

# MEDICINE

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## WOMEN IN white coats

There are more female doctors than ever before—and more coming out of medical school ... what does it mean to the practice of medicine?

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### Pearls in the OR

Shanda Blackmon, MD, MPH, a cardiothoracic surgeon at Mayo Clinic, wears pearls to remind herself—and others—that she is a woman in a very male profession. Her thoughts and those of another 23 women physicians and physicians-in-training start on page 17.

S. Blackmon, M.D.  
Thoracic Sur

### ALSO

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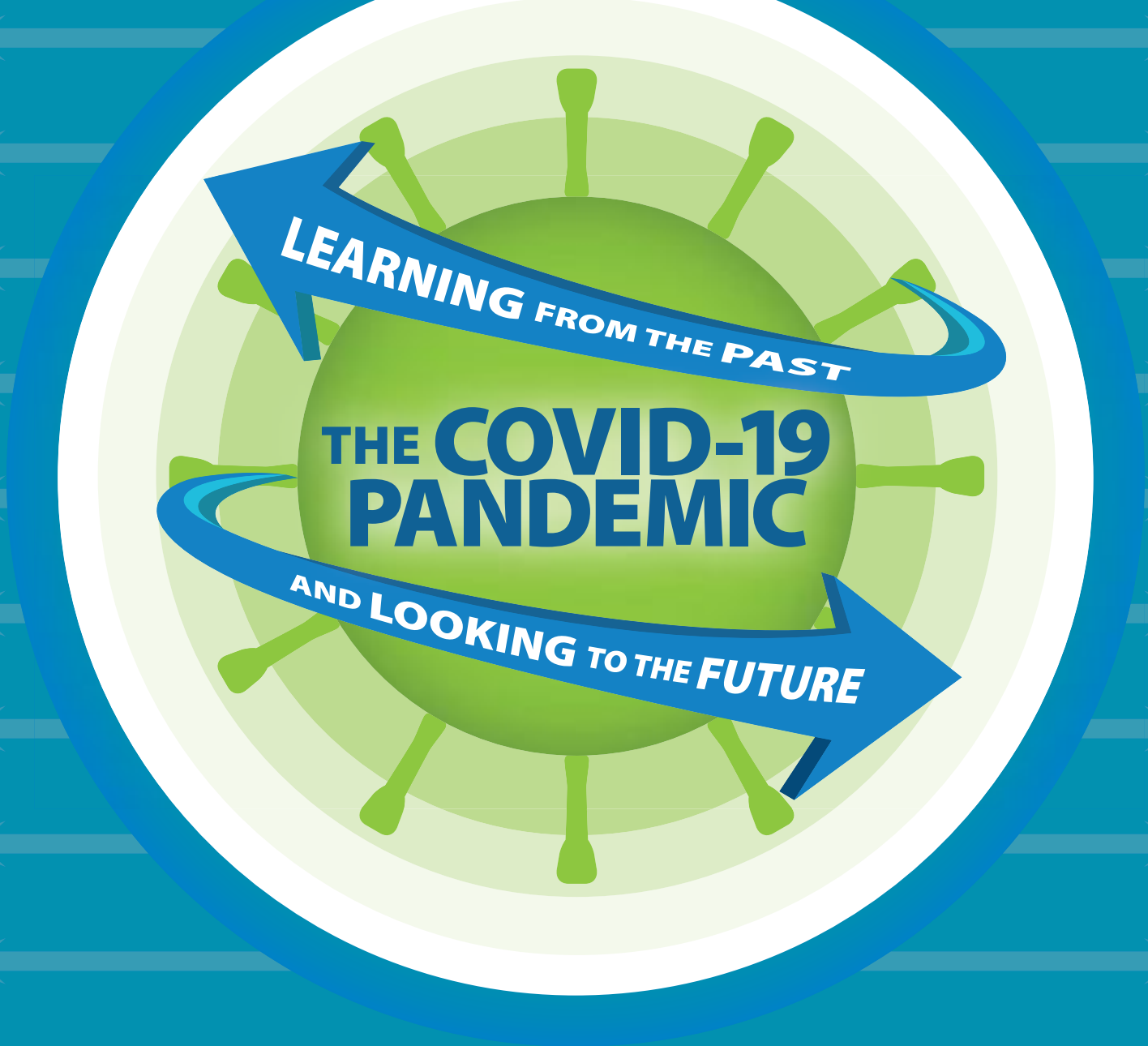
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PHOTO COURTESY MAYO CLINIC



# WOMEN IN white coats

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### 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](mailto:mm@mnmed.org)

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Minnesota Medical Association

### EDITOR

Linda Picone

### DIRECTOR OF COMMUNICATIONS

Dan Hauser

### ART DIRECTOR

Kathryn Forss

### CIRCULATION/WEB CONTENT

Mary Canada

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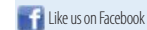
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## We need to recognize and support the power of women physicians

Women bring unique value to medicine. Indeed, studies have shown that compared to male physicians, women physicians are more likely to provide preventive care and psychosocial counseling, adhere to clinical guidelines, and spend more time with their patients. Some studies even show improved clinical outcomes with women physicians.

“Where are you from?” he asked and I replied, “I am originally from Ethiopia, a country in east Africa, but I am also an American. So I am African and American.” “You don’t look like the typical negro I am used to seeing. You are too good looking,” said my patient’s husband, a retired police chief.

How does one respond?

And then there are times when the intersection between my gender and my race doesn’t gel well with my profession as a physician or, much worse, as a surgeon. A few years ago, I introduced myself as the surgeon to my patient’s husband for the first time in the preoperative holding area. I noticed his eyes opened wide visibly and he couldn’t help but blurt out in disbelief, “You are the surgeon?” I smiled and said, “Yes sir, and I will take good care of your wife.” As we wheeled his wife to the operating room, I have to admit, I felt a tinge of pain and disappointment at his reaction to seeing me. But I also wondered how tortured the next four hours would be for him, leaving his beloved in my hands. These biases are harmful in both directions.

I have learned to throw up a gentle shield, like an invisible cloak, when I step out of my house, to prevent these toxins from permeating my body. But as an immigrant and a woman who has the luxury of drawing on the best of two cultures, I have found that the benefits of being exactly who I am far outweigh the barriers, especially for my patients.

My early lesson in what it means to be a woman healer started when I was a child growing up in communist Ethiopia in the 1970s and ‘80s. I was a frequent visitor to poorly lit and poorly staffed government hospitals. I don’t ever remember seeing

women doctors (only nurses) but what I do remember was that every time I got sick, my mom and her army of women elders would shower me with a medley of affection, herbs, incense, and holy water and mend me back to health. These were my early lessons on what it means to heal, and the seed of my deep respect for the wisdom of women in our communities. Women bring unique value to medicine. Indeed, studies have shown that compared to male physicians, women physicians are more likely to provide preventive care and psychosocial counseling, adhere to clinical guidelines, and spend more time with their patients. Some studies even show improved clinical outcomes with women physicians.

Although we have come a long way in increasing the number of women in medicine, we lag far behind on propelling women into leadership positions. In 2019, women constituted 42.3% of faculty and 46.8% of residents but only 38.7% of program directors and 18.5% of department chairs. Among women department chairs, the vast majority are white; only 8% and 5% of all women in these positions were Black or African American or Hispanic, respectively. This is most pronounced in obstetrics and gynecology, where there were 81.8% of female residents and 64.7% of women in academia but only 28.2% of women holding chair positions.

These gender disparities persist due to many factors, including gender bias in promotion, salary inequity, bullying, sexual harassment, lack of recognition, and delegation of women to leadership tasks that are less likely to lead to promotion. This leads to higher rates of attrition and burnout in women physicians.

There are other factors as well, such as pregnancy, childbirth, and motherhood, along with society's expectations that assume that women, regardless of age or profession, will continue to be the primary caretakers for their families.

Let me tell you about my own transition into motherhood while pursuing medicine. My first child was born when I was a second-year OB/GYN resident. I remember night shifts being particularly brutal for a new mom. The only time I saw my son during those night shifts was when I stopped by his day care for a few minutes on my way out in the morning or on my way in to work in the evening. I remember trying to breastfeed and utterly failing. Many times, I contemplated leaving residency. When I had my daughter seven years later as a new faculty member, I was in a better place—or so I thought. I spent eight weeks at home with her, double the amount of time I had with my son. The first day back to work after ma-

ternity leave, I was dropping her at her day care when I realized that I had forgotten the breast milk at home. When I tried to rush back home so that I wouldn't be late for "a very important" leadership meeting at work, I got stopped by a traffic cop for speeding in a school zone. After a \$400 fine and loss of precious time, I made it to my house—except that I could not open the door. Why, you ask? Because my key was bent from the sheer emotional energy flowing from my body. It was as if I were no longer in control. It didn't end well for me that morning, but I carry that key on my key chain to this day, to remind me to take a deep breath when the fine balance between a "human being" and a "human doing" seem to collide.

I think the world could greatly benefit from valuing women's role as caregivers, healers, and community builders. Our healthcare system cannot afford not to make space for these most valuable assets if the ultimate goal is to elevate the health

of communities that extend beyond the four walls of our medical institutions. **MM**

Rahel Nardos, MD, MCR, is associate professor, Department of Obstetrics, Gynecology and Women's Health, and director, Global Women's Health, at the University of Minnesota. She is one of three medical editors for *Minnesota Medicine*.



**Resources**

Madeline M. Joseph, Amy M. Ahasic, Jesse Clark, and Kim Templeton. State of Women in Medicine: History, Challenges, and the Benefits of a Diverse Workforce. *Pediatrics* 2021, Volume 148.

D.M. Lautenberger and V.M. Dandar. Exploring pathways to equity. Available from [aamc.org/publications](http://aamc.org/publications).

Bismarck C. Odei, MD; Phylcia Gawu, MD; Sonu Bae; et al. Evaluation of Progress toward Gender Equity among Departmental Chairs in Academic Medicine. *JAMA Network, JAMA Internal Medicine*, December 28, 2020.

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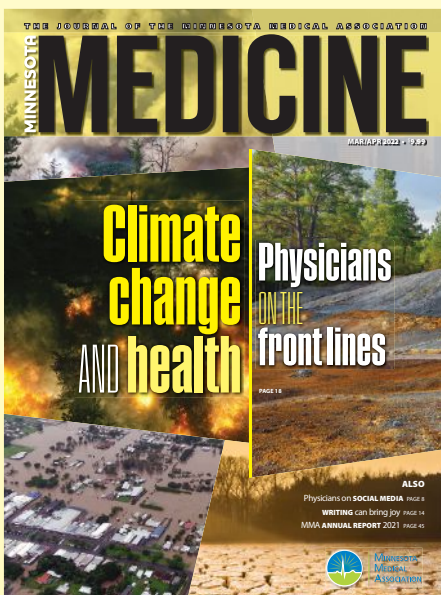
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Submissions will be evaluated by a panel of reviewers from a variety of disciplines; they will select the abstracts demonstrating the highest quality for publication.

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- Include the names of all authors, plus identification for each (eg. third year medical student, University of Minnesota; resident in gastroenterology, Mayo Clinic).
- Include email addresses for each author.
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# Our new normal

Learning medicine in a global pandemic

BY KIRSTEN SNOOK

“Can you ... please ... wash ... my hands?” My patient asked me, between shallow breaths. Her hands shook in front of me. Of course they shook, given the high dose of steroids she was on. Not to mention how scared I knew she was.

I felt my Apple Watch buzz. I couldn't read the text through the gown sleeve and gloves, but one look at the clock on the wall and I knew it was my resident telling me she was ready to round. I still had to check labs of another patient before I would be ready. I worried about being viewed as slow or inefficient if I stayed any longer in this room. Did I have time to search for hand wipes? I didn't know where anything was kept in these COVID rooms. It would be so much easier to just

flag her nurse on my way out and ask them to do it.

The hands in front of me were the same hands that 24 hours ago had desperately clenched my own as she asked, “Am I going to die?” I didn't know then that the hands in front of me were hands her daughters would not make it to the hospital in time to hold, one last time, when she passed away 11 hours later.

I scanned the room. The layout was familiar, not because I had multiple patients on this COVID unit. The room was familiar because four years ago, after my mother's breast cancer surgery, her recovery room at same exact hospital was just a few doors down. Those post-op rooms became COVID units, home to patients who in “normal” times likely should have been in the ICU. As a third-year medi-

cal student entering my clinical rotations amid a global pandemic, I realized that I and my peers had no idea what “normal” times were.

Medicine is hands-on. We learn our career best not from textbooks, but from patients. From doing, seeing, and experiencing. What we learn in medical school is the foundation for how we will go about the rest of our healthcare careers. My classmates and I, entering clinical training in the 2020s, only know how to care for health in the warped context of the pandemic. It was the spring of my first year when we were pulled from in-person learning. My second year was entirely on Zoom, our few and scattered clinical experiences significantly limited by no PPE, strain on the healthcare system, and the faculty and administrators trying their best to protect us from getting sick. We never learned in “normal” times. Will we ever?

My internal medicine rotation site had daily lunch lectures for medical students. We had a talk on pneumonia. We were given a case and the physician asked us, “Where do you want to admit this patient: observation, general floor, or ICU?” The patient in the case was clearly very ill and on a poor trajectory. We all knew that. We answered: Admit to the general floor, but you could probably call ahead to the intensivist, as the patient will eventually worsen.

The physician looked at us. You could see her eyes soften as she took in what we said, and what was happening to the future of healthcare. She said “I should have clarified ... in non-COVID times, normally, this patient would go straight to the ICU.” Our instincts on the patient's severe status were correct—but our gauges as to what defines “intensive care” were broken, significantly altered from what those physicians before us had learned. Yet our gauges were, appropriately, based on our clinical training in a time where ICUs have waiting lists, patients are sicker than ever, and healthcare is difficult for all involved.

We were reminded frequently during that eight-week rotation that we were caring for some of the sickest patients in years at this hospital. My team had a new attending physician weekly, and each Monday



I heard the same comment: “Wow, your team has some extremely ill patients.” It wasn’t just COVID-19. It was cancer, heart failure, kidney failure, blood disorders, you name it. I was reading palliative care and/or hospice notes on 30–40% of my patients.

is “normal” to me, but burning out and terrifying those above me who know a different, and better, situation.

I found the pack of hand wipes in my patient’s room. I gently cleaned her dry, shaking hands. She smiled underneath her oxygen mask, thanking me. I thanked her

we are just doing our job. They always deserve a thank you.

What I wish I understood that day was that “thank you” was about more than just a habit. That “thank you” was about what that little moment, washing her hands, taught me. Those little moments are what maintain the core of medicine, unchanging amid a forever changed and increasingly complicated clinical world. Medicine is a profound privilege, helping human beings in their times of deepest need. The global pandemic environment we are learning in now? It’s not “abnormal,” it is simply our new normal. It is, in a tragically beautiful way, reminding us more than ever of the deep privilege of being in medicine, as we learn how to care for patients on some of the darkest of human days. **MM**

Kirsten Snook is a fourth-year medical student at the University of Minnesota Medical School.

What is impacting my learning the most is the complex state of healthcare we walk into daily, the one that is “normal” to me, but burning out and terrifying those above me who know a different, and better, situation.

This is the only “normal” my cohort of future physicians knows. I thought 1.5 years of virtual basic science curriculum would be what impacted me as a future physician. In reality, I learned that content via Zoom just as I would have in a physical classroom. What is impacting my learning the most is the complex state of healthcare we walk into daily, the one that

as I walked to the door, out of habit more than anything. I say it to every patient as I leave their room. The way it works for students, I see the patient, I see them again with the resident, and then our attending sees them. I can’t help but think it must be somewhat annoying to the patients to keep being bothered by us, even though I know

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# Abortion is healthcare

Physicians need to step up

BY CHRISTY BORAAS, MD, MPH, AND SIRI FIEBIGER, MD, MPH

**T**he vast majority of Americans, and the vast majority of American healthcare providers, believe that abortion needs to be available to women who need to terminate a pregnancy. We wholeheartedly agree—access to legal and safe abortion is paramount, for each patient, for our communities, and for public health. The responsibility for making decisions about ending a pregnancy, including abortion, should rest with a woman and her physician without political interference.

The U.S. Supreme Court's *Roe v. Wade* decision in 1973 protected a pregnant person's right to have an abortion without excessive government restriction. As we write this article, we are waiting for the Supreme Court's decision on whether to overturn *Roe v. Wade* and turn abortion rights back to the states.

We are physicians who perform pregnancy terminations but, most importantly, we are physicians who see women every day celebrating or agonizing as they make important decisions about contraception, pregnancy, and childbirth. We are fearful

and deeply sad—but, most of all, angry—that the right to legal abortion we've had for nearly 50 years across this country may immediately be eliminated in many states. Whether a pregnant person can make their own reproductive decisions, based on their own health, family situation, religious beliefs, stage of life, education, or economic options will depend on where they live.

We have an unintended pregnancy rate of nearly 50% in the United States, not because people don't know how to prevent pregnancy, but because access to contraception is not universal—and has gotten worse during the pandemic. And no contraceptive method is 100% effective; half of all abortion patients were using contraception at the time they conceived.

Many people also don't know that it is always inherently riskier to continue a pregnancy than to have an abortion in the first trimester. When we talk about the decimation of access to abortion for half the country—in areas where maternal and infant mortality are already too

high—pregnant people are going to die on our watch. That should be unacceptable to everyone, but particularly to physicians.

## Minnesota impact

The impact of the expected ruling in Minnesota will not be immediately devastating to abortion rights, as it will be in North Dakota and South Dakota, where “trigger” legislation means that if the Supreme Court decision leaves abortion legislation to the states, a ban on abortion will kick in at once. But there will be an immediate impact and, quite possibly, a long-term impact.

We will have anxious patients, looking over their shoulders and wondering if their ability to control their reproductive health can be threatened.

We will have an influx of pregnant people from other states who come to Minnesota for a legal pregnancy termination. In fact, we already do; clinics in Minnesota that provide abortion care already are handling more patients from out-of-state than ever before. If we are taking care of out-of-state patients, will the states they come from go after healthcare providers here? How will we protect providers in Minnesota? How will they be reimbursed for their services?

Although we have constitutional protection for abortion in Minnesota, there already are several restrictive laws on the procedure, including a 24-hour waiting period. The U.S. Supreme Court decision will undoubtedly embolden some Minnesota legislators to push for more and greater restrictions in our state.

We have a DFL governor and majority in the Minnesota House, but we have an anti-choice majority in both the House and Senate. We need to educate our legislators, we need to vote, we need to support women's rights. Otherwise, we could easily become Wisconsin or Iowa in terms of women's reproductive health.

## Future for pregnant people

The future for many pregnant people likely will not be the dire back-alley abortion or

the fabled clothes hanger. There are many web-based resources on how to self-manage a first-trimester abortion. With the development of mifepristone and misoprostol—the standard of care for terminating a first-trimester pregnancy—even those in states banning abortion may be able to safely end a pregnancy at home.

But many pregnant people—women of color, poor women, those without financial resources or adequate support—will be less able to access termination by medication. Many will not have the resources (money, transportation, time off work, child care) to travel to another state and, especially for people of color, they are more likely to be criminalized if they do.

Abortion will become, as it once was, a healthcare procedure only for the privileged. The loss of *Roe* is an impending disastrous health-equity issue.

### Implications

The public health aspects of abortion are indisputable, as is the science. If abortion can be politicized, any aspect of our healthcare is at risk.

First and foremost, pregnancy complications that endanger the pregnant person's life will not be addressed in a timely fashion and more mothers will die, increasing our already unacceptable maternal rate further.

Any restriction or prioritization of a fertilized egg over the life of a pregnant person may impact access to in vitro fertilization and other infertility treatments. People suffering early pregnancy loss or miscarriage may not have access to the best therapies. When legislators regulate a pregnant person's reproductive decisions, what other healthcare procedures or therapies might they regulate in the future?

What about care for transsexual people (already at risk in some states)? LGBTQ people? Care for marginalized groups of any kind? What about autonomy in any healthcare determination during one's lifespan, including end-of-life decisions?

### Abortion is personal

One in four people who can be pregnant in our society has an abortion by the time they are 45. Everyone loves someone—a

parent, a child, a close friend, a partner, a grandmother, a cousin, a teacher, a religious leader—who has had an abortion. Their right to privacy means they don't have to share that information. Every physician—not just OB/GYNs—has patients who have had abortions.

Since roughly half of all physicians are women, reproductive rights—including the possibility of abortion—is a personal issue. But we can't leave men out of this discussion, since the right to abortion benefits them and the health of their partners and families as well.

Part of the reason people don't talk about abortion, physicians included, is that it has become a stigmatized part of our healthcare system, even in a state like Minnesota. Look at where people are able to access that care; it's not in most private clinics or hospitals. Abortion care has been largely disenfranchised, provided only in very committed freestanding clinics.

### Physician activism

As OB/GYNs, we deal with women's reproductive health everyday. We are passionate about the need to maintain safe access to abortion. For physicians who are not OB/GYNs or who don't take care of pregnant people, abortion access may have been taken for granted but now, alarm bells have started sounding for them as well. Many physicians are motivated to help support all our patients' needs.

If physicians are committed to science and to the public health of our communities, abortion has to be part of what we provide.

Physicians need to:

- Be able to say the word "abortion" out loud so it is less stigmatizing.
- Be part of the conversation at every level, from talking with patients to talking with healthcare administrators and lawmakers.
- Vote—and physicians do tend to vote—with reproductive rights at the top of our list of issues. ■■■

Christy Boraas, MD, MPH, is assistant professor, Department of Obstetrics, Gynecology and Women's Health, University of Minnesota. Siri Fiebigler, MD, MPH, is an OB hospitalist with Allina Health and ACOG MN section chair.



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# Physicians and civil disobedience

## Do the benefits outweigh the risks?

BY LORA PRINC, MD, MBA, AND D. BRENDAN JOHNSON, MTS

### Point

#### We must use our diagnostic skills to decide

**P**hysicians have earned respect from the public based on our actions and the long history of those who came before us. We are held in high regard because of our rigorous education, integrity, and compassion. Once in practice, our evolving individual reputation can give us even more opportunity to advance our goals and thus our profession.

This high regard is not a given and can be lowered. Criminal activity or causing unrest is at odds with the concept of a physician's integrity, calmness, and methodologic approach. Conflict will get the attention of others, including the media. Think of headlines referencing "Dr. X charged with DWI." This incident will not only make the news, it also will be indefinitely linked to a physician's name and reputation. For anyone without this title and prestige, it likely wouldn't have made the news at all.

As experienced practicing physicians, we are responsible to many entities. We must practice within the confines of our values, professional guidelines, and the law. Professional lives extend beyond the office and hospital walls, making our reputation multidimensional. Our private actions may be attributed to professional

### Counterpoint

#### Sometimes civil disobedience is necessary

**E**ngaging in civil disobedience is no small decision for anyone, let alone people who have invested decades of their lives and hundreds of thousands of dollars in their education—people who have devoted so much to gain the skills necessary to serve others well. We are held in high regard—a high regard that must be earned, not given.

What explains, then, why physicians across the world are claiming that their consciences and do-no-harm ethics are leading them to break laws in broad daylight? Reflecting after his arrest with the climate change group Doctors for Extinction Rebellion—he glued his hands to the JP Morgan headquarters to bring attention to the bank's ongoing underwriting of oil companies—British physician Patrick Hart says: "I don't generally like to rock the boat. But I feel I don't have an alternative; it's an act of conscience." The group was also influenced by recent statements by the WHO and others that climate change is the biggest threat to health in the 21st century.

Physicians have a *prima facie* obligation to follow the law. However, we also appeal to a higher law through our medical tradition

**Point** *(continued from previous page)*

qualifications. Not only will a legal claim make it to the media, it may require reporting to the state medical board. Our medical license application asks if you have had any criminal charges filed against you, which includes disorderly conduct. Per Minnesota statute 147.091, grounds for the medical board to consider disciplinary action include “engaging in any unethical or improper conduct.”

For example: In 2011, a group of family physicians at the University of Wisconsin showed their support for state employees—teachers, in particular—who were angry at the governor’s revocation of some collective bargaining rights. The physicians wrote fake “sick notes” for teachers, who then were able to attend protests. The Wisconsin Medical Society condemned the physicians’ actions and the Wisconsin Medical Examining Board privately censured at least 12 of them.

Credentialing relies on the ability to be licensed, so any infraction that affects your license may affect your employability. Any legal history may require reporting on all future credentialing and employment applications and will create at minimum delays, if not denials. The longer we have been in practice, the more contemplation should be given before going outside the confines in which we exist. We trade on our reputation. A complicated history associated with your name—even if not affecting your license or involving criminal acts—may make you a less desirable applicant for a job or impact your work relationships.

A decision to participate in an act of civil disobedience is not the same as managing a crisis where we must stop the hemorrhage by tamponade. Rather, it is likely an unpredictable evolving situation or the threat of a major undesirable change that conflicts with our values. We would benefit by using our methodical diagnostic skills to form the most reasonable conclusion and plan of action. A recent framework for health professionals contemplating civil disobedience developed in New Zealand suggests we consider three criteria before resorting to civil disobedience, assuming we have determined the situation to be unjust and have considered the current sociopolitical situation: The disobedience must be more effective than harmful, it is the last resort, and it is the least harmful action possible.

Consider the most effective use of the platform you have worked hard to build. For the cause at hand, how can you best use your highly developed skills and reputation? How will your decision reconcile with your duty to care for patients? Is there a way to maximize your platform by using the media and traditional government channels while continuing to care for your patients?

While we all have the same rights, physicians have additional privileges beyond those of non-physicians. Regardless of our personal opinions, we have obligations both morally and contractually. If you decide that the benefits of civil disobedience outweigh potential risks, realize that the repercussions may mean you will not be able to provide healthcare services.

—Lora Princ, MD, MBA, is an OB/GYN in Minneapolis.

**Counterpoint** *(continued from previous page)*

and professional commitments; we all recognize that just because something is legal, it isn’t necessarily right. We know that when the status quo doesn’t align with the values of justice, health, and life, we are called to change the status quo. Public-minded advocacy is affirmed in some form by all the major medical professional ethics documents. Furthermore, there is a strong (if minority) tradition of civil resistance in medicine, including ACT UP during the AIDS crisis, John Snow in London, and prominent physicians like Charles M. van der Horst in our day. These folks came to believe that education or polite advocacy was ultimately not effective enough at changemaking. And research by social scientists like Erica Chenoweth shows that large-scale social change comes most often not from elite policy spaces but from social movements and bottom-up pressure.

But engaging in such actions can come at a cost—how are we supposed to know when doing so is worth it? For medical students, while it is uncommon (and would be problematic) for residency programs to use the “history of legal involvement” filter to exclude these kind of applicants, it is conceivable that they do so. For residents, there also is the risk of missing out on clinical duties should court dates follow an arrest or charges not be dropped.

Because conscience-based civil disobedience is not presently common in medicine, employers or administrators may inaccurately assume that the existence of a disciplinary or legal record indicates a lack of professionalism or ability to care well for patients. There is at least a theoretical risk to a physician’s license to practice, although anecdotal data suggests that state medical boards have by and large realized that such conscientious arrests are not evidence of a lack of professionalism. There is a gut-reaction of discomfort that peers may have toward our involvement in such activities—although others may admire or be inspired by that involvement.

On top of these professional risks, there are the risks of a legal record, fines, an evening in jail, or, at worst, prison, although it is usually possible to titrate one’s level of risk during preparation. Police brutality must also be considered, especially given a physician’s racial or ethnic background. Through their caring and hard work, medical students and physicians have a high level of social capital and social protection, which make our risks somewhat less and our responsibilities somewhat greater.

While both the reasons for and costs involved in breaking the law for reasons of conscience are diverse, each person, group, and professional organization can begin to make such moral calculations. To do so well involves both attention to the world around us and reflection upon the best ethical traditions of our profession, especially as we consider our obligations to our patients and communities. **MM**

—D. Brendan Johnson, MTS, is a fourth-year medical student at the University of Minnesota Medical School and co-founder of the podcast “Social Medicine on Air.”

# WOMEN IN white coats

## THERE'S STILL FAR TO GO TO ACHIEVE gender equality

AT ALL LEVELS OF MEDICINE BY SUZY FRISCH

It's happened more times than Meghan Walsh, MD, MPH, can count in her 20-plus years as an internist. While working at the hospital, a patient or fellow employee presumes that she is a nurse. Walsh has grown so accustomed to these microaggressions that she brushes them off and goes about her job. But these days, she is taking cues from the younger women physicians following in her footsteps.

Walsh, a hospitalist and chief academic officer at Hennepin Healthcare, sees the next generation of women physicians handle similar situations much differently. "They are bothered by the assumption, and they correct the person in real time, in a respectful way. They don't laugh it off or brush it off. They stand their ground in a way that's both courageous and setting a tone that is important for the profession and for women in medicine and for other underrepresented physicians, like BIPOC physicians," Walsh says.

"Where traditionally women haven't had a seat at the table, I think we're making huge strides toward gender equality and inclusion. We're never too old to learn from this generation coming up and I think that's really exciting. It's changing us for the better."

Significant progress has been made toward gender equity in medicine, but significant work also remains. For three years in a row, the majority of students entering medical school in the United States were women: 50.5% in 2019, 51.5% in 2020 and 52.7% in 2021, according to the Association of American Medical Colleges. In addition, the share of women in practice rose to 36.3% in 2019, from 28.3% in 2007.

However, such ratios still aren't being achieved in all areas of medicine, including leadership positions, the higher ranks of academic



"When you have homogeneity in leadership, you have a loss of cognitive diversity," Núñez says. "The more we make the group different, with men and women and other folks, the more you will get other solutions to complex questions. We need that in health and medicine."

ANA NÚÑEZ, MD, PROFESSOR OF GENERAL INTERNAL MEDICINE AND VICE DEAN FOR DIVERSITY, EQUITY AND INCLUSION AT THE UNIVERSITY OF MINNESOTA MEDICAL SCHOOL.

medicine, and some traditionally male-dominated specialties, such as urology and surgery. Since COVID, women physicians have been experiencing burnout at higher rates and are leaving the profession in greater numbers than men. Then there is the macro toll from overt or benevolent sexism, the harmful undercurrent of microaggression, and the dual roles that women disproportionately play as physicians and caregivers at home.

Add to that a stubborn gender pay gap. In 2021, men physicians earned 28.2% more than women, even when controlled for specialty, location, and years of experience, according to Doximity's fifth-annual compensation report. That amounts to a \$122,000 annual difference in compensation. There are no medical specialties where women earned the same or more than men. Even more dispiriting, the pay gap has grown since 2017, when it was 27.7%. "It's really erosive when you find out that someone you work next to is making \$50,000 more than you do and has for the past 10 years," says Sharonne Hayes, MD, a cardiologist and professor of medicine at Mayo Clinic.

### Equity ebbs and flows

Ana Núñez, MD, professor of general internal medicine and vice dean for Diversity, Equity and Inclusion at the University of Minnesota Medical School, has witnessed improvements for women in medicine from the time she was considering medical school—and advisors tried to talk her out of it. Then, the prevailing at-



“Women are less likely to achieve the top academic ranks. You can point to a lot of things—a lack of mentorship, lack of support, caregiving responsibilities that slow people down, and sometimes a lack of support that’s societal, like not having parental leave. We need to change some fundamental things if we are truly going to have equity for women in medicine.”

SHARONNE HAYES, MD, CARDIOLOGIST, PROFESSOR OF MEDICINE AND DIRECTOR OF DIVERSITY AND INCLUSION AT MAYO CLINIC

titude was that women were being “let in” to the profession (but not too many, or that would lead to its downfall), compared to the current bounty of women pursuing science and medicine.

When Hayes became a cardiologist in the 1980s, about 6% of her peers were women. In 2020, 14.9% of cardiologists were women. In cardiology and many other specialties, women still are the only or the first to hold a position—often a lonely place to be, says Hayes, Mayo’s director of Diversity and Inclusion who researches equity in the profession and healthcare.

“Being an ‘only’ in a group or being a first, you carry a lot more emotional and professional weight to do well because you know if you screw up, they will never hire another one,” Hayes says. “If you are the only woman in the room, it gets pointed out all the time. Someone will turn to you and say, ‘You’re a woman, what do you think?’ If you have a critical mass, it happens much less that you’re supposed to speak for all women.”

Having that critical mass—or even one or two women physicians who established a beachhead—gives pre-med students, medical students, and trainees the confidence that they, too, can work in their desired field. Such role models affirmed Catherine Benziger’s choice to pursue a cardiology practice and research, despite some naysayers. Benziger, MD, MPH, director of research at Essentia Health Heart and Vascular Center, got involved in cardiology research during medical school and received encouragement from two mentors, one male and one female.

“If you can’t see one, you can’t be one. You need to start seeing people in leadership positions who look like you. Having female mentors was critical. It became something I could see myself doing,” Benziger says, such as when she visited her mentor’s house and saw that her role model cardiologist was a mom to three boys in a home filled with hockey gear. “I remember thinking, ‘You can do this, and you can be a mom and have a career.’”

Walsh picked internal medicine because she loved solving the puzzles of patients’ symptoms and test results to land on a diagnosis and determine a course of action. Another important factor was that during rotations in the late 1990s, Walsh saw many other women physicians practicing primary care. They provided her with mentorship and a window into a culture where she knew she would fit in. This contrasted with other fields like surgery, psychiatry, neurology, and anesthesia that were either all or largely men.

Even today, some specialties are more lopsided, with women making up 64.3% of pediatricians, 58.9% of OB/GYN physicians, and 54% of child and adolescent psychiatrists, according to the

AAMC. Practices like orthopedic surgery (5.8%), general surgery (22%) and pulmonary disease (12.3%) have a fraction of women physicians.

There are myriad reasons why. For many women, fields like OB/GYN, family medicine, and pediatrics align with their interests. Some decide that they will be just as happy working in a field that doesn’t require long residencies or fellowship training, like the seven years it takes to become a cardiologist or five years to become an orthopedic surgeon—training that often extends even



“If you can’t see one, you can’t be one. You need to start seeing people in leadership positions who look like you.”

CATHERINE BENZIGER, MD, MPH, DIRECTOR OF RESEARCH AT ESSENTIA HEALTH HEART AND VASCULAR CENTER

further into their reproductive years, Hayes says.

Rahel Ghebre, MD, MPH, a gynecologic oncologist and professor in the Department of Obstetrics, Gynecology and Women’s Health at the University of Minnesota, followed in the footsteps of her mother, a nurse and midwife, while also pursuing her passion for women’s health and health equity. She operates in two disparate worlds: a practice that has more women (OB/GYN) and a practice with more men (surgery).

Even as a surgeon who focuses on women, Ghebre stood out in the operating room early on. After completing one of her first surgeries as a faculty member, she lingered to help get the patient cleaned up and ready for transfer to the recovery center. A nurse said to Ghebre, “If you stay to help us, they won’t think you’re in charge,” because there were so few women surgeons, she recalls.

“More women in medicine go into primary care and fewer to surgical specialties and more male-dominated fields, and so they don’t have sponsors or mentors there,” says Ghebre, associate director of Diversity, Equity and Inclusion at the Masonic Cancer Center. Women also must conquer societal assumptions that surgeons need dominant personalities and stereotypically male characteristics like confidence and aggressiveness.

“Many of these qualities that are promoted are male-dominated. All of that and much more feeds into biases in fields

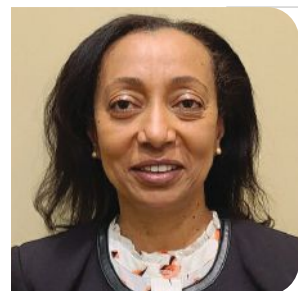


# WOMEN IN WHITE COATS

women should go into,” Ghebre says. Though she has seen some improvements over the years, it’s still a concern.

Evening out genders in male-dominated specialties can be done. It takes creativity, like developing ways to expose underrepresented groups to different fields, and eliminating traditions that become barriers, Núñez says. For example, interventional specialties like surgery often hold grand rounds at 7am on Saturdays—a tough time for many people with families for an “extra” that proves they are committed to their work, she adds.

It’s worth it, though. Having women in male-dominated specialties improves care for women, such as women cardiologists who take an interest in treating women with heart disease and improving cardiac care, Benziger says. Teresa Tran-Lim, MD,



“Many of these qualities that are promoted are male-dominated. All of that and much more feeds into biases in fields women should go into.”

RAHEL GHEBRE, MD, MPH, A GYNECOLOGIC ONCOLOGIST AND PROFESSOR IN THE DEPARTMENT OF OBSTETRICS, GYNECOLOGY AND WOMEN’S HEALTH AT THE UNIVERSITY OF MINNESOTA

an epileptologist and senior medical director of neuroscience at HealthPartners, has seen the same in urology and neurology. As of 2021, 10.9% of urologists are women, bringing fresh energy and attention to challenges that affect women, such as pelvic floor disorders and incontinence.

“When I was in medical school, urology was 100% a male-dominated field. But now there is a urogynecology specialty, recognizing that urology is not just about men and prostate disease but there is a female component we need to think about,” says Tran-Lim. More women than men have multiple sclerosis, which can cause urinary dysfunction; urogynecologists are essential to providing good care to these patients, she says.

Having more women engaged in research also matters. Historically, cardiology researchers and subjects were men, leaving the differences in women’s heart health unexplored, Benziger says. Women still are underrepresented in clinical cardiology trials, even though women have different symptoms and risk factors and even different kinds of heart attacks.

When there isn’t gender diversity in research, many questions just don’t get asked. “Without having female investigators, we have, for the most part, not fully understood how cardiac disease affects women,” Benziger says. She points to the recent Adaptable Aspirin study that included 20,000 women participants. Researchers were criticized for not including data about pregnancy-related risk factors in their *JAMA Cardiology* paper.

“Men wrote the grant, and no one thought to add pregnancy-related risk factors to the women’s survey,” Benziger adds. “That’s why we’re trying to support more women trainees and get more women in research so we can better understand women’s heart disease.”

## Lagging leadership

Even in fields where women hold the majority, it doesn’t mean that gender equity is uniform at all levels. When Núñez became a full professor of general internal medicine at Drexel University about a decade ago, she was one of just 22 Puerto Rican women in the United States to hold such a position, and that included women physicians in Puerto Rico. Numbers have improved for

women in practice and in leadership, but the pace of change is glacial and will take decades to achieve equity, especially for BIPOC and intersectional women, Núñez says.

In 2021, women lag behind at the highest levels of American academic medicine and leadership, holding 27.6% of full medical school professorships, 22% of department chairs and 28% of permanent

dean positions, the AAMC reports. Men and women start academic medicine careers in equal numbers as assistant professors, but women are less likely to be promoted to associate and full professorships, according to 2020 *New England Journal of Medicine* research. In the past 35 years, there has been no apparent narrowing of that gap.

“Whether it’s in academic medicine, medical centers, or private practice groups, the leadership in those organizations is disproportionately male compared to the workforce,” Hayes says. “If 70% of the OB/GYNs are women, that does not mean that the leadership in OB/GYN reflects that.”

“Women are less likely to achieve the top academic ranks. You can point to a lot of things—a lack of mentorship, lack of support,



“The whole culture is different because there are more women in the workplace. There is more consideration for us taking care of our families, and the guys benefit from it, too. The guys want to be with their kids just as much as we do.”

NICOLE WORDEN, MD, AN INTERVENTIONAL CARDIOLOGIST AT ESSENTIA HEALTH IN DULUTH

caregiving responsibilities that slow people down, and sometimes a lack of support that’s societal, like not having parental leave,” Hayes adds. “We need to change some fundamental things if we are truly going to have equity for women in medicine.”

There is a long list of reasons for women to be medical leaders. “When you have homogeneity in leadership, you have a loss of cognitive diversity,” Núñez says. “The more we make the group





different, with men and women and other folks, the more you will get other solutions to complex questions. We need that in health and medicine.”

Having a diverse roster of decision makers—including gender diversity—affects everything from care delivery models to work-



“The vast majority of caregivers for aging parents are women. That not only lends perspective into the patients, but also in caring for the caregiver.”

JAMES PACALA, MD, MS, A GERIATRICIAN, FAMILY MEDICINE PHYSICIAN, AND CHAIR OF THE DEPARTMENT OF FAMILY MEDICINE AND COMMUNITY HEALTH AT THE UNIVERSITY OF MINNESOTA

place policies, says Hsieng Su, MD, MPH, senior vice president and chief medical executive at Allina. Women physician leaders also influence how and when care is best delivered or how to shape practices to support physicians who are caregivers.

“A large proportion of our patients are women. It’s our goal to bring diversity and inclusion to our organization that reflects our community,” Su says. “We need a balanced look at issues. We need to be able to understand our community and the patients we serve, and women physicians bring a lens to that that is really important in how we deliver care.”

To that end, Allina is working to bolster its pipeline of women leaders. It will expand as women engage in its leadership development programs or take on an initiative in something they are passionate about, such as addressing burnout, improving quality, or bettering the work environment at Allina, Su says.

She hadn’t planned on a career in medical leadership, a career that is now more than 15 years long. But a mentor in Hibbing saw how passionate Su was about quality improvement and suggested that she take on a director of quality role shortly after completing her fellowship in preventative medicine. That nudge—and the positive experiences and feedback she received from mentors—fostered her enthusiasm for making a difference through leadership and encouraging other women to do the same.

**Robust contributions**

When women are in leadership, policies in the workplace also tend to be different. Nicole Worden, MD, an interventional cardiologist at Essentia Health in Duluth, observes that having women as half of her group at St. Mary’s Medical Center makes a big impact for all of the physicians.

The group provides meaningful support for work/life balance, such as offering men and women physicians the same amount of time for paternity and maternity leaves. “The whole culture is different because there are more women in the workplace. There is more consideration for us taking care of our families, and the

guys benefit from it, too,” Worden says. “The guys want to be with their kids just as much as we do.”

James Pacala, MD, MS, a geriatrician, family medicine physician, and chair of the Department of Family Medicine and Community Health at the University of Minnesota, agrees that having

more women in medicine—and in his department in particular—provides a valuable perspective that strengthens care.

“The vast majority of caregivers for aging parents are women. That not only lends perspective into the patients, but also in caring for the caregiver,” Pacala says.

“When we’re trying to figure out policies for how to run clinic operations, a woman

will be able to understand the perspective of half of our patients a lot better than the men. They will understand access to clinic issues regarding themselves and their kids, and they will understand issues surrounding families and family dynamics and caregiving.”

At Hennepin Healthcare, the orthopedic surgery practice is just about evenly split between men and women—a rarity. It started when a woman orthopedic surgeon led the residency program and encouraged more women medical students to consider orthopedics, Walsh says. Then they saw that other women were thriving in orthopedics at Hennepin. The department chief, a man, also championed recruiting women orthopedic surgeons.



“Women are more likely to get asked to do service time instead of leadership roles. Service time ...takes away from women’s ability to do other things that carry more weight for promotion and tenure.”

JERICA BERGE, PHD, MPH, VICE CHAIR FOR RESEARCH IN THE DEPARTMENT OF FAMILY MEDICINE AND COMMUNITY HEALTH AND DIRECTOR OF THE CENTER FOR WOMEN IN MEDICINE AND SCIENCE

This practice group is highly collaborative and puts a strong emphasis on helping its physicians integrate work and family life, Walsh says: “There is an accessibility to them, they are approachable, and the tenor and tone of a historically macho specialty is evolving in a really exciting way.”

Acknowledging that women are under-represented in leadership at the University of Minnesota Medical School, leaders launched the Center for Women in Medicine and Science in 2018. Its mission is not only to catch the University up to gender equity progress made at other academic institutions, but also to become a pacesetter in creating equity and advancing women into positions of leadership, says Center Director Jerica Berge, PhD, MPH, vice chair for research in the Department of Family Medicine and Community Health.

The center focuses on four main areas for which it created action groups—retention and recruitment; salary, resource and leadership equity; mentoring; and strategic communication and



# WOMEN IN WHITE COATS

collaborations—aiming to bring solutions to vexing gender equity problems. For example, the salary-focused action group conducted a salary equity report and created a dashboard of gender equity metrics for the dean and all department heads to keep data regularly updated and top of mind. A new compensation committee and salary equity review committee address real-world salary inequities. Combined, such efforts turn individual advocacy into a collective voice that is more powerful and effective, Berge says.

Promotion and tenure are ripe for innovation. Many physicians are in their peak years of childbearing and childcaring when they join academic medicine. The bulk of this caregiving still falls to women—despite some progress in sharing work between parents, Berge says. These responsibilities make it more difficult to engage in extras like submitting grant proposals, doing research, and writing papers—important contributions for achieving tenure.

“Women are more likely to get asked to do service time instead of leadership roles. Service time does not count in the same way [for tenure] as an administrative role,” Berge says. “It’s not necessarily a bad thing to be on a committee, but it does have less prestige and it takes away from women’s ability to do other things that carry more weight for promotion and tenure.”

Pacala agrees that it’s time to reevaluate tenure. “We need to think about better ways to be flexible. During the past two years of the pandemic and other challenges, we heard very loud and clear from parents—particularly from mothers—how important flexibility is,” he says. “That has given us some opportunities.”

Take the ticking clock of tenure that gives physicians a set window to be promoted: During COVID, that clock was paused. One thought would be to offer similar pauses when a physician gets ill, has a baby, or is caring for an aging parent. Another option is to reassess the weight that various activities hold, Pacala says, including ones where women physicians play a valuable role, such as outreach or mentoring.

For medical leadership in general, it would benefit medicine to rethink who can lead and what skills leaders can contribute, Walsh says. Women bring great strengths in building connections, engaging in teamwork, and collaborating—expertise that mirrors where healthcare is moving. Emphasizing these skills when considering promotions would add more women to leadership ranks while also benefitting organizations and care, she says.

## Breaking through

Many women physicians know that they stand on the shoulders of the women who came before them, while working in a field that still has not achieved gender equality. Yet progress has been made, Tran-Lim says.

“I’ve seen a lot of changes. As I went through my own personal career development, I thought, ‘Wow! I have it so much better than my female predecessors.’ Then I look at the present day and

think, ‘Wow! We’ve changed even more and it’s just so much more equitable,’ not just for women in the workforce but for everyone,” she says.

Tran-Lim has seen more men physicians taking full advantage of family leave after the birth of a child, as well as dual-career physician couples who reduce their hours so that both parents have more flexible schedules. “People’s mindset has really changed,” she says. “It’s that they want to raise their children together, not that it’s women’s responsibility anymore.”

Sade Spencer, PhD, an assistant professor in the Department of Pharmacology who researches neuroplasticity and addiction, has experienced the dichotomy. She completed undergraduate and graduate school and post-doctoral training with women overrepresented in all stages. Then, when she joined the University faculty in 2018, she saw gender inequality with few tenured women



“Retaining [women] will go a long way toward attracting the next generation and showing them that we have some movement on these large-scale, institutional challenges.”

SADE SPENCER, PHD, ASSISTANT PROFESSOR IN THE DEPARTMENT OF PHARMACOLOGY, UNIVERSITY OF MINNESOTA

and women in leadership. Yet she has benefited from mentorship, sponsorship, and leadership opportunities from other women scientists and physicians, including being invited to lead the recruitment and retention action group for the Center for Women in Medicine and Science, where Spencer and peers are working toward concrete change.

COVID has exposed some of the systemic problems in science and medicine—including stubborn burnout. It will take fixing the underlying problems leading to burnout to continue providing opportunities for women to thrive, Spencer says. “We need to continue working to make sure women we have brought into this career are happy and seeing the change we’re trying to achieve,” she adds. “Retaining them will go a long way toward attracting the next generation and showing them that we have some movement on these large-scale, institutional challenges.”

Many look to today’s medical students, residents, and newly minted scientists and physicians as beacons of hope for continued progress in gender equity in medicine. It’s a generation that questions time-honored traditions and speaks up when they see inequalities, Walsh says.

“I’m thankful for up-and-coming medical students saying, ‘We’re not going to take this anymore. We’re not going to work our lives away. We love medicine and we want to change the world and we want to spend time with our friends and families,’” Walsh says. “They are not just accepting things; they are forcing the change.” MM

Suzu Frisch is a Twin Cities freelance writer.



# WOMEN

# IN **white** **coats**

## STORIES FROM **women physicians**

**M**innesota Medicine asked a range of women physicians to talk about how their experiences might differ from those of their male colleagues. And, in sometimes small and sometimes quite large ways, their experiences *do* differ.

Seldom, if ever, is a male physician dismissed by patients waiting for “the real doctor” to come into the room.

Male medical students likely don’t spend as much time worrying about when/if will be the right time to start a family, given the years of training still ahead of them.

Female physicians with families still tend to feel that they carry the larger responsibility for making sure their children and partners and households are cared for.

The so-called imposter syndrome isn’t restricted to women physicians, but it seems to be more of an issue for them than for their male counterparts.

The women who shared their comments ranged from medical students to residents to physicians early in their practice to mid-career physicians and a couple of women who have been in practice long enough to see significant change (and some things that don’t seem to have changed all that much).

The fact that women now make up the majority of those admitted to medical schools means there is likely to be more change in the future—including more flexibility in work hours, training, and requirements for advancement, and more support for families. That will be good for *all* physicians, not just female physicians.

One thing we hope won’t change: The commitment and enthusiasm for the practice of medicine that every one of these women exudes.

—LINDA PICONE, EDITOR, MINNESOTA MEDICINE



**Shanda Blackmon, MD, MPH, age 52**

*CARDIOTHORACIC SURGEON, MAYO CLINIC*

## Pearls are made from grit



I never wear my wedding ring in the OR because it's not clean and you lose it, so I always wear my pearls. The very famous surgeon Nancy Perrier, MD, wrote an article in 2002, "Lipstick and pearls," about how women can maintain their femininity while working in a man's world. How you keep who you are at your core, but meet all the needs and still be strong. I just ran into Nancy Perrier at the American Surgical Association, which has been a men's club but it's changing. She told me something that really rang in my ear: A pearl is made with grit; every bit of grit you have can turn into something

beautiful. Lately she's shifted to wearing a diamond because a diamond is formed under pressure.

I was the first woman to graduate from my general surgery residency, a program that had been going on for over 50 years. When I went into cardiothoracic residency at Baylor University, I was the first woman to have a baby during residency. In practice at Baylor, I was the first woman to lead the Thoracic Surgery Division. At Mayo, I was the first woman to join the Division of Thoracic Surgery ever, in more than 100 years of the program.

I got married in 1995. My husband has stayed at home for 17 years and raised our children. We have a pretty traditional family, just reversed. I have twin 17-year-old sons and a 9-year-old daughter. They were all from one round of IVF. When women rotate into my service, I tell them to bank their eggs.

I go home and sometimes tell my husband I want a wife. My husband and I have always had a contract, more of an I'm going to do this and you're going to do this. We're going to help each other out, do the things we do best.

We have a housekeeper—one of the benefits of being a cardiothoracic surgeon is that I can afford a housekeeper—and I delegate what I can get off my plate. I don't do a lot of laundry. I don't put the mulch out, although I love gardening. I pick things that are important and I do them with my kids. We have a dog and four chickens. I feed the chickens with my daughter and I would rather feed chickens with my daughter than do laundry any day.

I've taken both of my boys to China for a medical meeting. I was speaking to a room of 400 or 500 Chinese men—not a single woman in the audience. My son was sitting in the front row and he turned around and looked at the rows and rows and rows of men. He then said, louder than he realized, "I thought this was a girl job!"

I used to be president of Women in Thoracic Surgery and we would bond together when we went to meetings, we would share babysitters to save money. Our kids grew up at these meetings together. Our kids frequently were meeting lots of other women in this specialty and seeing us support one another.

At Mayo, one of the things that has gotten us through COVID and this really difficult life of me always working is that we've got this huge community of surgeons and providers that have become friends, all coparenting together, building our village. We have become each other's support system.

The first barrier women encounter is ourselves, the whole idea of the imposter syndrome, feeling like you don't belong. And then there's sometimes a barrier of having people accept you. I have always believed that if I work as hard or harder than my colleagues, it shouldn't matter that I'm a woman. But sometimes it does.

At Mayo, a patient cannot request a physician based on gender. If they say they don't want a female thoracic surgeon, they can be released from clinic. That's one of the most positive things I've seen Mayo do that really makes a difference. I have been released in the past even before I even saw a patient because they saw I was a woman.

There are unique things that women bring to the table and the diversity of the team makes it stronger and better. Breaking down the barriers means finding good leaders. It doesn't matter what gender they are, it's the tone they set. I've always been mentored by men because there weren't any women around.

I would like for the opportunities to be equal regardless of gender, sexuality, nationality, or color, where everybody has an equal chance. When we get there, it's really not going to matter. I want to get to a point where they're writing about what you do, not what you are. And I think we're close.



**Bryana Andert, DO, age 39**

FAMILY PRACTITIONER, NEW ULM

# Two full-time jobs

**T**he culture of medicine, especially in training, is highly competitive. You are sort of pitted against each other from the get-go. The whole process focuses on who knows more, who is better, who can stand out. As a female, you tend to feel you have to be a little bit better, to stand out a little bit more. We live in a world where there are gender differences and different expectations. We'd be foolish to say these biases don't exist. As a female, I needed to prove myself a little bit more than the men did.

In practice, there's a big difference between being a mother and a physician and being a father and a physician. I have two jobs: I am a full-time physician and I go home and I am a full-time wife

and mother and I run a household. It's the "second shift" when I get home.

I'm not saying my male colleagues don't do anything at home, but it's different expectations. Women sort of naturally take on responsibility in a household. Many of my male partners have stay-at-home wives. I leave the clinic, but I don't get to go home and find supper routinely ready for me. My husband helps, but it's different.

There are situations where I'm working in urgent care and before I even have an opportunity to say my name, the patient says, "Oh, the nurse is back." Advanced practice providers are not doctors, but sometimes patients will refer to them as "Dr. So and So"—and then call me Bryana. I correct them and I try to do it in a tactful one.

One person was really very rude and I had to say, you know what, you're going to have to call me Dr. Andert. I always refer to my other female colleagues as Dr. to try to affirm the correct titles.

Someone once sent me a MyChart message that started, "Hello, Girlie."

There's a nurturing nature that comes more naturally in women. Many of the women physicians I see have wonderful rapport with patients, they really work on that connection.

We would be well served if we realized that there was no rush to finish training, that taking breaks is okay. A couple of women I went to medical school with had babies in residency. One took an extra year to finish residency and that was looked on very negatively.

I wish we could change the competitive piece, the feeling that you are rewarded, especially during training, for overworking and not taking care of your body. When you come out of training and start in practice, you sort of feel like you have to keep overworking. We burn ourselves out and are rewarded for it.

*Advice:* Go for it. The world needs good physicians. Patients are more likely to take the advice of a physician who looks like them. That means men, that means women, that means men of color, that means women of color.



## Women in medical specialties

In 2019, **36.3%** of active physicians in the United States were women. Percentages of women in the top 47 specialties ranged from **64.3%** in pediatrics to **5.8%** in orthopedic surgery.

PEDIATRICS **64.3%**

OB/GYN **58.9%**

CHILD AND ADOLESCENT PSYCHIATRY **54%**

NEONATAL-PERINATAL MEDICINE **52.8%**

GENERAL SURGERY **22%**

PULMONARY DISEASE **12.3%**

UROLOGY **9.5%**

ORTHOPEDIC SURGERY **5.8%**

*2020 Physician Specialty Data Report, AAMC*



**Vedavathi Bellamkonda-Athmaram (goes by Veda Bellamkonda), MD, age 35**

PEDIATRICIAN

## Dealing with microaggressions

**A**s pediatrics is an almost entirely female specialty, I have faced far fewer barriers than female physicians in other specialties. Signing on as a shareholder and becoming part-owner of my practice was definitely one of the best career decisions I have made. It gives me the ability to advocate for changes I want to see in our practice, the importance of which cannot be overstated. Being a shareholder has also allowed me



to build wealth more quickly, which gives me the ability to pursue my personal interests outside of work and provide financial support to causes and organizations which are important to me. As a shareholder, I am acutely aware of our practice's finances and I know that I am being compensated fairly. I am child-free, so I have not experienced the negative career effects that maternity leave and motherhood have on most women's careers.

I am a small woman of color who is often

mistaken for a child in daily life due to my size and ethnicity. When I walk into the room of a patient I haven't seen before, they typically do not anticipate that I am the physician; they often assume I am a nurse or medical assistant—at times some have even thought I was a pediatric patient!

Examples of comments I have received from both patients and providers include “You look like you're 12 years old! You can't

possibly know anything!” and “Doesn't she look like she could be 15? How could she possibly be a doctor?”

People don't recognize these types of comments as acts of racism but they are. Due to a lack of diverse representation in every forum, the appearance of white people has become standardized as “normal.” People don't stop to think that individuals of other ethnicities are more likely to be different sizes and have different skin that appears to age differently.

I feel that I have no recourse for addressing microaggressions. I cannot address them with patients out of fear of generating a patient complaint or losing their business, although at times my frustration is visible in my physical reaction to their comments. I hesitate to address microaggressions committed by providers out of fear of being labeled overly-sensitive or straining my relationship with them.

Like many minorities, I have internalized these microaggressions as well. Being frequently questioned and second-guessed by others ultimately can make you doubt your own abilities as a physician. This has improved with time, as my confidence in my own abilities and my experience as a physician have increased.

I have noticed that my patients who are young girls, especially girls of color, have looked to me as a role model at times, seeing a career in medicine or science as a possibility they may not have felt was attainable prior to having seen it represented in real life. It is my honor for them to view me as such, and I hope that I live up to their expectations of me and of their potential career prospects.

*Advice:* It is a long and difficult road, but for me it has been well worth the sacrifice and challenges. I have found more joy in my career than I imagined was possible. Being a physician, although challenging, is extremely rewarding and fulfilling.



**Melena Bellin, MD, age 45**

PEDIATRIC ENDOCRINOLOGY, PROFESSOR, UNIVERSITY OF MINNESOTA

# What is normalized

I think I've been more fortunate than many people. I haven't had a particularly difficult road to travel. Pediatrics is a very gender-balanced field; a lot of women go into pediatrics and the field has navigated this gender balance a lot longer than other areas. I've seen other colleagues who have struggled more to find their role, their leadership positions, their role in other areas of medicine. Part of that is about exposure and what is normalized.

If you're going into academics and research like I have, there is a lot of traveling for conferences that I think is tougher for colleagues with young children. When under consideration for grants and tenure, it's specifically recognized that you get an extra year if you have children. That's one accommodation that I've seen.



Obviously there's a lot of overlap between genders and people. I think women bring a lot of empathy and compassion to medicine. There also are a lot of female patients who like to have a female physician, they like to find a doctor that they feel comfortable with. Women can be very receptive to listening to junior faculty and colleagues, incorporating things in a respectful way.

I think that the burden of physician burnout for women and all people has been getting increasingly worse. There's more documentation, for the better of patients, but we also have to try to figure out that easy access. There's just not an easy answer. We try to teach skills to cope with stress or burnout, but that doesn't deal with the system.

*Advice:* The first step is just getting some real world experience, maybe shadowing. As you're going through med school, find something you're really passionate about because you're going to be really busy doing it. And remember, there are a whole lot of things you can do. If you decide clinical practice isn't for you, you can go into industry. If you don't find the right fit, be open to all options.

## Average annual physician compensation

PLASTIC SURGERY **\$576,000**

ORTHOPEDICS **\$557,000**

UROLOGY **\$461,000**

GENERAL SURGERY **\$402,000**

OB/GYN **\$336,000**

PM&R **\$322,000**

INTERNAL MEDICINE **\$264,000**

FAMILY MEDICINE **\$255,000**

PEDIATRICS **\$243,000**

*Medscape, April 15, 2022*



## Michelle Chestovich, MD, age 48

FAMILY PRACTITIONER FOR 20 YEARS, NOW PHYSICIAN LIFE COACH

# It doesn't have to be so hard

I've been passionate about physician wellness my whole entire career, and then losing my sister, on March 5, 2021, I felt I needed to speak up even louder. I think about her 10 times a day and I see her kids, who don't have a mom, and so I will speak up and say we have to stop putting up with the madness.



We lose about 400 physicians a year to suicide, and women physicians are 2.5 times as likely to die by suicide than the general population, male physicians about 1.25 times as likely as the general population. Let alone all the people leaving. By six years, up to 40 percent of female physicians go part-time or leave the profession (AAMC data). That's a bit of a red flag.

The culture of medicine needs to change. We ask way too much of these docs and they just keep going. Being a physician is tough, being a mom is tough, but it doesn't have to be so hard. Women need to stand up and say, you know what, that doesn't work for me. It's unhealthy for physicians.

I think we have abysmal support for women having children in medicine. I think our nation as a whole does an abysmal job supporting young families. So many women go back to work just a few weeks after having their babies. My residency director said take as much time as you can and I extended my residency by a month. When you go back to work with an infant, you're trying to pump, that's not very well supported, you need time off with the kids when they get sick. We women can hold our own with the men, but even when we have great partners, the lion's share of work at home falls on the women.

You don't get into medicine without being a straight-A student. We want to do the best at our jobs and we want to do the most in our family life. That gets really stressful. When do we get to rest? When do we get to relax? We just exhaust ourselves. We don't go from our A-plus attitude at work to a B at home.

We have a lot of mom guilt because we think we should be doing everything other moms do. There are lot of high expecta-

## Kelly Collins, MD, age 47

PHYSICAL MEDICINE AND REHABILITATION PHYSICIAN WITH BOARD CERTIFICATION IN BRAIN INJURY MEDICINE. MEDICAL DIRECTOR, INPATIENT REHAB UNIT, ST. CLOUD HOSPITAL

# Men and women are different

I chose to become a physician because I wanted to help people. That is a very generic answer, but it really is what led me into this field. My mother, who was a nurse anesthetist, told me that if I became a physician, it couldn't just be a job; it needed to be a calling. I debated between becoming a doctor, a physical therapist, exercise physiologist, or nurse. My mom had always thought, if she would have gotten the support in her time, that she would have liked to have become a doctor. Partly because of her support, I was able to dream big enough to become the first doctor in our family.

I chose my field, Physical Medicine and Rehabilitation, for a few reasons. It is very team-oriented, and I really love working with a team. I liked the idea of being an

tions that we should be doing everything. Instead of prioritizing, we beat ourselves up looking at all the things we haven't done.

There's a real feeling of lack of agency. To make medicine a better field for women, we need better maternity leave, like actual paid leave. Non-medical industries tend to do a better job at this. We need to offer these things, not wait for women to ask.

We should be supporting mental health preventatively, not just "call this number when you need help." Organizations need to start proactively supporting the brain health of our physicians: "Here's your badge, your parking card, and your coaching support." It's been proven to be helpful and it seems like a no-brainer. Organizationally, how can we better support the health of our people who are doing such a good job for others?

I became a coach because I had struggled for so many years with burnout and I tried all the things we are told to do, more sleep, more yoga. Then finally I got a coach and thought oh gosh, I am making it so much more complicated than it has to be.







## Gabrielle Cummings, age 25

MEDICAL STUDENT, MAYO CLINIC ALIX SCHOOL OF MEDICINE (WILL FINISH IN 2023). INTERESTED IN PSYCHIATRY

# Making more of an effort

As a woman, you have to make more of a conscious effort to prove that you know what you're talking about when you come into a patient's room. Some of my male colleagues are taller and they come in and assert this dominance—even if they aren't really saying anything about treatment strategy. You have to make put more of an effort to prove you've done your homework and you know a lot about them and are well informed about potential management strategies.



Once you've overcome that initial confidence hurdle, I think it's good to be a woman in medicine. Patients tend to tell women more than they tell some of my male colleagues.

In the beginning of medical school, it was more lectures and, for us, there was a second year on Zoom. But in third year, I think the instructors sometimes put a well-meaning paternalistic spin on things.

They're kind of surprised you can stand up through the surgery or keep a hand on the retractors for so long. They make an effort to check in more for some of the female students. It seems like it's a little bit of a shock to them when you can keep up with the physical things.

I have been called a nurse quite a bit, especially when I went into the hospital as a second-year student. It still happens quite a bit. You introduce yourself as a medical student, but some people keep asking when you're going to be a nurse. I personally haven't seen that ever happen to a man, not even when they're wearing the same scrub colors as the nurses.

On the pediatric clerkship, I was on rounds and our whole team was female: female resident, female consultant, two female medical students. A patient's family member kept saying, "Okay, ladies, what's the plan?" and "Bye, ladies." I didn't really think of it, but

## Natalia Dorf-Biderman, MD, age 46

INTERNAL MEDICINE, HOSPITAL MEDICINE SPECIALTY, PARK NICOLLET

# Things have changed

It's impossible for me to speak about my experiences as a female physician separate from my experiences as an immigrant physician and a female non-white physician. In general, I think females tend to get more "uncontrolled" comments, comments that men of all backgrounds would not receive. Immigrant female physicians, in particular, receive all kinds of unwelcome comments frequently. I try to come to these conversations with an open mind; I choose to believe that a lot of the comments are out of curiosity and interest as I have that same interest in other people's cultures. You can often tell however whether someone is asking questions out of distrust or disrespect or from a place of genuine interest.

the consultant said in the hallway, "Did you notice that he never called any of us doctor?"

I think women bring more of a humanistic, whole-body care perspective to medicine. I have seen women having more cognizance of all the other factors that go into health status: Are you able to pay for this medication? Do you have transportation to pick it up? Who is going to support you when you go home from the hospital? Asking patients how they are feeling in both physical and mental ways.

It would help to see more women in fields that are dominated by men, but there are a good amount of stereotypes when it comes to specialty choice. Quite a few of my female classmates want to go into long, rigorous, five- to seven-year training programs and they're often met with a gasp. That reinforces the stereotype that women should go into fields that have more of an 8-to-5 work life. I'm not sure the medical system itself is good at breaking down that stereotype.

*Advice:* I think you should take time to experiment. Some people go into medicine because of family members, some because they think they can make a lot of money. If it takes a long time to find what you want to do, it is completely okay to take that time to find your passion.



At the beginning of my career, I operated from the perspective of “I need to be accommodating, I need to not rock the boat, I need to adapt.” For a very long time, I felt I needed to accommodate to the system so that I would be accepted. More recently, because of many changes in society, and probably because of personal development and growth, I feel somewhat different. I am more able to bring my whole self to my professional life. When we are able to do that, it feels like we live in alignment, it feels more honest and with integrity with who we are as a whole.

The rhetoric has changed and there is more acceptance of all sorts of backgrounds and experiences in most settings, including medicine.

Especially if I’m not wearing my lab coat, it’s a given, no patient ever thinks I’m an MD. Even with a lab coat and the stethoscope and the badge, I introduce myself as Dr. Dorf, and at the end of the conversation the patient says, “When is the doctor coming in?”

In meetings, all the time, throughout the meeting they call the male physicians Dr. and they call me Natalia. I have had to have a side conversation with people I know to change this. I tell them that I personally don’t need you to call me Dr. Dorf and feel comfortable going by first name, but if you’re calling the men Dr., then please call me Dr. as well.

Women are just able to juggle so much, the level of complexity we are able to handle in general is off the charts. That even comes to our own personal detriment, frequently, but for patients and health systems, it’s an incredible asset. Also, the collaborative aspect of how a lot of women operate—it’s the future of medicine. The future of medicine is not the physician as the sole director of the care plan. It’s team-based care because there’s no way to accomplish what we need to do to keep our patients and communities healthy without team-based care, so you really need collaborative physicians. This is a big broad generalization, which I don’t frequently like, but female physicians in general just naturally operate that way.

The leadership capabilities of women are just incredible. We are people who lead teams, lead systems of people in our lives. We lead our villages, we lead our families. In an endearing way, my husband has coined the term for me: CFO of our household—Chief Family Officer.

The visual of the old white male doctor as the sage leader is so commonplace, it’s just woven into people’s views on leadership, even today. It is still hard for people to naturally place and naturally visualize women, especially women of color, in leadership positions in healthcare. We need to promote women, we need to pay attention as women’s representation is critical to change those assumptions.

Having children in training was extremely hard, one of the hardest times in my life. Especially the first one, because no one else was having kids. I felt it was almost frowned upon at the University of Minnesota at the time. The attitude was that the only thing

that mattered is medicine, what was I doing having children? I missed out on a lot of social events, get-togethers, and other things. I had very few friends in residency. It was a tough time in my life.

I started residency when my firstborn was 3 months old. During my second rotation as an intern, I had to stop breastfeeding after five months because I was on call six days a week from 6am to 10pm every other day with no protected time to pump. My father came from Uruguay to help us. He slept in the room next door to the baby and got up in middle of the night to feed her a bottle, which ended up being formula because I could not produce any milk. With so little sleep and so much stress there was no way to keep going.

I cried twice a week.



There’s such significant isolation here in the United States for families, especially for young families trying to raise children with little help. In many places in the world, in South America, you grow your children in a village. The saying “it takes a village” is rooted in reality and it really happens elsewhere in the world. People have their families around and their communities of friends who help care for the children and others. And they don’t feel ashamed about hiring help and asking for help. When I’ve talked to some colleagues about why they don’t get some kind of help they respond with amusement, saying why wouldn’t they be able to do it all.

How can we make it easy to find help, and support? For example, help with easily accessible resources for childcare or elder care, or help finding organizations families can easily tap for household chores, or everyday life chores? Not that your system would need to pay for them, but you could provide an information hub of trusted resources or even preferential access. This is something we’re exploring at HealthPartners. Stay tuned.

*Advice:* Choose where you train based on how it aligns with your values of how you want to live your life. People who go into medicine are so committed to their careers and their training. They are leaders, they want to be in leading places. They typically want to go to the best on everything. I would say know what’s important to you, know yourself outside of medicine; don’t just keep your hobbies but elevate them, care for your family, and don’t miss important events. You will need your life *out* of medicine to stay healthy *in* medicine



## Melissa Geller, MD, MS, age 49

PROFESSOR AND DIVISION DIRECTOR, GYNECOLOGIC ONCOLOGY,  
DEPARTMENT OF GYNECOLOGY AND WOMEN'S HEALTH,  
UNIVERSITY OF MINNESOTA

# Barriers for women

**T**here are still a lot of barriers for women. When I trained, we tried to ignore them; we didn't have any choice. Today, I think there's more of a recognition that women physicians are facing barriers that men do not.



When I graduated from fellowship, a woman who trained me said, "You're going to have to put your big girl panties on, because you are going to be working with a lot of men."

One of my greatest mentors was Linda Carson, MD, department chair.

There were pictures

on the wall of all the department chairs, which were all white men, and then Linda Carson in her bright orange dress. She really inspired me. Without her leading the way, much would have been different for my career.

Despite the number of women in the medical field, there's still not the representation at the top that we need to make changes.

You look at your peers and there's a lot to manage in a surgical profession. The majority of department chairs are men. All of the surgical specialty department chairs except two are men. There's still not the representation at the top that we need to make changes.

The curves are coming together, but it's slow. I try to be a leader to show women that we can get to those positions of department heads and division chairs.

What really convinced me to go into gyn onc was the surgery, but it was a lot of men at that point, which sometimes meant a lot of craziness in the OR—throwing of instruments, swearing, things that are not accepted today.

## Elisa Hofmeister, age 26

MEDICAL STUDENT, UNIVERSITY OF MINNESOTA  
(WILL FINISH IN 2024)

# Work-life integration

**A**s a white woman coming from a large family with female physicians to look up to, I wouldn't say that I encountered any strong barriers to medicine as I was preparing for medical school. I know that my aunt did when she went to medical school in the 1970s. Today, I think the greatest problem facing potential applicants to medical school is that there are more qualified students than spots! I am interested in orthopedic surgery these days. All of the faculty and residents at UMN have been incredibly supportive and welcoming, but I do get a lot of surprised looks and raised eyebrows when I tell that to people who are familiar with the stereotypes of orthopedic surgeons.

I have three girls, ages 13, 11, and 4. I was 35 when I had my first child. I didn't want to have children during my training, when I was working every other weekend. A colleague once gave me a print of a woman saying, "Oh no, I forgot to have children." It was a conscious decision I made to wait. Being an older mother and having my career on track was better for me, but everyone has to make this decision for themselves.

Medicine could be more family-friendly. I wish it were okay, or at least acceptable, to work part-time. At least in academics, it's very challenging and expectations are high for promotion, which comes at a time when many women are trying to start their families and develop a research career, all while practicing medicine.

We need a separation between work time and family time. People don't want to operate until 10 at night, but in the old days, we used to do that. Don't plan meetings for 5:30 at night—we were on a Zoom meeting recently at that time and all you could hear was kids' voices in the background, kids who wanted to be with their parent who had been gone all day.

*Advice:* You can do it all—but you need help. You have to surround yourself with a team to become the physician you want to be and the parent you want to be and the friend you want to be. I am lucky that my family lives in Minnesota, I have been fortunate to have very supportive colleagues and have had fantastic mentors throughout my career.



Most, if not all, events centered on women in medical school involve a discussion on work-life balance or work-life integration. I think this is great! But as soon as the event is “for all med students,” that conversation isn’t brought up very frequently anymore. I am a strong believer in changing the culture of medicine so that all participants can experience work-life integration. I ask my male friends whether they’ve thought about how to take paternity leave as a med student/ resident/ attending if having kids is part of their plan ... That’s my small way of pushing back on the idea that men don’t need to consider a family’s needs when thinking about their careers.

I think continuing to diversify medicine to include people from all backgrounds, particularly first-generation medical students, will serve the medical community well as we adapt to an ever-changing population and world. I would also hope to see a shift away from the business model of medicine during my lifetime—I’m here because I care about patients, health, and equitable safety nets for all. I don’t know if that is compatible with the big business model of healthcare. Sometimes good healthcare isn’t profitable!



### Elena (Ellie) Jelsing, MD, age 40

PHYSICAL MEDICINE AND REHABILITATION, MAYO CLINIC AT MAYO CLINIC SQUARE, MINNEAPOLIS. TEAM PHYSICIAN FOR THE MINNESOTA LYNX AND USA WOMEN’S SKI JUMPING TEAM

## We need flexibility

I wish there were more flexibility in medicine. Not necessarily working fewer hours, but a schedule that is just a bit more flexible—for example, being able to start the clinic day a bit later or end a bit earlier for a special occasion. From the physician-mother perspective, if it’s my kids’ first day of school, I want to take them to the bus stop and see them off but I’m typically at work before they are even awake. Trying to get kids to doctor appointments, dental appointments, parent conferences, sports practice ... it’s all a challenge with a physician’s inflexible schedule.

The microaggression that probably happens most often is being mistaken for a nurse or other team member. They are incredibly valuable members of the team—I certainly don’t take offense—but it sometimes creates role confusion for the patient. We can wear scrubs on our procedure days, but I choose not to in order to avoid confusion.

Women, in general, are pretty good listeners, which is an important skill to have. They tend to be empathetic. Women often are looking at the big picture, understanding how, in my world of sports medicine, an injury impacts someone’s entire life: physical well-being, mental health, social interaction, stress outlet, break from their other responsibilities such as childcare. Maybe it’s that women are good at not only seeing the impact, but asking about it. Patients sometimes aren’t comfortable expressing these concerns unless asked.

Quite a few of the barriers for women physicians revolve around childbearing. I have five children, the youngest is 7 months old. I was scheduled to go to the Beijing Olympics to take care of the athletes, but I had a 3-month-old whom I was breastfeeding. Despite the fact that this was my career dream, I just couldn’t bring a baby to China during the pandemic and I couldn’t be away for three weeks. Had I been male—with a very supportive wife—maybe I could have swung it.

As another example, I have been fortunate to be invited to give national lectures or teach at national





# WOMEN IN WHITE COATS

ELLIE JELSONG (CONTINUED)

conferences. With the courses in particular, if you do a good job, you often get invited year after year. But if I decline, that invitation is going to go to someone else and sometimes it's difficult to "get back in" if you will. With maternity leaves and young children, you sometimes have to say "no" to the invitations.

I have had three babies since I finished training (my older two children are step-children). I was lucky to be able to take 12 weeks off for each of those babies, which is unusual. I couldn't imagine returning to work after just six weeks. I don't know how women who have children during training manage it. If they have to prolong their training, it sets them off the normal academic cycle, which could have implications on obtaining a fellowship or potentially for job opportunities.

*Advice:* I would tell an early-career physician to say "yes" to lots of opportunities. When you walk through a door, other doors open. Once you get mid-career, though, you can't keep saying "yes." Pick out the things that are most important to you and focus on them. Throughout your career, stand up and advocate for yourself. I would say that to anyone, but it's even more important for women. And yet it can come across as aggressive, especially for women. It's a fine line between getting the respect you deserve and not having that advocacy seen as a negative.

## Rosemary Kelly, MD, age 57

*C. WALTON AND RICHARD C. LILLEHEI PROFESSOR AND CHIEF, DIVISION OF CARDIOTHORACIC SURGERY, DEPARTMENT OF SURGERY, UNIVERSITY OF MINNESOTA*

# More women, more fun

**T**he most fun now is that there are more women around as colleagues. That makes it great, as we have shared training and experiences. There's always that affinity for someone who looks like you and understands the work. It makes it easier to make friends at work and they become your comrades in arms.

I have a lot in common with male surgeons and many are great friends. But there definitely is an immediate affinity with my women colleagues.

As you move up in leadership, it's been nice to see other women physician leaders. I think women have a different way of managing teams in a way that's inclusive and that's better for everyone. It's not master-and-commander, it's more matrixed. Women understand the intricacies and demands of teams. They're just comfortable managing a complex group of people—and women listen!

I know I've had moments where there were condescending comments or some areas of discrimination, but I've also had equal and more powerful moments of support and mentorship. I think I've always had that there for me in my career and I feel really lucky.

It's possible I gravitated to those people and recognized the importance of those relationships to my success. My professional choices are often based on relationships rather than on titles or specific career moves. I've always loved being a surgeon and work hard to do good work. I have found that when you do good work, it turns out you often are offered more opportunities.

I've had people say, "Oh, that's going to be hard" when I talked about going into medicine. I thought, well, I'll find out if it's hard. I wasn't afraid to try. My aunt went to medical school at age 32 and was the first female intern at Ancker (now Regions) Hospital, so I grew up knowing women can be doctors.

I think were some people who kind of assumed that because I'm married but don't have kids that it was because of my career, but it was more a personal choice. We certainly could have managed being parents, despite my being a surgeon.



Microaggressions? Maybe. I'm just an optimist and I don't look at the world that way. If some patient calls me a nurse, I get it: 85% of nurses are women and only 3% of surgeons in my field are women. I don't take it personally. I think people can be particularly sensitive in an very complex, very intense, tired workplace. It's a demanding job.

The one thing I think we don't do well in healthcare is that we don't have built-in daycare support. I think a lot of businesses recognize the value of that. If you had daycare on site, you could see your kids at lunch time, pick them up, or drop them off without being totally stressed. Childcare doesn't have much value in our society; we have to change to be more like Scandinavia, where they invest in their children.

If we provided more of this support so that trainees, especially, could start families at a younger age, we wouldn't be delaying people getting on with their lives. We have all the potential here at the University of Minnesota to develop a childcare facility.

We could try to have more of the team approach in medi-



cal practice to make sure that when you're on call, you have a buddy system. Our surgical group moved to a back-up call. You're taking more call, but it's not as intense so it's easier on all the surgical teams and better for the patients.

If we don't figure out how to relieve the workload and stress, we won't have doctors. People will say it's just not worth it.

## Shanterian King, DO, age 31

PHYSICAL AND REHABILITATION RESIDENT, MAYO CLINIC (WILL FINISH IN 2023)

# Room at the table

**M**y mantra is that if there is no room for me at the table, I am going to bring my own chair. I carry that mentality to this day. I am passionate about being in medicine and being an example and a role model for others who look like me. I aspire to show that where you come from does not dictate where you will go.

My interest in becoming a physician stemmed from being involved in the medical care for some of my family members at a young age. Unfortunately, healthcare literacy in my family was limited and I felt that my relative's medical care might not have been as optimized as it would have been if we had more knowledge.

One of the most common things I have encountered is being mistaken for a nurse—not so much here, but throughout my medical journey. Not only have I been mistaken for being a nurse, I've been mistaken for someone who's bringing the lunch tray or coming to clean the room. That is in spite of me wearing my white coat and being part of a medical team. It is not just that I am a woman but that I am a woman of color; for some individuals, that is not something they are accustomed to seeing.

I must be confident in myself and my knowledge so I can present myself appropriately. It has been an interesting and challenging journey, but I would not change the process. My community continues to motivate me and remind me that the work I am doing is much bigger than myself. This is what sustains me during my most difficult moments.

My department has done an amazing job of increasing the number of women in PM&R. We have created these great support systems, including a PM&R women's family support group, and we are paired with mentors who have similar backgrounds to ourselves. When you are going through challenges, it is nice to be with someone who understands it, with whom you can discuss how they navigated similar situations.

To be a woman in medicine, specifically to be a physician, requires a level of dedication. Many of my counterparts are wives, they are mothers, they are mentors, they are amazing physicians, and they are phenomenal teachers and leaders. Each of those roles requires a significant amount of energy, but they do them all so effortlessly.

As I am coming close to the end of my training, starting a family is something I think about often. I do desire to have a family and to be able to nurture and mentor my own kids. I think about what that will look like for me while having spent the past 14 years developing my career. I acknowledge that there is never a perfect time; you must choose the time that is best for you and your partner.

Sometimes, I look at my counterparts who are not in medicine and wonder what life would look like if I were not in medicine and not studying for exams or preparing for a presentation. But there is a certain beauty when you get to the end of your training, and I am in that phase now. It has been a journey, but it has been worth every step.

*Advice:* The first reaction you sometimes hear when you tell someone you want to be a physician is, "Are you sure you want to do that?" My response is to just support and encourage that individual because that is what you need. I always say to remember why you went into medicine and what your purpose is and that will carry you through.





**Alice Knoedler, MD, age 34**

ALLERGIST AND IMMUNOLOGIST

## Never a perfect time for kids

I had three children in residency and fellowship—one every other year, starting my intern year. It was chaotic most days but nothing beats coming home from a bad 28-hour shift to see a toddler with their smiling face pressed against the window, waiting for you to come inside. I've pumped in the worst places—including both directions to and from work in DC traffic—for most



of my residency. I've started pumping right as the code pager went off on more than one occasion.

I was referred to as “one of our more fertile residents” at my residency graduation when they were announcing my name and where I was attending fellowship—in front of the entire audience.

We are able to balance a lot. One of my favorite nurses used to say women have three shifts

every day: the day shift with patients at the hospital or clinic; the evening shift (dinner, practice, baths, cleaning); and the night shift (waking up with the baby overnight). These shifts change depending on work hours and the field of medicine, but the general principle stands. Sometimes when I feel overwhelmed (often), I remind myself that three shifts is a lot.

I showed up at my allergy and immunology fellowship interview eight months pregnant and there was a PowerPoint slide on childcare and local daycare options. They listed all the (very nice) pumping rooms throughout the campus. The doctors all talked about their families. They had an actual maternity leave for trainees. Compared to my friends interviewing, this was unusual—and it turned out to be true. There is a lot of shame surrounding having kids during training. I was lucky to have a supportive fellowship.

*Advice:* There's never a great time to have kids in medicine. Do what's best for your family.

## Reducing to part-time

Within six years of starting practice, almost **three-quarters** of women physicians reported reducing work hours to part-time or considering part-time work.

*Gender Disparities in Work and Parental Status Among Early Career Physicians Elena Frank, PhD; Zhuo Zhao, MS; Srijan Sen, MD, PhD, et al. August 2, 2019, JAMA Network*





## Adrina Kocharian, age 29

MD/PHD STUDENT, UNIVERSITY OF MINNESOTA  
[WILL FINISH IN JUNE 2025]

# Being assertive

**W**hat does it mean to think like a woman? I'm not sure that's a real thing. Growing up in a culture (Armenian-American) where women are nurturers and caretakers generally, it's possible I might bring some of that with me to my practice of medicine. Everything that a man can bring, a woman can bring, and they also bring some level of grit because of having had to go through the system as a woman, there's some extra level of something you've had to put forward. Whether that's a different charisma or work ethic or whatever.

Rather than trying to prioritize historically "masculine" traits—things like being more direct, more authoritative—as examples of good business in medicine and masculinizing women to adopt those traits, we can be more receptive to historically "feminine" traits. Maybe there are alternative personality traits that can lend themselves to a successful career in medicine. Maybe we can even stop calling traits "masculine" and "feminine."

There are times I can think of where I've questioned whether if I were a man in the same context, would this question be asked of me? Would you be directing your eye contact to me more clearly? These are pretty rare occurrences. That's, in part, due to the fact that I've made tremendous efforts to not go unnoticed, and to bring it up when I feel I need to, but should I have to be doing that? I'm very much not Minnesotan (I'm from Los Angeles)—people in my class will tell you that—I'm very comfortable raising my hand and saying, "excuse me," and because of that, I've asserted myself and proven myself and kind of demanded attention and respect from male colleagues. I've also made tremendous efforts to seek out mentors who are mindful of mentoring a woman and who care deeply about that and who respect me deeply, so I've had generally good experiences.

The length of the training is a barrier for women, coming at a prime period of time in one's life. I'm in an eight-year training program and then I have to go into residency and I'm trying to envision a way to have a family life that I want that's balanced with my career life. People do it all the time, but it doesn't naturally afford that kind of balance.

Certain aspects of medical training are overkill. Medical school being four years? I don't necessarily think it has to be that way. I don't think a three-year intensive residency is much better than a four-year less-time-intensive residency. Maybe there's a case for

us doing 60 hours a week, rather than 80 hours as a resident. I know these can be controversial ideas.

Medical schools and residency programs can make more serious efforts to subsidize healthcare for fertility. Have a system where there is backup so that if you're pregnant or on parental leave, you don't feel like you're screwing over your colleagues.

*Advice:* Be aware that your mid-20s, late 20s, and early 30s are formative years. A lot of major life decisions are made in this time. Professional decisions, of course, but also many decisions pertaining to your personal life. You don't get these years back. Medicine requires a lot of sacrifice during these crucial years. Try to sit with yourself and think about what you would be willing to sacrifice—and what you wouldn't. Recognize your limits, then figure out how to balance them with your career goals in a way that makes sense for you.





**Wendy Laine, MD, age 48**  
EMERGENCY MEDICINE PHYSICIAN WITH EPPA

## Women step up

**W**ith this recent COVID pandemic, I saw so many of my female colleagues stepping up to volunteer for vaccine clinics and trying to bring up other concerns, like the safety of our coworkers; I just don't see as many men doing that.

During the pandemic, burnout hit women so much more because they're not only trying to do their work but now, all of a



sudden, they're the teacher for their kids and because of societal expectations, that pressure still falls on the woman more than the man. Even in smaller things, like we couldn't wear white coats during the pandemic. That was one of the things that protected me, and did make my patients realize that I was a physician.

Research on women in emergency medicine residency showed that it takes women residents longer to have the same experiences as the men. Are they not given

the same opportunities, or do they just not feel comfortable stepping up?

I was assistant medical director at our ER. I noticed that when new female physicians would start, they often had a harder time with female nurses. We as women get critiqued a lot more for behavior that would be tolerated and accepted for men. Being direct about who needs to do what, for women can be looked at as being bossy or bitchy.

Once they get that reputation, it's hard to break away from it. I know a couple of physicians who have purposely tried to be extra sweet, bring in cookies, and they do it very intentionally to make friends. I'm kind of naturally a little quieter and my voice is qui-

eter and I'm also short. I feel that some women come off as more intimidating because of their height. Just because of my stature and the timbre of my voice, I don't come off as intimidating, but I also study a lot of mindfulness and I try to be a good listener. I'm very intentional about trying to cultivate healthy relationships.

I was at a Females in Emergency Medicine conference where a transgender male physician gave a talk a few years ago. He started his training as a woman and then transitioned and practiced as an attending as a man. His perspective is just mind-blowing. My favorite line from that talk was he said going from presenting as a woman to being a man was like learning how to play a video game on the extra-hard level first, then suddenly going to easy.

We have all these societal biases about gender fit, that women should be warm and comforting and men should be assertive and decision-making. But the Catch 22 is that if, as a woman, you have some of those masculine characteristics, it serves you poorly. But as a man, if you take on those feminine traits, everybody thinks you're the most amazing doctor.

Microaggressions? Is it daily? It might be daily. In the emergency room, we have a lot of male nurses. The last shift I worked, I went to talk to one of the patients and he said, "The doctor was just in here." No, that was your nurse, I'm your doctor. That's certainly not uncommon. I definitely have had patients say, "Oh, you don't look like a doctor."

There are good studies that women physicians have better outcomes. I think we can be a little bit more comforting. Sometimes in the emergency room, you don't really need a certain test or a diagnosis, you need someone to provide you a little reassurance.

At EPPA we're in the middle of a big gender equity task force project. I'm very excited about the gender equity work we're doing. As women enter a field, it becomes more physician- and family-friendly.



## Kathy Lombardo, MD, age 62

ADULT PSYCHIATRIST, OLMSTED MEDICAL CENTER

# Strong mentors

**M**y father was a family physician and I was fortunate to be exposed to healthcare from a very young age through my father's practice in Brookings, South Dakota. I was always encouraged by my parents to pursue a higher level of education and my interests and experience limited barriers (that I perceived) throughout my earlier years in college or medical school—despite the limitations that women were experiencing at that time. Through the encouragement of my extended family, friends, teachers, and mentors, I was able to develop a level of confidence in my abilities and aspirations and was able to cope with and overcome barriers that occurred during my earlier education, training and employment.

I have greatly appreciated my career in medicine and my ability to care for patients for almost three decades. I also appreciate the opportunity to provide physician leadership at Olmsted Medical Center during a significant period of my career, which included being the first woman president at OMC from 2013 to 2019.

I believe it is important for women pursuing a career in medicine or leadership to have strong mentors during their education and careers. I was also fortunate to have significant support from my family—which included my husband and children. I would also recommend pursuing interests and friendships outside of medicine to provide a balance to a person's life and the intensity that a clinician experiences in a career in healthcare.



*Advice:* Pursue your interests and dreams. Despite the demands of a career in healthcare, I strongly recommend not delaying other aspects of one's life such as relationships, having a family, or pursuing interests outside of medicine. These pursuits only provide a greater breadth of support during an extended career in healthcare.

## Breadwinners

**71%** of women physicians were the main source of income in their families in 2015, earning **75%** or more of the total household income.

*AMA Insurance report*

## Caring for patients

**69%** of women physicians said they had frequent feelings of burnout, compared to **57%** of male physicians.

*2021 Survey of American Physicians, The Physicians Foundation*



## Nissrine Nakib, MD, age 46

ASSOCIATE PROFESSOR AND DIRECTOR OF FEMALE UROLOGY AND URODYNAMICS, DEPARTMENT OF UROLOGY, UNIVERSITY OF MINNESOTA

# Taught to be humble

I was influenced by the fact that my father was a cardiac surgeon. I grew up in Lebanon and my father was a war physician then, so he also did a lot of non-cardiac surgery. I cannot tell you how many times we would be walking in the street and people would say, “Your father saved my life, your father cured my mother.” He put a lot of good out there and it was something

to aspire to. I remember when I was 4 years old, I said I wanted to be a nurse because I thought that women had to be nurses, boys had to be doctors. My father said, “No, you can be anything you want.” “Okay, then I want to be a doctor.”

In med school, going through my rotations, for me there was no question that I needed to be in a surgical field, but I felt I would be giving up the continuity of patient care and the relationships you develop. The chair of the Urology Department, John Hulbert, asked me if I had thought about urology. I literally

just laughed. Why on earth would I go into male OB/GYN? He educated me on the field and it was really like an epiphany. Here’s a field you don’t have a lot of women in and there’s a need, a big gap. I’d be operating, but there are a lot of patient relationships that continue in urology.

John Pryor, the chair of Urology, was very empowering. He never made me feel different at all. In fact, he was always saying, “I know I can rely on you.” He expected a lot from everybody. He never put on his gentle gloves for me.



I would walk into a room and say, “Hi I’m Nissrine Nakib from urology,” and patients would say, “When is my doctor going to be here?”

Sometimes during residency I got a lot of pushback from female nurses, especially older ones, when it came to patient care; it was different treatment from the nurses than the male residents got.

There were patients who would say inappropriate things, like “You’re too pretty to be a doctor.” I tried to take it with the spirit with which it was intended. I’ve never had a patient, male or female, tell me they were uncomfortable with me because I was a woman. I’ve even had male patients request a female doctor because they may have had instances of sexual abuse in their past.

I’ve even had patients who I saw try to give me their number or hit on me.

In general, women are taught to be more nurturing, more humble. There are studies that women tend to practice more patient-centered care. They listen more, they involve the patients in their care, they have better outcomes surgically. They spend more time with patients.

Despite that, women don’t get any credit or extra credit for doing that because it’s expected of them. Whereas when men do these things, it’s seen as above and beyond. You see that in medicine all the time. It’s reflected in patient evaluations.

I remember when another chair of the department was stepping down, a few people—all men—were tapped to interview for interim chair. There was no transparency in the process. I serendipitously found out the application was due by 4pm that day. I applied because I felt it was very important to make a point. I don’t think my application was taken very seriously, but my point was made and got noticed.

Christopher Warlick, who was named interim chair, then became the chair. I walked into his office and said, “My kids are getting to an age where I can do more.” He said, “Great, have I got more for you.”

I felt like I was doing a lot in the department, but it was mostly behind the scenes. I have good ideas, but I realized that if I wanted to actualize change, I needed to get into leadership positions.

My chair was the one who said I should go for promotion. It seemed like such an overwhelming task but he said, “We have people who can help you.” He pushed me, encouraged me, and also helped me. We talk about women helping women, but everybody needs to help everybody. Everyone talks about mentorship, but what we need is sponsorship to help us stay in the game.

I have two daughters and a son. My husband is CEO of a big company but my children also need to see their mother stepping up.



Childbearing age coincides with the traditional time for advancement in academia. I was having children and trying to be a good mom. That was my choice, but the problem is it was so hard to get back into the pipeline. You need allies and sponsors who are helping you along so you don't exit the pipeline completely so that when you're ready to come back in, you're not starting at zero.

**Suzanne Norby, MD, age 51**

NEPHROLOGIST, MAYO CLINIC

## Different perspectives

**W**hen I first heard of imposter syndrome, I thought wow, is that a thing? You mean everyone is not just better than me?

In my early career, I took care of kidney transplant patients who would come for a general medical evaluation every year as part of their transplant follow-up. After several years, I learned that I was doing pap smears and pelvic exams on all the women patients, but my male colleagues were not; the patients they saw were being sent to gynecology. When I asked for my patients to go gynecology also, the appointment coordinator told me that patients "didn't want to have to go to two appointments." It was just assumed that because I was a woman, I would perform these exams myself. I raised the issue and said that when everybody in my division starts doing pelvic exams and pap smears on transplant patients, then I will.

Once, when a non-physician colleague introduced multiple physicians in a room, he referred to all the men as "Dr. So and So" and then introduced me as "Sue." I was early in my career at the time and afraid to say anything, but eventually I summoned the courage and told the person that, when he introduces all of us next time, he can introduce me as doctor as well. He was taken aback—but he did refer to me as doctor in those situations going forward.

*Advice:* You've got your job, your kids, your partner, whatever else is important to you. You might not be able to please all of those at the same time, but just make sure you're not neglecting the same thing over and over.

Women physicians bring different perspectives and life experiences that can raise awareness and ultimately benefit patients and improve the system.

Scheduling flexibility and more control over one's day are the main things that would make medical practice better for women.

To accommodate women in their childbearing years, it would be wonderful if the ACGME and certifying boards could develop alternate training pathways and schedules. The existing rules and regulations were put into place when there were not as many women medical graduates.

*Advice:* I would simply say, "you can do it!" Whatever allows you to feel happy and fulfilled, you can do. While it may take some creativity and effort, the results will be worth it.





## Sima Patel, MD, age 43

EPILEPTOLOGIST AND ASSISTANT PROFESSOR OF NEUROLOGY,  
UNIVERSITY OF MINNESOTA

# Implicit gender bias

**M**y parents passed away when I was younger. My parents and grandmother were often very sick, going in and out of the hospital, the emergency room, and doctor visits. Navigating the system unfortunately was a very familiar thing



to me at the age of 8, as I often stepped in and helped out at home. It laid the groundwork for a strong work ethic, compassionate care, and a career in medicine. When you're a kid and you have chaos in your life, a positive outlook would be trying to figure out that chaos in your adult life. Luckily, I've had the opportunity to do this and I continue to learn. I am grateful for this awareness and gift in my adult life.

There are a lot of implicit gender biases that professional women face in many fields, especially in a more competitive, demanding field like

medicine. People often are not aware of their unconscious bias and women have to work harder to get the same recognition as men. We all have these biases, although we might not realize it. I think people are genuinely well-intended and trying to change this.

I took the Harvard Implicit Association Test, which you take to understand what your biases are. Even though I'm an advocate and I work with DEI issues, I have gender biases. I grew up in a patriarchal culture. When you grow up with these strong patriarchal world views, you can't help but look at the world through that lens, and then you have to decode that as an adult and question your belief system. Now that I'm 10 years into neurology practice, I realize I'm decoding a lot of my own biases and challenging myself to grow.

When I was training, I didn't realize it, but I often subconsciously looked at my white male professors as though they were the ultimate authority. Sadly, my implicit biases mostly impacted myself because I was very self-critical. I'd wonder, can I do this, should

I be here, am I worthy, am I doing a good job, is my thought process correct?—the whole imposter syndrome. This was and is emotionally exhausting.

I'm realizing that a lot of this was in my head, they weren't real barriers.

In residency, I had an Indian woman role model who was a surgical epileptologist who made it look possible and fun. I looked at her and thought, if she can do it, I can do it. It's that simple. I had a role model. And here I am, I am a surgical epileptologist, in a pretty much male-dominated field.

I work with a lot of medical students, neurology residents, and fellows. What I see is this theme of imposter syndrome, women being self-critical, expected to be the "nurturer," and sometimes having to work significantly harder to get the same recognition. But with my male students, I often have to take a step back and ask myself, they appear confident, but do they really understand? As a professor trying to teach students in medicine, I have to take a step back and ask more questions and lean in with curiosity to overcome these differences. Women and men just present themselves differently, mainly due to societal influence.

Where I struggle the most is when I am judged unfairly and not given the same support as my male colleagues. I'm a single mom and juggle five calendars. I take my responsibility to my patients seriously and do my best not to let my personal life impact patient care. I often find myself managing my work schedule carefully and following up on requests if unresolved. Sadly, then I am considered the difficult one who is too demanding. These are common things professional women hear a lot: difficult, demanding, micromanaging, controlling, and angry.

There's an emphasis on patient-centered care now. A lot of studies show that women listen more and are more patient-centered; their emotional IQ tends to be higher. We're judged a lot on patient surveys, but patients don't give their female doctors credit for that listening and emotional IQ because it's an expectation for women to be the "nurturer." Bringing this extra consideration to patient care can be emotionally exhausting and it constantly goes unrecognized and underappreciated. I spend a lot of time with my patients, but it doesn't show in my reviews.

Women tend to have more burnout. Emotional exhaustion is really high. When we think about that and women leaving medicine, it's because the expectations are too high and positive reinforcement is low. It's the unconscious biases that are heavy and many times not that obvious.

Medicine needs equitable resources and accountability for women and those under-represented in medicine. By equitable resources, I mean access to leadership opportunities, salaries, recognition



(awards, funding, and promotion), and search committees that don't bring bias to the table. We talk a lot about accountability, but when you identify inequity, what is leadership going to do about it? On average, women in neurology get paid 11% less than men, even after controlling for confounders. When you try to create balance, some people are going to get upset. However, those impacted negatively by these inequities have been upset for many years.

**Elizabeth Phillips, MD, age 39**  
UROLOGIST, CENTRACARE UROLOGY CLINIC, SARTELL

## Ask for what you want

There are certain expectations that some people hold about how women should act. Women can be called names for being assertive. Women should ask for what they want and should not be apologetic about asking. I've had many talented and powerful women to model that for me. Women will be subjected to judgment based on their appearance by peers, instructors, and patients.

I was interested in science from an early age and my mother would foster that with regular trips to the science museum. As I got older, I became more interested in biology and specifically in human biology. By college, I felt that being a doctor was the *only* thing I would be happy doing—and I'm happy to have been able to realize that goal.

I particularly dislike when patients refer to me by my first name or call me Ms. Phillips—or comment about my appearance.

At the University of Minnesota, I participate and dedicate my advocacy efforts at the Center for Women in Medicine and Science (lead for action group focused on salary, resources, equity, and leadership) and the University DEI council. I look for opportunities to create more inclusivity and accountability. We have to create positive steps with mindful actions to forge a path forward.

Women are fantastic multitaskers.

I would like to see women valued equally. I would like to see better allowances made for maternity leave and breastfeeding for female physicians who plan to have families.

*Advice:* Understand your priorities, set your boundaries, make yourself proud.



### Pay equity

Female physicians earn an estimated **\$2 million less** than male physicians over a simulated 40-year career.

*Health Affairs December 2021 Christopher M. Whaley, Tina Koo, Vineet M. Arora, Ishani Ganguli, Nate Gross and Anupam B. Jena*



## Elizabeth Seaquist, MD, age 66

*PROFESSOR OF MEDICINE, VICE CHAIR FOR CLINICAL AFFAIRS, DEPARTMENT OF MEDICINE, AND ASSOCIATE DEAN FOR MEDICAL SPECIALTIES AND PRIMARY CARE, UNIVERSITY OF MINNESOTA. FIRST FEMALE DIVISION DIRECTOR IN THE DEPARTMENT OF MEDICINE*

# Acceptance of diversity

It's a very different world in many, many ways ... I wouldn't say in every single way. Not in every way. Society in general and medicine in specific has become much more accepting of diversity in their ranks. When I was a resident, coming out of medical school and thinking about faculty, I remember thinking that there was only a certain mold of a woman that would be allowed

to be successful in medicine. She had to be married, she probably had children but had to be able to be flexible and not let her children be front and center all the time. Had to be super smart and really organized—and let things roll off her back. Everybody in medicine is smart, you have to be to go to medical school and that hasn't changed. But there's no one mold anymore for people. Gender, sexual orientation, ethnicity, religious background ... it's much, much more accepting than it once was. I think we really

believe that teams are better with diversity.

Obviously I've worked with men my entire career, how could I not? But during my career, the closest connections I have with my colleagues are on teams that are mostly women. My research group, the service line, by chance, are all female-led. There is such an amazing opportunity to talk about things. I think some of the reason we're able to work so well together is there is no reason we need to hold our thoughts back. For many, many years as I was

trying to think about the right way to advance in medicine and serve the medical school in the best way, I was more reflective about what I could and couldn't say. I hope I've been able to encourage my younger colleagues to share their thoughts. We need everybody's voice.

It's only recently that I've been able to reflect on this. It's that kind of dynamic that has been most challenging to be successful. If you feel like you're not going to be heard, you may not be willing to put yourself out there so much because there's a risk with that. That has been one of the cultural ways medicine has been discriminatory for women and people who are different.

Learning initially to work on teams that were largely men was difficult. I think for a lot of physicians, particularly female physicians, you just give us a task, we'll get it done. But you have to realize that not everybody works that way, that sometimes you can be taken advantage of. If others aren't committed to the team the way you are, you end up supporting other people's work at the expense of your own.

I've gotten very clear about expectations. When people join my lab or I form new collaborations, I think we have to talk really early about who's responsible for what and who will get credit for what. If you wait until the end thinking it all will work out in the end, well, it doesn't. But maybe I didn't think about that early in my career because I was just so glad to be there and I found the work so exciting.

I have a great story from one of my female med school colleagues at the VA 40 years ago, who told me that a patient raised his hand and said, "Waitress!" Just last week I was in a big discussion about the value of wearing a white coat, the expense of laundering them, and so on. I said one reason I always wear a white coat is so people will know I'm a doctor. I like the idea of not making people guess.

Patients prefer a woman doctor because they say that they are better listeners and they give more time. It's not universally true, but there is data to support that.

I think women learn that we have to multitask in a very different way. Not every woman has a family, not every woman has children, but most women have some kind of connectivity to family with responsibilities they have to organize in their head. That's a skill that I think women bring to medicine.

I wish there were a way we could balance the needs of the moment, particularly with respect to finances and responsibility for work, against a person's needs to accomplish a number of things. Most women's lives have a lot going on. Men do, too, but I think probably it's different. If, at this point in time, you decide that for







your own well-being, for your family's well-being, for your practice's well-being, you need to be part-time, maybe that's for the best and we should respect that and not view that as being a sign that you're not committed to the profession. In 10 years, if you maintain some activity, if you remain current, you will be back. Those children grow up.

## Xiaoyi Teng, MD, age 38

VASCULAR SURGEON

# What a woman has to be

I was very lucky with my family. They wholeheartedly supported my choices, good or bad, in pursuing medicine. From society as a whole, I did not get a whole lot of pushback when I decided to go into medicine, but definitely when I decided to go into surgery. I remember announcing my decision, and immediately, someone responded with "Oh so you are giving up on having a family or kids." That was really shocking to me, when usually the response to my male colleagues going into surgery was "congratulations" or "good luck." It was immediately "How are you going to do this intensive training and job, *and* do all these other things that are expected of your gender?" Which is obviously unfair. For anyone with dreams and goals, our first reaction to them should be one of encouragement and not dismissal.

One thing that frustrates me is this constant filtering of women to make us palatable in our careers. This idea that women cannot be assertive and direct, otherwise they will be seen as bossy and mean, and yet, we are also told that we need to "speak up" or "speak louder" when we feel unheard or unseen. I have gotten a lot of unsolicited advice: You get frustrated or feel you need to command a situation? Well, don't be too aggressive, and do not be bossy. You need to be sweet and friendly. You feel like you are being steamrolled in a meeting? Well, you weren't aggressive enough. You should have spoken up and told people what you want. It seems to be a very narrow interpretation of what a woman needs to be in order to be "just right."

I think women bring what any underrepresented group brings to the practice—viewpoints and opinions that are not often discussed and are often overlooked when you have no diversity. Beyond that, representation matters. I was lucky in school and training that I had women surgeons that I used as goalposts: "I want to be like her." It felt easier when you knew someone had already done it.

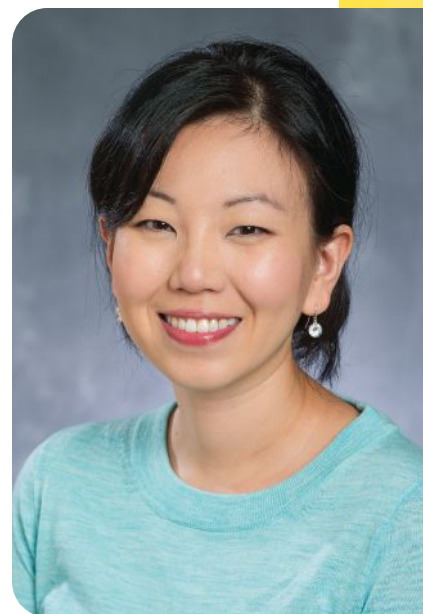
When I think about the faculty we have in medicine, I do think about that. This person has amazing talents, we're going to have to give this person some latitude because if we do that, we're going to reap the benefits of that in the future. I hope we can do that, but it's challenging because the bottom line is really important and if you can't support the enterprise, you lose it.

Women are routinely underrepresented in medical research and their medical care suffers because of it. In vascular and cardiovascular health, we are starting to recognize that women are not the average man and we do not present the same way nor should we be treated based on standards that may not represent us.

More mentorship and sponsorship needs to be geared towards women. I have been told before that "women don't want promotions because they want to stay home and have kids," which is just one of the most outlandish things I have heard. Lots of women want promotions, whether or not they have outside responsibilities, and instead of making them choose, we should value their work and help them continue.

I think that extends to better work/life balance for all physicians. Support for families or those who want to start a family. Paid parental leave, paid sick leave. Flexibility in the way we practice. These are all things that can increase happiness and satisfaction. The old tenet of the surgeon being in the hospital 24/7 is often put up as a symbol of devotion to the job and patients—except that we know overworked and burnt-out people make bad decisions. I don't think that's healthy for anyone.

*Advice:* Find good mentors. They will be your stewards in your journey. They won't always be in your particular field of interest, or even in medicine. But they will be your lightposts, and your wall to lean against. They should not only support you, but also try to promote you, push you forward, and be honest with you. Hard to find, but worth it.





**Rebecca R. Thomas, MD MHSc**

INDEPENDENT MEDICAL ONCOLOGIST

## The culture of medicine is unchanged

I have been fortunate to be a part of organizations that valued women doctors, understood the difficulties of being a working mother physician, and worked on solutions to allow women to continue to practice. Unfortunately, I have also been a part of health systems that failed to recognize the contributions of women physicians and hindered their advancement. In Minnesota, only one of the large health systems has a woman physician



CEO. The other systems are led by men or non-physician women. Women are more than 50% of medical school students, but this does not translate to the executive suite composition and there's no visible pipeline looking to address this discrepancy. This reaffirms the message there is a glass ceiling women doctors face, despite having the qualifications.

There are a number of microaggressions that women doctors face from being called by our first name, to facing inappropriate comments about pregnancy/child care, to being interrupted/dismissed at meetings, to underestimating our abilities. Microaggressions are just as harmful as overt aggression.

Women physicians are also often given tasks based on societal gender expectations that are not given to male colleagues, such as bringing in "treats" for the medical team, cleaning up the conference room/OR, or taking meeting notes. However, if a woman questions why her male counterpart is not asked to perform the same tasks she is labeled "not a team player."

To address microaggressions, organizations need to educate on how to recognize, acknowledge, and correct these actions.

Each individual brings their own experiences to the practice of medicine. It is by hearing and understanding the various perspec-

tives that we are able to best care for our patient population. As physicians, we are not treating a disease but the patient with the ailment. It is these diverse viewpoints that allow us to care for the *individual* dealing with diabetes, cancer, or heart disease versus treating just the breast cancer or the hypertension.

Despite the incredible scientific accomplishments made over the decades, the culture of medicine is unchanged. The expectation that physicians are interchangeable cogs in a healthcare machine slows advancement and contributes to a toxic culture. The fundamentals of medicine are unchanged: care and compassion. At the same time, we should appreciate the changing demographic of the physician workforce caring for a global community. We are not interchangeable and each individual brings attributes to advance the practice of medicine, which ultimately will improve health care. In order to recruit and maintain women physicians in the practice, organizations need to first understand the barriers for retention and advancement, then take the critical step of implementing actionable solutions while cultivating a safe and respectful work environment. Within six years of completing training, 40% of women doctors will leave or reduce their work hours. This will only exacerbate the looming physician shortage. Continuing to discuss the problems, forming more committees, and emailing surveys will not bring about change, but rather frustration. It is accountability and action that will make an impact.

Women physicians bring great value to the profession. Our identity should not be hidden or be a source of intimidation. It is in recognizing our stories and experiences that we are able to contribute to the field of medicine, deliver the best care for our patients, and move society forward. **MM**

# SOUL DOCTORS

## The role of **hospital chaplains** in medical care

BY NAIMA HASSAN; NERMINE ABDELWAHAB, MD; ASMA ADAM, MD; ALMA HABIB, MD; AND NASREEN QUADRI, MD

*“We all know healthcare can be improved, but we disagree with the idea that communities must be in tension with our healthcare systems to produce that improvement. We’re looking for ways where communities and healthcare systems together can ensure something better is created. For patients of faith, we want to see more culturally responsive spiritual care be a part of a patient’s care team—a part of how the hospital sees the whole person’s well-being.”*

– MICHAEL VAN KEULEN, PHD, OPEN PATH RESOURCES CO-FOUNDER

*“If there is trust, it makes a difference. If the patient or the family members trust you, it makes a difference. If we improve interfaith chaplains, it makes a difference for the spiritual role in the hospital setting.”*

– IMAM MOHAMED KHALIF ABDI, FORMER CLINICAL PASTORAL EDUCATION RESIDENT, CURRENT STAFF CHAPLAIN, CHILDREN’S MINNESOTA

*“The community must have an understanding of how the system works; it has to be part of the solution. The system must also see faith leaders as an asset for the healthcare system. We, as Muslims, believe in the idea of mind, body and soul; well-being requires addressing all of the human experience.”*

– IMAM SHARIF ABDIRAHMAN MOHAMED, OPEN PATH RESOURCES CO-FOUNDER

**W**hat do you mean I can’t see them?” Healthcare workers and families had this kind of conversation often during the COVID-19 pandemic as hospitals scrambled to create policies that would keep patients, families, and communities safe by implementing strategies like visitor restrictions. These visitor policies, although an important public health initiative, negatively impacted patients’ physical recovery and mental health, created greater family concern, and overall resulted in a need for greater social support. Initiatives like the placement of tablets in patient rooms and frequent family updates were established to bridge the gap that was created. The goal was to find

LEFT TO RIGHT: Imam Mohamed Khalif Abdi (Chaplain Resident, 2020-21); Rev. Kazahiro Sekino (Chaplain Resident, 2020-21)



LEFT TO RIGHT: Nunay Ali (Chaplain Resident, 2020-21); Imam Abdillahi Mohamud (Chaplain Resident, 2021-22); Mike Cassidy (Chaplain Resident, 2020-21)



ways to recreate personal connections and establish trust at a time when the medical system was strained. Often, however, certain groups were left behind. With COVID-19 disproportionately affecting patients from underrepresented groups, embracing spiritual connection was a way to promote increased trust and healing.

Hospital chaplains as “soul doctors” helped restore faith and trust in hospital systems during the COVID-19 pandemic and broadening representation among interfaith hospital chaplains made a mark for the Somali Muslim community at Abbott Northwestern Hospital in Minneapolis. It also expanded the conversation among all hospital staff, many of whom were not familiar with non-dominant faith traditions.

Census Bureau data shows that in the last decade, the diversity index has increased. About 70% of Americans identify as Christian, 23% as religiously unaffiliated, and 5% as other religions, including Jewish, Muslim, Buddhist, and Hindu. Awareness of population shifts can identify opportunities to meet individualized patient needs. Addressing spiritual needs during hospitalization positively influences patient care and satisfaction and can contribute to faster recovery, improved coping strategies, and increased confidence and trust in patient care teams. Interfaith chaplains are trained in meeting spiritual needs of hospitalized patients from various faith backgrounds. Healthcare systems can support expanding interfaith chaplaincy programs to meet the diverse spiritual needs of their patient populations as a key element of healing.

## Representation

*“Probably the most important decisions that can happen in your life—stressful, joyful, birth, death, those critical life decisions—have a spiritual and cultural belief system tied to them. And if your voice, your culture, your faith is not represented or you’re not supported in those ways, at those really important moments, we haven’t created a just healthcare system.”*

—MICHAEL VAN KEULEN, PHD

*“I became more convinced as a chaplain about how important it is for people to have their spiritual care needs met in the midst of what they are facing in the hospital setting. As I became an educator, I became aware of the lack of diversity there has been historically in the field of professional chaplaincy. I am hopeful about the capacity for us to expand what chaplaincy can offer. I would love to see a truly interfaith group of professionals that is representative—racially, culturally, and religiously—of the population that is being served.”*

—REV. JEANINE DORFMAN, ASSOCIATION FOR CLINICAL PASTORAL EDUCATION CERTIFIED EDUCATOR

Race and demographic concordance between a patient and physician have been shown to improve health outcomes, adherence to medical recommendations, and patient satisfaction. Comparatively, there is little research about the impact of demographics including age, gender, religion, and race concordance between patients and spiritual care providers on the effectiveness of spiritual care services. One study of pastoral care in New York City



LEFT TO RIGHT: Imam Abdillahi Mohamud (Chaplain Resident, 2021-22); Rev. Kazahiro Sekino (Chaplain Resident, 2020-21); Mike Cassidy (Chaplain Resident, 2020-21)

hospitals found lost opportunities in optimizing spiritual care for Muslim patients in the absence of religious concordance with chaplains. Certified interfaith hospital chaplains are effectively trained to support religious and spiritual needs with a lens of cultural humility as fundamental to the field. When more context-specific spiritual care needs are identified, chaplains can connect patients with faith leaders on chaplaincy staff or in the community. Chaplains representing non-dominant faith traditions and cultures can add an additional layer of value in supporting a more inclusive sense of belonging in healthcare spaces.

During the COVID-19 pandemic, Abbott Northwestern Hospital actively addressed the representation gap by inviting chaplain students from the Somali Muslim community to the accredited Association for Clinical Pastoral Education (ACPE) residency training program, supported through Abbott Northwestern Hospital Foundation grant funding. The trainees were integrated into the well-established educational program in clinical pastoral education (CPE) and, through their participation, influenced curricular content. Training used the Simulation Center for role play and adaptation of core curriculum by educators to better suit the needs of all residents. The opportunity to offer CPE to high-potential candidates with endorsement from their faith communities with equivalent theological training through non-traditional routes fulfilled the health system’s commitment to diversity and inclusion of patients, families, healthcare team members, and the community as a whole. The goal of extending these training opportunities was to mobilize the existing powerful but underutilized resource of spiritual care services, making it accessible and impactful to the health of all patients.

## Awareness

*“I had no idea there was a Muslim chaplain available in the hospital. The only thing we knew, from my community, was that imams come from the mosques and these come through the requests from families.”*

—NUNAY ALI, CLINICAL PASTORAL EDUCATION RESIDENT

*“We are the best kept secret in the hospital. People who work here have no idea what kind of education or training or capacity we have. There are still a lot of stereotypes [about what a chap-*

*lain looks like]. When chaplains show up and start really working effectively with patients, then staff on the unit start recognizing that and referrals largely become word of mouth.”*

—REV. KIMBERLY GOODMAN, ASSOCIATION FOR CLINICAL PASTORAL EDUCATION CERTIFIED EDUCATOR

Awareness of chaplaincy availability remains a barrier to use of spiritual care services in hospitals, particularly among younger patients and those from non-dominant cultures. A 2021 study of about 1,000 participants in the United States found that only 15% of participants had an experience with healthcare chaplains and those unaware of chaplains were more likely to be younger and non-white. About 70% of the cohort reported interest in having religious or spiritual needs met during their healthcare. Increasing awareness of spiritual care services in the hospital by encouraging referrals by all hospital staff, from environmental services to nursing assistants, nurses, and physicians, would increase utilization to meet the spiritual care needs of patients. Even those now integrally involved in training as chaplain residents note the lack of personal knowledge about chaplaincy services as a patient or the rewarding career path prior to professional training.

This shift in the narrative requires grassroots efforts and involvement of community-based organizations. In Minnesota, Open Path Resources, a community organization that focuses on building capacity and influence within East African immigrant populations, supported pre-clinical pastoral education training of Muslim chaplains to prepare them for rigorous CPE training programs as a route to future employment. The partnership with Open Path Resources has allowed community ambassadors, who are well integrated and respected in their communities, to educate members outside of healthcare spaces about hospital services.

## Chaplaincy support

*“We would like to see chaplaincy play a key role in community and healthcare system relationships and understanding. We think chaplains can play a key role in helping bridge the connection between community interest and values and improved health outcomes.”*

—MICHAEL VAN KEULEN, PHD

*“One of the greatest gifts that this group did really well was to continue to engage in intercultural conversation. In religious communities, ideas of leadership are really different across both faiths and traditions and within denominations.”*

—REV. KIMBERLY GOODMAN

*“Some of the gaps are around the standards by which our job descriptions are limiting rather than inclusive. The pedagogical model of education needs to be expanded to include life experience and world experience. I think we have to give credibility for years of experience.”*

—REV. TANIA HAMMER-LUKEN, DIRECTOR OF SPIRITUAL CARE AND PASTORAL EDUCATION

Healthcare systems can expand interfaith chaplaincy by implementing innovative educational pathways and addressing current barriers. Traditionally, the educational pathway includes a graduate theological degree and may include ordination by a community of faith preceding clinical pastoral education. This is not representative of how spiritual care leaders in non-dominant faiths are selected by their communities. Historically, this has resulted in exclusion of potential candidates from non-dominant faiths and cultures. Recognizing the vast spiritual knowledge, faith leadership, community connection, and shared lived experience of individuals from diverse backgrounds and applying these attributes towards current educational competencies can support recruiting and certifying interfaith chaplains from non-dominant cultures.

## Conclusion

*“We are kind of like soul doctors. So we assess how they do, emotionally and spiritually. How can I make this patient feel supported?”*

—NUNAY ALI

*“We learn more about ourselves as we understand how other people process their experience. When we increase the diversity in our midst, we learn more about ourselves.”*

—REV. TANIA HAMMER-LUKEN

*“We all want to be responsive; capable of responding to the spiritual needs of everyone, regardless of faith background. We strive to be interfaith, truly, and we can’t possibly have a chaplain from every distinct background of the patients who come through our door. But we can work on our cultural and religious competency to be able to meet people and understand their needs, and then help them get connected to resources in their community.”*

—REV. JEANINE DORFMAN

Ongoing awareness among hospital staff to refer patients to spiritual care services can optimize opportunities to address spiritual



LEFT TO RIGHT: Nunay Ali (Chaplain Resident, 2020-21); Fr. Marcus Milless (Chaplain Resident, 2020-21)



LEFT TO RIGHT (FRONT ROW): Rev. Jeanine Dorfman (CPE Educator); Imam Abdifatah Abdi (Chaplain Resident, 2021-22); Jay Ludwig; Rev. Kimberly Goodman (CPE Educator); Fr. Marcus Milless (Chaplain Resident, 2020-21); Nunay Ali (Chaplain Resident, 2020-21); Imam Abdillahi Mohamud (Chaplain Resident, 2021-22). (BACK ROW): Mike Cassidy (Chaplain Resident, 2020-21); Rev. Michael Le Buhn (Chaplain Resident, 2020-21); Imam Mohamed Khalif Abdi (Chaplain Resident, 2020-21); Rev. Kazahiro Sekino (Chaplain Resident, 2020-21); Ali Chamseddine (Chaplain Resident, 2021-22)

care needs during hospitalization. The year-long expansion of positions in the chaplain residency program through an Abbott Northwestern Hospital Foundation grant supported two chaplain residents as part of a total of eight in the program that year. In 2020-2021, these two Somali Muslim chaplain residents collectively served 1,954 patients in 55,900 minutes of patient care. Both served as interfaith chaplains while also providing extensive care for Muslim patients at Abbott Northwestern Hospital, twice at United Hospital, once at Mercy Hospital, and three times at St. Francis Regional Medical Center. An additional two non-dominant culture chaplain residents were supported by grant funding for 2021-2022.

The Abbott Northwestern Hospital Spiritual Care and Pastoral Education Department will continue intentional recruitment of diverse candidates from non-dominant cultures and faiths for their chaplain residency program. Support from health systems is needed for ongoing training and maintenance of a diverse chaplain workforce. The Abbott Northwestern Hospital Clinical Pastoral Education residency program is one micro-model of building on the talents from communities to provide culturally inclusive spaces in healthcare to partner with healthcare professionals in delivering medical care. The model can be further expanded to other underrepresented groups based on the cultural and religious demographics of local communities and hospitals. **MM**

Naima Hassan is a student in the Health to You (H2U) program, University of Minnesota. Nermine Abdelwahab, MD, is an internal medicine resident, University of Minnesota. Asma Adam, MD, is an internal medicine and pediatrics resident, University of Minnesota. Alma Habib, MD, is an internal medicine physician, University of Minnesota. Nasreen Quadri, MD, is an internal medicine/pediatrics hospitalist, Allina Health, and adjunct assistant professor, Department of Medicine and Department of Pediatrics, University of Minnesota.

## CHAPLAIN RESIDENTS at Abbott-Northwestern Hospital 2020-2021



**Nunay Ali**

Ali earned her nursing certificate in Mogadishu, a bachelor's degree in Social Work from Metro State University and an associate of arts from Minneapolis Community and Technical College. She has worked as a family advocate for the Greater Minneapolis Crisis Nursery and an interpreter for non-English speaking persons in healthcare, education, and human services. Ali completed Pre-CPE Interfaith Chaplaincy for Muslim Faith prior to enrolling in the CPE Residency at Allina. She is a trained guardian ad litem, Rule 114 mediation training. Her immediate family resides in Somalia; she has been in the Minneapolis area since 2007.



**Imam Mohamed Khalif Abdi**

Abdi has a bachelor's degree in Public Health. He was a nurse in Kenya and at a government-run hospital in the United Arab Emirates. He worked with forensic pathology and as a health authority for Emirates of Abu Dhabi where he focused on prevention of communicable disease, malaria control, STD's, etc. He was born in Ethiopia in the Somali Region of Ogaden and moved to the United States in 2016. He also works as a mental health provider for the Somali Family Youth Services in South Minneapolis. He is an interpreter of Arabic and Somali at Midwest Language Banc. He lives in St. Paul with his wife and two children. Abdi is now a staff chaplain at Minneapolis Children's Hospital.

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sor. “However, these patients face numerous practical hurdles in moving from pediatric care to adult providers. The project aims 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.”

Founded at the University of New Mexico in 2013 out of a need to expand access to hepatitis C treatment, the ECHO model has been adopted to create virtual telementoring to support providers around the world on diseases as diverse as diabetes, substance use disorder, bone health, rheumatological disorders, and many more. Since then, the model has expanded to democratize knowledge in education by connecting teachers and school leaders with experts who can address needs specific to their school’s culture and students.

The online sessions begin July 18 (from 12:15 to 1:15 pm) and will continue every few weeks through early 2023. A summit that will summarize much of the learning in the sessions will take place in March 2023.

For more information and session dates, visit the MMA website [www.mnmed.org/ECHO](http://www.mnmed.org/ECHO). **MM**

## MMA offers ECHO series on transition from pediatric to adult care

**B**eginning July 18, the MMA will host a series of free, noon-time sessions called “Project ECHO: Navigating Transition for Youth with Medical Complexity to Adult Care.”

The purpose of this project, which is funded by a grant from COPIC Medical Foundation, is to develop a sustainable and collaborative knowledge-sharing commu-

nity to improve the transition from pediatric to adult care for youth with medical complexity.

“Thanks to clinical and technological advances, many children with medical complexity now live into adulthood,” notes Tori Bahr, MD, associate medical director of pediatrics at Gillette Children’s Specialty Healthcare and the project’s medical advi-

## News Briefs



### MMA/MHA release statement condemning recent spate of gun violence

On June 1, the MMA and the Minnesota Hospital Association (MHA) released a statement calling for more firearm safety and prevention measures in the wake of the nation’s recent mass

shootings, including a shooting at a Tulsa OK healthcare facility that took four lives earlier that day.

“The mass shootings throughout our nation in recent months due to gun violence are unfathomable,” the statement read. “The hospital, health system, and physician community cannot and

will not be silent as gun violence increasingly enters our places of healing, learning, and other community settings—these senseless acts of violence must be stopped. This is a public health crisis and must be addressed.”

The MMA included preventing firearm death and injury as one of its top legislative priorities this past legislative session. With a split Legislature, however, nothing moved forward at the Capitol. In recent sessions, the MMA has advocated for: 1) universal background checks on all firearm transfers and sales; 2) extreme risk protection orders (“red flag” laws) that allow family members a mechanism to temporarily remove firearms if there is a concern that an individual will harm themselves or others; 3) authorizing the use of firearm ownership data for public health research or epidemiologic investigation; and 4) raising awareness of the role that firearms play in suicides.

“Minnesota’s healthcare facilities and campuses must remain places of healing—ensuring they are safe for patients, our staff



and volunteers, and visitors,” the MMA/MHA statement also says. “As guardians of community health, we stand ready to work with policymakers and stakeholders on solutions to prevent these tragedies now and in the future.”

If you are looking for a way to engage on policy-related issues and lend your voice to the conversation, you can join the MMA Advocacy Action Team on “Firearm Death and Injury Prevention.” Go online for more information ([www.mnmed.org/advocacy/MMA-Advocacy-Toolkit/Advocacy-Action-Teams](http://www.mnmed.org/advocacy/MMA-Advocacy-Toolkit/Advocacy-Action-Teams)).



### U.S. Surgeon General releases advisory on health worker burnout

In late May, U.S. Surgeon General Vivek Murthy, MD, MBA, issued an advisory highlighting the urgent need to address the health worker burnout crisis in the United States.

The Surgeon General’s Advisory Addressing Health Worker Burnout ([www.hhs.gov/surgeon-general/priorities/health-worker-burnout/index.html](http://www.hhs.gov/surgeon-general/priorities/health-worker-burnout/index.html)) lays out recommendations to address the factors underpinning burnout, improve health worker well-being, and strengthen the nation’s public health infrastructure.

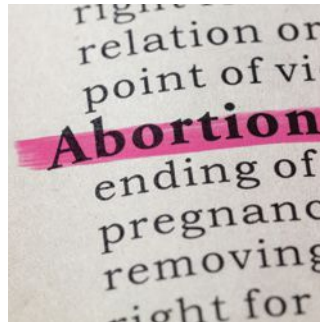
Even before the COVID-19 pandemic, health workers were experiencing alarming levels of burnout—broadly defined as a state of emotional exhaustion, depersonalization, and low sense of personal accomplishment at work. Burnout can also be associated with mental health challenges such as anxiety and depression.

In 2019, the National Academies of Medicine (NAM) reported that burnout had reached “crisis” levels, with up to 54% of nurses and physicians, and up to 60% of medical students and residents, suffering from burnout. The pandemic has since affected the mental health of health workers nationwide, with more than 50% of public health workers reporting symptoms of at least one mental health condition, such as anxiety, depression, and increased levels of post-traumatic stress disorder (PTSD).

Health worker burnout not only harms individual workers, but also threatens the nation’s public health infrastructure. Already, Americans are feeling the impact of staffing shortages across the health system in hospitals, primary care clinics, and public health departments. With more than half a million registered nurses anticipated to retire by the end of 2022, the U.S. Bureau of Labor Statistics projects the need for 1.1 million new registered nurses across the country. Further, within the next five years, the country faces a projected national shortage of more than 3 million low-wage health workers. The Association of American Medical Colleges (AAMC) projects that physician demand will continue to grow faster than supply, leading to a shortage of up to 139,000 physicians by 2033, with the most alarming gaps occurring in primary care.

Topline recommendations to address burnout in the Surgeon General’s Advisory include:

- Transform workplace culture to empower health workers and be responsive to their voices and needs.
- Eliminate punitive policies for seeking mental health and substance use disorder care.
- Protect the health, safety, and well-being of all health workers.
- Reduce administrative burdens to help health workers have productive time with patients, communities, and colleagues.
- Prioritize social connection and community as a core value of the healthcare system.
- Invest in public health and our public health workforce.



### MMA Board revises policies on abortion

At its May meeting, the MMA Board of Trustees (BOT) adopted revisions to MMA’s policies regarding abortion.

The first policy adopted, once titled “Adoption of AMA Position on Abortion,” is now titled “Abortion is a Component of Comprehensive Medical Care.” The title change reflects amendments to the policy that vary from that of the AMA.

While the AMA makes no mention of a patient’s right to an abortion, the MMA now “affirms a person’s right to an abortion as a medical decision to be made under the advice and guidance of their healthcare professional. The MMA understands that abortion is an essential component of reproductive healthcare and that all healthcare decisions—including whether or not to have an abortion—are deeply personal and should be made between a patient and their healthcare professional.”

Also, while AMA policy opposes allowing non-physicians to provide abortions, the MMA now affirms that “abortion is a medical procedure and should be performed only by a duly licensed healthcare professional with appropriate training and proper credentialing in conformance with standards of good medical practice and the Medical Practice Act of their state.” This amendment is consistent with the position of the American College of Obstetricians and Gynecologists (ACOG).

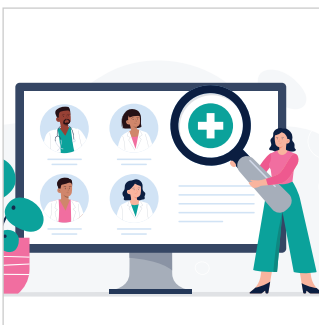
The second policy adopted, “Barriers to Abortion,” clarifies the MMA’s opposition to legislative or regulatory efforts to deny or restrict access to safe abortions, including, but not limited to:

- Statutory definitions of informed consent that impose criminal penalties on physicians who perform induced abortions without first disclosing anesthetic or analgesic options to alleviate pain of the fetus, such as the definition currently imposed in Minnesota Statutes Chapter 145.4242.
- Informed consent waiting periods for abortions, such as those currently imposed by Minnesota Statutes Chapter 145.4242.

- Data reporting requirements for abortions, such as those currently imposed by Minnesota Statutes Chapters 145.4131-145.4135.
- Statutory definitions of “family planning” that preclude organizations that provide abortion counseling, referrals, and procedures from applying for family planning grants, such as the definition currently imposed in Minnesota Statutes Chapter 145.925.
- Restrictions on the use of medically appropriate abortion services rendered via telehealth.
- State-based laws that restrict access to abortion by minors through mandatory parental notification, such as those currently imposed by Minnesota Statutes Chapter 144.343, Sub. 2.
- Insurance plan designs that limit coverage for reproductive care, including induced abortion.
- Non-evidence-based requirements targeted toward facilities providing abortion care.
- State-based and institutional restrictions that exclude abortion and abortion-related topics in medical education and training programs.

The adopted policies are the culmination of a deliberate, eight-month process. In September 2021, the MMA Policy Council created an Abortion Policy Work Group, charged to “conduct an in-depth review of, and offer recommendations on, MMA’s existing policies on abortion.” The work group had 12 physician members from a variety of specialties, including OB/GYN, family medicine, urology, pediatrics, occupational and environmental medicine, and psychiatry. In March 2022, the work group presented its recommendations to the MMA Policy Council, which unanimously endorsed the recommendations for the Board of Trustees’ consideration.

Prior to Board action, the proposed policies were disseminated to members via The Pulse for member-wide polling. On the first policy proposal, 110 members voted; 89 voted yes, 18 voted no and three didn’t take a position. On the second policy proposal, 119 members voted; 95 voted yes, 21 voted no and three didn’t take a position. The BOT ultimately decided to adopt the recommended amendments with a few minor edits based on concerns raised by comments on The Pulse.



### Three-quarters of American docs are now employed

More than 75% of physicians are now employed by hospitals, health systems, and other corporate entities, according to a recent report looking at trends in physician employment and acquisitions of medical practices between 2019 and 2021.

The research, conducted by the Physicians Advocacy Institute and Avalere Health, shows that the pandemic accelerated the ongoing trend of physicians leaving private practice for employ-

ment, spurred by hospitals and other corporate entities acquiring medical practices, part of a wave of consolidation throughout the healthcare industry.

Other key findings include:

- 108,700 physicians shifted to employment since January 2019. This growth split nearly evenly between hospital employees (58,200 additional physician employees) and other corporate entities (50,500 additional physician employees).
- Of those, 83,000 physicians (76%) became employees since the pandemic began.
- 2021 alone saw a marked increase in employed physicians, growing by 19%, from 69.3% to 73.9% of all physicians.
- Hospitals and corporate entities, including private equity firms and insurance companies, now own more than half (52.1%) of physician practices (hospitals own 26.4% and other corporate entities own 27.2%).
- While hospital and health system acquisitions continued at a steady pace (9% growth), the sharpest increase (86% growth) in medical practice acquisitions over the three-year study period was by corporate entities.
- The COVID-19 pandemic accelerated corporate ownership of physician practices and physician employment by hospital systems and other corporate entities in the last half of 2020 and throughout 2021.
- Every region of the country saw a steady trend towards increased employment and hospital and corporate ownership of practices, but there are distinct differences among regions.
  - The Midwest continued to have the highest percentage of physicians employed by hospitals and health systems (63.5%, growing 9% over the study period).
  - The South saw the highest rate of acquisitions by corporate entities (94% increase).

### Five docs receive endorsement for state office

Ahead of the 2022 primaries and general election, five physicians received party endorsements at their party conventions this spring.

Rep. **Kelly Morrison**, MD, (DFL-Deephaven) earned the party endorsement at her Senate District convention in early April. After being redistricted into the same district as a fellow DFL House member, Morrison, an OB/GYN, decided to challenge incumbent Sen. Ann Johnson Stewart (DFL-Minnetonka) for the endorsement for Senate District 45 and won.

**Alice Mann**, MD, MPH, received the DFL party endorsement for the open Senate District in Edina, Senate District 50. Mann, a family physician, is a former member of the Minnesota House, representing House District 56B in 2019 and 2020.

**Aleta Borrud**, MD, a geriatrician, received the DFL endorsement and will face a rematch against incumbent Sen. Carla Nelson (R-Rochester) to represent Senate District 24. Borrud lost to Senator Nelson in the 2020 election by 909 votes.

The only current physician in the Minnesota Senate is Sen. **Matt Klein**, MD, (DFL-Mendota Heights). Klein, an internal

medicine physician, received the DFL endorsement to run for reelection in Senate District 53, an area he's represented since 2016.

Gubernatorial candidate **Scott Jensen**, MD, (not an MMA member) received the GOP endorsement in May at the Republican state convention in Rochester. Jensen, a family medicine physician, served one term as a state senator.

There are currently no physicians running for the Minnesota House of Representatives.

### MDH data shows uninsured rate decreases but racial disparities grew

The Minnesota Department of Health (MDH) released new data in April showing mixed results for health insurance coverage in Minnesota during 2021. While actions taken by state officials helped drop the state's uninsured rate to the lowest level ever measured, racial disparities in coverage worsened.

Federal and state policies and funding during 2021 shielded Minnesota's health insurance coverage against the pandemic's economic shock. With the help of these efforts, the state's uninsured rate fell to 4%.

Economic downturns often result in higher rates of uninsurance in the United States due to the link between employment and health insurance coverage. With the help of state and federal funding, Minnesota took steps to prevent insurance loss in 2020 and 2021, including government efforts to maintain coverage for low-income Minnesotans and premium subsidies in the individual market. Data from the Minnesota Health Access Survey found that 34,000 fewer Minnesotans went without health insurance in 2021 compared to 2019. Fewer Minnesotans also said they went without some type of needed healthcare due to cost in 2021 (20%) compared to 2019 (25%).

However, not all Minnesotans were able to access or retain coverage. Racial disparities worsened as the uninsured rate among Minnesotans of color and American Indians rose from 7.6% in 2019 to 10.2% in 2021. In contrast, the uninsured rate dropped among non-Hispanic Whites from 3.7% in 2019 to 2.4% in 2021.

The number of Minnesotans with public insurance increased by 238,000 so that 41.2% of those insured had coverage through public sources in 2021, including Medicare, Medical Assistance, and MinnesotaCare. This growth in public coverage made up for a decrease in private coverage, which was down from 57.8% in 2019 to 54.8% in 2021.

While most Minnesotans weathered the first two years of the pandemic with health insurance, there are concerns about maintaining coverage moving forward. Many government programs that added financial supports to families, increased subsidies for private health insurance plans sold through MNsure to make insurance more affordable, or allowed people to stay on Medicaid longer ended or are set to expire this year.

The survey suggests that COVID-19 had an impact in delaying care in 2021 but didn't keep most people from getting that care eventually. In the second year of the pandemic, COVID-19 concerns affected only 8% of people not receiving healthcare. The

primary reasons for not using healthcare were cost or not needing it.

Both physical and mental health declined during the pandemic, according to the survey. The number of unhealthy days reported for a 30-day period climbed to an average 3.3 days for physical health and 4.3 days for mental health, compared to 2.8 for physical health and 3.7 for mental health in 2019.



### Appeals court rules that eviction moratorium case can continue

In early April, the Eighth Circuit Court of Appeals ruled that a lawsuit filed by metro-based Heights Apartments, challenging the constitutionality of an executive order from Gov. Tim Walz, can move forward.

In late May 2021, the MMA, with the AMA Litigation Center, submitted an amicus brief in support of the eviction moratorium Walz declared at the start of the COVID-19 pandemic. Walz's executive order was done to prevent the spread of the virus that would likely occur if individuals were evicted and forced to stay in crowded shelters or move in with family.

Heights Apartments challenged the executive order, claiming that it was unconstitutional. Heights Apartments appealed the District Court's dismissal of the case.

The amicus brief argued the significant public health implications that would occur if the moratorium were to be revoked. An estimated 30% of Minnesota renters were already at risk of eviction at the start of the public health emergency.

In April, the Court of Appeals made the decision to reverse the District Court's dismissal, allowing the lawsuit to move forward on its constitutional claims. The decision did not address the merits of Walz's eviction moratorium.

### In-person networking events return

After a two-year absence due to the pandemic, the MMA's Doctors' Lounges are back. Join your colleagues for a beverage and casual conversation at one of five locations this year. These casual events offer physicians and physicians-in-training an opportunity to get together and network. They are also an opportunity to celebrate the practice of medicine, thank our members, and welcome new or prospective members. Significant others and children are welcome, too! Drink tickets and appetizers will be provided.

The 2022 Doctors' Lounges take place:

- July 14, 6 to 8 pm: Bad Habit Brewing, 25 College Ave. N., St. Joseph
  - August 11, 6 to 8 pm: The Lynhall No. 3945, 3945 Market St., Edina
  - October 20, 6 to 8 pm: Site to be determined in Duluth
- To register, visit [www.mnmed.org/socials](http://www.mnmed.org/socials). MMA



# 2022 Legislative Session in review

## Session veers back toward normal

Business at the Legislature started to normalize a bit during the 2022 session. Floor sessions and some committee meetings took place in-person and advocates were once again seen roaming the halls and pressing the flesh.

However, as the session wound down in late April and early May, lawmakers were heard muttering under their breath that “we don’t have to get anything done this year.” While true—they’re legislatively mandated to pass budgets during odd-numbered years—it’s still frustrating that lawmakers couldn’t agree on uses for the \$9.2 billion surplus.

Nonetheless, the MMA advocacy team was able to lobby successfully on behalf of Minnesota physicians.

Here’s a review of the 2022 session, including reports on MMA priorities as well as other healthcare-oriented legislation.

## MMA’s priority issues at the Legislature

### ISSUE

### RESULT

#### Protecting patients from arbitrary medication changes

Ensure patients have access to medications by prohibiting insurers or pharmacy benefit managers (PBMs) from altering patient’s drug coverage for medications they are already on, which currently can occur in the middle of a patient’s contract year.

Also, improve patient health by prioritizing the decisions made between a physician and a patient, rather than changes to a drug’s formulary by an insurer.

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.

#### Improving patient safety with straightforward communications

Improve patient safety by protecting from discovery discussions that are held between physicians and patients following an adverse event.

Also, endorse the Communication and Optimal Resolution (CANDOR) model, which is designed to include patients and family members in timely and honest information following an adverse event, support caregivers, and work to improve patient safety.

The MMA worked with stakeholders to move this forward, but discussions continued past the legislative deadline for bills to receive a committee hearing. Consequently, the bill did not move this session. Proponents remain hopeful that it will advance during the 2023 session.

#### Increase immunization rates

Repeal existing personal belief exemption (PBE) from Minnesota’s childhood immunization laws.

Fund education and outreach efforts in communities with lower immunization rates.

The MMA worked to stop legislation that would weaken laws related to childhood and COVID-19, and other, vaccines. Although several bills were introduced to create a vaccine consent form and other efforts to dissuade individuals from receiving COVID and other vaccinations, these bills did not receive a hearing. Legislation to remove the personal belief exemption did not advance this year.



## MMA’s priority issues at the Legislature *(continued)*

| ISSUE   | RESULT  |
|---|---|
| <p><b>Create a POLST registry</b><br/> <i>Authorize a feasibility study to establish a statewide registry for Provider Order for Life-Sustaining Treatment (POLST) to ensure EMS and emergency departments have access to POLST orders patients may have.</i></p>   | <p>The MMA achieved strong bi-partisan support for this in the House and it was included in the House omnibus Health and Human Services 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 program had a \$292,000 fiscal note. With no final agreement on the HHS bill at the end of session, it did not pass.</p> |
| <p><b>Prevent firearm death and injuries</b><br/> <i>Expand criminal background checks to all firearm transfers and sales.<br/>                     Enact a “red flag” law to allow law enforcement to protect those who may be a danger to themselves or others.<br/>                     Authorize the use of de-identified firearm ownership data for public health research and epidemiologic investigations.</i></p> | <p>No legislation moved on these issues this session.</p>   |

## Other healthcare legislative issues

| ISSUE  | RESULT   |
|--|--|
| <p><b>APCD update</b></p>                                      | <p><b>Background:</b> Legislation led by the Minnesota Academy of Family Physicians (MAFP) would have updated the state’s All-Payer Claims Database to include non-claims payment information that reimburses for value-based care (VBC). It would have required a report on how much VBC is being paid for, including how much is used for primary care services.<br/> <b>Legislative action:</b> Included in the House omnibus Health and Human Services bill but was not accepted by the Senate.<br/> <b>MMA position:</b> <b>Support</b></p>   |
| <p><b>Barriers to COVID-19 vaccine</b></p>                     | <p><b>Background:</b> Multiple bills were introduced to prohibit COVID-19 vaccine mandates by government or employers.<br/> <b>Legislative action:</b> No bills received hearings.<br/> <b>MMA position:</b> <b>Oppose</b></p>   |
| <p><b>Board of Medical Practice authority modification</b></p> | <p><b>Background:</b> The Board of Medical Practice (BMP) wanted increased authority to levy fines of up to \$10,000 against licensees to “discourage future behavior.” There were no limits on when or how these fines would be used and no reasons provided as to why the BMP needed this authority.<br/> <b>Legislative action:</b> Following the MMA’s objections, this new authority was removed from the bill.<br/> <b>MMA position:</b> <b>Oppose</b></p>   |
| <p><b>Chronic pain/opioids</b></p>                             | <p><b>Background:</b> Patients with chronic, intractable pain are being forced to taper their opioid use because insurers, pharmacies, or pharmacy benefit managers (PBMs) are misusing CDC guidelines on opioid use, even if this tapering is not in the best interest of the patient. The legislation protects these patients by stating that prescribers cannot be disenrolled or disciplined solely for exceeding a morphine milligram equivalent guideline.<br/> <b>Legislative action:</b> Passed as part of the omnibus Health and Human Services policy bill and signed into law.<br/> <b>MMA position:</b> <b>Support</b></p> |
| <p><b>Copay extension</b></p>                                  | <p><b>Background:</b> Requires insurers to offer an insurance product that allows enrollees to spread out high-deductible payments into smaller monthly installments over the entire year.<br/> <b>Legislative action:</b> Passed and signed into law as part of reinsurance package.<br/> <b>MMA position:</b> <b>Support</b></p>   |

| ISSUE   | RESULT   |
|---|--|
| <b>Frontline worker bonuses</b>                     | <p><b>Background:</b> Provides a one-time bonus payment of up to \$750 each for frontline workers required to work during the start of the pandemic. These workers include physicians, nurses, other healthcare workers, childcare workers, long-term care workers, and others who meet the income limits of less than \$350,000 for joint taxpayers or \$175,000 for single taxpayers.</p> <p><b>Legislative action:</b> Passed and signed into law.</p> <p><b>MMA position:</b> <b>Support</b></p> |
| <b>Interstate nurse compact</b>                     | <p><b>Background:</b> Would have allowed nurses licensed in other states to practice in Minnesota without having to receive a Minnesota license, if the other state is also participating in the compact.</p> <p><b>Legislative action:</b> Included in the Senate omnibus Health and Human Services bill but not accepted by the House.</p> <p><b>MMA position:</b> <b>No position</b></p>  |
| <b>Long-acting reversible contraception (LARC)</b>  | <p><b>Background:</b> Would have expanded Medical Assistance (MA) coverage to pay for the insertion of a long-acting, reversible contraception device immediately following a delivery. Currently, MA will not cover the cost of the device post-partum.</p> <p><b>Legislative action:</b> Included in the House omnibus Health and Human Services bill, but not accepted by the Senate.</p> <p><b>MMA position:</b> <b>Support</b></p>  |
| <b>Loan forgiveness for healthcare workers</b>      | <p><b>Background:</b> State funding for healthcare-specific loan forgiveness programs.</p> <p><b>Legislative action:</b> Included in the House omnibus Health and Human Services bill, but not accepted by the Senate.</p> <p><b>MMA Position:</b> <b>Support</b></p>  |
| <b>Mental health funding for healthcare workers</b> | <p><b>Background:</b> \$1 million for healthcare systems, hospitals, nursing facilities, community health clinics or consortium of clinics, federally qualified health centers, rural health clinics, or health professional associations for the purpose of establishing or expanding programs focused on improving the mental health of healthcare professionals.</p> <p><b>Legislative action:</b> Passed and signed into law.</p> <p><b>MMA position:</b> <b>Support</b></p>                     |

| ISSUE   | RESULT   |
|---|--|
| <b>Preceptor tax credit</b>                       | <p><b>Background:</b> Allows physicians and other healthcare providers who serve as preceptors for a health profession student or medical resident to qualify for a tax credit equal to \$5,000.</p> <p><b>Legislative action:</b> Included in the House Omnibus Tax bill and the agreed-to conference committee report, but not did not pass either body.</p> <p><b>MMA position:</b> <b>Support</b></p>  |
| <b>Prenatal health</b>                            | <p><b>Background:</b> Requires health plans to provide coverage for comprehensive postnatal care for both babies and mothers for up to 12 weeks following delivery.</p> <p><b>Legislative action:</b> Passed and signed into law as part of reinsurance package.</p> <p><b>MMA position:</b> <b>Support</b></p>  |
| <b>Public option</b>                              | <p><b>Background:</b> A bill establishing a cost-sharing reduction, the authority for small employers to purchase coverage through MinnesotaCare, and a transitional healthcare credit was proposed to provide small employers a “public option” for more affordable coverage.</p> <p><b>Legislative action:</b> The MinnesotaCare buy-in was included in the House omnibus Health and Human Services bill, but not accepted by the Senate.</p> <p><b>MMA position:</b> <b>No position</b></p> |
| <b>Recreational adult-use cannabis</b>            | <p><b>Background:</b> This legislation would legalize and regulate the use of adult-use recreational cannabis in Minnesota.</p> <p><b>Legislative action:</b> A bill passed the Minnesota House of Representatives but failed on a procedural vote in the Senate.</p> <p><b>MMA position:</b> <b>No position</b></p>   |
| <b>Reduce multiple criminal background checks</b> | <p><b>Background:</b> Physicians and other healthcare providers who work for DHS-licensed programs are required to have one criminal background check to receive their license and another to participate in the DHS program. This would have allowed one background check to be used for both.</p> <p><b>Legislative action:</b> Passed as part of the omnibus Health and Human Services policy bill and signed into law.</p> <p><b>MMA position:</b> <b>Support</b></p>                      |



## Other healthcare legislative issues *(continued)*

### ISSUE

### RESULT

|  |   |
|--|---|
| <b>Reinsurance extension</b>                             | <p><b>Background:</b> Extension of the state’s reinsurance program, designed to reduce volatility in the individual health insurance market. Under Minnesota’s program, the cost of high-cost claims is not borne exclusively by insurers. Rather, the state’s reinsurance fund covers 80% of an individual’s annual claims costs between \$50,000 and \$250,000.</p> <p><b>Legislative action:</b> Passed and signed into law.</p> <p><b>MMA position:</b> <b>Support</b></p>                                |
| <b>Rural residency</b>                                   | <p><b>Background:</b> Establishes a health professionals’ rural and underserved clinical rotations grant program, a primary care rural residency training grant program, and a grant program to support clinical training for healthcare students in areas of high need where there are shortages of healthcare professionals.</p> <p><b>Legislative action:</b> Included in the House omnibus Health and Human Services bill, but not accepted by the Senate.</p> <p><b>MMA position:</b> <b>Support</b></p> |
| <b>Temporary license for physicians new to Minnesota</b> | <p><b>Background:</b> Creates a temporary permit for physicians and physician assistants while they await their final license approval if they were previously licensed in another state before coming to Minnesota.</p> <p><b>Legislative action:</b> Included in the mental health bill that passed at the end of the session.</p> <p><b>MMA position:</b> <b>Support</b></p>   |
| <b>Tobacco cessation</b>                                 | <p><b>Background:</b> Expands Medical Assistance (MA) coverage of tobacco and nicotine cessation services. Changes include covering phone counseling through an audio quit line, expanding eligible providers, and eliminating prior authorization and volume requirements.</p> <p><b>Legislative action:</b> Included in the House omnibus Health and Human Services bill, but not accepted by the Senate.</p> <p><b>MMA position:</b> <b>Support</b></p>  |
| <b>White-bagging</b>                                     | <p><b>Background:</b> Prohibits a pharmacy benefit manager or insurer from “white-bagging” or otherwise requiring a patient from receiving their clinician-administered drug from a pharmacy selected by the pharmacy benefit manager or insurer instead of from the clinic that is administering the drug.</p> <p><b>Legislative action:</b> Introduced in both bodies but did not receive a hearing.</p> <p><b>MMA position:</b> <b>Support</b></p>   |



### How does an issue become an MMA priority?

The MMA Board of Trustees defines MMA priorities based on input from our physician members through their participation in committees, task forces, policy forums, the Policy Council, The PULSE, listening sessions, member events, surveys, and online discussions. MMA policies serve as the foundation for our legislative, regulatory, and administrative advocacy efforts during the legislative session and throughout the year.

To get involved in MMA legislative and grassroots efforts, contact our legislative team or someone from our member relations team.

#### The MMA legislative team



##### Dave Renner

Director of Advocacy  
 drenner@mnmed.org  
**OFFICE** 612-362-3750  
**MOBILE** 612-518-3437



##### Chad Fahning

Manager of State Legislative Affairs  
 cfahning@mnmed.org  
**OFFICE** 612-362-3732  
**MOBILE** 651-890-7466

#### The MMA member relations team



##### Mandy Rubenstein

Director, Membership  
 mrubenstein@mnmed.org  
**OFFICE** 612-362-3740  
**MOBILE** 612-380-0645



##### Kimberly A. Anderson

Membership Manager  
 kanderson@mnmed.org  
**OFFICE** 612-362-3748  
**MOBILE** 218-820-5153



## FROM THE CEO

### Influencing national policy and advocacy

For the first time since November 2019, the AMA House of Delegates gathered in-person in Chicago in mid-June. It was both a surreal experience to be among a large (fully masked and vaccinated) crowd at a conference and a welcome relief from two years of virtual meetings.

The AMA House of Delegates is the policy-setting body for the AMA. For 2022, the AMA House was made up of more than 700 delegates—306 delegates from states and territories, 304 delegates from specialty societies, and nearly 100 other delegates representing medical students, residents/fellows, and various other organizations, associations, and sections. Among this total were 17 Minnesotans—10 physicians (five delegates and five alternates) from the MMA, one regional medical student representative, one delegate from the AMA Resident Fellow Section, and five physicians from national specialty societies. It was an impressive state showing.

The MMA is apportioned its number of delegates based on the number of AMA members in Minnesota. The MMA and AMA are completely independent organizations, including separate membership. Minnesota physicians are not required to join AMA as a condition of joining MMA or vice versa. The MMA is a part, however, of the national “federation” of organized medicine and, as such, we work with the AMA on issues of mutual interest.

Both the AMA and MMA advocate on behalf of physicians and patients. The MMA’s main focus is at the state level, while the AMA takes the lead on federal policy and advocacy issues. Federal health policy decisions—whether laws, regulations, or court decisions—are, of course, extremely consequential to Minnesota physicians. As a result, it is important that the MMA works to influence the policy positions and advocacy direction of the AMA, and we do that most directly through our elected delegation to the AMA House of Delegates.

Over the course of the five-day meeting each June and another four-day meeting each November, the MMA’s delegates to the AMA generously volunteer their time to bring the voice of Minnesota physicians to the national stage. Periodically, Minnesota submits resolutions for consideration by the AMA. At this June’s meeting, the House of Delegates considered approximately 245 resolutions and/or reports, including one resolution co-sponsored by the MMA seeking to declare climate change a public health crisis. Through testimony, deliberations, multi-state caucuses, amendments, and voting—an often messy and sometimes painstaking process—we help establish new and revise existing AMA policy.

Among the numerous policies adopted at this meeting were preserving access to reproductive health services in light of an expected and significant Supreme Court decision; seeking changes to discharge summaries to provide more concise and meaningful clinical information; seeking implementation of a comprehensive strategy to address health-related disinformation disseminated by health professionals; and reaffirming the need to reduce gun violence.

Like many large and complex organizations, the AMA can be slow and sometimes resistant to change. Yet change is only possible through an engaged physician membership and involvement in the AMA.

Minnesota physicians can be proud of the MMA’s delegates and alternate delegates to the AMA. They work extremely hard on your behalf to reflect the values and needs of Minnesota patients and physicians. Do you have ideas for policy or work you’d like to see AMA pursue? Share your ideas—your delegation welcomes your input! **MM**

Janet Silversmith  
JSilversmith@mnmed.org



## VIEWPOINT

# Our ranks are shrinking: How do we prepare for the future?

**H**ave we won the battle, but lost the war?

I can't help but be concerned when I read studies that show the current level of clinician burnout. Now in the third year of the COVID-19 pandemic, it appears we have stemmed the tide of the deadly virus but are facing a potential mass exit of talent. Has the stress of battling the disease decimated our future ranks?

A recent American Medical Association (AMA) study (*COVID-Related Stress and Work Intentions in a Sample of US Health Care Workers*) notes that nearly one in four physicians surveyed plans to leave the workforce in the next two years.

The most recent workforce forecast from the American Association of Medical Colleges anticipated shortages of between 38,000 and 124,000 physicians by 2034.

A recent report (*Minnesota's Health Care Workforce: Pandemic-Provoked Workforce Exits, Burnout, and Shortages*) from the Minnesota Department of Health (MDH) tells us the workforce shortages in parts of Minnesota mirror national trends—nearly one of every three rural physicians reported they plan to leave the profession in the next five years. As a rural family physician, I have witnessed dimensions of burnout, including emotional exhaustion, depersonalization, and loss of personal accomplishment, up close—with my coworkers and in the mirror each morning.

The MDH report found that vacancies have increased in nearly all health professions from their pre-pandemic levels. The largest increases are in mental health and substance-abuse counseling occupations, where one in four jobs is currently vacant and open for hire.

In nearly every health profession, more providers than in prior years reported that they planned to leave their profession within the next five years, and a much higher share of these exits is due to burnout, according to the MDH report.

“We are going to need several approaches and solutions aimed at both recruiting the future workforce and retaining the current one,” said Health Commissioner Jan Malcolm upon the release of the report. “We in government and healthcare must do more to prioritize retention, work with educational institutions to expand clinical training opportunities, and focus more broadly on the care team, including nurses, physicians, physician assistants, respiratory therapists, and others.”

The MDH report finds potential solutions, including keeping the incumbent workforce through programs such as loan forgiveness for healthcare providers, career exploration initiatives for new and dislocated workers, and programs aimed at increasing the diversity of the workforce. Employers can also focus on overcoming the hiring challenge by making healthcare jobs safe, flexible, well-paid, and family-friendly.

Other possible solutions discussed at the Capitol include launching rural clinical training tracks to create a pipeline of primary care physicians and psychiatrists trained in greater Minnesota; funding to expand rural rotations and clinical training opportunities for pre-licensure nurse practitioners, physician assistants, behavioral health students, and dental graduates; and financial supports to mental health providers to pay for the supervised training they are required to complete before becoming licensed to practice.



Randy Rice, MD  
MMA President

Earlier this year, Gov. Tim Walz proposed more than \$250 million to address the workforce shortage, including an incentive program that would provide retention and bonus payments for workers who join and stay in the healthcare professions, including those who provide care to our vulnerable neighbors, older adults, those with disabilities or behavioral health needs, or people experiencing homelessness.

Please remember the MMA has resources available to help battle fatigue. Our Practice Well Collaboratory is an innovative and cooperative thought laboratory to share, promote, and explore strategies and best practices to support physician health and wellbeing. Find more at [www.mnmed.org/resources/MMA-Practice-Well-Collaboratory](http://www.mnmed.org/resources/MMA-Practice-Well-Collaboratory). Also, please join us at our Reclaim the Joy of Medicine conference December 8. The conference is planned to create a space for our members and other healthcare professionals and leaders to reconnect with colleagues from across the state to build relationships and social connections, discuss strategies and best practices to build individual and organizational resilience, and instill hope.

We know there are many factors that contribute to clinician burnout and professional well-being. If you have ideas, let us know ([mma@mnmed.org](mailto:mma@mnmed.org)).



**WADE LARSON, MD**

- General pediatrician at Partners in Pediatrics, Rogers.
- MMA member since 2004.
- Born in St. Louis Park. Graduated from Rensselaer Polytechnic Institute, Troy, New York. Completed medical school and residency at University of Minnesota.

**Became a physician because...**

I found an interest in physiology in college and have always been fascinated by the complexity of both the human body and human behavior. I was fortunate to be able to serve in the U. S. Air Force as a pediatrician and have always valued the flexibility and job security of a career in medicine.

**Greatest challenge facing medicine today...**

There seems to be a trend towards acceptance of the notion that “truth” is subjective. Use of “alternative” or distorted “facts” can be corrosive to trust and faith in science, and consequently, the practice of medicine.

**How I keep life balanced...**

I enjoy reading, and have continued to explore my “pandemic hobby” of working with wood and “poured” acrylic paint. I also enjoy running, mountain biking, hiking, and everything outdoors.

**If I weren't a physician...**

I suspect I'd enjoy exploring a career in sociology and anthropology, particularly if it could be applied towards public health policy ... but my first choice would be to be a wildland firefighter.

**DENISE LONG, MD**

- Family medicine physician with Entira Family Clinics, St. Paul.
- MMA member since 2009.
- Born and raised in Hector, Minnesota. Graduated from College of St. Benedict, medical school at University of Minnesota and family medicine residency at St. Joseph's Hospital, St. Paul.
- Married to Marty Long for 35 years with three adult children and five grandchildren.

**Became a physician because...**

Initially I started in the music program at St. Ben's, but it seemed fairly isolating and I had always entertained medicine as a career. Our small town had a wonderful family doctor and I really liked the idea of providing care to a community through all stages of life.

**Greatest challenge facing medicine today...**

For Entira Family Clinics as a group, our biggest challenge is the ongoing one of remaining independent. We continue to explore creative ways to do this. Personally, I have found the EMR to be my biggest challenge. So much time out of the office is spent completing work on the computer.

**How I keep life balanced...**

I try to practice what I advise patients daily. Exercise, spend some time daily seeking calmness—such as with prayer and meditation. And I very rarely turn down an opportunity to be with my grandchildren !

**If I weren't a physician...**

I think that I would work in a quilting store. Perhaps on the North Shore!





COME JOIN  
US AT THE

# Doctors' Lounge!

## In-person networking events

*Come join us!*

**Enjoy networking with your colleagues at a free, casual event for physicians, residents and medical students.**

The Doctors' Lounge is designed to thank MMA members, and welcome new and potential members.

These networking events, now in their seventh year, include free food and beverages.

In 2022, we will host in-person events on the following dates, so make sure you put them in your calendar:

**ST. CLOUD**  
Thursday,  
July 14

**EDINA**  
Thursday,  
August 11

**DULUTH**  
Thursday,  
October 20

**VISIT [WWW.MNMED.ORG/SOCIALS](http://WWW.MNMED.ORG/SOCIALS) for more details.**



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