive profits. No, they cut physician pay.

This can't stand. It's not sustainable. And it's an abject insult after what physicians have been through.

The Medicare payment system is broken and Congress needs to fix it. A system that balances costs on the backs of physicians using annual end-of-year cuts while other sectors increase their costs unabated will make it impossible to deliver Medicare patients the care they need.

A pandemic and then a pay cut. Physicians deserve better.

You better believe the MMA will continue to advocate for Medicare physician payments that actually reflect the costs of practicing medicine.

We've been through too much to be treated so poorly. That's why organizations like the MMA are so important. And that's why I'm so proud to be a member. On with the fight! MM



Will Nicholson, MD
MMA President

You better believe the MMA will continue to advocate for Medicare physician payments that actually reflect the costs of practicing medicine.

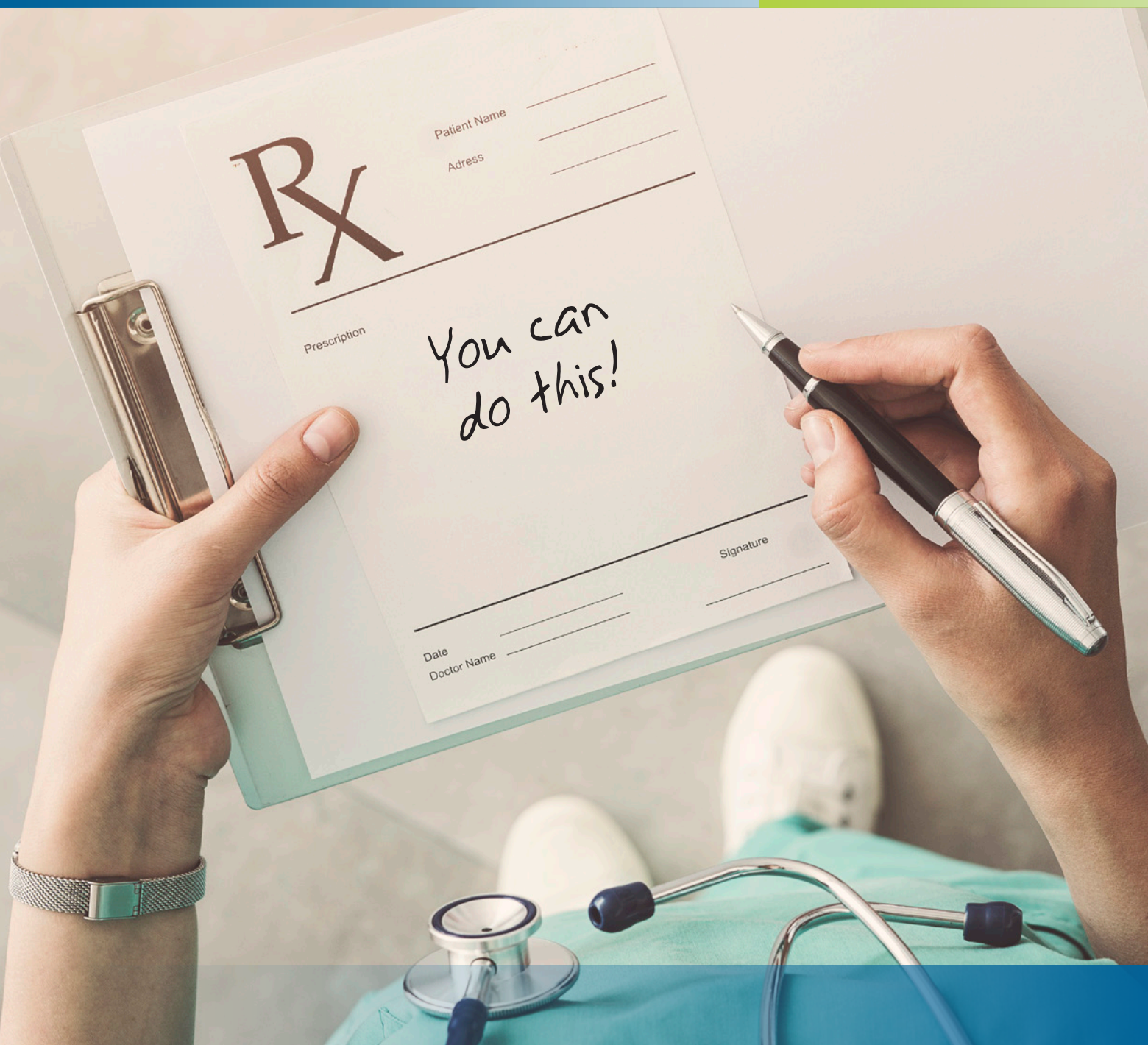
Continuing to persevere



MINNESOTA
MEDICAL
ASSOCIATION

Annual Report

2022





Reflections on 2022

On behalf of the MMA, it is my privilege to present the MMA's 2022 Annual Report. This report offers a high-level overview of our key work over the past 12 months.

As I reflect on 2022, I am struck by the continued perseverance of the medical profession amid continued challenges and change. The COVID-19 pandemic maintained its grip; workforce shortages persisted; nurses at many Minnesota hospitals went on strike; inflation and economic uncertainty increased; and the U.S. Supreme Court's decision to strike down longstanding reproductive healthcare rights for women sent shock waves across the country. To name just a few.

The MMA rose to the challenges of 2022 thanks to our dedicated leaders, active volunteers, and incredible staff.

I am proud of the impact we made in 2022 and excited about our plans for 2023. Thanks to your support, the MMA remains focused on making Minnesota the healthiest state and the best place to practice.

In gratitude,

A handwritten signature in blue ink that reads "Janet L. Silversmith". The signature is written in a cursive, flowing style.

Janet L. Silversmith, CEO

MMA LEADERSHIP

(JANUARY THROUGH SEPTEMBER 2022)

2022 Officers

PRESIDENT

Randy J. Rice, MD, Moose Lake

PRESIDENT-ELECT

Will Nicholson, MD, Maplewood

IMMEDIATE PAST PRESIDENT

Marilyn J. Peitso, MD, St. Cloud

SECRETARY/TREASURER

Carolyn McClain, MD, Edina*

CHAIR OF THE BOARD

Edwin Bogonko, MD, MBA, Shakopee

CHIEF EXECUTIVE OFFICER

Janet Silversmith

Trustees

NORTH CENTRAL TRUSTEE DISTRICT

Kim Tjaden, MD, MPH, St. Cloud

NORTHEAST TRUSTEE DISTRICT

Dania Kamp, MD, Moose Lake

NORTHWEST TRUSTEE DISTRICT

Abigail Ring, MD, Detroit Lakes

SOUTHEAST TRUSTEE DISTRICT

Lynn Cornell, MD, Rochester

Dionne Hart, MD, Rochester

SOUTHWEST TRUSTEE DISTRICT

Amrit Singh, M.B.B.S, Mankato

TWIN CITIES TRUSTEE DISTRICT

Elizabeth Elfstrand, MD, Minneapolis

Rebecca Thomas, MD, Plymouth

RESIDENT/FELLOW

Saam Dilmaghani, MD, Rochester

MEDICAL STUDENT

Derrick Lewis, Rochester

POLICY COUNCIL APPOINTEE

Jonathan D. Gelber, MD, Rochester

AMA Delegation

Chair: Cindy Firkins Smith, MD, Willmar

Vice Chair - David L. Estrin, MD,
Minnetonka

John Abenstein, MD, MSEE, Rochester

Andrea Hillerud, MD, St. Paul

David Thorson, MD, White Bear Lake

AMA ALTERNATE DELEGATES

Lisa Mattson, MD, Plymouth

Dennis O'Hare, MD, St. Paul

Ashok Patel, MD, Rochester

Laurel Ries, MD, St. Paul

Randy Rice, MD, MMA President, Moose
Lake

MMA Committees

FINANCE AND AUDIT

Chair: Carolyn McClain, MD, Edina*

ETHICS AND MEDICAL-LEGAL AFFAIRS

Chair: Dennis O'Hare, MD, St. Paul

EQUITY IN ACCESS & QUALITY

Chair: Kevin Donnelly, MD, St. Cloud
Public Health

Chair: Shari Bornstein, MD, MPH,
Rochester

COMMITTEE ON ACCREDITATION AND CONTINUING MEDICAL EDUCATION

Chair: Robert Moravec, MD, Oakdale

MMA Policy Council

Chair: Britt Ehlert, MD

Nusheen Ameenuddin, MD

Amy Boles, MD

Christy Boraas, MD, MPH

Steven Callori, MPH

Nicole Chaisson, MD

John Dillon, MD

Jonathan Gelber, MD

Rachel Gordon, MD

Giovanna Grigsby-Rocca

James Hebl, MD

James Hoffman, DO

Ryan Kelly, MD

Meg Kersey-Isaacson, MD

Thomas Kingsley, MD

Kevin Koo, MD, MPH

Robert Koshnick, MD

Anne Pereira, MD, MPH

Laura Princ, MD

Frank Rhame, MD

Jennifer Tessmer-Tuck, MD

Rebecca Thoman, MD

Verna Thornton, MD

RESIDENT FELLOW SECTION REPRESENTATIVE

Zach Shaheen, MD

MEDICAL STUDENT SECTION REPRESENTATIVE

Riley Shearer

MMA PRESIDENT-ELECT

Will Nicholson, MD

MMA Medical Student Section

Co-chair: David Soriano (Mayo Clinic Alix
School of Medicine)

Co-chair: Kaylie Evers (University of
Minnesota, Duluth Campus)

MMA Resident and Fellow Section

Chair: William Minter, MD (through June);
Teshfatsiyon Ergando, MD (second half of
the year)

MMA Foundation

Board President: George Schoephoerster, MD,
St. Cloud

CEO: Kristen Gloege

BOARD MEMBERS

David Agerter, MD

Luis A. (Alex) Antezana

Macaran Baird, MD

Juan Bowen, MD, Past President

Gabrielle Cummings

Ed Ehlinger, MD, MSPH

Fatima Jiwa, MBChB

Nick Jungbauer

George Lohmer

Stephen Palmquist, MD

Marilyn J. Peitso, MD

Verna Thornton, MD

Janet Silversmith

MEDPAC (MMA's political action committee)

Chair: Will Nicholson, MD, Maplewood

**Through May 2022*



Healthiest in the Nation

Making Minnesota the healthiest state

In 2022, physicians confronted many forces that challenged their work to keep Minnesotans healthy — an ongoing — pandemic, dramatic changes in law, persistent inequities, an exhausted and dwindling healthcare workforce. Through it all, the MMA remains steadfast in its commitment to work with and for physicians to make Minnesota the healthiest state. In particular, we are focused on improving patient and population health, advancing health equity, and ensuring patient trust in the medical profession. Here's how we furthered our mission in 2022.

Protecting Reproductive Rights

In May, the MMA Board of Trustees adopted recommendations from the Policy Council to update policy affirming that abortion is an essential component of comprehensive medical care. In June, the MMA joined with four other physician specialty groups to

speaking out against the U.S. Supreme Court's decision on June 24 in *Dobbs v. Jackson Women's Health Organization*, which overturned a nearly 50-year precedent set by *Roe v. Wade* and reaffirmed by *Planned Parenthood v. Casey*.

"Healthcare decisions, including whether to have an abortion, are deeply personal and should be made between a patient and their physician. The implications of this decision are profound and will include disruption and, in some states, elimination of equitable and safe access to medical care for women in the United States," the statement read.

Joining the MMA on the statement were: the American College of Obstetrics and Gynecology Minnesota Section; the Minnesota Academy of Family Physicians; the Minnesota Association of African American Physicians; and the Minnesota Chapter, American College of Physicians.

Defending the Power of Vaccines

Public and political attack against vaccines continued in 2022, including at the Minnesota Legislature. The MMA was ready to fight and proved successful at keeping these harmful efforts from moving forward.

On the first day of session, a bill was introduced that would have required healthcare providers to provide a new list of specific disclosures to the patient before administering a vaccine. Presented as improving informed consent, the intent, and impact, would have been to dissuade the patient from getting vaccinated.

Other bills were introduced that would have prohibited enforcement of government vaccine mandates. One bill would have allowed proof of presence of natural antibodies as an alternative to vaccination against COVID-19, a practice that contradicted the Centers for Disease Control and Prevention's public health guidelines. Other bills would have outlawed local governments from enforcing face mask requirements, from requiring distance between customers in private businesses, and from showing proof of vaccination to enter private businesses.

The MMA will remain vigilant in fighting efforts that seek to spread misinformation or undermine the benefits of vaccines.

Helping with the Transition to Adult Care for Medically Complex Youth

Thanks to clinical and technological advances, many children with medical complexity now live into adulthood — yet they face numerous practical hurdles in moving from pediatric care to adult providers. With a grant from the COPIC Medical

Foundation, the MMA, in partnership with the MMA Foundation, established a Project ECHO program designed to improve the competence and confidence of Minnesota adult primary care clinicians to manage youth with complex conditions, thereby increasing the capacity and number of such clinicians willing to accept new patients. During the second half of 2022, the MMA hosted a series of online sessions on transition care. The sessions are available on the MMA website.

Improving Health Equity

The MMA's ongoing commitment to improving health equity was reaffirmed by the Board in 2022 and our work remains focused on three key priorities — diversifying the physician workforce, addressing social drivers of health, and changing the culture of medicine to mitigate implicit bias and advance an anti-racist culture.

Our work to change the culture of medicine recognizes the role that implicit bias and institutional racism play in health outcomes. To help drive change, MMA, with funding support from UCare, offered a new educational series in 2022, Conversations on Race & Equity (CoRE), which is designed to be a safe space for physicians to discuss topics related to anti-racism, implicit bias, and cultural humility. Sessions are held virtually under the guidance and support of a physician and a health equity specialist.

We also expanded training in implicit bias to offer practical strategies for mitigating the effects. The resources also provided an introduction on how to be an ally and leader in diversity, equity, inclusion, and health equity. The MMA offered both public and private implicit bias training for healthcare organizations.

Started in 2020, the MMA Barriers to Workforce Diversification in Physician Education, Training, and Licensure Task Force delivered 14 recommendations to the MMA Board in September to mitigate identified barriers in medical education, residency training, and the licensure process that affect the number of Black, Indigenous, and others underrepresented in medicine. One of the key recommendations from the report is aimed at reducing financial barriers to attending medical school. In an act of support for this work, the MMA Foundation launched a new Changing the Face of Medicine campaign to provide scholarships for MCAT fees for students from populations historically underrepresented in medicine. The response to the campaign has been extremely strong.

Preserving Patients' Access to Medications

A top priority at the Capitol during the 2022 session was to ensure that patients continue to have access to their medications. Our advocacy team worked to prohibit insurers or pharmacy benefit managers (PBMs) from altering a patient's drug coverage for medications they are using, which currently can occur in the middle of a patient's contract year. These changes often cause gaps in medication use, which can exacerbate conditions and cause complications. In the end, the House passed limits on mid-year formulary changes in its omnibus Health and Human Services bill. However, the Senate, expressing concerns with growing prescription drug costs, did not pass it.

Ensuring Patients' Wishes are Followed

Our advocacy team also worked to authorize a feasibility study to establish a statewide registry for Provider Orders for Life-Sustaining Treatment (POLST) forms to ensure easy access to such forms by EMS and other healthcare providers.

The MMA achieved strong bi-partisan support for the proposal in the House and it was included in the House omnibus Health and Human Services (HHS) bill. However, the legislation never received a hearing in the Senate—mostly due to its members' intention not to pass any state spending bills. The POLST statewide registry had a \$292,000 fiscal note. With no final agreement on the HHS bill at the end of session, it did not pass.

Making Minnesota the Best Place to Practice

The MMA continued its work in 2022 to make Minnesota the healthiest state and the best place to practice medicine. Our work to make Minnesota the best place to practice is focused on providing physicians with tools and resources to support professional success; delivering timely news and information about Minnesota healthcare trends and changes; ensuring a practice environment that facilitates high-quality medical care; and advocating for changes that remove barriers and burdens that stand in the way of patient care. Here are some of the highlights of the work in 2022.

Advocacy

One of the MMA's top legislative priorities in 2022 was to improve patient safety and harm following an adverse event by shifting from the current "deny and defend" culture to one of transparency and support. To accomplish this, the MMA supported legislative enactment of the evidence-based CANDOR (Communication and Optimal Resolution) model, which is designed to include patients and family members in timely and candid conversations following an adverse event, protect such conversations from legal discovery, support caregivers, and prevent future events. Although we made progress with legislators on a CANDOR bill and have actively engaged patient/trial attorneys in the bill development, it did not pass. We intend to continue to move this important issue forward in the 2023 session.

At the federal level, we fought to preserve insurance coverage for low-income Minnesotans by supporting a new IRS regulation, adopted in October 2022, that fixed the so called "family glitch" when determining ACA premium subsidies. Previously, individuals were not eligible for premium subsidies if they had access to employer-sponsored insurance. The family glitch impacted families when the employee received employer-sponsored healthcare, but the cost of dependent coverage was unaffordable. With the new IRS rule, dependents will now qualify for premium subsidies through the ACA if the cost of the employee's dependent coverage exceeds 9.5% of the family's income. It is estimated that approximately one million Americans will gain coverage or see more affordable insurance with this rule change.





In an oft-repeated effort, the MMA again joined the AMA and other medical societies in 2022 to urge Congress to address Medicare physician payment rates. In December, the MMA, AMA and the other medical societies sent a letter to House and Senate leadership to stop the entire cut. In the end, the proposed cut of 4.5% was reduced to 2%. Work needs to continue to fix the flawed Medicare payment system that results in annual payment cuts.

Helping Physicians Succeed Professionally

In 2022, the MMA renewed its commitment to helping physicians cope with the ever-increasing strain of the profession. As part of this commitment, in January and April, the MMA delivered Physician Forums focused

on burnout awareness, mindfulness, and resilience. Our November forum focused on physician suicide awareness.

The MMA also participated in a six-month campaign to share news and resources leading up to National Physician Suicide Awareness Day. While physician suicide was a crisis long before COVID-19, the demands of the pandemic have created a sense of urgency to better support physicians' mental health and wellbeing.

In addition, the MMA's Physician Well-being Advisory Committee kicked off a series of convenings of systems' well-being leaders and champions. These convenings are intended to build community and offer a collaborative space to share system-level approaches for designing workplaces that foster well-being and respect professionalism. These will continue in 2023.

Along with these wellness efforts, the MMA announced the launch of its new Minnesota Physician Leadership Institute (MPLI), which will offer innovative, best-in-class training to provide Minnesota physicians with the skills, insights, and competencies required to lead successfully. Working with the Carlson School of Management as its faculty partner, the MPLI will kick off its inaugural cohort in fall 2023. Class-size is limited to 25 physicians and is only available to MMA members.

The MMA also continued: its Mentorship Program to pair pre-med students, medical students, and residents/fellows, with medical students, practicing physicians, residents/fellows, and retired physicians.; its Physician Employment Contracting resources; and its 10% premium discount with COPIC, the MMA's endorsed medical professional liability insurance provider.

Members Making a Difference

All Minnesota physicians make a difference in the lives of their patients. The MMA is fortunate to have many members who volunteer their time above and beyond their regular day-job duties. These people truly make a difference in people's lives. We are proud to call them MMA members.



Christy Boraas, MD, MPH

Boraas, an OB-GYN in Minneapolis, chaired the MMA's Abortion Policy Work Group, a body of 12 physicians who, in anticipation of the *Dobbs v. Jackson Women's Health Organization* decision and subsequent end of *Roe v. Wade*

protections, spent three months reviewing and recommending changes to MMA's policies regarding abortion. Boraas, a member since 2014, also serves on the MMA's Policy Council.



Natalia Dorf-Biderman, MD

Dorf-Biderman is chair of MMA's Physician Well-being Advisory Committee, which advises the MMA on strategies and approaches to help physicians and physicians-



Siri Fiebiger, MD

Practicing as an OB-GYN in Minneapolis, Fiebiger is a leading champion of reproductive rights and health equity. She helped develop and moderate the September 2022 MMA Physician Forum titled, "Examining Maternal Mortality Through a Health

Equity Lens." She's been an MMA member since 2015. In addition to her service to the MMA, she served on the Board of Directors of Planned Parenthood North Central States for six years and was chair of the Minnesota Section, the American College of Obstetricians and Gynecologists.



Kacey Justesen, MD

Justesen served as co-chair of the MMA's Barriers to Workforce Diversification in Physician Education, Training, and Licensure Task Force. Justesen, who is an assistant professor at the University of Minnesota's Department of Family Medicine and Community

Health, became program director of the University of Minnesota North Memorial Family Medicine Residency program in 2018. She is a member of the University of Minnesota Physician's board of directors. She has been an MMA member since 2016.



Ryan Kelly, MD, MS

Kelly is chair of the MMA's Illicit Drug Harm Reduction and Decriminalization Work Group, a body of 25 members who spent five months researching, discussing, and developing recommendations for MMA policies concerning the health of people who

use illicit drugs. Kelly, a member since 2019, is also on the MMA's Policy Council. Kelly is an assistant professor of medicine at the University of Minnesota Medical School, as well as a general medicine hospitalist, and medicine and pediatrics primary care physician at the Community-University Health Care Center.



Adrina Kocharian

A MD/PhD student at the University of Minnesota Medical School, Kocharian currently serves as the AMA/MMA delegate on the MSS Executive Committee. She has also been elected by her peers to serve as an MSS delegate for the AMA House

of Delegates. In this role, she has advocated on such issues as lifting restrictions on abortion care and exploring harm reduction strategies for illicit drug use. She also served a term on the Policy Council and was part of the MMA's Illicit Drug Work Group. She has been an MMA member since 2018.



Corey Martin, MD

Martin, founder of the Bounce Back Project conference that has now become the Reclaim the Joy of Medicine Conference, is a leading champion of physician well-being. He still serves in an advisory role overseeing the Joy conference along with advis-

ing on the MMA's new Minnesota Physician Leadership Institute, which is scheduled to debut in 2023. Martin, who practices family medicine in Buffalo, has been a member since 2020.



Dennis O'Hare, MD

O'Hare serves as the chair of the MMA's Ethics & Medical-Legal Affairs Committee. He also serves as an alternate delegate to the AMA. In 2022, he moderated one of the MMA's Physician Forums on "Medical Liability in Minnesota."

O'Hare, a member since 2017,

is board certified in family and geriatric medicine.



Carolyn "Carrie" Stelter, MD

Stelter, a member since 2016, received the 2022 COPIC/MMA Foundation Humanitarian Award which recognizes MMA members who go above and beyond to address the healthcare needs of under-

served populations in Minnesota. Stelter co-founded the St. Peter Community Free Clinic after realizing that the local Hispanic and Latinx communities were being excluded from medical care opportunities, support, and funding mechanisms in ways other communities were not. Stelter practices family medicine in Le Sueur.

Making a Difference at a Local Level

MMA's Component Medical Society leaders

STEELE COUNTY MEDICAL SOCIETY

PRESIDENT: Grant D. Heslep

WRIGHT COUNTY MEDICAL SOCIETY

PRESIDENT: Robert G Milligan, MD, FAAFP

ZUMBRO VALLEY MEDICAL SOCIETY

PRESIDENT: Thomas C. Kingsley, MD, MPH

EXECUTIVE DIRECTOR: Beth Kangas, PhD

Membership Overview

Year	Total Members
2000	9,089
2001	9,162
2002	9,109
2003	9,116
2004	9,297
2005	10,858
2006	10,835
2007	10,909
2008	10,969
2009	11,330
2010	11,250
2011	10,106
2012	10,347
2013	9,998
2014	10,309
2015	10,257
2016	10,171
2017	10,260
2018	10,637
2019	11,011
2020	12,017
2021	11,711
2022	10,168

Membership Types

Member Type	2022 Count
Regular	4,245
Resident/Fellow	2,588
Retired	1,741
Student	1,594

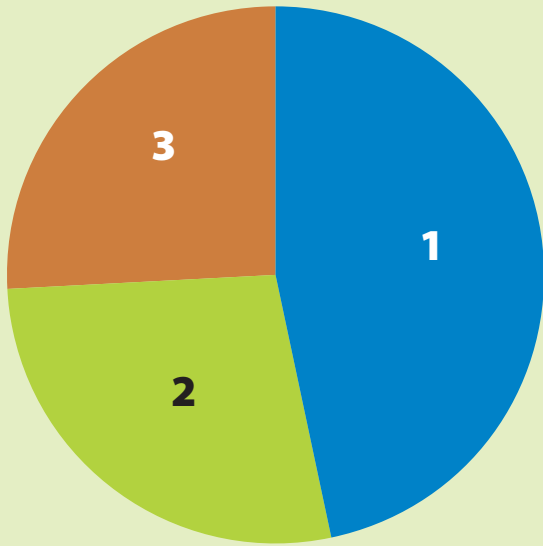
By District*

NORTHWEST TRUSTEE DISTRICT	59
NORTHEAST TRUSTEE DISTRICT	509
SOUTHEAST TRUSTEE DISTRICT	4495
SOUTHWEST TRUSTEE DISTRICT	522
TWIN CITIES TRUSTEE DISTRICT	4018

*District total as of January 31, 2023



2022 Financial Highlights



TOTAL MMA REVENUE: \$3.2M

- 1 **DUES** 49%
- 2 **NON-DUES REVENUE** 24%
- 3 **INVESTMENT SPENDING POLICY** 27%



HOW YOUR DUES ARE USED

- 1 **MEMBER ENGAGEMENT** 15%
- 2 **ADVOCACY** 19%
- 3 **COMMUNICATIONS** 23%
- 4 **GOVERNANCE** 12%
- 5 **INFRASTRUCTURE AND OVERHEAD** 31%



MINNESOTA
MEDICAL
ASSOCIATION

3433 Broadway Street NE, Suite 187; Mpls, MN 55413

PHONE: 612-378-1875 or 800-342-5662

FAX: 612-378-3875

EMAIL: mma@mnmed.org

WEB: mnmed.org

JOIN US ON FACEBOOK, TWITTER, INSTAGRAM AND LINKEDIN



THE PULSE



An Easy-to-Use Tool to Help Shape MMA Policy

The Pulse is an innovative, online policy development and polling tool designed to give MMA members the opportunity to directly influence MMA policy.

To learn more, go to mnmed.org/ThePULSE

"I love The Pulse! Before (it), I wasn't sure how to propose anything to the MMA. The Pulse makes it incredibly easy. I submitted something last week!"

— LYNN CORNELL, MD

4 WAYS TO USE



SUBMIT a policy proposal for MMA consideration



VOTE and give feedback on proposed policies **BEFORE** MMA Board action



VOTE and give feedback on policy decisions **AFTER** MMA Board action



MONITOR proposals in the archive



Minnesota Physician Leadership Institute

Turning physicians into highly effective leaders

Learn more today at
WWW.MNPLI.ORG

Lead. Influence. Advocate.



Introducing world-class leadership skills exclusively for MMA-member physicians. Challenge yourself beyond the clinical world and learn from the best. The Minnesota Medical Association has partnered with the Carlson School of Management to design and deliver a new leadership curriculum exclusively for physicians.

Program begins September 2023

This activity has been approved for AMA PRA Category 1 Credit™



MINNESOTA
MEDICAL
ASSOCIATION



CARLSON SCHOOL
OF MANAGEMENT
UNIVERSITY OF MINNESOTA

Carlson Executive Education

Copyright © 2023 Minnesota Medical Association



AMY GILBERT, MD, MPH

- Family medicine physician, St. Paul.
- MMA member for about 25 years. "I got involved with the MMA because I was advocating for access to emergency contraception. I spoke to the public health committee and joined the MMA so I could speak and vote at the House of Delegates."
- Grew up mostly in St. Cloud, "but I got to spend the year after eighth grade living in London with my family and going to school there. It was the Queen's Silver Jubilee year, and we heard about that everywhere."
- Reed College in Portland with an interdisciplinary major in biology-philosophy, and medical school at Northwestern. "I always intended to do family practice. Northwestern didn't actually turn out many family docs. When I interviewed for residencies, they said, 'You must really want to do family medicine!'"
- My husband and I have two young adult daughters—one is training sled dogs in Alaska and one is spending a semester abroad in London. We have a senior dog named Moppet and two (surviving) backyard chickens.

Became a physician because...

I wanted to be a doctor because I heard about family members, like my great-grandfather, who was a much-loved small-town doctor in Indiana, and my uncle the pediatric neurologist. I'm left-handed, and when my hand smeared what I was writing as a small child, my mother would assure me, "Uncle Bob is left-handed, too, and he's a doctor."

Growing up I read lots of stories where a doctor turned up just at the emotional crux of the story, sitting by the bedside, or arriving in a hurry in the night. I wanted to be right there at the heart of things.

I've always been interested in the subjective experience of patients. What is it like for you to have this illness, to be in this situation? I don't assume I know what it's like, or what will work for them. I like to work it out together.

The best thing about my practice...

The exciting thing for me right now is I'm employed by a new practice called Herself Health. It's specifically for women 65-plus. The practice is in St. Paul's Highland Park. We started seeing patients at the beginning of January. More offices will be opening around the metro in the coming years.

It's really something to see how excited women are about this practice! We can have real depth in geriatric care—like alterations in prescribing, osteoporosis, hypertension in seniors, urinary issues—and all about Medicare.

I'm loving this practice. I enjoy every single one of my patients. As a start-up, we are developing as we go, and we have the support from leadership and the flexibility to respond to what our staff and patients need for quality care.

Greatest challenge facing medicine today...

Physicians need more time to spend with patients. Patients' biggest complaints are, "They didn't listen to me" or "They didn't explain it to me." We talk about moral injury from not being able to care for patients as they need. It comes from having too much to do in too little time.

How I keep life balanced...

As the new practice develops, I'm trying to follow the advice I've given to patients: Build in healthy habits from the beginning. I get as much of my work done at work as possible. I see patients on Tuesday, Thursday, and Friday. If I have work at home, I'll get it done in the mornings on Wednesday and Saturday, *after* I go work out at the Y. My husband is retired, and we enjoy playing board and card games, going to movies and performances together, and lots of bike riding in the summer. I go to opening day of the State Fair every year!

If I weren't a physician...

If I were starting college right now, I would study nonviolence. There are practical skills and knowledge that could help avoid violent conflict between nations, communities, cultures. It's hard work and deserves serious focus. **MM**



JOIN US FOR

Conversations on Race & Equity (CORE)

A virtual space for physicians to discuss topics related to **anti-racism, implicit bias and cultural humility.**

Participate in guided conversations and critical reflection on important issues that impact health equity.

Registration is free and open to all Minnesota physicians and trainees.

AMA PRA Category 1 Credits™ are available

OCTOBER *Anti-Racism: Why is it so difficult to talk about race?*

MARCH *Cultural Humility vs. Cultural Competence*

APRIL *Implicit Bias and Microaggressions*

MAY *Centering Experiences of Diverse Physicians*

JUNE *Allyship and Action*

Visit www.mnmed.org/core for details and registration



MINNESOTA
MEDICAL
ASSOCIATION



P E A C E O F M I N D

BEYOND

C O V E R A G E

As a premier medical liability insurance carrier, we are committed to being there when you need us. Our physicians and other staff serve as extended members of your team to help answer questions or navigate difficult situations. And when it's urgent, you have 24/7 access to a physician via our Risk Management hotline. Plus, our legal and HR experts help you tackle other issues as they arise.

That's Value Beyond Coverage.

COPIC is proud to be the endorsed carrier of the Minnesota Medical Association. MMA members may be eligible for a 10% premium discount.

 **COPIC**[®]
Better Medicine • Better Lives

CALLCOPIC.COM | 800.421.1834