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MINNESOTA MEDICINE

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Fiercely independent

Minnesota physicians who work in private practice find that the rewards vastly outweigh the challenges. So why do so few do it?

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Erin Stevens, MD, is a physician-owner of Clinic Sofia, an OB/GYN practice with locations in Edina and Maple Grove.

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PHOTOGRAPHY BY MIKE KRIVIT / KRIVIT PHOTOGRAPHY

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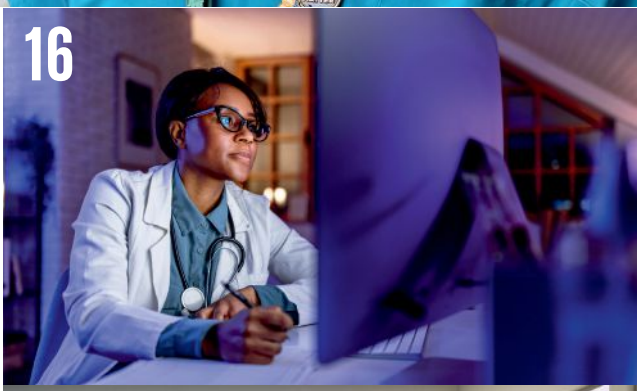

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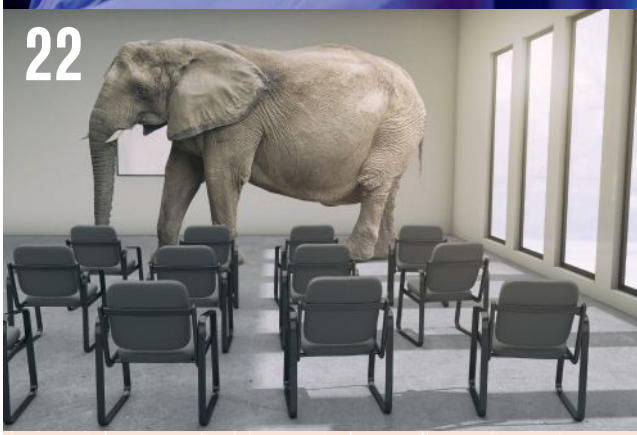

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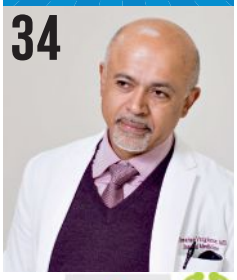

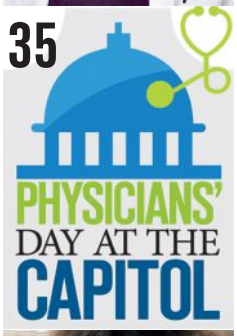

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Christopher Wenner, MD

RIP independent medicine

Independent Medicine of Minnesota died Tuesday, after a long and courageous battle with inequitable insurance payments, absent facility fees, and legislative neglect.

Born to frontier parents, Independent Medicine of Minnesota (IMM) was raised in both urban and rural areas of the state. She excelled in school and had a keen sense of inquiry. Her formative years exposed her to healthcare that was delivered only to a privileged few, leaving many Minnesotans suffering unnecessarily, thus shaping her desire to provide equitable patient care.

IMM, in her early practice years, worked collaboratively with hospitals. Those were halcyon days for the health of the state: Access to care was easy and costs were contained—a direct result of this symbiotic relationship. However, the relationship became strained as insurance companies and Medicare developed more influence in the management of patient care. Powerful entities and equally powerful enticements supplanted the basis of this relationship. Many of her offspring, swayed by said powers, felt as though her independent, yet collaborative, methods of practice were anachronistic and fiscally unwise, leading them to abandon the family name and assume the monikers of burgeoning healthcare systems.

Although her family—and heart—were broken, she did not limit her care. She was always buoyed by the patient interaction. Her staff became familiar with the oft-cited refrain: "Take care of the patient and the rest will take care of itself." Her peers often commented (with thinly veiled envy) on her nimbleness, her ability to expeditiously enact meaningful improvements to her practice—without a committee. Her patients often commented (with gratitude) on her efficient care and ease of scheduling.

Unfortunately, the comorbidities accumulated and proceeded to exsanguinate her dwindling capacity. She was incrementally diagnosed with: anemic negotiation clout with insurers, discriminatory Medicare reimbursement, government-mandated administrative bloat, and absence of not-for-profit status. "Site-neutrality" was the much-anticipated treatment prescribed by her specialists. Despite her appeals, Congress repeatedly refused to authorize this life-saving measure.

Like any self-respecting doctor, IMM refused to accede to her terminal diagnoses and remained steadfast in her patient-centric cares. She was especially proud of her ability to accept eggs, fishing tips, and general goodwill as payment from those unable to pay in the usual and customary fashion.

Despite her historical prominence, IMM declined many public accolades. She was infamously "otherwise occupied" for most honorary functions. Likewise, she was not fond of meetings, but when the gavel was in her hand, she had no tolerance for loquacity or rote reporting. She struggled with the concept of "free time," begrudgingly learning to accept it with grace as she aged, eventually seeing the importance of being well-rounded and well-rested.

She is survived by her sole living heir, Independent Medicine of Minnesota II. **MM**

Like any self-respecting doctor, Independent Medicine of Minnesota remained steadfast in her patient-centric cares. She was especially proud of her ability to accept eggs, fishing tips, and general goodwill as payment from those unable to pay in the usual and customary fashion.

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

BURNING ISSUES

Wildfire smoke poses many health hazards

A record acreage of Canadian forests—an area nearly the size of Louisiana—has burned this summer, triggering a record number of air quality alerts in Minnesota. Vishnu Laalitha Surapaneni, MD, MPH, an assistant professor at the University of Minnesota Medical School, studies how climate change affects human health. She discusses the impacts of this summer's wildfire smoke.

Vishnu Laalitha Surapaneni, MD, MPH

Let's talk about the source of the smoke we've been experiencing this year.

We've seen smoke from Canadian wildfires. And we know that with climate change there are going to be worsening wildfires—increasing severity as well as a prolonged period of wildfires. I think this is going to be, unfortunately, an issue that Minnesotans need to be concerned about going forward.

I imagine wildfire smoke is a rather complex stew of chemicals. By the time the smoke reaches people outside the immediate area of the fire itself, what pollutants are of greatest concern?

Closer to the source, we're concerned about buildings that are burning, things like lead and asbestos. Those are heavier pollutants and they might not reach us all the way over here. But particulate matter—PM2.5—is something that we worry about. That does reach farther distances. Particulates from the Dixie fire in California in 2021 reached all the way to New York and resulted in the worst air quality days at that time in New York and Maine.

Describe from a physiological standpoint why PM2.5 is of such concern.

We've known about PM2.5 from fossil fuel emissions. That's a similar pollutant. 2.5 is 2.5 microns. That's about a tenth to a fifteenth the diameter of a human hair. It's an extremely tiny particle. When we breath it in, it gets into your circulation and ends up in nearly every part of your body, wherever the blood goes. It ends up producing an inflammatory reaction. That can then lead to myocardial infarction. There's a causal relationship between PM2.5 and cardiovascular mortality. There's also a causal link to developmental childhood asthma. So, it's a pretty bad pollutant to have around.

Basically every part of your body can be impacted. There are associations with dementia, with children's neurodevelopment, hypertension, atrial fibrillation. There's asthma exacerbation. There's some association with diabetes as well, and preterm birth and low birth weight. Research from the University of Minnesota showed that there are also associations with incidence of chronic kidney disease.

There's emergent evidence that PM2.5 from smoke may actually be worse than PM2.5 from fossil fuel emissions.

What groups are most at risk?

Children, elderly, and those who are pregnant are going to be more at risk. The ones who are really at highest risk are the ones with underlying lung and heart diseases. I've taken care of patients during the smoke who come in with worsening respiratory illnesses. We know from the Minnesota Pollution Control Agency that in Minnesota we have around 2,000 deaths a year attributable to air pollution.

What should family physicians and general practitioners be aware of as they see patients during these times of poor air quality?

The first thing would be to make sure that our patients have access to the air quality index. They can check those alerts regularly at airnow.gov—or most of the weather apps these days, if you have a smartphone. Make sure to follow the guidelines there because they do have the danger separated by healthy versus sensitive populations.

Try to limit your time outdoors if there's an air quality alert. If you do have to go outdoors, wear an N95 mask. That's supposed to help with most of the pollutants—not all of them. And when you're at home, have a clean air room. That would be at least one room in the house where the windows are well sealed and smoke doesn't get in, and inside the room there's no other source of smoke. Ideally you'll want a portable air filter that is high-efficiency—so anything above an MERV [minimum efficiency reporting value] 13, and have that running during the highest smoke days.

Those who don't have access to a portable air filter and those who are unhoused are especially at risk. Those folks should try to get access to places like libraries or other areas where there is indoor good air quality. Let patients know that this is not something to be taken lightly.

Anything else to touch on?

We know from studies that low-income communities and communities of color experience poor air quality disproportionately in their neighborhoods, and wildfire smoke is just adding to that.

The other thing I want to add is about climate change. As we talk about wildfires, we cannot forget to address the root cause. This would be an opportunity to reach out to your legislator and tell them how wildfire smoke is impacting your health and ask them to take action to move away from fossil fuels. **MM**

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

The pamphlet approach

A revised look at how social needs are addressed in healthcare

BY LUCAS ZELLMER, MD

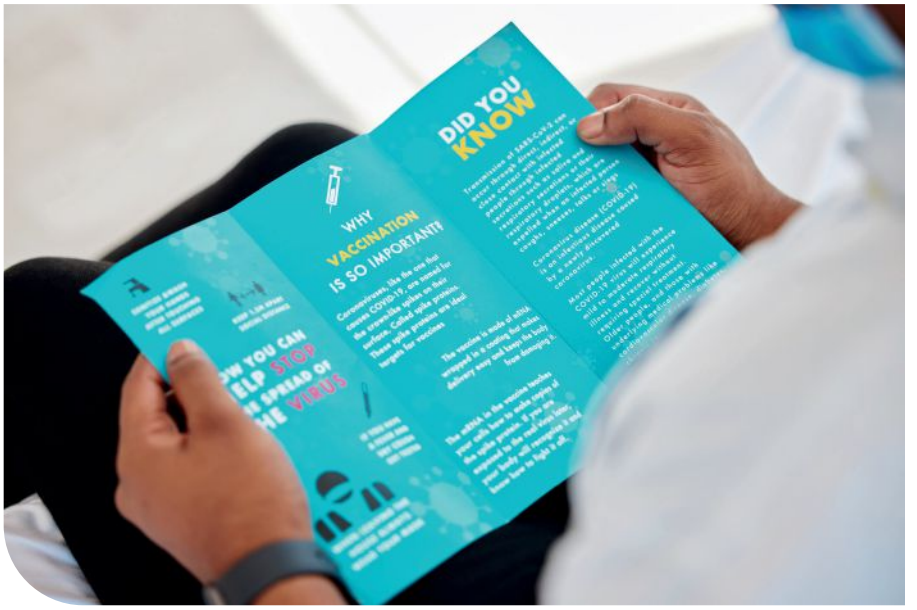
As I wrote in an article several years ago for *Minnesota Medicine*, a brochure or pamphlet wall is a fixture in most healthcare systems, free clinics, schools, and other community agencies.

But this "pamphlet approach" exemplifies a big misapprehension in medicine—the belief that simply putting information on display efficiently conveys information and addresses patients' medical and social needs. Without the ability to follow up with patients and discuss information in light of a patient's social circumstances, these efforts may be of little value.

Now as a third-year internal medicine resident training at a safety-net hospital, I am increasingly aware of the impact that social factors have on patients, staff, and health systems as a whole. These factors dictate whether a patient can afford their medicines, if they can make it to their appointments, and if they have a safe, reliable place to live after they are discharged from the hospital. Despite decades of research characterizing the importance of addressing these nonclinical determinants, such as housing and transportation, traditional healthcare remains siloed in its approach to embracing social care as a healthcare intervention.

Recognizing the limitations of modern healthcare is important; there are certainly diseases that cannot be cured and patient needs that will not be met. However, I believe that innovation in medicine should not solely be defined by more targeted medications or less invasive procedures. Rather, improved interpersonal communication and intervening on all determinants of health should parallel the incredible diagnostic and therapeutic discoveries that are to come.

The purpose of this short commentary is threefold: (1) to provide additional evidence against the pamphlet approach; (2) to highlight key challenges in how social needs are addressed (or not addressed) in current clinical practice; and (3) outline broad steps to achieve more equitable, social-minded healthcare.



The current state of social needs

The burden and health impact of social needs, and the overarching social determinants of health, are well-defined in the literature. There is a high prevalence of social needs among patients, particularly in underserved patients with high healthcare utilization. Various strategies to identify and address social needs have shown promising results in both health outcomes and return-on-investment. At this time, addressing a social need generally includes an interaction with a frontline professional (community health worker, social worker, etc.) who provides a referral to an outside agency deemed able to address the need. Broad translation of published interventions and programs into daily clinical practice remains inconsistent for myriad reasons, as discussed below.

The challenges

Challenges exist in identifying social needs, addressing those needs, funding social needs programs, and interacting with outside organizations. Despite recognizing social determinants of health, and specifically social needs, as worthy of healthcare time and dollars, a more complete paradigm shift is needed to best care for the most medically and socially complex patients. Outlined below are two examples of current challenges: "social needs paradoxes" and the "referral loop," intended to question existing thought processes and social needs strategies.

Social needs paradoxes

Intervention paradox: Successful social needs programs often define success, or meeting patients' social needs, as screening and providing information on community resources. While certainly a component of success, screening for needs and providing information does not mean allocation of resources or services.

The "pamphlet approach" typifies the intervention paradox. An intervention aimed at addressing a social need should not begin and end within hospital or clinic walls or solely include an impersonal, untraceable referral (such as plucking a pamphlet off a display). Rather, success should incorporate appropriateness of referrals and capture cross-sector utilization, including the acknowledgment of other frontline, community-based social service professionals the patient may be working with. Addressing the intervention paradox requires a deeper connection with outside agencies, improved tracking of referrals, and extension outside of the health system and into the community.

Funding paradox: Social needs programs are primarily supported by time-sensitive grants and other inconsistent reimbursement streams. In other words, financing structures in healthcare often prioritize reactive medical interventions, such as management of acute on chronic disease manifestations, over interventions targeting the most important contributors to a patient's overall health, like housing and access to nutritious food. The funding paradox is driven by the failure of healthcare to put dollars where they make the most sense.

Challenges with staffing consistency and the time lag between intervention initiation and ability to report outcomes are among the challenges surrounding grant funding in healthcare- and community-based social needs programs. To address these issues, several alternative funding structures have been proposed in the literature. For example, the Pathways Community HUB is a model that links successful social needs screening and intervention with insurance-based payments in real time. This approach relies on shared documentation with common language, cross-sector buy-in, and rigorous care coordination within the community. Although not applicable for all communities, HUBs providing community-based care coordination provide a glimpse into the future of social needs funding and care.

Accessibility paradox: Patients possessing certain social needs, such as housing or transportation insecurity, are generally required to first present to a health system or other organization to receive referrals to outside agencies. The accessibility paradox includes the common practice of patients needing to access healthcare to subsequently access social care. While some medical centers are well-positioned to engage and support these patients, many are not. As one example of the accessibility paradox, select studies characterizing interventions to address patients' nonclinical needs often cite accessibility or communication challenges as barriers to success. That is, addressing the social needs of certain patients is predicated on the patient getting to a certain place and speaking a certain language.

The referral loop

The "referral loop" refers to the process in which a patient has a social need identified, receives a referral to an outside agency capable of addressing the social need, and presents to the outside agency and has their need successfully addressed. The referral loop is complete only when the success of the referral is communicated back to the referring organization.

There are certain barriers to "closing" the referral loop. As we have discussed before, interactions between health systems and outside agencies are largely nonexistent. Such silos are built, in part, from a lack of common-language communication streams, differing documentation strategies, and challenging funding mechanisms. Recent studies depicting "successful" social needs interventions are limited in their ability to capture referral loop closure; therefore, significant gaps exist in accurately depicting cross-sector utilization as it pertains to patients' social needs.

Call to action

Appropriately addressing the needs of underserved patients requires changes in procedures, processes, and policies. Community-minded research aims to characterize the real-life needs of patients, acknowledge cross-sector service utilization, and promote effective translation from study to practice. To this end, rigorous qualitative and quantitative research is warranted to better understand the needs of marginalized populations and break down the walls separating healthcare and communities.

Establishing the role of physicians in addressing social needs is a crucial undertaking. We are not educated on social service systems and are barely trained on healthcare systems. We spend years learning how to identify and treat disease; prevention of disease comes later, I am learning. Not all physicians have the desire, expertise, or bandwidth to incorporate social care into their clinical practice. Perhaps the most appropriate starting point involves using the status afforded to us as physicians to advocate for a more complete healthcare system—one that acknowledges clinical disease in the context of social needs and determinants of health. **MM**

Lucas Zellmer is a third-year medical resident in the Department of Internal Medicine, Hennepin County Medical Center, Minneapolis.

REFERENCES

Berkowitz SA, Hulberg AC, Hong C, Stowell BJ, Tirozzi KJ, Traore CY, Atlas SJ. Addressing basic resource needs to improve primary care quality: a community collaboration programme. BMJ Qual Saf 2016;25:164-172.

Jones KG, Roth SE, Vartanian KB. Health and health care use strongly associated with cumulative burden of social determinants of health. Popul Health Manag 2022;25(2):218-226.

Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-based community health worker program addresses unmet social needs and generates positive return on investment. Health Aff (Millwood) 2020;39:207–213.

Morales ME, Epstein MH, Marable DE, Oo SA, Berkowitz SA. Food insecurity and cardiovascular health in pregnant women: Results from the food for families program, Chelsea, Massachusetts, 2013–2015. Prev Chronic Dis 2016;13:E152.

Poleshuck E, Wittink M, Crean HF, Juskiewicz I, Bell E, Harrington A, Cerulli C. A comparative effectiveness trial of two patient-centered interventions for women with unmet social needs: Personalized support for progress and enhanced screening and referral. J Womens Health (Larchmt) 2020;29:242–252.

Schickedanz A, Sharp A, Hu YR, et al. Impact of social needs navigation on utilization among high utilizers in a large integrated health system: a quasi-experimental study. J Gen Intern Med 2019;34:2382–2389.

Zeigler BP, Redding SA, Leath BA, Carter EL. Pathways Community HUB: A model for coordination of community health care. Popul Health Manag 2014;17:199–201.

Zellmer L. A closer look at the pamphlet approach. Minnesota Medicine 2018;101(2)31-33.

Zellmer L, Johnson B, Idris A, Mehus CJ, Borowsky IW. Post-identification approaches to addressing health-related social needs in primary care: A qualitative study. J Gen Intern Med 2022;37:802-808.

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Fiercely independent

Minnesota physicians who work in private practice find that the rewards vastly outweigh the challenges. So why do so few do it?

BY SUZY FRISCH

John Bollins, DO, couldn't believe how fast he went from an enthusiastic and passionate trauma surgeon to completely burned out. Working 36-hour shifts, often being on call for 24 hours straight—which really meant being in the OR for another full day before his regular shift—and getting little rest for months on end took its toll on his health.

Bollins tried switching from one health system employer to another, and it was the same story of vast overwork with scant time for sleep, exercise, or the outdoor activities that drew him to Duluth and the North Shore. He assumed leadership roles to try to make a difference. He suggested scheduling and organizational changes to executive leaders to make work life for surgeons more tenable. His ideas fell on deaf ears.

Feeling a lack of control over his work and personal life, Bollins decided about a decade into his medical career to take matters into his own hands. One thought was to leave the profession entirely. But he would still need to work for a couple more years to make that realistic. The other notion was to start his own surgical practice.

"Working for another two years felt like a prison sentence. Every day going to work—it's unhealthy, it's unsafe. I'm exhausted and

"There hasn't been a single day that I said, 'I wish I could go back and work at the hospital as an employee.' It's very challenging, but it's a fitting set of challenges, and for me, it's worth it."

JOHN BOLLINS, DO
ADVANCED SURGICAL ASSOCIATES OF NORTHERN MINNESOTA
HIBBING

patients are going to get hurt," Bollins says. "I should be in the peak of my career. So I decided to try starting a private practice."

Though there have been numerous challenges and risks to opening Advanced Surgical Associates of Northern Minnesota, based in Hibbing, Bollins has been thrilled with his decision in 2020 to become an independent physician. Doctors that work for physician-owned practices are a small but mighty contingent in Minnesota—just 15%, according to the Minnesota Department of Health's latest physician workforce data from 2019. Yet like Bollins, many report deep satisfaction with their ability to live and practice medicine as they see fit.

"There hasn't been a single day that I said, 'I wish I could go back and work at the hospital as an employee.' It's very challenging, but it's a fitting set of challenges, and for me, it's worth it," Bollins says. "I was so broken in the system, and I couldn't keep taking care of patients in an unhealthy manner. I wanted to give back to the community and provide good care. My goal is to make my own little island doing surgical care the way it should be done and leave a legacy of people behind me who can do the same."

Practice trends

Since the 1980s, there has been a steady decline in physicians working in private or small-group practice, according to the American Medical Association. In 2020, patient care physicians working in private practice dropped nearly 5 percentage points to 49%, marking the first year that less than half of physicians worked independently, according to the American Medical Association's 2020 physician practice benchmark surveys. This proportion has been dropping since the first benchmark survey in 2012, when 60% of physicians worked in a practice fully owned by physicians; in 2018, 54% were independent.

The AMA cites potential causes such as practice closures, mergers and acquisitions among practices or by a system, physicians changing jobs, and trends like new physicians starting their careers in different settings compared to retiring physicians.

Then add in another wild card: Private equity firms have started buying up private practices across the country. A 2023 report from the University of California, Berkley, and the Washington Center for Equitable Growth found that acquisitions of private practices have increased more than sixfold in only a decade, from 75 in 2012 to 484 in 2021, and PE firms are increasing their market share in many metropolitan areas. These acquisitions are associated with price increases, especially in areas where PE firms have amassed more market share, according to the report.

Historically in Minnesota, fewer physicians have worked in private practice than the nation as a whole. There are many reasons, some rooted in the state's large population of German and Scandinavian immigrants who brought with them a collectivist culture instead of an exceedingly independent mindset, says Stephen Parente, PhD, a professor and Minnesota Insurance Industry Chair of Health Finance at the University of Minnesota Carlson School of Management.

In Midwestern states like Minnesota, Wisconsin, and Iowa, going to a hospital-based clinic was socially acceptable, whereas on the East Coast, where Parente grew up, clinics were associated with medical care for poor people. In addition, he says, Minnesota played a big role in the origin story of health maintenance organizations in the 1960s and 1970s. HMOs typically featured a health system–owned primary care clinic serving as a gatekeeper to the larger network of multispecialty practices.

"HMOs were an idea that came out of Minnesota, with clinics being an acceptable way to operate and drive a more efficient way to structure care," Parente says. "The HMO design was a group practice

"Independent practitioners have a lot of anxiety. They say, 'My choices are really to try to carry on and make less of a margin or hang up my spurs because I prefer not to be a W-2 employee.'"

STEPHEN PARENTE, PHD
PROFESSOR AND MINNESOTA INSURANCE INDUSTRY CHAIR OF HEALTH FINANCE
THE UNIVERSITY OF MINNESOTA CARLSON SCHOOL OF MANAGEMENT

"There are a lot of obstacles that a health system has. I wanted to dictate how I practice medicine, and I didn't feel like a midlevel manager knew best how to deliver care. I felt like I could deliver care in a more efficient fashion and in a fashion that was better suited to primary care, with unfettered access to a provider."

CHRISTOPHER WENNER, MD
FAMILY MEDICINE CLINIC
COLD SPRING

model, coupled with health insurance like HealthPartners intending to provide high-quality medical care and be efficient as a path for the rest of the country to follow and save money."

More recently, physicians have gravitated away from starting private practices—or their practices were acquired by larger systems—thanks to mounting back-end frustrations with rising costs, administrative burdens, and unfavorable finances. "Minnesota has never had that much of an independent streak to begin with," says Par-

Surviving start-up

It can feel like a daunting proposition to start an independent medical practice, but it can be done. Many physicians have blazed the trail, and it's important to remember that no one needs to go it alone, even as a solo practitioner. There are numerous resources at their disposal.

Take Integrity Health Network (IHN). The independent health practice supports 30 independent health clinics in Minnesota and Wisconsin with a range of services, from health plan contracting to group purchasing. President and CEO Melissa Larson reminds physicians who are considering hanging their own shingle that such entities also provide a professional cohort, including more than 200 physicians and providers at IHN, plus clinic administrators who consult with each other on the details of running a practice.

There are many considerations to ponder. Take it from the folks who regularly help physicians open their doors.

"It is important to note that there are alternative pathways to independent practice, such as joining an independent clinic as an employed provider, buying into a practice over time, purchasing a practice from a retiring physician, or establishing a franchise practice," says Larson. "That's the beauty of independent medicine—there is no one-size-fits-all."

Timing

It often takes more time than one would expect to get vital aspects of a clinic set up, such as electronic health record systems, contracting and credentialling, lining up insurance, and other details—often at least 12 weeks, if done properly, says Teri Shelton, IHN director of quality improvement and population health.

Resources

Physicians are intimately familiar with providing patient care and have strong opinions on how they want to operate in private practice. But it's critical to give the same attention to setting up their new business, Larson says.

Groups like IHN, the Minnesota Medical Group Management Association, consultants, and other organizations can provide guidance to help physicians optimize the structure of their businesses from the start, avoiding headaches down the road. Make sure that those resources are deeply knowledgeable about navigating the Minnesota market, the payers, and the claims process, Larson says.

Finances

Even if physicians have a strong book of business from day one, they will need financial resources to keep the lights on because it takes three to six months to establish cash flow, says Craig Ward, IHN director of operations. "A lot of what we do in healthcare is sort of done on credit," he says. "You provide the service, but you don't necessarily see the money in the bank for one to three months. There can be a long delay."

ente, who is quite familiar with physicians' challenges through family and colleagues working in independent medical practices. "Independent practitioners have a lot of anxiety. They say, 'My choices are really to try to carry on and make less of a margin or hang up my spurs because I prefer not to be a W-2 employee.'"

Increasingly, regulations passed at both the state and federal level do not differentiate as to the size of the practice. For example, Minnesota requires that all insurance claims be submitted electronically. What seems like good policy may discourage physicians from working independently or part-time, or incentivize them to go to a cash-based system which can decrease access to care.

"Practicing in corporate medicine was a shock to my system. I did not anticipate the lack of autonomy. There are more than those two people in the examination room driving those sometimes critical decisions in treatment, and that is not the way medicine should be practiced, in my opinion."

JULIE ANDERSON, MD
SIMPLICITY HEALTH
ST. CLOUD

Not having a strong foundation of independent physicians in Minnesota means that many newer doctors don't see independent private practice as a viable option, says Christopher Wenner, MD, who opened his family medicine clinic in 2009 in Cold Spring. He trained in Colorado, where it was common to have independent practices owned by one to three physicians. "People coming out of training here just don't see that this is an acceptable route," Wenner says, adding that many physicians' student debt loads are another strong deterrent.

And when people have fewer options for care, especially from independent physicians, patients tend to lose. With the dominance of health system providers, it's common for patients to have a harder time accessing care; wait times for routine visits often stretch to many months, Wenner says. Healthcare costs also increase when larger systems take over more of the sector, usually because of decreased competition.

Origin stories

Physicians come to the decision to work in private practice for myriad reasons and at diverse points in their careers. Some go back and forth between working independently and being employed by a larger system. Many start their careers in private practice and stay, while others transition to winding down their work at an independent clinic. What often underlies their move away from being employed is their desire to care for patients the way they see fit.

Wenner spent his first five years working for a large hospital system, where he saw patients and taught residents. He sought to open his own practice to reduce barriers to care and serve patients as a traditional small-town physician. "There are a lot of obstacles that a health system has. I wanted to dictate how I practice medicine, and I didn't feel like a midlevel manager knew best how to deliver care," he says. "I felt like I could deliver care in a more efficient fashion and in a fashion that was better suited to primary care, with unfettered access to a provider."

"I really value the flexibility. I'm not sure that would be possible while working in a big system, where they try to maximize the number of patients you see each day, with charting after hours."

ERIN STEVENS, MD
CLINIC SOFIA
EDINA/MAPLE GROVE

He starts seeing patients at 6:30 or 7 a.m.—the most popular appointment times because people can get in before work. It also allows Wenner to go home for family dinners and obligations. Patients can call him directly if there's an emergency. If someone can't get to the office, Wenner will make a house call, and if a patient lacks insurance and is struggling to pay, Wenner finds a solution right then, such as providing a significant fee reduction or free care, instead of needing to send them through a charity care application process.

Family medicine physician Julie Anderson, MD, took the route to private practice right from residency, working at a physician-owned multispecialty clinic of about 60 doctors in St. Cloud. When they sold the clinic to a large health system,

Anderson went to work there, but it just wasn't a fit.

"Practicing in corporate medicine was a shock to my system. I did not anticipate the lack of autonomy. I was used to having a say in how each of my patients were cared for. There wasn't one particular issue that was challenging, it was a buildup of multiple bureaucratic things that piled up on each other making it insurmountable for me to stay. I went into medicine to be a partner in the health choices between myself and my patients. In a corporate system, there are more than those two people in the examination room driving those sometimes critical decisions in treatment, and that is not the way medicine should be practiced, in my opinion."

After two years, in 2018, Anderson returned to her roots and opened Simplicity Health in St. Cloud. Options for primary care in the area were shrinking, and residents craved care from independent providers. Before long, patients and providers voted with their feet and helped grow Simplicity into a multispecialty practice of seven physicians and six advanced practice providers who have cared for over 25,000 people in the St. Cloud community.

"It became clear that [financial instability] was causing an incredible level of worry and stress among the partners."

CHRISTOPHER BOELTER, MD
UROLOGIST
CENTRACARE
SARTELL

To Anderson, Simplicity stands for flexibility, being nimble to serve patients in the amount of time providers deem necessary, while providing high-quality care targeted to each patient.

"When I have a patient come in and thank me for being here—which happens every day—it's a cool feeling. This helps to confirm my belief that our community needed another option for care," she says. "We don't answer every problem as a primary care practice, but patients deserve choice."

As Erin Stevens, MD, completed her OB/GYN residency, she considered all formats for practicing medicine. She chose to launch her career in 2017 at Clinic Sofia, a private practice based in Edina, favoring its smaller format and ability to provide highly personalized care. First as an employee and now as a co-owner, Stevens has found the independent clinic the right setting for her to forge connections with patients. She enjoys the opportunity to collaborate often with fellow providers about patient care, and the flexibility she needs with a young family of her own.

"I like to be there for my patients when they need me the most. When a patient calls, I always know who it is, what their story is, and what they are struggling with. They can talk to a nurse who gets them on my schedule and tailors the appointment to fit how much time they need," Stevens says. "I like having ownership over my patient care and schedule."

Being one of the physician owners means that Stevens has equal say over how Clinic Sofia operates. She appreciates its commitment to work-life balance, which helps her pursue her interests in legislative policy work and writing, including a magazine column and a recent book, *Unexpected: A Postpartum Survival Guide*. Every physician at the clinic has one standard day off every week, giving Stevens time for self-care, advocacy work, writing, or other pursuits. "I really value the flexibility to do that," she adds. "I'm not sure that would be possible while working in a big system, where they try to maximize

the number of patients you see each day, with charting after hours."

Cost-benefit analysis

There are challenges with opening and operating a private practice. When starting a clinic from scratch as a solo practitioner, every decision is yours, from what kind of blood pressure cuffs to purchase to what electronic health record system to use. There often is a steep learning curve to figure out the best ways to run a small business. And start-up time usually means minimal staff, which can result in long stretches of being on call.

Some physicians decide that the financial realities of operating an independent practice add too much anxiety to an already challenging profession. Christopher Boelter, MD, a urologist at CentraCare and physician vice president of the specialty care division, lived that stress during a decade in private practice in Sartell. In search of autonomy, he initially opted to work at an independent clinic and eventually became managing partner. CentraCare would periodically ask the practice's leaders whether they wanted it to become part of its system, and the answer was always no. Then increasing costs and declining reimbursement rates—especially for an older patient population that relies heavily on Medicare—started taking their toll.

"It became clear that [financial instability] was causing an incredible level of worry and stress among the partners," Boelter says. The group joined CentraCare in 2014, continuing to operate from its original clinic space. "If you talk to any of the partners who are still practicing with the group, they will say it was the best decision we ever made. It took the business stress out of the equation."

Boelter notes that he and his seven urologist co-workers retained their autonomy to provide care how they see fit. In addition, the clinic benefits from CentraCare's deeper pockets to pay for the medical equipment and electronic health record systems the urologists wanted to invest in. "In our journey," he adds, "the comment I hear all the time is, 'Gosh, we should have done this years ago.'"

"Independent providers can only negotiate their own professional service fees, but a big health system can negotiate facility charges and labs and other things in addition to the professional component."

MELISSA LARSON
PRESIDENT AND CEO
INTEGRITY HEALTH NETWORK

In Anderson's view, the challenges of running a private practice are not insurmountable. When she opened Simplicity, she brought along several nurses and staff she worked with for years to help her run the clinic the way she envisioned. She invested in Epic so that her patients' electronic health records are accessible by providers at other systems. Anderson also turned to Integrity Health Network (IHN), a Duluth-based independent practice association. Its staff helped ease the process of credentialling—verification that a physician is qualified to practice medicine—and put the clinic on solid financial footing through its group purchasing and contracting services.

Finding a support network of fellow physicians and healthcare veterans is vital because the financial playing field isn't always even for physician-owned clinics compared to corporate systems. The U.S. model of employer-based health insurance means that employers or insurers typically have plans that favor larger systems by offering lower co-pays or better access to the more comprehensive system compared to independent practices, says Melissa Larson, IHN president and CEO.

"Independent providers can only negotiate their own professional service fees, but a big health system can negotiate facility charges and labs and other things in addition to the professional component," giving them the upper hand. The same is true with reimbursement for Medicare and Medicaid, with larger systems getting paid facilities fees that independent clinics don't, Larson says.

Wenner notes that as a solo physician, he finds it challenging to work with insurance companies, contend with denials of coverage, and get paid in a timely fashion. "That's not why any of us went into medicine, but it's part of being a small business owner," he says. "You do what you have to do to keep the lights on, and dealing with insurance companies is part of that."

Specialists such as surgeons find themselves in vulnerable positions if the bigger players put up roadblocks to independent physicians operating at their facilities. Aiming to offer surgical services in Duluth and Hibbing, Bollins has faced various obstacles to getting access to operating rooms and patients. He's had the best luck building a strong relationship with the Ely-Bloomenson Community Hospital, where leaders are happy to make an expert in robotic surgery available for patients.

"I'm finding tons of challenges. I didn't realize how broken our healthcare industry is," Bollins says. "They are supposed to be nonprofits operating for the greater good of the community and they get giant tax breaks. But in my view, they are doing aggressive anti-trade maneuvers."

Even so, Bollins does not harbor regrets for opting to steer his own ship. "The upside is that I've slept every night since June 2020. When I operate, I've had adequate time to prepare and go into each case rested," he says. "I can really focus on my individual patients again. It's an amazing transformation, and it's allowed me to enjoy my work again." **MM**

Suzy Frisch is a Twin Cities freelance writer.

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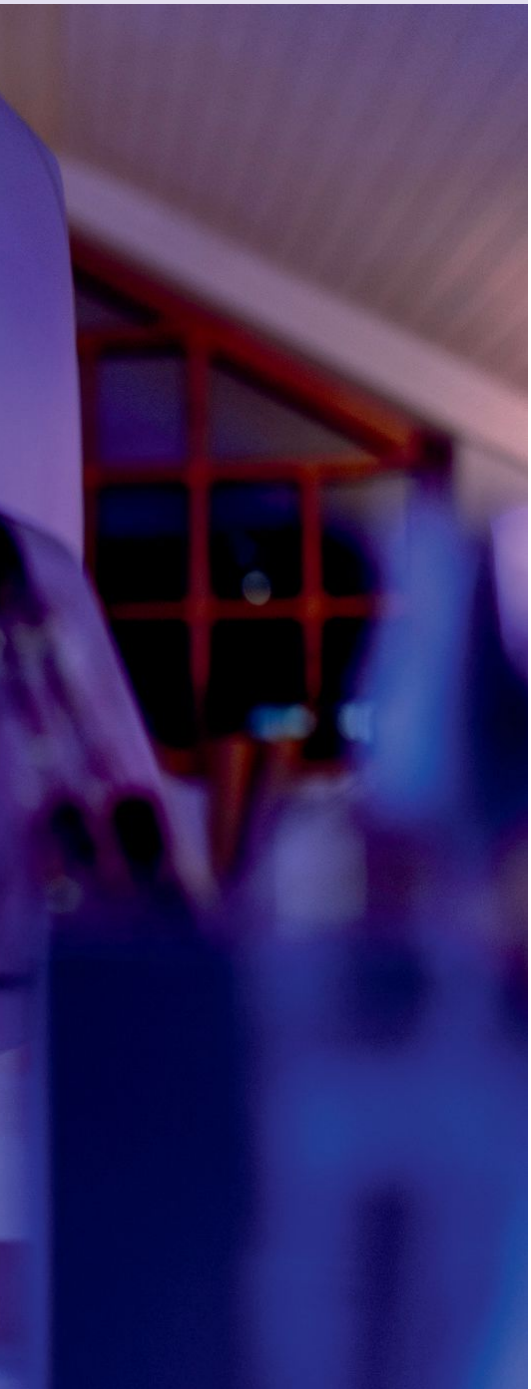
Minnesota Medical Association

THE future OF telemedicine

Medical visits by computer were a pandemic necessity. **What happens now?**

BY ANDY STEINER



Every Thursday morning, Annie Ideker, MD, a HealthPartners family medicine physician, sees patients in a virtual clinic.

"It's one of my favorite parts of the week," she says. "I talk to people all over doing all sorts of different things." Most of these visits are yearly check-ins with established patients, Ideker explains. "I'm able to have that connection and know it is convenient for the patient. It is a really nice feeling."

The feeling was much different back in March 2020, when the global COVID-19 pandemic hit Minnesota. As a clinician leader on a team charged with developing a way for patients to safely see their healthcare providers, Ideker was on the front lines of her health system's rapid shift to telemedicine.

"My job was to quickly develop, implement and train 2,700 clinicians on a platform that we could use to do video visits," she says. "In about 96 hours we got something up and running and got everyone trained. In nine months we did 1 million video visits."

This rapid shift to telehealth in the face of crisis won praise from the state's health and human services leaders. "We had to shift overnight," says Neerja Singh, Minnesota Department of Human Services behavioral health clinical director. "I'm so thankful to our provider community who stepped up, who were able to immediately do everything so well."

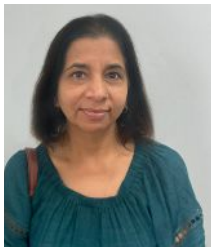
More than three years later, there's less urgency in the air, and telemedicine, a technology that was in its early days not so long ago, is now considered an acceptable—and even preferred—option for many medical visits. While the percentage of total telehealth visits is down from pandemic-level heights, the choice is more available than ever and is popular with patients and physicians alike.

At HealthPartners, Ideker said, "We do about 15% of our total ambulatory care via telemedicine. That's a significant number of visits. In some parts of our organization, particularly our behavioral health line, it is significantly higher than that."

Susan Pleasants, MD, a family physician and M Health Fairview senior vice president for optimal care, had never done a virtual patient visit before spring 2020 when she was asked to oversee her system's shift to telemedicine. Today, she says the option remains popular in many specialties, particularly in primary care, the system's largest service line: "We do about 25% of our care in a virtual setting, messaging back and forth with patients, conducting video visits and some telephone consults."

Though they'd been offering video visits as an option for years, as the pandemic took hold, staff and physicians at Mayo Clinic drastically beefed up their telemedicine options. Brian Crum, MD, a Mayo neurologist and vice chair of the clinic's outpatient practice subcommittee, said that the even though the technology was already in use pre-pandemic, it still took a coordinated effort to get it up and running for everyone.

"We had a couple of departments that were already testing the waters to see es-



"I'm so thankful to our provider community who stepped up [to practice telemedicine], who were able to immediately do everything so well."

NEERJA SINGH
BEHAVIORAL HEALTH CLINICAL DIRECTOR
MINNESOTA DEPARTMENT OF HUMAN SERVICES

tablished patients so they wouldn't have to travel to Rochester," he says. "Technically, we could use it, but it was sparsely used." The option proved popular with patients for a number of reasons, including convenience. Because of the clinic's more remote location, he explains, "many patients really liked having telemedicine as an option. It saved them a trip and a hotel and parking and meals and time off work."

These days, many patients are again traveling to Rochester to see their providers in person, Crum says. "I think our clinic itself is pretty much back to where

"Anecdotally, we have observed a lower no-show rate in our behavioral health department with telehealth than with in-person visits, which suggests that since more patients are actually completing their scheduled appointments it would likely lead to better quality outcomes for those patients who actually receive care."

ANNIE IDEKER, MD
FAMILY MEDICINE PHYSICIAN
HEALTHPARTNERS

HOW TO do telemedicine better

While some practitioners might think that setting up a telemedicine practice is as easy as booting up their laptop, Annie Ideker, MD, a HealthPartners family medicine physician, begs to differ. In March 2020, as the world faced down a global pandemic, the family physician led her health system's shift to virtual care. What she's discovered as some 35% of her own practice shifted online is that practicing telemedicine well requires special skills and practices.

Here are her top tips for successful video visits:

1 Lights, camera, action

Ideker reminds her fellow physicians that not all patients, especially those "who are not 12 and didn't grow up with TikTok," understand the best way to position themselves for a video visit. This means that physicians have to take on a new role. "You have to teach patients how to flip their camera around and hold it at eye level or set it down so it is not bouncing around and you can have a good visual," she says.

2 Enhance your image

For physicians, just as important as the camera angle is the overall image they project, Ideker says. Positioning yourself in front of a noncluttered, professional background presents an image that helps build trust. And building this image goes beyond visuals, she adds.

"You want to be in an environment where you have good audio quality headphones or not a lot of ambient noise. In the clinic we always do telehealth visits behind a closed door in an exam room. We tell clinicians who work from home to be in a space where they don't have kids running around or pets barking in the background."

3 Read the signs

Though telemedicine works well for many patient visits, Ideker reminds her fellow physicians that it is harder to read patients' more subtle cues when you aren't face-to-face.

"In an in-person visit you can read your patient's body language," Ideker says. "Are they shifting their feet around? Are they leaning forward?" With telehealth, where the view tends to be from the shoulders up, "you have to watch for the subtleties of facial expressions to form those good connections with patients."

Take a closer look at your patients' eyes and eyebrows, she advises. "Are they grimacing or smiling? Are their eyebrows scrunched together? You have to take your cues where you can get them. You can tell a lot by how someone's shoulders are positioned."

4 Don't fear the pause

It's natural to want to avoid awkward conversational pauses, especially when you're seeing a patient over video, but Ideker says she's learned to lean into the silence. "As clinicians we ask a lot of questions. Patients need to process those questions and how they want to answer them. Sometimes it takes a little time. You have to be OK with the silence, leave space in the conversation."

This is particularly true in a virtual visit, she continues: "Creating a sense with a patient that it is OK to have silence during a virtual visit is important. We do that in the exam room but it is different type of interaction when you are virtual. To create that space and awareness you have to think about it differently. Give your patients the time they need to complete their thoughts."

"We do about 25% of our care in a virtual setting, messaging back and forth with patients, conducting video visits and some telephone consults."

SUSAN PLEASANTS, MD
FAMILY PHYSICIAN AND SENIOR VICE PRESIDENT FOR OPTIMAL CARE
M HEALTH FAIRVIEW

it was pre-pandemic," Still, thanks to the COVID boost, telehealth is stronger than ever, opening virtual options for patients and providers that didn't exist before. As many as 15–20% of all visits are now done by video, Crum says: "We've shifted many in-person visits to telemedicine, mostly with established patients."

The story is similar for Ideker and her colleagues. Even post-pandemic, telehealth remains popular with a significant percentage of the patient population, and many physicians—Ideker included—embrace the technology. "We believe this is not going to go away," she says. "Everyone has acknowledged that this wasn't a temporary thing, and consumer behavior and choice demand that we meet patients where they are."

"A great way to deliver care"

In the beginning, the boosting of telemedicine was considered a temporary response to crisis, but the option has proved so popular with patients and providers that it is here to stay. Even with the pandemic pressure off, many patients continue to opt for video visits because of the convenience and time savings.

Telemedicine is "a huge satisfier," Crum says. "Honestly it's been interesting. If you've done video visits, you can see how great it is. Sometimes you need to come in and be seen and that's fine, but it is pretty nice when you can do it from home."

Expanding access to telemedicine has illustrated ways the technology can be used for ongoing care, Ideker says. While in-person visits are important in some situations, once video visits took off, patients and providers realized that a large percentage of appointments can be handled virtually. "We realized this is a great way to deliver care for some patients. We can accomplish providing high-quality care with these virtual methods."

Expanding telehealth also expands access for patients who might otherwise have had a hard time making it to appointments, she adds: "It has allowed them to access care that they couldn't access before."

For physicians, enhanced telemedicine options offer greater opportunities for flexibility and creativity with patients—or in their own personal lives.

When he is working with a patient who has family members spread around the country, Crum now is able to use telemedicine to bring everyone together for important appointments.

"Many times a family member wants to sit in and ask questions and participate," he says. With telemedicine, "we can connect a son or daughter in Chicago, a patient somewhere else, and me in the clinic."

Technology also opens options for physicians interested in building a less traditional work schedule. "The thing that we're trying to do at Mayo is provide some flexibility for providers who found video visits advantageous mainly because it meant that they could work from home or could work alternative hours," like evenings and weekends, Crum says. Though staffing issues mean that brick-and-mortar clinics have limited ability to run extra hours, thanks to telemedicine, providers have the option to offer a more flexible schedule. "We are working on how to more hardwire these flexible schedules for providers where this works," he says.

Potential concerns

While telehealth has taken off around the state, the practice still has its detractors, who express concern that the increase in virtual visits may signal a decrease in the quality of care offered to patients.

"The thing that we're trying to do at Mayo is provide some flexibility for providers who found video visits advantageous mainly because it meant that they could work from home or could work alternative hours," like evenings and weekends. "We are working on how to more hardwire these flexible schedules for providers where this works."

BRIAN CRUM, MD
NEUROLOGIST AND VICE CHAIR OF THE OUTPATIENT PRACTICE SUBCOMMITTEE
MAYO CLINIC

Ideker says that she is not aware of any research published on whether the increased use of telehealth has had a negative impact on healthcare quality and outcomes. In fact, she says, many of her colleagues are seeing improvements in quality of care.

"Anecdotally," she says, "we have observed a lower no-show rate in our behavioral health department with telehealth than with in-person visits, which suggests that since more patients are actually completing their scheduled appointments it would likely lead to better quality outcomes for those patients who actually receive care."

Researchers at Mayo have found few, if any, negative outcomes related to telehealth, Crum adds: "Mayo has done some research on whether there has been missed diagnosis or bad outcomes from telehealth, and the answer was no."

While telemedicine consistently wins high marks from patients and providers, there continue to be situations where it can never replace in-person visits.

"In general," Crum says, telemedicine visits, "work well for follow-up visits where an examination is not needed. They are not as useful for a brand-new patient, as one typically needs an examination in that setting." Another time when telemedicine might not be preferred, Crum said, is a "brand-new and/or worsening problem which may need examination to determine next steps." Though in these situations "the video visit could assist in preparing the testing needed when the patient comes on site for that new face-to-face visit."

Other types of visits that should never be done virtually, Ideker adds, are those where a physical examination is required, like pediatric well-child exams or newborn exams. But telehealth is, she says, "excellent for chronic conditions, such high blood pressure and diabetes, where patients can obtain the data needed for management at home."

> "It may be an option for people to see specialists through telemedicine, but the flip side we want to pay attention to is we don't want telehealth to exacerbate existing inequities in access to in-person care."
>
> **PAMELA MINK**
> DIRECTOR OF HEALTH SERVICES RESEARCH
> MINNESOTA DEPARTMENT OF HEALTH

Telemedicine has made great progress in Minnesota, but the state's technology infrastructure needs a boost to guarantee that its future is just and secure for all. Along with a team of her colleagues, Pamela Mink, Minnesota Department of Health director of health services research, is conducting a research study on telehealth expansion and payment parity directed by the Minnesota Legislature. The preliminary report is available on the Department of Health website. The final report will be released in January 2024.

"There are a number of challenges or potential challenges that need to be explored," Mink says of her group's research. A significant challenge to telehealth access is broadband internet. High-speed connections can be difficult even in some of the state's metropolitan areas; in Greater Minnesota, broadband coverage remains even spottier: "For many people in rural communities, it might be much more challenging to get a connection for audio-visual telehealth. Sometimes the only option is for someone to go through a landline only."

Where good connections are available, telehealth visits can be a good option for rural Minnesota residents who'd otherwise have to travel hours to see a specialist, but Mink cautions that even though that option is helpful, it may also mask the true disadvantage created by provider shortages in Greater Minnesota. "It may be an option for people to see specialists through telemedicine," she says, "but the flip side we want to pay attention to is we don't want telehealth to exacerbate existing inequities in access to in-person care."

With a team of colleagues, Neerja Singh at the Minnesota Department of Human Services is working on a study of benefits of flexibility in providing financial reimbursement for telemedicine services. There is a concern that many of the state's residents will lose the powerful access to healthcare that telehealth has demonstrated it provides if lawmakers and payors scale back pandemic-era changes to healthcare reimbursement practices. Because of this, Singh advocates for continuing that option indefinitely. "I think giving providers and patients this flexibility would be the best decision," she says.

Ever the telehealth champion, Ideker said she'd hate to see lawmakers and insurers create roadblocks that could slow the technology's growth in the state: "Our hope and desire from a policy perspective is that insurers continue to honor this reality and that payors continue to pay for those services."

It's still too soon to celebrate—or mourn—the fate of telemedicine in the state, Mink cautions. A deal has not been struck on reimbursement. "It's still very much a work in progress," she says. "Stay tuned." **MM**

Andy Steiner is a Twin Cities freelance writer and editor.

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In 2023, the MMA, in partnership with the University of Minnesota Medical School, once again sponsored the "Exceptional Primary Care Community Faculty Teaching Award" at the Dean's Tribute to Excellence in Education Event.

Will Nicholson, MD, MMA President and Michael N. Stiffman, MD

From the MMA

"The role of teacher is one of the most important roles that a physician can take. Thank you Dr. Stiffman for inspiring your students to take on a career in primary care, and for serving as a model of professionalism for so many."

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"Thank you to all the physicians who educate our students and serve as role models during their medical education journey. We are very grateful for all you do, and could not be successful without you. A special congratulations to Dr. Stiffman for this important award."

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MINNESOTA MEDICAL ASSOCIATION

FEATURE

THE elephant IN THE room OF MEDICAL EDUCATION

A curriculum review of two Minnesota medical schools shows students get little training in healthcare policy, costs, and payment systems.

BY KIANNA NGUYEN, LAUREN HARVEY, GRACE JOHNSON, PREETHIYA SEKAR, ANDREW YANG

In the United States, medical practice is intertwined with complex health policies and economics. Cost and payment systems directly impact patients' interactions with physicians. A study by Rook et al. in the September 2019 issue of *Academic Medicine* found that most medical students agree that addressing health policy issues, such as insurance and healthcare pricing, falls within a physician's professional obligations. However, students report feeling unprepared to join the discussion on these topics. A 2012 study conducted by Perelman School of Medicine at the University of Pennsylvania observed that up to 40% of graduates deemed their health policy education inadequate. Reddy et al. reported in the June 2020 issue of *Healthcare* that more than half of medical school deans believe their schools had insufficient exposure to health policy.

Undergraduate medical education is subject to continuous structural and content adjustments, which often occur in response to student feedback. Traditional passive lecture formats are being replaced with newer active learning. Content has expanded to include more information on addiction medicine, gun violence, racism, and health policy. However, formal healthcare policy training continues to be highly variable. The U.S. Liaison Committee on Medical Education (LCME) currently has no curriculum standardization or requirement for health policy and payment systems in undergraduate medical education.

Examining current curricula provides a starting point to address this knowledge gap. The existing body of research regarding health policy and payment education is small and mainly comprises survey-based studies. We assessed the prevalence and nature of discussions on healthcare costs and payment systems in preclinical curricula at two Minnesota medical schools, Mayo Clinic Alix School of Medicine (MCASOM) and the University of Minnesota Medical School, Twin Cities (UMMS).

Evaluating the curricula

We reviewed preclinical curricula at MCASOM and UMMS with the primary objectives of quantifying the proportion of lecture material on healthcare costs and payment systems and qualitatively evaluating the nature of these discussions. Both MCASOM and UMMS preclinical curricula (years 1 and 2) are structured via basic sciences and organ systems. Students at each school also participate in a longitudinal course on health systems, population health, and health policy.

Mandatory preclinical learning materials in DOC/X, PPT/X, and PDF file formats were included. Coursework from both schools was organized by school and course. Year 1 courses were from 2019 to 2020; Year 2 courses were from 2020 to 2021. A keyword list was curated from a literature search of systematic reviews related to healthcare cost and payment structures. A custom Python script with the keyword list was utilized to systematically filter and select relevant course content.

The screening script included a two-step filtering process: first, automated keyword presence filtering, and second, manual keyword relevance filtering. In the

TABLE 1

10 most prevalent keywords by school SHARED TOP KEYWORDS ARE BOLDED

MCASOM		UMMS	
KEYWORD	OCCURRENCES	KEYWORD	OCCURRENCES
cost	**164**	**cost**	**115**
insurance	**118**	**insurance**	**115**
covered	52	**payment**	**48**
payment	**36**	spending	37
policy	29	fee	33
income	29	price	26
federal	27	covered	26
value	25	medicare	18
economic	21	managed care	17
government	21	income	16

presence filtering step, the custom Python script searched all course materials for inclusion of any keywords in the curated list to generate a report. These reports documented (1) the matched keyword, (2) the file path (which includes school, year, and course), (3) the page or slide number corresponding to the matched keyword, (4) a screenshot of the title page or slide, and (5) a screenshot of the page or slide with the highlighted matched keyword.

Following automated presence filtering, paired reviewers evaluated each report to determine relevance and context. Reports with keywords used to describe non-healthcare systems or cost-related items were deemed irrelevant and removed from consideration (e.g., a match for "network" in the context of a capillary network rather than an insurance network would be removed). The filtering process is detailed in Figure 1.

The final reviewed reports were then qualitatively analyzed for common themes. Each reviewer synthesized common themes across the relevant reports at their respective institution and then compared their findings with the reviewer at their same school. From this, lists of common themes and notable absences for both MCASOM and UMMS were generated. Our final analysis consisted of comparing these curricular themes between both institutions.

Themes of preclinical coursework

Our keyword search process reduced the full course material search space of 60,004 pages across 1,699 documents to 473 pages across 176 documents for analysis (Figure 1). We thus estimate that references to content in healthcare payment systems and costs occur in 0.8% (473/60,004 × 100) of all course material pages or slides.

The 10 most prevalent keywords for each school are listed in Table 1. "Cost," "insurance," and "payment" were common as top keywords for both schools. Notably, "cost" and "insurance" are by far the most common keywords, accounting for 20% and 17% of all keyword occurrences, respectively.

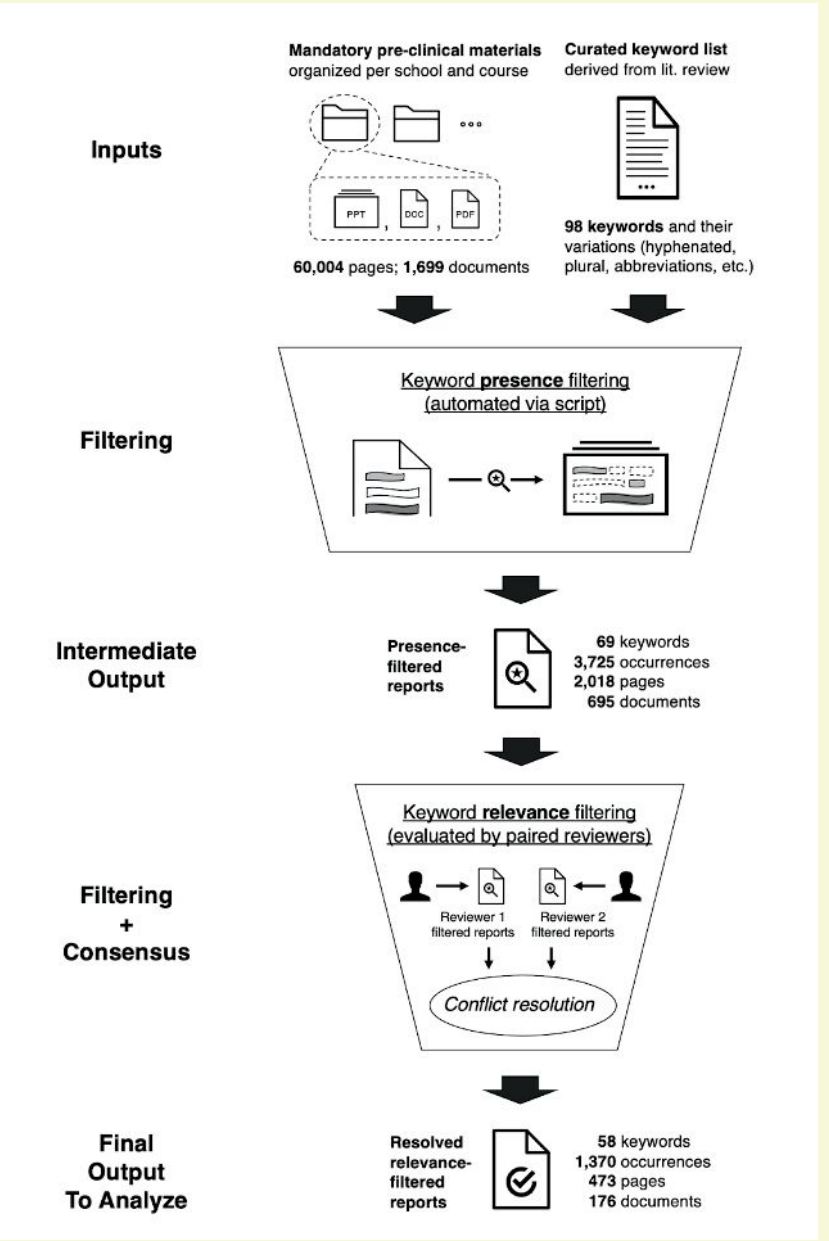
Materials across most courses do not reference concepts related to healthcare payment and cost. Thirty-three out of 38 (87%) courses matched fewer than 20 unique keywords, with the majority referencing only three. The same pattern holds true for the total number of match occurrences. Five courses with the most references to concepts related to healthcare payment and cost are courses with specific social themes such as healthcare delivery or public health, and not courses focused on biomedicine.

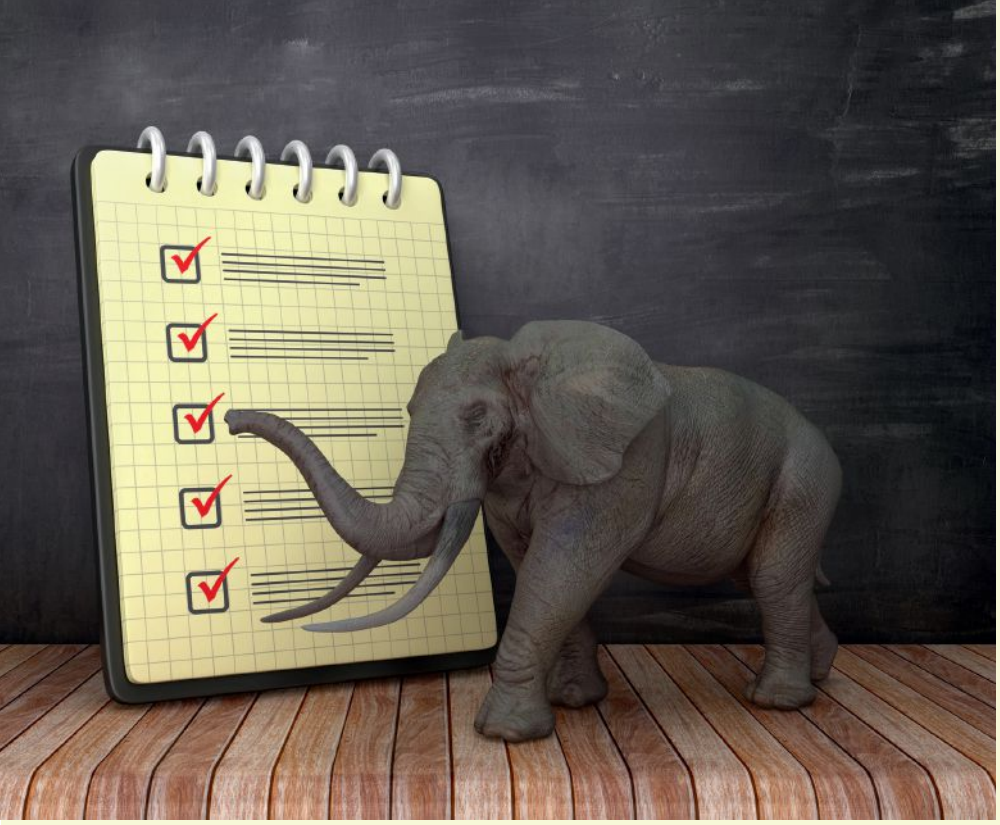
Three major themes emerged throughout content analysis of course materials: passive method of content delivery, discussions of cost, and discussions of payment systems.

Passive vs. active learning

Our analysis identified that most content was delivered via passive coursework. Passive learning is a method of instruction where students unidirectionally receive information from the instructor, as seen in traditional lectures. In comparison, active

FIGURE 1





We need education on healthcare reform and cost of care

Medical students inevitably encounter the shortcomings of the current United States healthcare system during our training. It stands out as we work in low-income clinics, treat patients who have deferred care because of inability to pay, and reassure financially worried family members during a hospital stay. Irrespective of where our training occurs, we empathize with these patients and internalize the conflict between wanting to provide high-quality care and lessening its financial burden on patients.

Our group came together because of our shared interest to explore, discuss, and challenge the elephant in the room of our medical education: the financial implications of healthcare. As members of Students for a National Health Program (SNaHP), we were united by a mutual interest–health policy, particularly relating to healthcare costs and payment systems. We shared our own encounters with these issues, from personal battles with health insurance coverage to experiences working as patient advocates.

Our discussion turned from our past experiences to our current education on the healthcare system. As we compared our courses at the University of Minnesota and Mayo Clinic, we grew frustrated by the lack of consistent exposure to important health policy topics. Further research (see accompanying article) revealed just how little attention both medical schools' curriculums devote to teaching medical students about the healthcare business, medical costs and payment systems, and alternative systems in use in other countries.

Given the current political climate surrounding healthcare reform, we believe students should understand contemporary healthcare movements involving our payment systems. Currently, the U.S. Liaison Committee on Medical Education does not have any required benchmarks for health policy, leading to a wide variety of course material covered across medical schools. To establish a basic level of health policy literacy, we encourage schools to expose students to different healthcare systems and health policy movements. Such curricular enhancements would equip us with the knowledge to generate meaningful policy changes as future doctors.

We also encourage medical schools to more actively teach medical students how patients interact with healthcare costs and payment systems. Hearing patient testimonies on navigating insurance (or lack thereof), using actual patient bills in case studies, and providing an overview of billing and coding would help students better appreciate the patient experience. One notable example of this concept is the Penn State College of Medicine System Navigator Curriculum, a longitudinal program where medical students help patients maneuver through the complex healthcare system. Active learning opportunities like this one expose students to the barriers patients face regarding healthcare access and insurance coverage.

Through our own discussions and extracurricular learning, we have come to support a single-payer stance that insists the government should ensure healthcare for all. There has long been a majority of public support for national health insurance in the United States. However, a single-payer system was mentioned less than five times in the combined required curriculum of both schools. While we don't expect all of our colleagues to share our opinions, medical students need the training to engage in informed discussions about healthcare reform with patients, peers, and community members. Our hope is for a medical training system that better equips fellow learners to advocate for patients on individual and systemic levels.

To make these changes possible, everyone must play a role. While we encourage educators to build solid foundations for discussions of our healthcare system, students must also be willing to actively engage and take ownership of their learning. Additionally, we call on educational boards to reevaluate current curricular standards and include components of health policy as required training. Through education on the roles of cost and payment systems in healthcare, we can better prepare ourselves to provide the best patient care.

learning is an umbrella term that embraces a variety of educational techniques, including case-based learning, experiential learning, peer problem-solving, and project-based learning.

There were, however, a few standout examples of activities that required active student engagement in teaching about healthcare systems. A UMMS course emphasized the importance of medication affordability during a case-based activity on diabetes that asked students to consider cost when choosing a medication regimen for a patient on a fixed income with limited health insurance. The activity explicitly states that "lack of access to medication and healthcare due to costs seems to have played into the complications" experienced by this fictitious patient, thus emphasizing the relevance of cost to health outcomes. In another UMMS course, students participated in a case-based learning activity. They received a budget and a list of diagnostic tests with associated costs and had to make cost-conscious decisions in choosing appropriate tests for a given clinical scenario.

Cost

Healthcare costs were occasionally mentioned throughout lectures. Most often, cost arose in an epidemiological context whereby the economic burden of a given disease was used to emphasize the disease's societal impact. For example, a MCASOM lecture stated that the "total cost of diabetes in the U.S. in 2017 was $327 billion." Other chronic conditions such as coronary heart disease and mental illness were introduced similarly. In other cases, precise dollar amounts were not given, but the lectures still emphasized significant healthcare expenditures associated with these diseases.

Additional mentions of cost in both curricula centered on efficiency and effectiveness, typically about tests, interventions, and medications. In some cases, dollar amounts were presented for tests and interventions, while others were deemed "cost-effective" or not. Increasing cost was partly attributed to technological advances and public policy changes. Of note, most mentions of cost did not identify a payer; it was unclear whether these costs were assumed by patients, providers, insurers, or government.

Payment systems

Education on healthcare payment systems predominantly occurred in the longitudinal courses on health systems and policy. The development of a multiple-payer system was historically contextualized, primarily focusing on landmark health policies. One MCASOM lecture explained how U.S. health insurance became tied to employment and identified a missed opportunity for the development of national health insurance. Slightly more attention to historical context was present in the UMMS curriculum, outlining the history of payment systems in the U.S., including specific mentions of physicians and medical associations that advocated against universal healthcare. Examples of changes in healthcare coverage demonstrated the dynamics of payment structures over time. UMMS lectures also identified how financial incentives and other players (pharmaceutical industry representatives, lobbyists, etc.) have influenced payment systems. Lectures and articles included topics such as utilizing physician reimbursement to drive hospital efficiency and ethical implications of industry representatives and lobbyist involvement in practice and policy.

Identified gaps

Our study identified several curricular content gaps across both schools, which are described in Table 2 alongside proposals for addressing these deficits. As previously noted, most education on healthcare costs is delivered passively and without additional context. Prices of common medications or interventions are occasionally included in presentations but rarely identify by whom the cost is born. By presenting these costs as dollar amounts with no clear payer, this material does not allow students to fully appreciate the negative implications of such expenditures. Furthermore, passive learning format fails to engage students and equip them with the tools to help patients and themselves navigate the healthcare financing landscape.

TABLE 2

Gaps in current curricula with proposed resolutions

GAP	IMPORTANCE OF EMPHASIS	EXAMPLES
Knowledge necessary for basic discourse	Provides students with the basic language and concepts to discuss healthcare cost and systems	• Highlight major healthcare reform events in healthcare policy lectures • Identify players when discussing costs and payment structures • Illustrate the influence of pharmaceutical companies, hospitals, government, insurance companies, and individuals on healthcare costs
Patient interaction with healthcare systems	Helps future physicians better understand the challenges faced by patients and facilitate shared decision-making	• Continue case-based problems and patient testimony when introducing pathophysiology • Provide patient testimony on experiences with healthcare costs and insurance systems • Encourage students to become patient insurance navigators through their states' programs
Differing healthcare systems and opportunities for change	Allows students to conceptualize alternative healthcare systems and reform of the existing system	• Utilize active discussion to educate on global healthcare systems • Review proposed healthcare movements currently existing in the United States
Lack of active learning opportunities	Encourages students to actively participate in improving payment systems in the United States	• Create activities in which students can engage with costs of diagnostics and treatments

Healthcare payment systems are subject to a similar approach. Neither curriculum allows much room for students to question the current payment systems in the United States, brainstorm alternative options, or explore trending healthcare policy movements. We argue that a passive approach to healthcare system education contributes to inaction, deterring students and physicians from seeking solutions to current obstacles in medicine.

Our examination also noted significant education gaps when healthcare policy was discussed, particularly concerning historical health policy, influential forces in healthcare systems, and the various players in payment structures. Understanding the history and various interests influencing U.S. healthcare reform is fundamental to engaging in discourse on our current healthcare system. Historical context was only intermittently provided within the examined curricula and frequently failed to characterize the various influences on healthcare policy.

Detailed descriptions and discussions of patient experiences with the healthcare system were rarely included in the curricula. Both UMMS and MCASOM presented case-based problems and patient testimony to discuss the pathophysiology of various diseases but didn't use these kinds of anecdotes and testimony to help students understand the range of interactions that patients must participate in to access healthcare, including healthcare staff, health plans, transportation, and social services. Understanding the patient experience would help physicians improve patient-provider relationships and promote shared decision-making.

Finally, the curricula provide students with little information about healthcare systems elsewhere in the world. Medical students frequently hear "the U.S. healthcare system is broken," yet students have little exposure to alternatives and strategies for improvement. Descriptions of systems in other countries were primarily limited to optional reading materials, if present at all. This shortcoming would seem particularly serious given widespread dissatisfaction with the existing healthcare system and controversy over how to fix it.

Conclusion

Education covering healthcare costs and payment systems is an essential yet underaddressed topic in preclinical medical curricula. Medical schools deliver insufficient information about cost and payment systems to students. Notable educational gaps include basic knowledge of cost and payment systems, patients' experiences within the healthcare system, alternative systems and current reform discourse, and opportunities for students to actively engage with these topics. While more education on cost and payment systems occurs during the clinical years via the "hidden curriculum," early exposure to these concepts is crucial to establish foundational knowledge. More robust curricula on cost and payment will help equip future physicians with the knowledge to better care for patients and advocate for healthcare policy changes. **MM**

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REFERENCES

Agrawal JR, Huebner J, Hedgecock J, Sehgal AR, Jung P, Simon SR. Medical students' knowledge of the U.S. health care system and their preferences for curricular change: A National Survey. Academic Medicine. 2005;80(5):484-488.

Berridge V, History matters? History's role in health policy making. Med Hist. Jul 2008;52(3):311-26. doi:10.1017/s0025727300000168

Blood AD, Farnan JM, Fitz-William W. Curriculum changes and trends 2010-2020: A focused national review using the AAMC Curriculum Inventory and the LCME Annual Medical School Questionnaire Part II. Acad Med. Sep 2020;95(9S A snapshot of medical student education in the United States and Canada: reports from 145 schools):S5-s14. doi:10.1097/acm.0000000000003484

Heiman HJ, Smith LL, McKool M, Mitchell DN, Roth Bayer C. Health policy training: A review of the literature. Int J Environ Res Public Health. Dec 23 2015;13(1):ijerph13010020. doi:10.3390/ijerph13010020

Hirsch MA, Nguyen VQC, Wieczorek NS, Rhoads CF, Weaver PR. Teaching health care policy: using panel debate to teach residents about the Patient Protection and Affordable Care Act. MedEdPORTAL. Nov 21 2017;13:10655. doi:10.15766/mep_2374-8265.10655

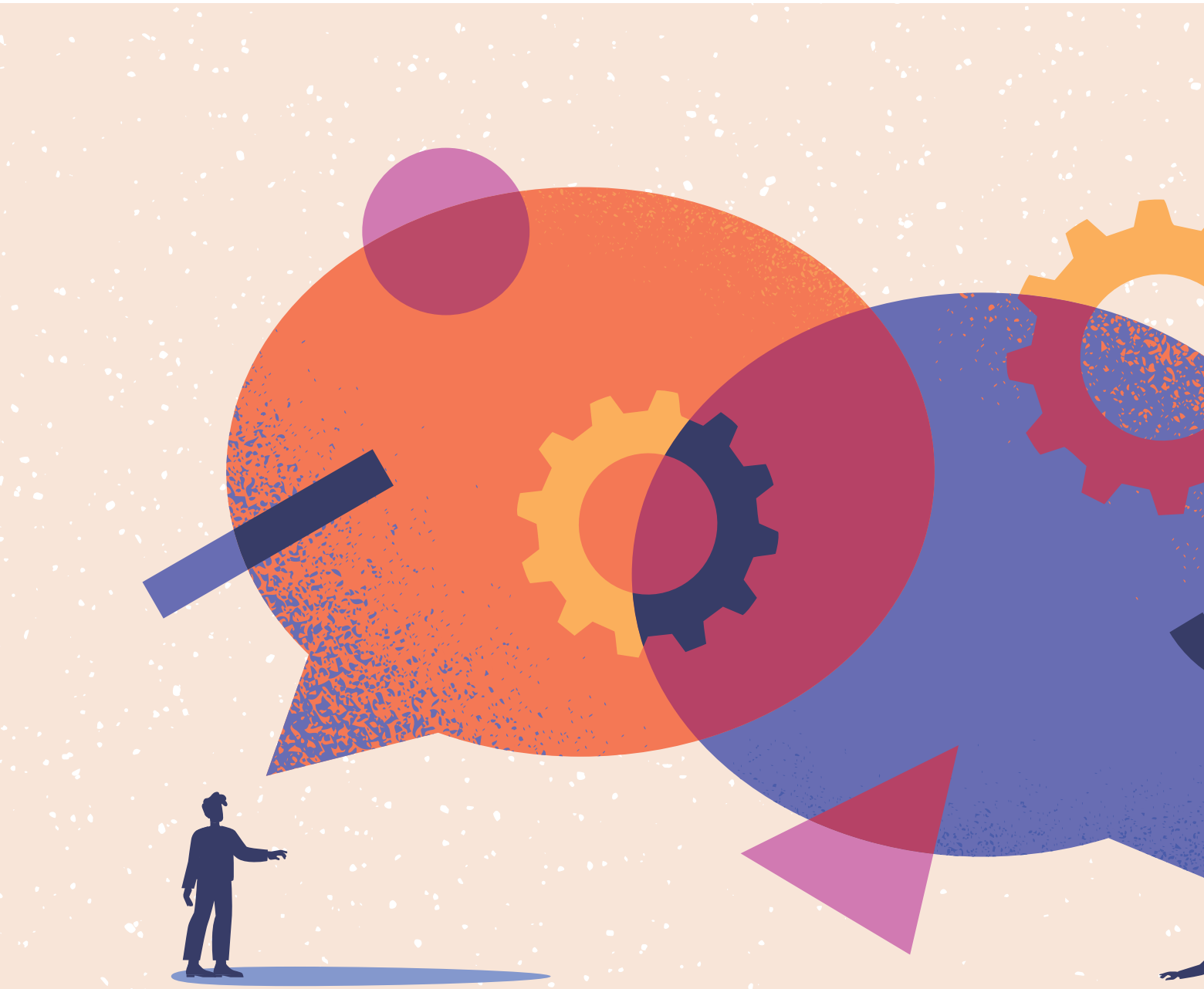
McCoy L, Pettit RK, Kellar C, Morgan C. Tracking active learning in the medical school curriculum: a learning-centered approach. J Med Educ Curric Dev. Jan-Dec 2018;5:2382120518765135. doi:10.1177/2382120518765135

Patel MS, Lypson ML, Miller DD, Davis MM. A framework for evaluating student perceptions of health policy training in medical school. Academic Medicine. 2014;89(10):1375-1379. doi:10.1097/acm.0000000000000408

Reddy S, Obremskey A, Hochman M, Schaff P, Harlan G, Saluja S. The impact of a new curriculum on medical students' interest in and knowledge of health systems science. Healthcare. 2020/06/01/ 2020;8(2):100409. doi:https://doi.org/10.1016/j.hjdsi.2020.100409

Rook JM, Winkelman TNA, Fox JA, et al. Looking to the future: medical students' views on health care reform and professional responsibility. Acad Med. Sep 2019;94(9):1361-1368. doi:10.1097/acm.0000000000002621

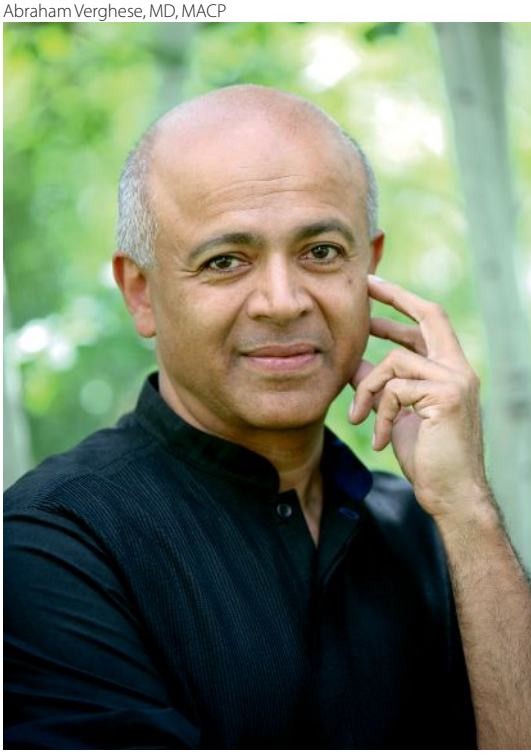
Smith T, Better care through deeper understanding of policy and economics. Accelerating Change in Medical Education. AMA; 2017. https://www.ama-assn.org/education/accelerating-change-medical-education/better-care-through-deeper-understanding-policy-and



Vital stories

Author and physician **Abraham Verghese** says stories are essential in medicine, from diagnosis to the meaning of a patient's illness.

Abraham Verghese, MD, MACP



Abraham Verghese, MD, MACP, is the Linda R. Meier and Joan F. Lane provostial professor, and vice chair for the theory and practice of medicine at the School of Medicine at Stanford University. But far more people know him as a best-selling novelist and nonfiction author. And MMA members may know he is the featured speaker at the Empowering Physicians Conference September 21 in Minneapolis.

Verghese is known as an advocate of the physical exam, a skill he was drilled in during his medical training in Ethiopia and India before coming to the United States for his medical residency in 1980.

Verghese's first book, the nonfiction memoir *My Own Country: A Doctor's Story*, recalls his struggle to treat AIDS patients in eastern Tennessee in the early days of the epidemic. His latest book, the novel *The Covenant of Water*, was published this year. He received the Heinz Award in 2014 and was awarded the National Humanities Medal, presented by President Barack Obama, in 2015.

Verghese spoke to *Minnesota Medicine* about the value of low-tech observation and in-person interrogation in an era of incomparable scientific discoveries and technology. The interview has been edited for clarity and brevity.

I wanted to start by saying that I just finished your book, *My Own Country*, your first book—wonderful memoir. I was particularly struck by the vivid detail you used in describing characters and reconstructing events. I was impressed by the importance you gave to stories. Their importance to writing is obvious, but explain the significance of stories to medicine.

Well, I think stories are fundamental to medicine. When we see a patient, we take a history, and what is the history but a story? When you hear a story from a patient, even though the patient may deliver it in a sort of impromptu and less organized manner, we train our medical students to take that story and translate it into a very clear beginning and then asking all the positive and negative elements that help them construct a sort of diagnosis. And so, history becomes a very important tool of diagnosis.

I mean, it's often the case that patients will begin to tell me a story, and I don't stop them. I've already intuited where the story is heading and what the diagnosis is. If you interrupt them and say, "Oh, I know what this is," it's actually distressing to them. They have a need to tell the story. We have a need to take that story and match it with our repertoire of stories. And the longer you're in the business, the more extensive your repertoire, and you try and match it with the elements that you're looking for. And you come up with a potential diagnosis.

And then, when you do the physical exam, to me that's another form of story. You're reading the body for the story the body's telling. So I really think story is fundamental to medicine.

And there's a third level where story operates. Very often, whether we know it or not, we become the spokespersons for a patient's illness. My father underwent some prostate surgery and, you know, I

waited for the surgeon, and he told me everything that had happened. And then I fielded phone calls from all my brothers and extended family, and I found myself repeating exactly what the surgeon had said. Basically, the surgeon had become the spokesperson for the story of that illness.

You had a long discussion toward the end of the book about the satisfaction of percussing a patient, percussing your own body, percussing the tabletop and everything else. It was a wonderful passage. You've been portrayed as a champion of the physical exam and the importance of the initial inventory upon meeting a patient. Talk about that a little bit and it's importance as a ritual for the satisfaction of the patient.

The physical exam—that's become the thing that I'm known for within medicine, and I believe that physicians 100 years ago were very, very good at it. With all our technology and ways of confirming what we suspect in real time, you would think that we would get even better at the skill because we can confirm what we're seeing. Paradoxically, we've gotten a lot worse. People are just getting more and more sloppy, and I think as a result, we're missing a lot of diagnoses. We're missing a lot of low-hanging fruit and thereby exposing patients to unnecessary radiation or tests and even to surgical misadventure and diagnostic error.

I think there will always remain a role for the physician reading the body, even if machines can do it better, because you don't always need the machine for something say as obvious as shingles. This is a great example—a patient comes in with chest pain and goes to the cath lab. And only as contrast is being injected, does somebody notice that there's a rash that looks like teardrops on rose petals along a rib. And that this is really, you know, shingles. Those kinds of errors are easily avoided by doing the exam that we claim to be doing on the forms we bill with.

But as you point out, more importantly, there's an important ritual aspect to this. If you think about it, you're seeing a stranger and putting them in this room that has furniture so different from the furniture in your house and mine. And one person is, you know, wearing a shamanistic white outfit, and the other is wearing a paper gown that no one knows how to tie or untie. And then, incredibly, one individual tells things to the other that nobody would normally tell a stranger. And then even more incredibly, one member of this dyad disrobes and allows touch, which in any other context in society is assault. But the great privilege of being a physician is you get to do this in the context of a skilled examination.

My sense is that patients are very, very astute observers of your technique. You and I are really good at picking up on when a mechanic or a barista or a hairdresser is being sloppy. Even if we can't do what they do, we understand when someone's doing something very well. And so in that same vein, I think it's important for physicians to do the examination with some skill. If you just wind up doing a half-ass prod of the belly and stick your stethoscope on the paper gown, the patient's on to you. It has all the trappings of ritual, and rituals are all about transformation. When you shortchange the ritual, the transformation that I think you miss is the ceiling of the patient-physician relationship.

Given the importance of observation, physical contact, and initial impressions, what do you think about the increasing use of telemedicine and Zoom meetings, even after the epidemic?

You're limited by the nature of the interaction on Zoom or on telemedicine. But I do think it has a role. I think during COVID, I was deeply impressed that for all our lip service about the social determinants of health, it was really interesting how for the first time I was getting a glimpse into the patients' homes—recognizing that someone is making their call from a car parked outside a Holiday Inn because they don't have Wi-Fi, or they're in this one room with so many family members, or they have a significant other or pets that are hugely important in their life and something that you may not have registered. So I think it has its own strengths, but it has considerable weakness, too. As long as we're aware of that, that's fine.

> "I mean, it's often the case that patients will begin to tell me a story, and I don't stop them. I've already intuited where the story is heading and what the diagnosis is. If you interrupt them and say, 'Oh, I know what this is,' it's actually distressing to them."

***The New York Times* recently proclaimed that, quote, suddenly, it looks like we're in a golden age for medicine, end quote, and they were referring to genetic engineering of vaccines, to characterizing the genome, to development of new drugs, to artificial intelligence for diagnoses, and so on. Do you share that enthusiasm?**

Yeah, absolutely. I don't think I've ever lived through a period of time more strik-

ing. It's just truly astonishing. You know, that doesn't always translate directly to the patient experience. If you speak more narrowly about the patient experience, sometimes patients are completely lost, like the hospital in charge of my care—when are they going to come and tell me what they're doing? Meanwhile, the physicians are often feeling like they're busy doing everything they need to be doing. But in the absence of clear communication, you wind up spending a lot more time on the computer than feeling that you're caring for the patient. And you are, because everything is channeled to the computer, but the patient doesn't always register that. And so I think that's why I'm a great fan of the major advances in science, but it's not necessarily being translated to the patient experience.

I have intuited and heard directly about a lot of frustration on the part of physicians about computers and electronic health records. It seemed to promise so much, but they speak as though it feels like a real barrier between them and patient care. It's a time sink. It's an awkward thing to be typing this information if you don't have a scribe. What are your feelings about it?

Yeah, I completely agree. I mean, I think hospitals have spent literally billions of dollars. And you know, it isn't designed for our use. It's designed solely to capture every last cent in the system, OK, and to bill accordingly. It was never designed for the ease and comfort of the physicians or the nurses. It really is a very poor interface for physicians. We wind up spending—these are well-documented studies from a woman called Chris Sinsky [Christine Sinsky, MD, vice president for professional satisfaction at the American Medical Association, as well as a primary care physician in Dubuque, Iowa]. She has shown that for every one hour cumulatively that we spend with patients, we're spending one-and-a-half hours on the inbox and the documentation. Mind you, this in an era when we have the technology that should allow us to get past that. So there's some excitement that finally, finally, finally natural language processing and AI might be able to relieve this burden of mindless documentation for the sake of billing. I think right now, we're the highest paid clerical workers in the hospital.

> "I think it's important for physicians to do the examination with some skill. If you just wind up doing a half-ass prod of the belly and stick your stethoscope on the paper gown, the patient's on to you. It has all the trappings of ritual, and rituals are all about transformation. When you shortchange the ritual, the transformation that I think you miss is the ceiling of the patient-physician relationship."

You mentioned natural language and artificial intelligence. You've written about the difficulty in talking about death. Knowing about the compassion and empathy for patients that you write about, I have to ask you about ChatGPT, the artificial intelligence chatbot. I've read that some doctors are using ChatGPT to write scripts that they can use in telling patients about difficult medical conditions.

I mean, it's not a terrible idea in the sense that it gives you some ideas. We, most of us, never were really coached on how to break bad news or talk at the end of life. And we learned, I guess, by watching our peers and by figuring out what works. So when we now teach it, we actually do teach people to follow sort of a script and a method. With ChatGPT—provided that whatever is coming out is accurate—at least they're being thoughtful about it.

What is the greatest challenge facing medicine today?

I think it's cost. I think the cost has spiraled out of control. The red tape has made it so onerous on physicians. We give lip service to the importance of primary care, and we give lip service to the importance of geriatrics, but our whole reimbursement model is predicated on doing things to people, not for people. Put something into somebody or do a procedure on them, and you're reimbursed much, much more than if you spend a valuable one hour going over their medications and sorting things out for them. We basically are badly in need of some sort of payment reform, because it skews medicine towards doing more things to people, as opposed to doing things for them. It's become a very, very difficult thing to tackle because every group that's making money has their lobbyists in D.C. to make sure that anything that sounds remotely like it might challenge their income is going to be shut down.

In working with AIDS patients, the possibility of burnout, personal burnout on your part, emerged as a real threat late in the book. It's a big issue with physicians today. Thoughts and recommendations based on your personal experience with this?

Yeah, I think that I was experiencing burnout at that time related to the work I was doing in dealing with the patient population that was being marginalized. The disease came with a huge stigma that was far from fair. That was not something that other people with other illnesses had to wrestle with. This phenomenon is huge now. It's a much bigger phenomenon than it was before. Burnout is happening at epidemic levels and it's a huge waste in terms of training people in medicine, only to have them basically disappear. They're burned out, especially in primary care. The place that we need the most people is the place where we're struggling.

How do you deal with it?

Well, I think every system is doing their best to make workplace modifications. I think the C suite is finally listening about the number of keystrokes and certification that we have to keep doing. Every keystroke is another stone you're putting on the donkey's back. Honestly, none of these solutions are earthshaking, when the fundamental problem is that everybody's being asked to do more with less.

I think there's a form of moral injury that's taking place when physicians are recognizing that they just cannot do the job required—you know, see a new patient in 35 minutes. Hats off to you, if you can do that. I think it's incredibly hard to do that and feel like you're addressing their issues. It gives you the sense of being driven to practice the kind of corporate medicine that isn't in keeping with what we teach as being necessary and required.

"I think there's a form of moral injury that's taking place when physicians are recognizing that they just cannot do the job required—you know, see a new patient in 35 minutes. … It gives you the sense of being driven to practice the kind of corporate medicine that isn't in keeping with what we teach as being necessary and required."

Any parting thoughts? Anything we haven't touched on that you'd like to make a point of?

I noticed you read my nonfiction books, but you don't mention my fiction books. My latest book, *The Covenant of Water* is—

The reason is because my own background—I write nonfiction, I read nonfiction, more so than fiction, certainly. And so, tell me about your fiction writing.

To come back to your thoughts on story, story is the fundamental way that we educate our children. Stories are the way we make a map of the world. And it's always puzzling to me that given our dedication to stories and children, how I have a lot of colleagues who say, "Well, I don't read fiction. I'm a serious kind of guy. I only read nonfiction." I think, really? You've heard of *Uncle Tom's Cabin*? That book ended slavery in America. That one book captured the public's imagination and made slavery unpalatable. Or *The Citadel* in the UK. That book depicting mining conditions in a Welsh town basically caused so much outrage that it caused the generation of the National Health Service. So to me, fiction is the great lie that tells the truth about how the world lives.

Basically, you know, we make sense of our lived experience, much more by fiction and to resonating with what we're reading than any other way. Proust said, the reader is also reading themselves as they read the book. When we try to teach doctors about end of life, you can point them to a textbook, or you can point them to the story *The Death of Ivan Ilyich* by Tolstoy. If you want to teach about child abuse, you can point to *Bastard out of Carolina* by Dorothy Allison. And they will palpably feel what it is like.

We live much more rich lives, we put ourselves much more firmly in the shoes of our patients if we're reading fiction. Some of the greatest leaders I know in medicine have this in common—they tend to be unapologetic readers of good fiction and literature.

Here I am a writer. I provide the word, but the reader provides their imagination. And in middle space, they make this mental movie. It's theirs more than it's ours. It becomes their creation, which is the great joy of reading fiction. **MM**

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

PHYSICIANS' DAY AT THE CAPITOL

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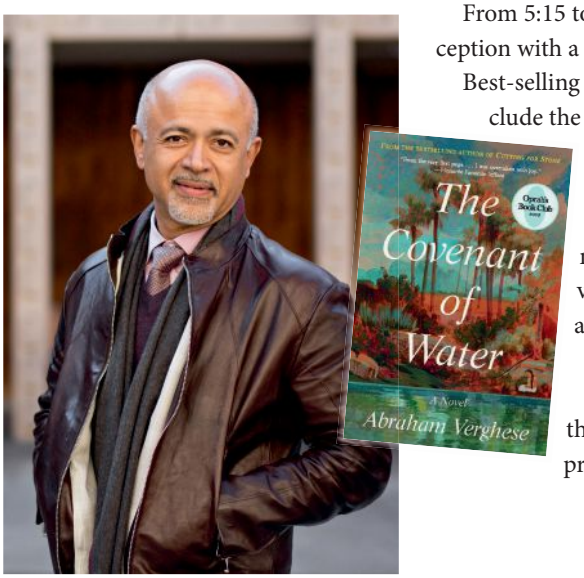
Empowering Physicians Conference promises a packed agenda

The Empowering Physicians Conference on September 21 at The Marquette Hotel in downtown Minneapolis promises to be an event full of robust discussion, learning, and entertainment.

Minnesota Health Commissioner Brooke Cunningham, MD, PhD, will kick off the event at 1 p.m. with a talk on how the state is partnering with Minnesota physicians to make Minnesotans the healthiest in the nation.

At 2:30 p.m., a three-person panel will discuss collective bargaining, private equity, and independently owned practices. Moderated by former MMA President Cindy Firkins Smith, MD, the panel will include Julia Reiland, JD; Rebecca Kolins Givan, PhD, and Michael Cumming, MD, MBA, FRCPC.

Reiland, a partner at Lathrop GPM in Minneapolis, advises healthcare organizations on complex business transactions and strategic partnerships. She has significant experience in joint ventures, affiliations, antitrust, governance, and contracting matters. She also counsels providers on state and federal regulatory compliance, including licensure, reimbursement, enrollment, HIPAA and state privacy, and participation issues.



Best-selling author Abraham Verghese, MD, MACP, will conclude the conference with a talk on refocusing the physician-patient relationship

Givan is an associate professor of labor studies and employment relations in the School of Management and Labor Relations at Rutgers University in New Jersey. She has published widely on employment relations in healthcare, comparative welfare states, and labor studies in journals such as *Social Forces*, *ILR Review*, and *British Journal of Industrial Relations*. Her recent book *The Challenge to Change: Reforming Health Care on the Front Line in the United States and the United Kingdom* was published in 2016 by Cornell University Press.

Cumming is a board-certified radiologist with a certificate of added qualification in vascular and interventional radiology. In 2020 he cofounded Edina-based Vascular and Interventional Experts (VIE) in partnership with the Infinite Health Collaborative. VIE is the first comprehensive outpatient vascular center in the Upper Midwest with a state-of-the-art Interventional Suite and CT scanner.

At 4 p.m., Martin Stillman, MD, JD, will lead a workshop on conflict resolution. Stillman has expertise in mediating conflict within healthcare, and understanding and minimizing physician burnout. He is a practicing internist at Hennepin County Medical Center, where he also serves as the mediation and conflict resolution officer, an assistant director of the Institute of Professional Worklife, and assistant chief for department and faculty affairs within the department of medicine. He is also an associate professor of medicine at the University of Minnesota Medical School and teaches about medical error, medical malpractice, disclosure of unexpected patient outcomes, and the risk management aspects of physician-patient relations and communication.

From 5:15 to 6 p.m., attendees will gather for a networking reception with a cash bar and hors d'oeuvres.

Best-selling author Abraham Verghese, MD, MACP, will conclude the conference with a talk on refocusing the physician-patient relationship.

The conference will also include exhibit space where attendees can purchase Verghese's newest novel, *The Covenant of Water*, as well as meet with vendors such as MEDPAC, the MMA Foundation, and more.

To register, visit www.mnmed.org/ac23.

The premier sponsor of the conference is COPIC, the MMA's preferred medical liability insurance provider.

News Briefs

2024 Physicians' Day at the Capitol scheduled for February 28

Hundreds of white coats are expected at the State Capitol in St. Paul next winter as the annual Physicians' Day at the Capitol takes place February 28.

The MMA and several specialty societies are currently planning for the big day of advocacy. Stay tuned to *MMA News Now* for updates as the next legislative session approaches.

The day includes a visit from a pro-medicine legislator, instructions on how to maximize your time with lawmakers, and scheduled meetings with representatives and senators.

"Physicians' Day at the Capitol is a great opportunity to really influence the legislative process and advocate for how medicine is practiced in the state," says Dave Renner, MMA's director of advocacy. "We hope as many physicians and physicians-in-training can save the date as possible. We can really make things happen when a lot of white coats are seen at the Capitol."

Part of Minnesota's AMA delegation: David Thorson, MD (left); Cindy Firkins Smith, MD; John Abenstein, MD; Andrea Hillerud, MD; and Laurel Ries, MD.

MMA delegation has busy agenda at AMA Annual Meeting

At the June AMA Annual Meeting in Chicago, Minnesota's delegation at the House of Delegates submitted resolutions on supervised injection facilities, the creation of an ICD code for patients presenting with conditions related to racism; and revising the U.S. Standard Certificate of Death. All three were favorably received.

Members of the Minnesota delegation included Cindy Firkins Smith, MD; John Abenstein, MD; Andrea Hillerud, MD; George Morris, MD; Will Nicholson, MD; David Thorson, MD; Laurel Ries, MD; Ashok Patel, MD; and medical student Adrina Kocharian.

Minnesota's first resolution called on the AMA to support additional steps to allow the use of supervised injection facilities. The AMA reaffirmed its existing policy in support of supervised injection facilities.

The second resolution called on the AMA to advocate for the creation of an ICD code for patients presenting with conditions related to experiencing racism, including systemic racism and unconscious bias. This will provide physicians with a tool to document the clinical impact of racism within the clinical encounter. There was strong support for better data, yet concerns were raised whether current codes are already sufficient to accomplish this goal. The resolution was referred to the AMA Board for a final decision.

The third resolution asked the AMA to work to change the U.S. Standard Certificate of Death to add a check box to capture deaths while in custody and further categorize the custodial death using cause and manner of death and information from the "how injury occurred" section of the death certificate. This proposal, which was adopted, is intended to improve data for further research into the public health consequences of negative police interactions.

MMA board OKs policies on gun safety, suicide prevention

At its May meeting, the MMA Board of Trustees approved three policies—two dealing with firearm safety measures and one on suicide prevention. All three were submitted to the Pulse by the MMA's Public Health Committee.

One item included revising existing policy on firearm locks. Previously, MMA policy supported mandating the use of a locking device on all firearms stored in homes where children 18 years of age and younger are present or reside. The policy proposal submitted by the committee was amended by the board, and the adopted language states that the MMA supports mandating and promoting the use of locking devices on all firearms stored in the home.

Via the Pulse, this policy proposal generated 140 "yes" votes from members, 25 "no" votes. Six members voted "neutral."

A second item urged the MMA to support state legislation that authorizes the use of firearm ownership data for public health research or epidemiological investigations. It also directed the

MMA to support state and federal legislation to establish a waiting period of at least one week before purchasing any form of firearm in the U.S., as well as calling for background checks for all firearm purchasers. In addition, it directed the MMA to support legislation requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms. The policy proposal, as recommended by the committee, was adopted by the board.

This policy proposal generated 155 "yes" votes from members, 20 "no" votes. Two members voted "neutral."

The third item dealt with several recommendations the MMA should pursue on suicide prevention, including:

- Working to combat stigma regarding mental health conditions through the normalization of discussions around depression and suicide and screening of these issues.
- Supporting programs and policies that will work to address the social drivers of health with the goal of decreasing suicide risk.
- Supporting the incorporation of anti-bullying messaging into schools.
- Educating physicians and disseminating tools that encourage conversations between physicians and patients that use a harm-reduction approach, and that are tailored to each patient's needs.
- Supporting initiatives that aim to increase connectedness in one's community and family structure; promote culturally appropriate messaging about suicide; and provide individual, interpersonal, and community-level approaches to addressing and preventing suicide among these populations.
- Supporting and advocating for strategies to improve access and availability of mental health resources, such as increased funding for more mental health facilities and hospital beds, and increasing the numbers of psychiatrists and other mental health professionals, with attention to the shortages that exist in rural and underserved areas.
- Advocating for adequate coverage of mental health conditions by insurance providers. In addition, the MMA also encourages the investigation of new models of healthcare delivery that aim to ease the burden on current healthcare providers and increase the availability of mental health care services.
- Encouraging Minnesota's medical schools and residency programs to incorporate suicide risk assessment and management into their curriculum. The MMA will also encourage medical specialty societies to offer continuing medical education on assessing and managing suicide risk for their members. The MMA will also continue to promote physician participation in evidence-based suicide prevention training programs such as Question-Persuade-Refer (QPR) and Counseling on Access to Lethal Means (CALM).
- Continuing to work to address the factors and stigma that are contributing to suicide— among both physicians and physicians-in-training.

The policy proposal generated 166 "yes" votes from members, three "no" votes. Three members voted "neutral." This policy proposal, as recommended by the committee, was also adopted by the board.

The Pulse, available only to MMA members, can be used to submit policy proposals for MMA consideration, vote on policy proposals prior to MMA Board action, and provide feedback on decisions made by the board.

U.S. surgeon general: Social media can harm youth

A new report from the U.S. surgeon general warns that social media use can be harmful to the mental health of children and adolescents.

The report, *Surgeon General's Advisory on Social Media and Youth Mental Health*, was released in late May.

"Children are exposed to harmful content on social media, ranging from violent and sexual content, to bullying and harassment," said U.S. Surgeon General Vivek Murthy, MD. "And for too many children, social media use is compromising their sleep and valuable in-person time with family and friends. We are in the middle of a national youth mental health crisis, and I am concerned that social media is an important driver of that crisis—one that we must urgently address."

According to the report, 95% of young people ages 13–17 use a social media platform and more than a third say they use social media "almost constantly."

The surgeon general is urging policymakers, technology companies, researchers, families, and young people to gain a better understanding of the full impact of social media use, maximize the benefits and minimize the harms of social media platforms, and create safer, healthier online environments to protect children.

In December 2021, Murthy issued a report calling attention to the national crisis of youth mental health and well-being. Earlier this month, he released a report outlining the profound health consequences of social disconnection and laid out six pillars to in-

crease connection across the country, one of which was the need to reform digital environments.

MN Supreme Court hears case on state health records act

The Minnesota Supreme Court heard oral arguments in June in a case pitting the Minnesota Health Records Act (MHRA) against the federal Health Insurance Portability and Accountability Act (HIPAA).

Minnesota is one of only a handful of states that have a state health records law that offers more protections to patients than HIPAA. This has caused headaches for healthcare providers and facilities when they try to comply with both laws.

Parents of a patient at Children's Hospital Minnesota have sued the hospital for releasing their child's health records to its foundation without their consent. The parents have argued that the MHRA allows for the release of health records on only two occasions: (1) with the proper written consent of the patient or their representative, and (2) with specific authorization in law. The parents claim that because the MHRA generally provides more protections of health records, the specific authorization in law must come from a state law and that a federal law, such as HIPAA, cannot provide authorization. Both the district court and the appellate court that heard the case sided with Children's Hospital, finding that the specific authorization could come from HIPAA.

HIPAA allows for the use or disclosure of protected health information for "treatment, payment, or healthcare operations." This exception is broad and includes fundraising activities, which is the exception that Children's Hospital and other Minnesota facilities rely upon.

The decision made by the Minnesota Supreme Court will result either in additional burdens for facilities and healthcare providers as they work to comply with the very narrow MHRA, or it could result in the ability of facilities and healthcare providers to conduct their business activities without additional burdens but while continuing to protect patients' health information.

Two more ailments qualify for medical cannabis

The Minnesota Department of Health has added irritable bowel syndrome (IBS) and obsessive-compulsive disorder (OCD) to the list of qualifying medical conditions for participation in Minnesota's medical cannabis program.

Minnesota patients certified with either of these ailments can now enroll in the state's program and buy medical cannabis at a dispensary.

The two new conditions were approved last year during the department's annual petition and public comment process.

With the two newest additions, the medical cannabis program now has 19 qualifying medical conditions. For more information on qualifying conditions, visit the Office of Medical Cannabis website (www.health.state.mn.us/people/cannabis/patients/conditions.html).

Medication repository program off to strong start

Many Americans, including Minnesotans, skip doses or ration medications because of their high costs. To address this issue, states across the country have funded medication repository programs, which take in unused medications for redistribution.

Since late 2020, Minnesota's medication repository program, administered by RoundtableRx, has supplied 30,270 days of medications to Minnesotans.

Each donated product undergoes a rigorous quality and safety inspection by a pharmacist before being accepted for inventory. Clinics and pharmacies then order inventory from the repository program to dispense to under-resourced Minnesotans at little to no cost.

Since its inception, RoundtableRx has been operating under a pharmacy wholesale license, which enables it to redistribute medications through partnerships with clinics and pharmacies. These partner sites assume the role of dispensing repository medications to patients in need.

RoundtableRx's medications are reserved for Minnesota residents who are uninsured or "underinsured." Because its inventory fluctuates, RoundtableRx is intended as a safety net program for affordable medications during challenging times (coverage lapse, Medicare "donut hole," etc.), or for patients who do not qualify for insurance.

Prescribers and pharmacists interested in accessing these medications for their patients can learn how on the RoundtableRx website (www.roundtablerx.org/partner).

FROM THE CEO

A little bit of horn tooting

One of the MMA's current strategic priorities is to be recognized as a credible and valuable resource and leader. This spring, the Board of Trustees set out to measure our progress toward that goal by commissioning a "reputation audit"—qualitative research aimed at capturing feedback from critical stakeholders across the state about MMA and our work.

Over the course of approximately two months, our research consultant, Rapp Strategies, conducted 26 one-on-one interviews with key leaders from healthcare, business, government, community, and media organizations.

The research results found that the MMA has an overall positive reputation, which is extremely gratifying. Most participants agreed the MMA is focused on improving healthcare for all Minnesotans and recognized us as a respected healthcare leader in the state. Participants widely regarded the MMA as an effective advocate for Minnesota physicians. When asked to describe the MMA, the most cited descriptions were member-focused, policy expertise, nonpartisan, collaborative, public health–focused, and strong voice.

In considering specific advocacy issues, most participants agreed that the MMA was effective in its efforts to improve access to care, to enhance public health, to strengthen the quality and safety of patient care, and to improve the practice climate for physicians. Although most participants understood the MMA's commitment to advancing health equity, they were unable to assess our effectiveness in doing so. The issue most participants recommended that the MMA work harder to address was reducing healthcare costs.

There is much to be proud of in these results. There is also room for improvement. MMA leadership will use these results, along with prior research on physicians' attitudes and opinions, to continue to refine our ongoing work to make Minnesota the healthiest state and best place to practice medicine.

Speaking of our ongoing work, I am proud to share that in July some of the MMA's recent work was recognized by the American Association of Medical Society Executives (AAMSE). The group's Profiles of Excellence (POE) awards acknowledge the work of medical societies that make positive impacts on their members and in their communities. The MMA's special publication, *Health, equity, racism and the Minnesota Medical Association*, was selected as the winner in the Membership category in the large organization division. This publication, published as a supplement to the November/December 2022 issue of *Minnesota Medicine*, includes a historical analysis of MMA's role in perpetuating racism/discrimination as well as a progress report on MMA's health equity activities. The MMA's Advocacy Champions program, which profiles physicians who are involved in advocacy to improve health and healthcare in Minnesota, was selected as the winner in the Advocacy category in the large organization division. And the MMA's implicit bias training, which has reached nearly 500 physicians and other healthcare professionals to date, was selected as the runner-up in the DEI category in the large organization division. AAMSE is the professional association of more than 1,300 medical society executives and staff specialists from more than 300 member organizations, including county, regional, state, state specialty, national, national specialty, and international medical societies, as well as affiliated healthcare organizations and industry partners. It is a real honor to be recognized by our professional peers.

I may have challenged the Minnesota tradition of modesty and humility by sharing the results of our reputation audit and our three recent awards. But as a dues-paying member of the MMA, you deserve to see the results of your investment—results for which all staff and leaders are very proud. There is, of course, more work to do and challenges to overcome, but we have a solid foundation to build upon and a clear vision for our future.

Thanks for your continued support.

Janet Silversmith
JSilversmith@mnmed.org

VIEWPOINT

Changing the face of medicine, despite the hurdles

PHOTO BY KATHRYN FORSS

Edwin Bogonko, MD, MBA
MMA board chair

For far too long, it's been a difficult task to get individuals from underrepresented backgrounds into medicine's ranks. A case in point—in 1978, Black men accounted for 3.1% of the national medical student body. By 2019, a span of 40 years, the comparable figure was 2.9%.

The task became that much more difficult in late June, when the U.S. Supreme Court ruled in a 6-3 majority decision that admissions programs at Harvard College and the University of North Carolina cannot consider race as one of the factors in deciding which of the qualified applicants is to be accepted. The ruling effectively ends the consideration of race as a factor in admitting students to higher education, and it's a critical blow to our physician workforce diversification efforts.

"This ruling will make it even more difficult for the nation's colleges and universities to help create future health experts and workers that reflect the diversity of our great nation," said Health and Human Services Secretary Xavier Becerra in a statement. "The health and well-being of Americans will suffer as a result. We need more health workers, especially those who look like and share the experiences of the people they serve."

Since the 1960s, affirmative action has been an effective tool to help students from underrepresented backgrounds get into colleges, universities, and other professional schools. It has leveled (or at least tried to level) the playing field, opening doors for students from marginalized communities who have made the grade.

Developing a more diverse physician workforce is crucial in the fight to ensure that everyone has an equal opportunity to live the healthiest life possible. Affirmative action has played a significant role in improving the diversity of the healthcare workforce—but with the court's ruling, many are now working to reevaluate diversity initiatives in medical education and what needs to change.

As we observe and absorb what has transpired, it is clear the court's decision shows a lack of understanding of the essential benefits of racial and ethnic diversity in educational settings and a failure to recognize the urgent need to address health inequities in the U.S. Multiple studies have shown access to physicians who look like and speak the language of patients they see translates into better care.

The need to find ways to increase opportunities for underrepresented minorities is not dispensable. Research suggests that a diverse physician workforce could help to advance cultural competency and increase access to high-quality healthcare, especially for underserved populations.

The MMA is committed to changing the face of medicine to ensure that it is more diverse. For example, the MMA Foundation (MMAF) has created "Changing the Face of Medicine," a dedicated campaign to support initiatives that tear down the barriers that stand in the way of too many whose dream is to become a physician (www.mnmed.org/about-us/mma-foundation/changing-face-medicine).

Please donate to the fund and support local initiatives that show promise to diversify the physician workforce. Our initial priority is to offer grants to pay Medical College Admission Test fees for students who come from Black, Indigenous, and other backgrounds underrepresented in medicine. The MMA and the MMAF have plans to address other nontuition barriers and support opportunities to expose students to careers in medicine. We call on Minnesota's physician community to lend their experiences, expertise, and voices to programs such as our MMA Mentorship Program and other opportunities that we have planned to work to diversify our physician workforce.

The court's decision is certainly a roadblock, but it will not dissuade us. The MMA is committed to strengthening the diversity of the physician workforce to improve health outcomes, improve patient trust and satisfaction, and ensure that our physician workforce is equitably representative of the racially and ethnically diverse populations that it serves. "You can't be what you can't see"—a message that we hold close as we lift up the work needed to change the face of medicine. Let's be bold to state, "I am well if you are." **MM**

VEDA BELLAMKONDA, MD

- General pediatrician at Partners in Pediatrics Brooklyn Park.
- MMA member and *Minnesota Medicine* Advisory Committee member since 2020.
- Grew up in Mansfield, Ohio, a small town north of Columbus.
- Accepted into a combined BS/MD program out of high school. Undergraduate degree in biology. Attended The Ohio State University for college and medical school. Had the honor of being a Buckeye for seven years!
- Moved to Minnesota to be closer to my family, who now live in Rochester. Have the privilege of being an aunt to three amazing nephews ages 10, 8, and 3. Currently live in Plymouth with my boyfriend of seven years.

Became a physician because…

I was sick as a child and wanted to help others in the way I had been helped. I was a premature infant with refractory hypoglycemia and required admission to the NICU after birth. I know I wouldn't be where I am today without the help of the exceptional physicians who helped resuscitate me and save my life as a newborn.

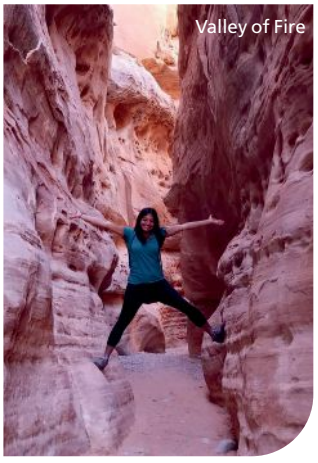
How I keep balanced…

As I am child free I have plenty of time to pursue hobbies and interests. My boyfriend and I are massive nerds. We plan our lives around Marvel and Star Wars movie release dates. Four years ago we started cosplaying and going to comic-cons, and it has been a blast! I have enjoyed cosplaying as several characters, including the Scarlet Witch, Captain Marvel, Rey, and Hela. I have had the privilege of meeting many amazing celebrities such as Chris Evans, Sebastian Stan, Elijah Wood, Hayden Christiansen, and Billy Dee Williams. My love for and immersion within nerd universe provides a needed escape from the challenges of daily life.

At Chicago Comic & Entertainment Expo with Chris Evans

I am obsessed with food. I take an inordinate amount of pleasure in eating. Trying new restaurants and indulging in my favorite foods adds a ton of enjoyment to my life. In my mind there are few joys greater than a delicious burrata, balanced cacio e pepe, or a spicy khadai paneer.

I love to travel. This past March I spent a fantastic week in Spain. I enjoy hiking (but only when the weather is nice!). A few years ago I spent a week hiking at Yosemite—definitely one of the best weeks of my life. I also had the pleasure of rock scrambling at Valley of Fire State Park in southern Nevada. On a day-to-day basis I find balance by spending time outdoors, walking around Lake Harriet and following the River Walk at Minnehaha Falls.



Valley of Fire

I love to read. Some of the best books I have read this year include *Rest is Resistance, Sorry I'm Late, I Didn't Want to Come,* and *Dopamine Nation*. Regular prayer and my church community help me find balance and peace as well. Of course spending time with my nephews is the greatest joy of my life.

If I weren't a physician…

In my dream life where I no longer need a steady income I would be a professional traveler, food critic, and cosplayer. In reality when I stop practicing medicine I will likely pursue environmental and social justice work full time, as I currently engage in this work on the side of practicing medicine. As a child I dreamed of being a writer and would love to pursue this as well.

Involvement in urban health…

I have the privilege of working with a very diverse patient population to help address their medical concerns as well as address numerous social determinants of health. In addition to pediatric medical providers, our clinic has a behavioral health specialist who can help address mental health and behavior concerns. We also have a community-connect person to help address food and transportation insecurity as well as help with child care programs, educational programs, and legal concerns. Our clinic also frequently gives out food boxes containing nonperishable food items to families struggling with food insecurity. As we know, many health problems in our society are largely due to systemic inequity and social determinants of health, and I'm blessed to be able to help address all of these issues. **MM**

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