THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

NOV/DEC 2022 • $9.99

How to recognize—and be—a good physician

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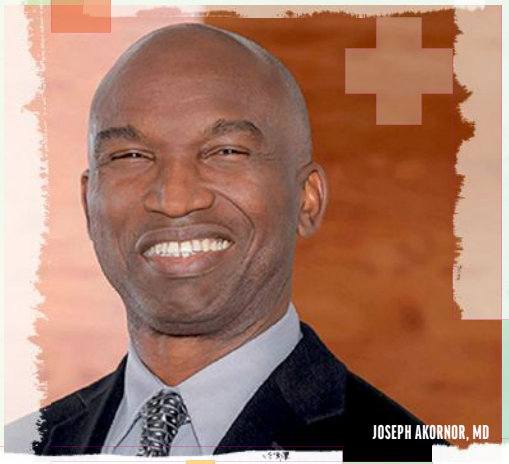
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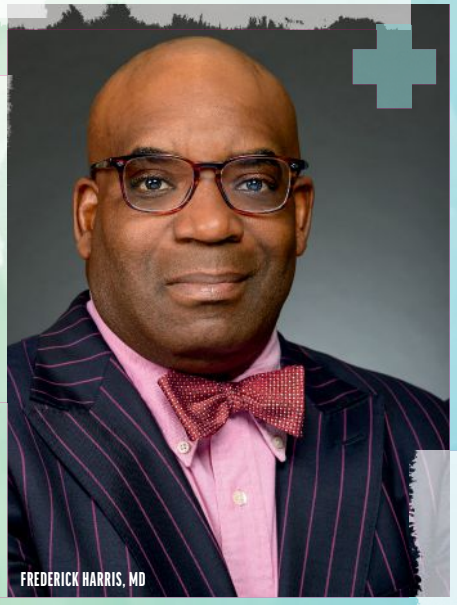
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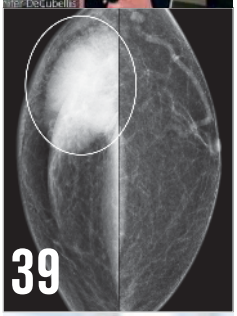

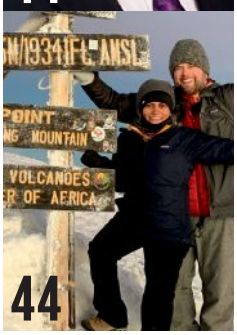

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Colin West, MD, PhD

Is the perfect the enemy of the good?

We aspire in medicine to help every one of our patients live their best possible life. As my dear departed colleague Ed Rosenow, MD, famously stated in his Platinum Rule of Medicine: "Treat every patient the way you would want a member of your family treated." There are numerous qualities that help physicians meet these goals. We all know them well, including curiosity, dutifulness, empathy, humanity, medical knowledge, respect, technical skill, and trustworthiness.

It is incredibly uplifting to see our efforts positively affect patients and their families. The meaning and purpose behind our work shines with clarity in these moments, and energizes us for the next challenges we know we will face. And yet, physicians and other healthcare professionals struggle under the weight of these challenges. A fundamental tenet of medical professionalism is the primacy of patient welfare, a value that should resonate with all healthcare professionals. Altruism associated with this tenet, however, is widely misunderstood as a concept without boundary. In fact, without necessary parameters, these efforts can lead to "pathological altruism" as defined by Barbara Oakley and colleagues: altruism in which attempts to promote the welfare of others instead result in unanticipated harms.

Consider two obvious parallel examples. First, as many of us return to air travel, we have become reacquainted with the safety instruction to "secure your own mask before assisting others." When was the last time anyone reacted to this instruction with a protest that this behavior would be unprofessional and selfish? We inherently understand that to optimally help someone else, we have to be safe ourselves.

Second, a medical career is commonly described as a marathon rather than a sprint. The world record for the marathon was recently lowered to just over 2 hours, a pace of well under 5 minutes per mile. To be fair, that would represent an unsustainable sprinting pace for me, but for the sake of further comparison, Usain Bolt's 100 meter record time of 9.58 seconds equates to a pace of under 3 minutes per mile! The point is that not even the world's greatest sprinters can sustain a true sprint for long distances without collapsing, and yet this is what we seem to expect of physicians.

Not even the world's greatest sprinters can sustain a true sprint for long distances without collapsing, and yet this is what we seem to expect of physicians.

Individually, we will always place patient needs before our own and aim for perfection. Without boundaries and support, however, the aim for individual perfection in medicine will often paradoxically compromise our ability to deliver even good outcomes. We need to understand (and more importantly, our practices, organizations, and the healthcare system as a whole need to understand) that as human beings, we require rest and renewal; when we become depleted, we cannot achieve our aspirations for ourselves or for our patients. Striving for perfection on our patients' behalf should always be our goal, but this must occur within a medical system that recognizes the need to shift the burden of this goal from each individual alone to a distributed expectation supported across the healthcare system as a whole. **MM**

Colin West, MD, PhD, is professor of Medicine, Medical Education and Biostatistics, Mayo Clinic. He is one of three medical editors for *Minnesota Medicine*.

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Neuromodulation

STIMULATING THE BRAIN CAN HELP WITH SERIOUS DEPRESSION

BY LINDA PICONE

For decades, psychiatrists have known that the single most effective treatment for serious depression is electroconvulsive therapy, says Alik Widge, MD, PhD, psychiatrist and biomedical engineer, University of Minnesota Medical School.

"But that is technically challenging because it requires a psychiatrist, anesthesiologist, and trained nurses, and it has to be done in a hospital and it's got a lot of uncomfortable side effects for the patient," he says. "When they need it, they need it, but they don't like it."

So, Widge says, the question psychiatrists have been exploring is whether they can come up with treatment that is more precise. "Instead of resetting the whole brain, could we just adjust the activity of a single connection, a single communication link, or a single network that's not doing what we and our patients want it to do?" he says. "That is the realm of interventional psychiatry. We think in terms of the delivery of small targeted amounts of electricity to to nudge or adjust different parts of the brain." Two treatments that do this are transcranial magnetic stimulation and vagus nerve stimulation.

Transcranial magnetic stimulation (TMS) uses a small but powerful electromagnet, which is placed against the side of a person's head. It pulses magnetic energy that the brain picks up and then converts to electrical energy that changes the activity of the brain cells directly under the magnetic flow.

"It changes them in a complex biological way that we are still developing and deepening our understanding of," Widge says. "It appears to increase or augment the activity of whatever portion of the brain the electromagnetic coil is being aimed at."

The primary site for treatment in depression is the dorsal lateral prefrontal cortex (DLPFC), which is involved in executive function and decision-making. "It's the part of the brain that we engage when we need to think about what the right approach to a problem is, when we really need to ponder whether we need to change our strategy or how we interpret the world," Widge says.

"Instead of resetting the whole brain, could we just adjust the activity of a single connection, a single communication link, or a single network that's not doing what we and our patients want it to do? That is the realm of interventional psychiatry. We think in terms of the delivery of small targeted amounts of electricity to nudge or adjust different parts of the brain."

—ALIK WIDGE, MD, PHD

"What we think we're doing for our patients is maybe making it possible for them to get unstuck from negative thought loops. People with depression often get stuck in negative thought loops that become a self-reinforcing, self-perpetuating pattern. 'Well I can't possibly, I don't think I can do that so I'm not going to try, and now I feel bad about myself for not trying.'

"Or there's something in their life that causes them a lot of distress and they're not able to disengage from that enough to say, 'Okay, this is distressing me but I'll feel better if I take a walk or apply for a new job or start to work on this relationship.' Or even as simple as saying, 'Maybe there's a way out other than killing myself.' All of these are examples of flexible thinking. What we think we're doing with TMS is giving patients that little bit of extra that lets them start to take the next step on their own."

TMS is an office-based treatment of 30-minutes per session, five days a week for six weeks. "The main side effect is a slight headache," Widge says. "They can leave the office and go back to work, go back to class, but now with improved ability to function."

He says that about 60% of those treated with TMS end up feeling better—and that result lasts for about a year. After that, they may relapse and suffer depression again, and then will need to be treated once more. Often, Widge says, talk therapy augments TMS both during and after the treatment.

TMS is available at multiple centers in the Twin Cities and it's available in Duluth, Widge says, but it's not easily available in rural Minnesota—areas that have plenty of people with treatment-resistant depression—because of the distance patients would have to travel daily for treatments for six weeks.

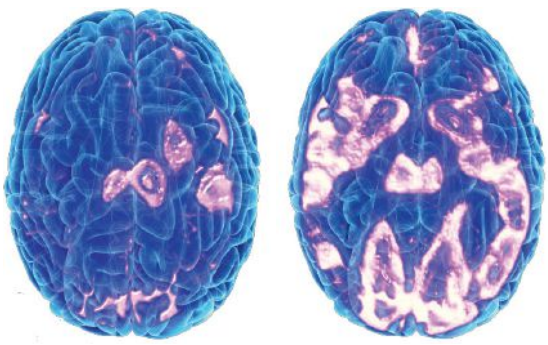
"One of the things we've started talking about with the company—Magstim—is how would we scale this to cover all of Minnesota?" Widge says. "We're thinking about questions like: Does this have to be a physician-supervised treatment? Could we build a device that could used in someone's home if they were being carefully supervised by video? Could we find a way to embed it in primary-care clinics with remote supervision and assistance from an expert psychiatrist?"

These questions are being explored by the University of Minnesota and Magstim: "It's us, as the University, working with a Minnesota company to do something that's really a public health, Minnesota-communities-in-need, mission-driven kind of thing," he says.

Widge says the more urban, minoritized population would also benefit from greater availability of TMS. For this population, time and lack of knowledge—and trust—often stand in the way of treatment for depression. But with TMS developed by Magstim, "all you need is to be able to reliably get to where the machine is located and then go back to work." He says work is currently going on to understand the needs of that urban community—"which is massively underserved by advanced psychiatric treatment"— in order to determine what kinds of treatment would be accepted and successful.

Vagus nerve stimulation (VNS) is done through an implantable device that stimulates the vagus nerve with electrical impulses. This device is currently FDA-approved for treatment of epilepsy and depression.

For the average person with treatment-resistant depression, Widge says, TMS treatment lasts about a year, but for some people, TMS with or without medication may only last two or three months. Since the TMS treatment is daily for six weeks, it doesn't make sense to continue it if it doesn't last for a sufficiently long time. For patients who don't get the full benefit of TMS, a VNS implant gives electricity to a little nerve in the left side of the neck. "It's surgical, but it's not brain surgery," Widge says. "It's mechanisms we do not completely understand, but in some way it appears to modulate the brain."



In depressed patients the electrical activity in certain areas of the brain is reduced *(illustration based on PET scans)*

Widge says VNS appears to be an adjunctive treatment, used in combination with other kinds of treatment to help make them more successful. "If something else gets the patient better, VNS can keep them better," he says. "If they would have gotten three months from TMS, now they get a year or they get two years. So we can make treatment that wouldn't have worked, work for them."

He says there is some animal data and anecdotal human data that VNS works especially well in cases where severe depression is being caused in part by trauma. "One of the things I've come to understand is that the prevalence of childhood sexual trauma or early life sexual adversity is far higher that the average American—or even the average physician—understands," he says. One theory is that past trauma means that these patients are in a constant state of fight-or-flight response. The vagus nerve, which VNS targets, is the main component of the parasympathetic nervous system. What VNS may do, Widge says, is "turn down the background noise." Patients who get a VNS implant report increased coping skills, he says. "They are better able to feel okay with all the slings and arrows that life throws at us."

Researchers at the University of Minnesota have won a multi-million-dollar NIH grant to map out what functions in the body VNS is impacting. Widge says the University is now the leading center in the country that NIH has funded to research what the vagus nerve does when it is stimulated. "And that is because of the unique convergence in Minnesota of biomedical engineering devices and clinical expertise."

Deep Brain Stimulation (DBS), which implants electrodes in areas of the brain, is more experimental for psychological issues like depression. It is used for treating Parkinson's disease, but the same technology can be moved to target other parts of the brain. Widge's clinical research currently is looking at whether DBS can be used for severe depression and obsessive-compulsive disorder. "DBS is more invasive; it is actual brain surgery. It involves having something surgically placed in the brain. But, in the right hands, we can take patients who haven't responded to anything else—not medication, not even electroconvulsive therapy, not TMS—and two-thirds of them will get better. That's not 100%, but we think that's pretty good odds when literally your choices are brain surgery or suffer for the rest of your life."

TMS and VNS are available now, but Widge says he thinks that many primary care providers who see patients with symptoms of depression are not aware of them. "Many physicians just don't know that if your patient has tried a bunch of medications and is still having significant depressive or anxious symptoms, there are options, there is hope, there are technologies available right now," he says. "You can refer them to the neuromodulation program at the University and we can at least talk to them via telehealth and then work with them to find appropriate locations for treatment." MM

Linda Picone is editor of *Minnesota Medicine*.

Supplying more than 20%

Community Health and Wellness Hub hopes to reduce barriers to healthcare

BY LINDA PICONE

Sanneh Foundation, with Second Harvest Heartland, offers food-centered operations at the Hub.

The health of an individual and of communities depends on many factors, from genetics to finances to race and racism and more; most estimates are that only 10% to 20% of health is determined by traditional healthcare—physicians, clinics, and hospitals.

Fairview Health Services, faced with decisions about what to do with St. Joseph's Hospital in St. Paul, decided it was important to do something different, says James Hereford, president and CEO. "As we looked at the footprint of the hospital and at the community, it was clear that a traditional community hospital was not meeting the unique needs of the community," he says. "People were getting primary care in the ED, for example. We decided to think bigger: What could be the offering?"

The answers, he says, were determined through a three-year process that involved the community and that reflected the history of the hospital, which was founded by the Sisters of Carondelet in the 1850s in the middle of a cholera epidemic. Just as the Sisters responded to the health needs of the community at the hospital's founding, Fairview Health Services, which acquired the hospital in 2017 in its merger with HealthEast, wanted to create something that would respond to current needs.

In 2021, Fairview surveyed St. Paul residents to see what they wanted and needed in health services. More than half of those who responded said existing health services didn't meet the needs of the community, especially for low-income, racial, or ethnic populations experiencing health disparities, and refugees. More than half of those who identified as persons of color said they face barriers to staying healthy.

The Fairview Community Health and Wellness Hub opened in August. While it has some of the essentials of traditional medical care, including the St. Paul Wellness Center, a community health clinic operated by Minnesota Community Care, the largest federally qualified health center in Minnesota, the Hub also includes services not normally seen at a healthcare clinic.

Current partners and programs include:

- St. Paul Wellness Center, a community clinic with affordable primary care, wellness services and education, preventive medicine, chiropractic care, and gender care.
- M Health Fairview Mental Health & Addiction Services, with expanded outpatient care, including psychiatry, addiction medicine, and psychotherapy. The clinic also has same-day or next-day appointments for transitional care and mental health bridging services.
- Fairview Frontiers conducts clinical trials of health technologies, wearable

"We have a long history in healthcare of tolerating a pretty significant set of health inequities. This provides a great platform for us to explore a very different way of being connected to the community. It gives us the opportunity to be shoulder-to-shoulder with partners on a daily basis and to find ways to work collaboratively."

James Hereford, president and CEO, Fairview Health Services

devices, and new therapies. Through its base at the Hub, interested individuals can connect to low-barrier and non-invasive medical research.

- Sanneh Foundation, in coordination with Second Harvest Heartland, operates food storage, distribution, and pop-up food shelves at the Hub. These food-centered operations also create job opportunities for young people in the community.
- Daybreak of St. Paul, expected to open this fall, is an adult day services program operated by Ebenezer, a subsidiary of Fairview Health Services. The program is intended to help underserved seniors maintain independent lives through an enhanced day experience.
- A Transitional Care Unit is expected to open in 2023, also operated by Ebenezer. New skilled nursing and transitional care beds will help address a critical shortage in the Twin Cities.
- M Health Fairview Center for Community Health Equity is headquartered at the Hub, with health equity and community engagement work expected to impact all of M Health Fairview. The Hub includes meeting and events space where Fairview and community partners can convene to develop new health equity programming.

Hennepin Healthcare in Minneapolis has some initiatives that are similar to programs at the Hub, Hereford says, but he doesn't think there are any organizations in Minnesota doing things at the same kind of scale. "There are various efforts by healthcare organizations, but they tend to be more single-threaded. They take on one aspect of healthcare, not the broad sweep we are doing."

UnitedHealthcare provided a $1 million investment to the Hub while also partnering with Fairview to launch a new Communities of Health program that creates an infrastructure for delivering fresh, Minnesota-grown produce, pantry staples, dairy, and protein to food-insecure Fairview patients in St. Paul. The partners will track health outcomes for patients participating in UHC's Minnesota health plans over the course of the program.

Diane Tran, system executive director, Community Health Equity and Engagement for Fairview Health Services, says that since the Hub opened in early August, more than 500 patients have been seen in the Wellness Center and roughly 100,000 pounds of food have been distributed each week. The Center for Community Health Equity is beginning to fill with different events. "People want to reconnect after a long period of pandemic separation," she says.

Will the Hub be a success? And how will success be defined? "The measures of success are not as precise as looking at hemoglobin A1C levels," says Hereford. "But we're advantaged because of our relationship with the University of Minnesota and some talented researchers there, as well as a national network of people committed to the same sort of goals, so we're able to tap into that expertise from an evaluation standpoint. We continue to evolve that evaluation schema, but we very much intend to be driven by the data."

Tran says there are opportunities to develop new measures of success. "Preliminarily, we will look at volume—the number of patients, the number of youth employed [as part of Sanneh's youth workforce development programming], the dollars spent on local businesses—but over time, we'll start to shift and be able to talk about the referrals between the co-located partners, some of the initiatives they are able to jointly create, and then what we can measure in terms of population health. We necessarily have to start with some of these rote counts, but that will become more sophisticated over time."

Community connection, which helped shape the Hub, will also be important in determining what additional programs and partners might belong there, and in deciding whether it's a success, both Hereford and Tran say.

"We have a long history in healthcare of tolerating a pretty significant set of health inequities," Hereford says. "This provides a great platform for us to explore a very different way of being connected to the community. It gives us the opportunity to be shoulder-to-shoulder with partners on a daily basis and to find ways to work collaboratively." **MM**

Linda Picone is editor of *Minnesota Medicine*.

Sanneh Foundation has food storage and distribution at the Hub and a youth workforce development program.

Experiential social medicine

The missing rite of passage

BY ARMAN A. SHAHRIAR, MD

"Structure before function."

Most physicians-in-training have heard these words. Gross anatomy is widely considered the backbone of modern biomedicine. It is among the first courses that most medical schools offer, guided by the philosophy that a strong foundation in anatomic structure is a necessary precursor to the microscopic study of organ function and pathology.

At many U.S. medical schools, the dissection of a human cadaver, as part of required coursework in gross anatomy, facilitates this foundation early during training. The cadaver dissection experience is considered a rite of passage into the medical profession.

Cadaver anatomy was an unforgettable experience for me. I can still vividly remember isolating each of the glistening forearm flexor tendons and tracing them beneath the tensile carpal ligament, only then realizing that our dexterity is made possible by a marvelously coordinated system of ropes and pulleys. The details (e.g., motor pathways, the action potential, and the neuromuscular junction) would come with subsequent coursework; the cadaver lab was about painting the big picture and igniting curiosity to learn more.

Like the human body, our local environment—from its diverse neighborhoods and people to its highway systems—has anatomy that requires a foundational understanding before details are brought into focus. Despite this, contemporary preclinical curricula concerning these topics do not embrace the same "structure before function" philosophy. When the social determinants of health (SDH) are introduced peripherally in a didactic lecture-hall format (e.g., discussing differential neighborhood air quality during a lecture on asthma management), learners are left without foundation or context. This is a problem, because disease often arises from a combination of factors involving our patients' biology and their lived environments, and physicians are empowered to confront both.

An elective course taught me early during training that in introducing medicine's social side, foundation is equally important, and experience ought to be the backbone of pedagogy. The course is called Global Health in a Local Context ("Global-Local") and is offered through the Center for Global Health and Social Responsibility at the University of Minnesota. I was one of four medical students in the small class that included community members, social workers, physicians, and other health professionals. Class convened each week at a different community site for a practical and locally pertinent lesson on SDH.

In a way, our city became the human body and we spent the semester studying our local sociocultural anatomy.

The brilliance was the absence of a formal classroom.

One of our first sessions, focusing on city planning, structural racism, and health, took place in St. Paul's Rondo Neighborhood. We gathered at the Rondo Commemorative Plaza, a space honoring the community's rich history, juxtaposed with the Interstate 94 freeway responsible

PHOTO COURTESY OF THE MINNESOTA HISTORICAL SOCIETY

A child watches as bulldozers level what used to be the Rondo neighborhood in preparation for the new Interstate 94.

for its dismantling. Our community instructor, a Rondo native, told the story: In the 1920s–1940s, Rondo was a vibrant middle-class neighborhood and the heart of St. Paul's Black community. Then came the federally funded expansion of the interstate highway system, partially in response to commercial growth and predominantly White suburbanization following World War II. In Minnesota, there was a need to connect Minneapolis and St. Paul, leaving city planners with a choice: a longer northern route along abandoned railroad tracks, or a shorter route through Rondo. Dismissing the disenfranchised Rondo voice, they decided on the latter, bulldozing homes and commercial buildings and displacing hundreds of predominantly Black families to accommodate the interstate.

The social, economic, and direct health effects of these decisions are still felt today. At the time of the I-94 construction, many families—including our instructors'—had to accept unreasonably low, discriminatory offers for their homes. Even worse, for these families, relocating meant abiding by racist redlining practices and housing covenants; discriminatory homeownership practices are a root cause of the prominent (and widening) Black-White wealth gap in America. The physical displacement and generational trauma have unsurprisingly resulted in higher rates of chronic disease among Black individuals living in the area.

Growing up in Minnesota, this was not the first time I had heard about Rondo, but it was certainly the first time I had felt it. Standing outside that rainy evening, watching cars fly by on an interstate I had conveniently used for a decade, I could not help but wonder what else I was missing. As with each dissection in the cadaver lab, the experience in Rondo was about the big picture—laying a foundation and igniting curiosity to read, learn, and engage in discussions with colleagues and patients.

Other transformative experiences from the course include a day at the Agape Hmong farm, where we discussed Hmong history, culture, and health, and a visit to Bdote—sacred land at the confluence of the Minnesota and Mississippi Rivers—where we heard stories of White settlement, colonization, and the genocide of Indigenous People in Minnesota. The introduction of SDH at these sites, like the introduction of anatomy in the cadaver lab, brought life to the foundational subject matter.

Just as experiential cadaver anatomy serves as the rite of passage into biomedicine, a locally tailored and experiential social medicine course, like the Global-Local course and similar courses in their infancy at other institutions, could be the missing rite of passage into medicines' social domain—paving the path toward a more socially and structurally competent generation of physicians.

The American Medical Association and other powerful entities in organized medicine are committed to addressing SDH and advancing health equity. Despite expert consensus that SDH ought to constitute one-third of preclinical curricular time, medical students may be spending very little time on—and be unsatisfied with—SDH content. Fortunately, with the USMLE Step 1 examination transitioning to pass-fail scoring, medical schools have a unique opportunity to reassess educational priorities. The "structure before function" paradigm should apply to both sides of medicine—biomedical and social. Arguably, the pedagogy used to deliver foundational SDH content is as important as the content itself. Just as experiential cadaver anatomy serves as the rite of passage into biomedicine, a locally tailored and experiential social medicine course, like the Global-Local course and similar courses in their infancy at other institutions, could be the missing rite of passage into medicines' social domain—paving the path toward a more socially and structurally competent generation of physicians.

Alas, the 19th-century physician, pathologist, and social medicine scholar Rudolf Virchow (yes, of Virchow's Triad) once said, "If medicine is to fulfill her great task, then she must enter the political and social life. Do we not always find the diseases of the populace traceable to defects in society?" **MM**

Arman A. Shahriar, MD, graduated from the University of Minnesota Medical School this year and is now a resident in internal medicine, University of Chicago Medical Center.

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GOOD DOCTOR IN THE HOUSE

What qualities make someone an exceptional physician—and what leads some astray?

BY SUZY FRISCH

When anesthesiologist Anna Budde, MD, works as an intensivist at the M Health Fairview University of Minnesota Medical Center, she can tell pretty quickly when fellow physicians are at the top of their game.

Good physicians take the time to be at the bedside for consultations with her and other clinicians about care plans. Their communication is on point with her, patients, and families. And they quickly and reliably answer Budde's calls when conditions change—being flexible and adapting to new approaches when needed.

"In the ICU, physicians will see things differently and interpret the same data differently. When you have a colleague who is present at the bedside, it's the easiest way to sort out a dispute and the management of a patient," says Budde, an assistant professor of anesthesiology at the University. "Sometimes what I think in the morning is not what I think in the afternoon because things really change. The best physicians are the ones who are able to trust what they are hearing on the ground and not stick with what they thought was working before."

MariBeth Olson, RN, chief nursing officer and vice president of patient care at Allina's United Hospital, has seen ample physician excellence in action during nearly 40 years as a nurse. One surgeon getting ready for an operation really stood out. The patient was terrified about the procedure and the potential outcome. Although the entire surgical team was waiting in the OR, the physician paused before starting surgery. He put his hand on the person's shoulder, explained more about the procedure, answered questions, and reassured the patient, saying, "We will take good care of you."

"It's that personal touch and meeting patients where they are," Olson says. "I saw that with physicians in the ICU where they took time to make a connection, sat down with the patient and the family and talked eye-to-eye, and spent time to make sure all of their questions were answered. They provided reassurance and explained what was going to happen. It makes such a difference."

Like many subjective things, people know a good physician when they see one. Having a firm grasp on the science and the medicine is table stakes. But what are the qualities that make someone outstanding? Patients, employers, and co-workers think highly of physicians who are good listeners, who bring bountiful integrity and empathy to their practice. They also can see when physicians aren't at their best, rushing through an office visit or explaining an illness in undecipherable terms to a patient. On both ends of the spectrum, there are signs that emerge indicating whether someone is a good physician or someone who needs to recalibrate.

Defining greatness

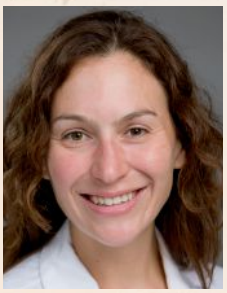
Gratia Pitcher, MD, chief quality officer and a hospitalist at Essentia Health in Duluth, observes that being a good physician starts with character. "It's someone who does the right thing when no one is looking," she says. "It's someone who is kind and tries to deliver the care they would like to receive. It's also anticipating people's needs, being humble, reflecting on those times it didn't go as intended, and reflecting on what you can do differently if you are put in that scenario again."

In every specialty, communication and curiosity rank at the top of the list of key traits for a good physician, says Siobhan Pittock, MB, BCh, a Mayo Clinic pediatric endocrinologist and program director of the Mayo Medical School pediatrics residency. "Communication and listening are absolutely number one," she says. "If we can't connect with our patients, we can't help our patients."

"If you're curious, you will be interested and stay interested. Those physicians who are curious will continue to learn and continue to work hard on behalf of patients, when not every patient fits into a cookie cutter shape," Pittock adds. "When you're curious and learning, you are far less likely to burn out."

"Good physicians are deeply invested in ensuring the best outcomes for patients—tailoring an optimal plan and acting quickly to change course when challenges emerge," says Faisal Choudhry, MD, anesthesiologist and medical director of Associated Anesthesiologists, P.A., (AAPA), which primarily services the East Metro.

Choudhry highlights integrity and consistently providing the care physicians would seek for their own family members. And then there is humility, including pushing to improve intellectually and technically, and seeking advice from others. To that end, AAPA holds regular peer reviews where clinicians bring forth challenging cases to dissect. The forum allows the team to identify obstacles to excellence and room for improvement that they and others can learn from.



"Sometimes what I think in the morning is not what I think in the afternoon because things really change. The best physicians are the ones who are able to trust what they are hearing on the ground and not stick with what they thought was working before. –ANNA BUDDE, MD

Anesthesiologists have a unique vantage point in medicine in that they work with a wide variety of surgeons and other physicians. Setting aside clinical excellence as a given, Choudhry stresses having a team mentality as another key quality that makes for exemplary physicians.

"Our exceptional physicians view the enterprise as a team sport and are skilled in navigating relationships with the rest of the team—not just our CRNA colleagues but all perioperative staff, our patients, and their families," Choudhry says. "That makes other team members more likely to engage meaningfully, ask clarifying questions, and partner for better outcomes."

"Those physicians who are curious will continue to learn and continue to work hard on behalf of patients, when not every patient fits into a cookie cutter shape."
–GRATIA PITCHER, MD

Training and hiring for excellence

Many people have innate gifts that make them spectacular physicians. Helping trainees and newly minted physicians bring out these attributes and develop other vital traits is essential to creating a workforce of good physicians. Concurrently, health systems, clinics, and other providers want to hire the best. But how can they assess which physicians are really the good ones?

"Relationships are our superpower. If you're having a hard time communicating with us, you will have a hard time communicating with patients and building bonds and building those relationships."
–ANDREW SLATTENGREN, DO

Graduate and post-graduate medical training is evolving to better address some of the interpersonal skills physicians need to thrive. These days, newer trainees and physicians are experiencing approaches that emphasize the important human relationship components of medicine along with diagnostic and technical skills.

Training has evolved away from the see one, do one, teach one tradition, says Andrew Slattengren, DO, associate program director of the North Memorial Family Medicine Residency. Instead, programs are adopting a competency model for medical students entering residency, following AAMC guidelines to ensure that graduates have mastered 13 core entrustable professional activities before beginning the next phase of training.

Although this approach is only recently being incorporated into medical training, Slattengren finds the competency model useful as way to provide continuous feedback. Giving quick reactions so that trainees can learn from mistakes and quickly improve is a way to strengthen the muscle of career-long continuous improvement, he says.

Some of the ways Mayo helps its learners become excellent physicians is to help them develop key professional skills, Pittock says. Some of the components that Mayo physicians model include being a team player, taking good care of all patients, and communicating with patients in an empathetic way, even when they are rude or generally aren't at their best.

"We try to model behavior in the training program and the entire ethos of the place," Pittock says. "Many of these traits we talk about are the pillars and primary values of Mayo—that the needs of the patient come first, respect, compassion, and dedication. We try to make sure what we are asking of them is what they are seeing around them every day, and then we talk about it."

When hiring for University of Minnesota Physicians, CEO Bevan Yueh, MD, MPH, wants to see qualities that line up with its mission. "We're fortunate to attract candidates who are well-trained, bright, innovative people who want to be part of a large medical school and a big practice.

"We try to model behavior in the training program and the entire ethos of the place. Many of these traits we talk about are the pillars and primary values of Mayo–that the needs of the patient come first, respect, compassion, and dedication." –SIOBHAN PITTOCK, MB, BCH

"We can go after really great people and good human beings. These are people who spend a lot of time listening to their patients, good people who can communicate effectively with patients, who will spend time with their patients." –BEVAN YUEH, MD, MPH

We look for really great people and good human beings," says Yueh, an otolaryngologist. "These are people who spend a lot of time listening to their patients, good people who can communicate effectively with patients, who will spend time with their patients."

Yueh likes to see job candidates who talk about providing compassionate, innovative, high-quality care from the start of interviews. If they are overly focused instead on things like salary and benefits, or personal opportunities for fame, they aren't right for the job, he adds.

Megha Tollefson, MD, a pediatric dermatologist at Mayo Clinic, points to core traits she looks for when interviewing candidates for the Mayo Clinic Alix School of Medicine or the pediatric residency program, which she recently directed. She wants candidates to have a record of service to others, being a good team member, and treating people with respect, regardless of who the person is and how they might be acting.

"As a physician, you work with and rely on so many other people to deliver the kind of care we all hope to deliver," Tollefson says. "Another important thing is reliability. That goes with being a good teammate—showing up when expected and then following through."

North's family medicine residency gets hundreds of applicants each year for eight spots. To narrow the field to 90 candidates for interviews, the team looks for people who have demonstrated an interest and bring experience in family medicine or community work, Slattengren says. It's not really about their grades and test scores as much as their passion for the program's patients.

During interviews, program leaders ask questions that assess candidates' comfort and experience with being adaptable and resilient, as well as caring for people from diverse backgrounds and cultures. "Throughout the whole process, it's about communication skills," Slattengren adds. "Relationships are our superpower. If you're having a hard time communicating with us, you will have a hard time communicating with patients and building bonds and building those relationships."

When HealthPartners and Park Nicollet merged in 2013, clinicians from both organizations spent two years and more than 130 meetings developing the new entity's mission and values, spelling out the way that clinicians should provide care. They sought to build a culture with patient-centered care at its core, built on a foundation of humility, compassion, respect, and shared leadership, says Mark Sannes, MD, an infectious disease physician and co-executive medical director of the HealthPartners care group.

Whether HealthPartners is recruiting residents for their first jobs or experienced physicians for new positions, the organization aims to ensure that candidates mesh with that point of view. "It's almost a matchmaking process we're going through during the interview process. We're looking for someone who wants to be part of the HealthPartners culture," Sannes says.

"It may sound cliché, but if folks don't see themselves showing up in medicine that way, then we might not be a good fit. We want to be deliberate in how we recruit and how we attract people to join us. There should be no surprises."

Off the rails

Of course, no physician is always excellent. Anyone can have a bad day or week or month. And, although it's exceedingly rare, there are physicians who stop performing to the best of their abilities. Perhaps it's from burnout or other stresses in their personal lives, revealing itself in how they interact with other providers. Or they have drifted away from the ideals they worked toward earlier in their career, feeling frustrated with bureaucracy, electronic health records, or other aspects of medical care.

"As a physician, you work with and rely on so many other people to deliver the kind of care we all hope to deliver." –MEGHA TOLLEFSON, MD

What is an employer to do when this occurs? In hindsight, often there were warning signs that someone might be headed down the wrong path. When a problem has been identified, employers have ways to help physicians get back on the right track.

Olson says she might get concerned when she called a physician with questions

"A hallmark of a good physician and good clinician is someone who is willing to listen to what their patients are telling them and have a partnership with that person."
–MARK SANNES, MD

or new details about a patient's condition. If the physician started taking way too long to return her pages, or was short and irritated about her calls, that raised a red flag. "When that happens often, it makes you pause and think that maybe they aren't the greatest person to work with," she says.

Pitcher thinks back on stories of surgeons who would throw instruments at people in the operating room, or the once-common notion that someone could be an excellent clinician or an excellent person but not both. There has been significant progress away from those times, she says, when medical errors were more common. There is better communication, more professionalism, more leadership.

Still, many physicians continue to recover from the bruising work of the pandemic, and everyone is not all right. "As colleagues, we need to give each other grace as we are all in this pandemic and have had different experiences," says Pitcher. "Though I would not want to be judged by my worst day, new patterns of behavior and crispy interactions are all signs that can indicate burnout and should be collegially discussed."

The idea of focusing on physician well-being isn't something that came up much during her medical school or residency years, but it's more prevalent now, Pitcher says. When someone is struggling, she might suggest getting involved with Essentia's wellness program or considering options like coaching or switching to a reduced schedule, at least for a while.

Peers or physician leaders at HealthPartners might notice a physician not performing well at work. They might receive declining patient experience scores, get negative comments from patients or families, or receive feedback from concerned colleagues. "A hallmark of a good physician and good clinician is someone who is willing to listen to what their patients are telling them and have a partnership with that person," Sannes says. "When we start to lose that, it becomes fairly obvious that we need to make a course correction."

In these cases, department chairs or site leaders will check in with physicians, see how they are doing, and find out if HealthPartners could make changes for them to address whatever is affecting their performance. It might mean a more flexible schedule, mental health counseling, chemical dependency treatment, technology assistance, or anything else that might help, says Steven Connelly, MD, an otolaryngologist and co-executive director of the HealthPartners care group.

"We are very lucky that the occurrence is small. But it does occur, and we'd rather get early warning signs and have a conversation and then act, not in a punitive way but a, 'How can we help you?' way," Connelly says. "We're saying, 'We want you here. Tell us what you need and how we can help.' And then we give it as much effort as we can."

Worst case scenarios

A few physicians run into real trouble. Complaints come into the Minnesota Board of Medical Practice, malpractice claims rack up, or patients file lawsuits. Executive Director of the Board of Medical Practice Ruth Martinez has seen just about everything in 35 years at the medical board. It gets about 1,000 complaints annually for the eight professions it regulates, including physicians, physician assistants, respiratory therapists, and acupuncturists. About three-fourths of complaints are physician-related.

The board must investigate every complaint, and close to 85% are dismissed without action, Martinez says. When the board finds violations, it can issue reprimands, limit physicians' practices, suspend their licenses, or have licenses revoked.

Physicians who deviate from minimum prevailing practice standards in their specialty is a common theme in violations, Martinez says. In other cases, physicians crossed professional boundaries, from sexual misconduct to improper prescribing. Many factors can impede physicians' abilities to provide safe and proper care: Clinicians who did not stay current in their prescribing practices or treatment protocols, those having mental or physical challenges, or some who struggle with addiction.

As patients and employers work to determine who might be a good physician,

[When physician performance issues occur] "We'd rather get early warning signs and have a conversation and then act, not in a punitive way but a, 'How can we help you?' way. We're saying, 'We want you here. Tell us what you need and how we can help.' And then we give it as much effort as we can." –STEVEN CONNELLY, MD

insurers also are gauging who might be a safe or risky bet for medical malpractice coverage. Underwriters have a variety of parameters they consider. Red flags include physicians who failed their board certification exams multiple times, or physicians who practice in a field for which they did not train, says Janel Loud-Mahany, senior vice president of underwriting and policyholder services at COPIC.

COPIC also considers the physician's history of prior claims. Having claims generally is not a deal breaker; it often depends on their frequency, severity, and circumstances, Loud-Mahany says. Was it a major error with costly damages, or were there inherent risks in a surgical procedure? "We're really not in a position to say this is a good doctor or a bad doctor," she adds. "We're looking to see, is it a good risk? Is this a physician we want to bring into this pool of insured that will help improve the pool?"

In 33 years of litigating medical malpractice cases for clients, some trends have emerged for Peter Schmit, a partner at Robins Kaplan in Minneapolis and chair of its medical malpractice/personal injury practice. Often there is a lack of communication that leads to a deviation from standard medical practices. It might occur at shift changes during a handoff between providers or as a patient moves from the care of one department to another.

Danger also arises when physicians practice outside the scope of their training instead of referring a case to a physician with the right expertise. Other times, physicians fail to rule out a life-threatening illness during a differential diagnosis, homing in on a less severe condition and not budging from that initial opinion, Schmit says. He also has seen occasions when a physician does not recognize the symptoms of a complication like a perforated liver or bowel, and then fails to treat it before it's too late.

A lot of these concerns boil down to physicians having humility about the limits of their expertise and decision-making. "I firmly believe that the vast majority of providers are out there doing good jobs. A good provider is curious, an advocate for their patient, and an investigator. They continue to investigate the cause of their patients' problems until they find a solution," Schmit says.

"On the other side, when providers are in over their heads, are they willing to reach out and accept help? Perhaps some of the ones who get in trouble aren't willing to do that. They just assume, since they are doing it, it has to be right. It requires the ability to question oneself."

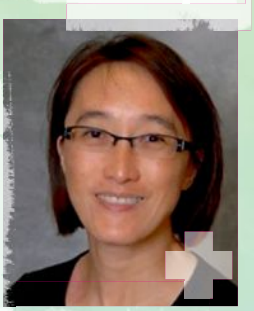
Occasionally, healthcare providers need a reset to work through the issues that are impeding their performance. Minnesota's Health Professionals Services Program has helped many physicians obtain early intervention, support, and assistance for varied concerns, including stress, grief, and addiction. Providers can receive confidential monitoring or step away from practice to allow time to recover from an illness.

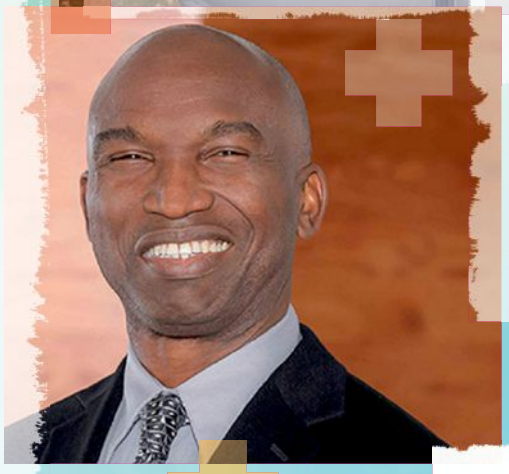
"We've had a lot of success stories," Martinez says. "It has enabled a significant number of providers to continue practicing safely while they work on their recovery from an illness. They might come in kicking and screaming on the front end, if an employer invites them into the program or it's mandatory from a board disciplinary order."

Martinez says it takes eight years to educate and train a physician—a huge investment in education, training, time, and energy. "To lose that is devastating," she adds. "If the Board can play a role in getting people back on track, through rehabilitation from illness or remedial education … often they can tell you better than anyone that they were grateful for the intervention."

Interventions that focus on remediation and rehabilitation, and an overall high quality of healthcare, means that Minnesota often ranks at the bottom when it comes to significant disciplinary actions. "Despite having been immersed in many investigations over the years, I remain very positive in how I view medical providers," Martinez says. "I think there is no better place to get your healthcare than the state of Minnesota." **MM**

Suzy Frisch is a Twin Cities freelance writer.





How to recognize—and be—a good physician

How do you recognize a good physician? What are the personal and clinical qualities that you think are important? How do you know when a physician is not good? Have you ever had to act on that? Think about the best physician or physicians you have encountered, in your work or even as a patient. What made them a good physician? Did it inspire you in any way? Have you ever changed something about the way you practice medicine in order to be a better physician?

Minnesota Medicine asked a dozen physicians to think about just what it means to be a good physician. The answers varied, and yet some common themes emerged. Good physicians, the best physicians, know how to communicate—both how to listen and how to provide medical information in ways that patients can understand. Good physicians show empathy. Good physicians work well with others. Good physicians put in the time.

And, of course, good physicians are technically skilled in their specialties.

Before doing any interviews, we asked our three medical editors for their thoughts on this topic. They wondered if the qualities that a patient wants in a physician are different than the qualities other physicians might think are important. The answer likely is no, or at least not for the most part.

The topic of how to deal with physicians who are not doing well, perhaps even endangering patients, is an uncomfortable one and not all of the physicians interviewed talked about it. Although most have seen patients who got incorrect or incomplete diagnoses from other physicians, they either didn't talk to the previous physician or they had very simple, neutral conversations about their own diagnosis. The assumption seems to be that anyone can make a mistake; it doesn't make someone a bad physician.

Almost every physician wants to not be *considered* good by patients and peers, but to actually *be* good at the work they love. It's just not a job where you put in your time but not your heart and brain.

—*Linda Picone, editor of* Minnesota Medicine

Communication, empathy, love of medicine are key qualities

Louis Ling, MD

EMERGENCY MEDICINE, HENNEPIN COUNTY MEDICAL CENTER, NOW RETIRED

IN PRACTICE 35 YEARS

I have had some side gigs that involved judging physicians in training: I was formerly senior vice president of the Accreditation Council for Graduate Medical Education and I have been chief academic officer at Hennepin County Medical Center and associate dean at the University of Minnesota Medical School.

The six core competencies laid out by the American Board of Medical Specialties and the Accreditation Council for Graduate Medical Education are pretty much what you would expect, they're what training programs are supposed to provide:

- ***Medical knowledge***. Knowledge about established and evolving biomedical, clinical, and cognate sciences, as well as the application of these sciences in patient care.
- ***Patient care and procedural skills***. Use of clinical skills and ability to provide care and promote health in an appropriate manner that incorporates evidence-based medical practice, demonstrates good clinical judgment, and fosters patient-centered decision-making.
- ***Practice-based learning and improvement***. Ability to investigate and evaluate patient care practices, appraise and assimilate scientific evidence, and improve the practice of medicine, the collaborative practice of medicine, or both.
- ***Systems-based practice***. Awareness of, and responsibility to, population health and systems of healthcare.
- ***Interpersonal and communication skills.*** Skills that result in effective information exchange and partnering with patients, their families, and professional associates.
- ***Professionalism***. A commitment to carrying out professional responsibilities; adhering to ethical principles; applying the skills and values to deliver compassionate, patient-centered care; demonstrating humanism; being sensitive to diverse patient populations and workforce; and practicing wellness and self-care.

But there are certain things that aren't quite so obvious. For example, with professionalism, we tend to pick people for medical school who are really good at individual achievement. We select team leaders, but we also need them to be team players.

Or for knowledge, people expect top doctors to be really smart, but even more important, we want them to be evidence-based, to be able to interpret advancements in science and new research, not just relying on their personal experience.

Often the best treatment isn't clear for a particular diagnosis. Not knowing is kind of uncomfortable. A good physician has to be honest and accept the idea that they're not going to know everything. This uncertainty is really uncomfortable for young doctors, but in real life, there isn't always a right answer.

A good physician has to be honest and accept the idea that **we're not going to know everything**. This uncertainty is really uncomfortable for young doctors, but **in real life, there isn't always a right answer**.

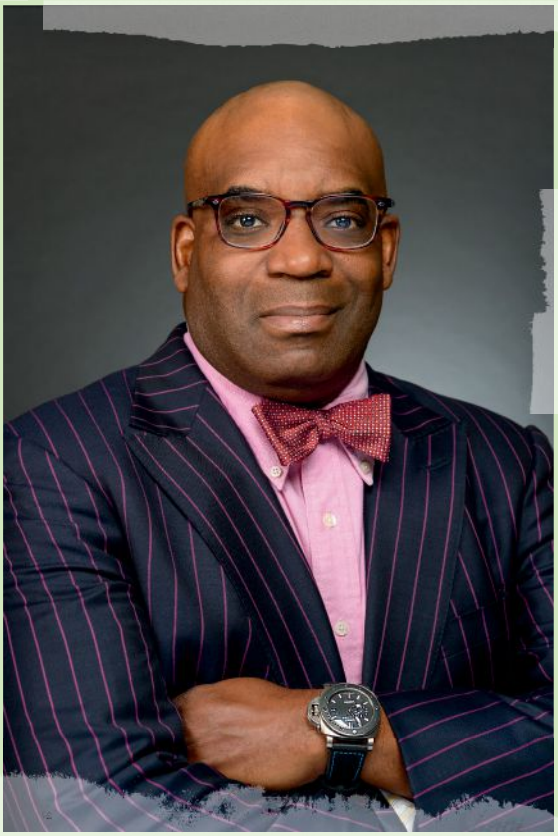
You're always going to be learning. You have to be honest with yourself when you find weaknesses in how you do things. The human thing is to try and come up with a defense mechanism, but a good physician should think, "How can I do this better?" But you can't do that unless you can be honest with yourself about what you don't know. With experience, physicians, hopefully, get to this point.

Every physician has to communicate, but they don't necessarily know that they have to communicate in a way the patient understands. Physicians use big words that are very precise and correct, but the patient doesn't always understand them. If we don't talk

Frederick Harris, MD

NEUROSURGEON AT TWIN CITIES ORTHOPEDICS

IN PRACTICE 15 YEARS



Throughout my time in private practice, it has always been my preference to refer my patients to physicians who are affable, available, and willing to see the patient in a timely fashion. It is disappointing to call a physician and get the response, "Call my scheduling line," when I have a sick patient in my office who needs to be seen and evaluated urgently. When a physician makes the effort to call, text, or email me, I make sure I am very responsive to their concerns for their patient. My top priority in patient care has always been and continues to be responsive and timely with both my patients' needs and referring physicians' request for assistance.

It is my preference to refer my patients to physicians who have the vast knowledge of their required treatment. I want to make sure my patients always feel comfortable with my recommendations and that they know I'm referring them to someone who can truly help them resolve their medical issues. It is never a good practice for a physician to speak negatively about another physician to patients. I give my recommendations of physicians who I know that will really listen to the patient, and develop a plan that makes things clear for them.

During residency 21 years ago, I had the honor of training under several physicians who were excellent in both their surgical skills and bedside manner. I have emulated these physicians by using those invaluable skills throughout my career. These role models were beneficial in the shaping of my career and I feel that I am a better surgeon because of their tutelage.

about what they are afraid of, we miss the whole point and they leave us still in fear.

Systems-based practice is kind of hard for physicians. We're used to being the heroes, but it's not about the one patient, but the whole system with all those social determinants of health. The actual care we can bring as a physician affects about 10% of the patient's health. A lot of doctors ask, "What can I do about that?" or say it's just way beyond what we can do, but if we're looking at their total health, we need to be involved. It's about access, food, vaccines, and how we can improve the big picture for the patient.

How we would deal with a physician who is not doing well depends on how open they are to new ideas. For people I know really well and who seem open, we'll have a chat about what's going on. When dealing with residents or students, I can be more direct, but it's really hard for a peer to tell another independent physician that there are problems. I'm not their boss, I don't have any authority; I approach it just as a conversation.

If it seems to be a dangerous situation, at a hospital I would bring it up to the medical director. If an informal peer-to-peer discussion doesn't work, there are more formal ways to do things. Sometimes, a physician leaves that practice—and then they go somewhere else. If an investigation doesn't come to a conclusion [because the physician leaves], it isn't reported. As a profession, we can do better to self-police.

I do feel responsible for doing something, but I know a lot of people close their eyes and don't want to rock the boat—and they don't want to be called up if they do something wrong themselves. Since Hennepin is a teaching hospital, it's a little easier for us.

My first boss was Ernie Ruiz, MD. He started as a surgeon, then ran the Emergency Department at Hennepin County Medical Center. He was so gentle and kind, it was really hard to overlook that. He was a very good clinical physician, but just so kind to patients, to me, to everyone.

Dave Plummer, MD, was one of our residents who had a way of being good at explaining everything. When he worked, he would talk out loud all the time, explaining what he saw and what he was thinking. If you kept your ears open and listened him, you understood how he made decisions. That's really hard to teach.

If you know more, you're better—but the more important thing is what you do with what you know.

Grant Botker, MD

FAMILY PRACTICE WITH OBSTETRICS, ORTONVILLE AREA HEALTH SERVICES

IN PRACTICE EIGHT YEARS

There are many different types of personalities, so what makes a good physician for individual specialties varies quite a bit. Some physicians don't really interact with patients much as part of their jobs. With my experience in family medicine, being able to relate to patients is very important. I know a lot of my patients personally because they've known me since I was a child. That builds trust in the relationship.

I don't believe in being too high on yourself because you're a physician. A lot of people here refer to me by my first name, and I'm fine with that.

A good physician has a willingness to make sacrifices. I'm on call a lot, partly because of the OB practice. In general, you put in a lot of hours. My day is usually not done when I'm finished in clinic; there's documentation to be done going into the evening and I'll round on patients in the hospital on my days off. I see a lot of people struggle with the idea of making a sacrifice to be a physician.

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You have to have a belief in science and evidence-based medicine.

You have to have a curiosity and a willingness to learn things you don't know. I feel as if I'm learning new things almost every day.

I've worked with many physicians that I think have been good, including many of my classmates, people I went through training with who have gone on to be excellent physicians, but one who stands out to me is my colleague Bob Ross, MD, who has been here for more than 40 years—he was my doctor when I was growing up. Over the years, he's given a lot of his time outside the clinic, doing things for the community. He was always the doctor on the sidelines when I was on the football team; now I've taken that over for him.

Being in a small town and being a role model to others means carrying yourself in a certain way. You are very visible, looked up to in the community. You have to be sensitive to that.

Devon Callahan, MD

GENERAL SURGEON, SPECIALIZING IN ACUTE CARE SURGERY,
ABBOTT NORTHWESTERN HOSPITAL

IN PRACTICE FIVE YEARS

There's the way physicians look at other physicians and the way patients look at physicians. Sometimes those things overlap, but I don't know that they universally overlap. Within our group, we see patient comments for the whole group. The things that are emphasized are that physicians take time, they make the patients feel heard, they answer all the questions patients have. Patients appreciate it when the physician speaks to them in language they can understand that doesn't seem dumbed down.

If we see any concerning feedback about a physician, we try to figure out what happened and why the patient had a less than optimal experience, and we explore whether there's anything we can do to improve that going forward.

We find certain trends in feedback, but physicians don't necessarily know that they're doing these things. We ask, "What are you doing that makes the patient feel you don't totally understand their history?" We see that after doing that, physicians get much better feedback from their patients.

What physicians look for is someone who obviously has the patient's best interests in mind and acts as an advocate for their patients, but even more than an advocate, physicians who are well respected take action. The physicians I respect and admire are able to make things happen.

If you encounter a physician who is not performing well, first, you're obligated to make sure they aren't truly harming people; it's such a spectrum of ability. If it's a family member who might go to that physician, I'd say, "Here's who I'd go to." If it's patients, you judge what they need and how capable that physician is. I would mostly keep my judgments to myself, but if I felt truly that they were going to see someone who wasn't as able as they ought to be, I might say, "This *other* physician is very well respected for this condition." I try to give them options.

I think the physicians who are Affable, Available, and Able do very well in practice. One colleague told me that those three things—Affable, Available, and Able—are in that order of importance.

Affable: Good physicians are respected throughout the institution. They're not just liked by other physicians, but also by the nursing staff, ancillary staff, receptionists in the clinic. Often you can tell who they are pretty easily. That collegiality tends to imply a quality physician, although there are some people who are not well liked and yet they are geniuses in their field.

Availability: This is mainly that you give your attention to your colleagues and to your patients. Even if you're busy, you chisel out moments of undivided attention and make people feel heard and not that you're rushing the conversation. You can spend five minutes in a patient's room and go through all their questions and they're going to feel like you spent an hour with them, but if you seem like you're not listening or you're distracted, you can spend 15 minutes and they will feel like it was no time. The same kind of thing happens with our colleagues; if you take the two or three minutes to listen and engage with them, it really goes a long way.

Able is sort of self-evident.

Eric Johnson, MD, one of my senior partners, meets all of these qualities. He's highly technically skilled, very available—every physician in the city has him on their contacts—and extremely easy to get along with and talk to. He helps physicians out with things, and his patients love him. He's been a huge mentor in my fairly young practice.

Even more than an advocate, physicians who are well respected take action. The physicians I respect and admire are able to make things happen

Jon Hallberg, MD

FAMILY MEDICINE AND MEDICAL DIRECTOR, M PHYSICIANS MILL CITY CLINIC

IN PRACTICE 27 YEARS

Of course a good physician is competent. If you are incompetent, by definition you are not a good physician. We measure competence by boards, Step 1 and Step 2, etc. But other qualities of a good physician are:

- Taking an interest in the patient. You can see it in their eyes, you can hear it in their voice.
- A deep sense of curiosity. I would argue that curiosity makes everyone better.
- Being well-rounded. They can speak on a variety of topics.
- Asking questions that build trust, which tells a patient that they are interested in them.
- Practicing efficient medicine.
- Able to translate medical thoughts into plain speech.
- Being comfortable with ambiguity—and that's hard for us.
- Being patient and not condescending.
- Loving what they do—and truly enjoying the company of others.

I like to believe I'm a good physician.

Patients would all love to have the doctor's cell phone number, but the reality is that it's overwhelming. I can't personally call every patient back.

As we get older, there's a certain amount of wisdom we acquire. Tapping into that wisdom is important.

I used to give a lecture on professionalism to first-year medical students, and one of the tenets is self-reflection. If I get criticism, I don't just reject it. If there is any legitimacy to the criticism, I reflect on it and possibly act on it. I had a patient who came in with a cold, just a cold, and I gave her reassurance. She complained later that I hadn't listened to her lungs or performed a more comprehensive exam. It was clear that a patient needs to be touched, to be looked at, even if you don't need to do that to make a diagnosis. Another patient told me that I had bad breath (when I was dealing with an infection). I was taken aback, but since then, I've told medical students, I don't breathe when I'm close to patients, like when I'm looking in their eyes, ears or mouth; I hold my breath.

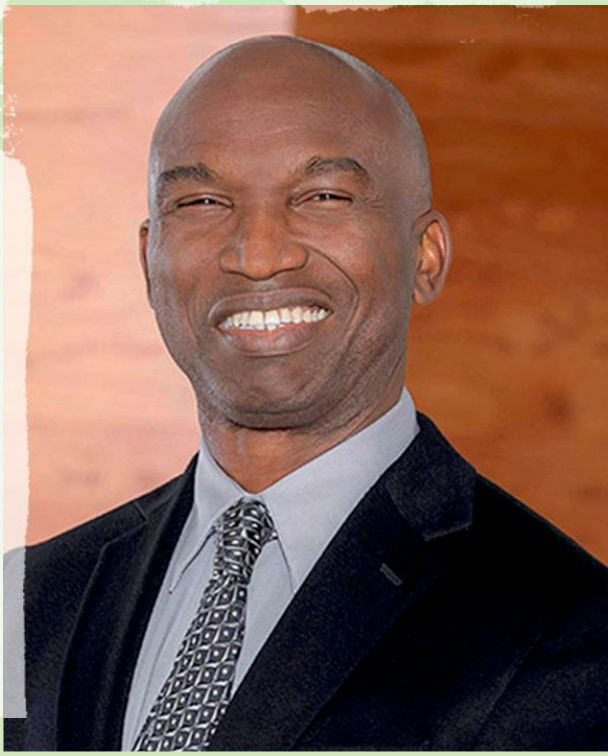
In my first rotation in internal medicine during my family medicine residency, I met Gerald Mullin, MD. I could tell right away that he was beloved. What stuck out was his kindness and his gentleness.

I used to give a lecture on professionalism to first-year medical students, and one of the tenets is self-reflection. If I get criticism, I don't just reject it. **If there is any legitimacy to the criticism, I reflect on it and possibly act on it.**

Joseph Akornor, MD

UROLOGIST, MINNESOTA UROLOGY GROUP

IN PRACTICE 14 YEARS



I know a physician is good or bad from what my patients tell me. When patients are not happy with the interactions at the clinic or during the procedure, you will hear about it.

Listening is important. Especially in these days when we're doing electronic medical records, where everything has to be done and you don't even look at the patient in front of you. I don't do that. It takes more work to see my patient while they're telling me what's wrong, but it's important. And I only talk when they're done.

Just being available is part of being a good physician. It's frustrating to try to call the doctor's office and you can't get in touch with anyone. Sometimes I will call patients back after work, or even on a weekend.

And, of course, you need to know what you're doing. I had good training, I'm very well rounded in what I do. I see a lot of cancer patients and I know how to help them. But a good physician also should know where there ought to be limits, when they need to get other people involved. If I see people who would be better served by someone else, I make a call and they're there.

The biggest thing, to make all this work, is to be able to communicate, both with the patient and with your team. Your work is not done in isolation.

A good physician should know where there ought to be limits, when they need to get other people involved. If I see people who would be better served by someone else, I make a call and they're there.

I see a lot of referred patients diagnosed with cancer. Some patients show up and they don't even know why they're coming to see me; I am the first person they're hearing it from. Just last week, I saw two people who walked into my office and had bad tumors and they had no idea. That is bad medicine.

What are you going to do about the physician who referred them? The patient already is in a bad situation, they're still going to be working with that physician.

You have to be compassionate. I always put myself in the shoes of the patient. What would I do? Then I start from there. I try not to do anything I wouldn't do to me.

My mentor, the late Joe Segura, MD, a urologist at Mayo Clinic, was the person I tried to emulate. Even though he's gone now, he's been my idol. I try to practice the way he did. He never said "no" to any patient, but he had a way of getting the same result without saying "no." He knew his stuff and he could get the patients there without them feeling their problems wouldn't be solved long term. I've said "no" a few times.

You have to like the work. If you do it for the money, you will never enjoy it.

Rebecca Johnson, MD

ANESTHESIOLOGY, MAYO MEDICAL SYSTEM

IN PRACTICE 10 YEARS

It's natural to assess individuals, but I try to be open-minded. A lot of how I gauge another physician is in that initial greeting, whether it's collegial or authoritative, whether we're sharing the care of the patient or whether it's "this is my patient and this is how I like to see things done."

If a situation is emergent, sometimes you just need to get things done. It's not about the physicians, it's about the patient. If it's not emergent, it would be extremely important to me that there is that collegial exchange.

Who I would recommend to friends and family comes down to outcomes and timeliness and how those two things relate. It is no secret, there is mounting evidence on perioperative and periprocedural outcomes, that duration of anesthesia, across all age groups, across all subspecialties, makes a difference. The time that it takes under anesthesia is related to adverse outcomes. If I'm given wonderful physicians—and it would be very rare in today's world that you find someone who is not professional, I've not seen that, they're all wonderful physicians—I would want a fast, efficient, and safe physician over everything else. It's an added bonus if the surgeon is also kind and considerate.

There are a few common characteristics I think good physicians share. They are knowledgeable, which is slightly different than intelligent, knowledgeable could be knowing where to go for assistance. They are approachable, meaning being able to connect and find common ground in a short time period. You can build background with somebody. You might have common media sources, or cooking, or travel, etc. Particularly if you're working with a certain patient population. Here in southern Minnesota, it's important to know something about farming to connect with patients. Even though I'm from northern Minnesota and farming isn't a big thing there, I have learned a lot about farming.

And then they are professional and dedicated. You can be approachable, but then you lose your credibility because you are too casual in conversation, as if you were talking to a family member. You need to bring your expertise to patients.

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Robert Larbi-Odam, MD, MPH

FAMILY PHYSICIAN AND CEO/MEDICAL DIRECTOR
ODAM MEDICAL GROUP, MINNEAPOLIS

IN PRACTICE 17 YEARS

A good physician must be able to listen and to have what we call cultural humility. To be able to provide the care they need, you must listen to the patient and be aware of some of their cultural needs and perspectives. You also need to know how a patient is going to pay for medical services.

There are multiple facets these days of being a good provider and having a patient walking away being satisfied. We're always doing these patient surveys and we get feedback: "He didn't listen to me." "I couldn't pay for the drug he prescribed."

At the end of the day, the patient's satisfaction is kind of carved into who is a good doctor.

Because of where I practice, I tend to see patients who come to me after several visits to other physicians. Sometimes there's a language barrier; all the words we get in our medical school training don't always translate into what a patient understands. Different words mean different things; we have to take our time to really understand what the patient is saying. We also review medications because a lot of patients don't know why they're taking certain medications.

The challenge we face right now is the time restraints that providers are under. We're rushing through and aren't able to connect the dots that would form a good diagnosis. I often hear from patients, "The doctor just left."

I have seen some really bad diagnoses from other physicians. One woman said I've had back pain forever, I'm always asking for an x-ray but I'm told it's muscular. It had gone on for years. I sent her for an x-ray and it was clear the patient had multiple kidney stones and one kidney had shut down completely as a result.

Another case was a young woman who was fatigued, tired, and exhausted for several months. She was diagnosed with depression. I put my hands on her head and ran them down her neck and discovered huge lymph nodes. She also had high white blood cell counts.

Another patient had been going to a clinic with leg pain. He's a smoker. There was no pulse in his leg. He has severe peripheral artery disease, yet no one had even considered it.

When I came out of residency, I saw a gentleman with chronic low back pain. He said he was really fatigued as well. We got some basic blood work and lab tests and saw a lot of protein in his urine and no iron. We got him to the hospital right away. I said I thought he might have multiple myeloma and was told that couldn't be diagnosed in a clinic. I said, you trained me.

PHOTO PROVIDED BY ERNEST NORRIS, EN PHOTOGRAPHY

If the person making the wrong or inadequate diagnosis is in another practice, I send my notes over to let them know this is what we saw and this is what we're doing.

Jeremy Springer, MD, family medicine residency program director at Park Nicollet Methodist Hospital, stood out as a great mentor. He always talked about making sure you pay attention to the language and culture of the patients and I think I learned from those things.

> To be able to provide the care they need, **you must listen to the patient and be aware of some of their cultural needs and perspectives**.

Ryan O'Donnell, MD

GENERAL SURGERY, M HEALTH FAIRVIEW RIDGES HOSPITAL

IN PRACTICE 14 YEARS

You kind of know who the good docs are and who they aren't. I think it has a lot to do with thoroughness. If a patient tells you about their condition, is it the same thing the physician tells you? If it really varies, did the ER physician miss something? Were they thorough, or did they miss some big red flags? How cohesive is everything when you meet the patient?

You need to trust, but verify. Being a good physician means taking everybody's story into account, but also verifying for yourself what is true in terms of somebody's history or presentation. When in doubt, go ask the patient because they usually know if something doesn't make sense.

There were a few people I trained with that I thought if I could be half the professional they are, I would do okay. They are dedicated to continuing their education, they are dedicated to really following up and they really follow the details. A vascular surgeon I trained with said, "You can't just go through the motions; you're not just checking off a list of things you need to do. You need to actually digest and consider everything you're doing. There's no routine about any of it."

I've added skills to my repertoire because medicine evolves. It just means I'm competent and current.

As a son and husband and father, I'm constantly asked by my family and friends, "Who would you send someone to?" That's hard. I can meet physicians in the doctors' lounge who are very collegial, but they may be real jerks in the OR. Or vice versa, they may be jerks but everyone in the OR says that's who I would send my mother to see. My opinion of other providers is greatly influenced by all of our adjunct staff.

I've had occasions where I get a consult for x, y, or z and I read the notes and it doesn't say a darned thing about what I've been asked to consult about. There are a few physicians I've worked with who are terrible about notes. They're going through the motions. Does anything happen to them? Not to my knowledge.

There's one thing I would like to do better. One of our senior physicians calls every patient the night before surgery to ask how they're doing; he would spend an afternoon or evening calling patients. It takes two minutes, but it means a lot. He's part of the old guard; the people he trained with do that.

There were a few people I trained with that I thought if I could be half the professional they are, I would do okay. **They are dedicated to continuing their education, they are dedicated to really following up and they really follow the details.**

Ruby Tam, DO

FAMILY PRACTICE, NORTHWEST FAMILY CLINICS, ROBBINSDALE

IN PRACTICE 10 YEARS

If I were a patient, I would look for a physician who has very good listening skills. When we talk, he/she looks me in the eyes and is interested in what I'm saying, cares about what I think. He/she is not judgmental and doesn't push their agenda on me. He/she will respect my culture and background. We should work together to come up with a plan to diagnose or treat a disease.

A good physician makes patients feel important. Some patients said their physicians are hard to get hold of or do not call back for days or sometimes weeks. It is not safe and it is poor patient care. Another situation is lab and scan results. I know doctors who do not review their results for one to two weeks. Their patients may have deteriorated while waiting. I will not choose physicians like that to be mine.

If I were a patient, I would look for a physician that has very good listening skills. When we talk, he/she looks me in the eyes and is interested in what I'm saying, cares about what I think. **We should work together to come up with a plan to diagnose or treat a disease.**

Different specialties in medicine require different skill sets. Orthopedists don't always have the best people skills. They are like the plumber you called to fix a leak. You want them to do a good job; they are not here to be your confidant. However, an orthopedist with good people skills is extremely popular. My mentor was like that. He always got gifts from patients.

Because of my profession, I tend to regard good physicians as those who have good people skills, who don't make me feel like I'm a number. I once saw an eye doctor for a routine exam. He hardly looked at me and went through things very quickly. He made me feel like I was a number.

We primary-care physicians are patients' first line of contact when they do not feel well. We need to listen intently without bias or filtering out information to accurately come up with the correct diagnosis.

I see many patients with chronic fatigue syndrome (myalgic encephalomyelitis). It is a disease that got dismissed by many physicians. We did not learn about COVID, long COVID, or chronic fatigue syndrome in medical school. It does not mean that they do not exist. Many physicians in Minnesota do not even acknowledge that chronic fatigue syndrome exists, let alone treat it, even though CDC diagnostic criteria were published in 2015. Many patients who come to me were traumatized by physicians. They were told that the disease is in their heads, they just need to push harder, or that everyone is fatigued. These comments are hurtful and disrespectful. Because the cause of long COVID or chronic fatigue syndrome varies among patients, what some doctors do not understand is that there is no one way to treat these diseases. Graded exercise programs may work for some, but not all; some people get worse with exercises.

Kathryn Lombardo, MD

PSYCHIATRY, OLMSTED MEDICAL CENTER, SEMI-RETIRED

IN PRACTICE 28 YEARS

I've always worked in a multi-specialty group practice and have been involved in hiring many, many physicians over my years. I think the easy part is assuming people have received good training. What I look for, of course, is how they are going to care for patients. But I also look at how they are going to work with their coworkers. They need to collaborate with the patient, with partners, with nurses, with every single employee in the organization.

At Olmsted Medical Center, for our annual reviews, we have a 360-degree review. I think it's very important to have people provide that feedback for each other, especially when working so closely.

When I look at an individual who wants to work in an organization, they need to fully understand the mission and vision of that organization. At Olmsted Medical Center, we also had core values, that the patients always come first. I've always felt that my career is a service to others. You really have to have that type of lens, that patient's care comes first and you're looking out for their welfare.

How are clinicians created? It's really about educating them about what's important in an organization. Every single day, at work or not at work, the priority of their career is to provide great care to patients.

Medicine is a rigorous career. Every physician today would say it's more rigorous than it was even three years ago, a result of the challenges placed on us by the pandemic. During the pandemic, we had many needs for patient care and not very many good outcomes. This is a career that demands a lot from people, which means you need a lot of self-care. You have to take care of yourself, to be able to step away at times.

It takes really good clinicians and support staff supervisors to recognize bad performance. We need to ask, is there anything in their life that's changed. Are they coming to work late? Is care of patients declining? Have we not educated them enough?

Then we need to have conversations with the physician. Do they know there's a concern? Where is it coming from? Hopefully, with interventions, improvements can be made. Unfortunately, sometimes that doesn't work out and physicians have to look for a different position, or sometimes a different career.

My dad was a family physician—I'm 62 now, he's 89—and I spent many, many hours with him as he was doing his clinical work. I followed him to the hospital, to the clinic, while he was on house calls. His priority each day was to give the best care to his patients. He loved his practice and worked hard. I think that had a large impact on how I am as a physician and how I provide care not just to my patients but to families. I have provided care when they need it—sometimes house calls—all the way to the end of life.

What I look for, of course, is how they are going to care for patients. **But I also look at how they are going to work with their coworkers**. They need to collaborate with the patient, with partners, with nurses, with every single employee in the organization.

Vic Sandler, MD

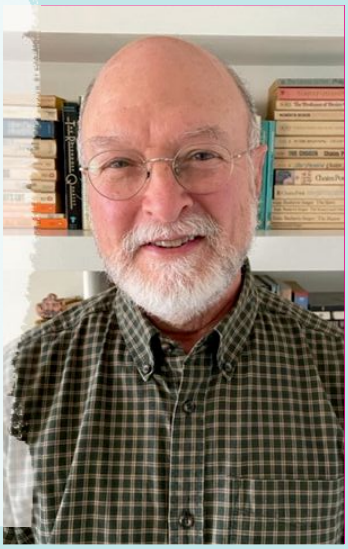
INTERNAL MEDICINE AND GERIATRIC MEDICINE, SPECIALIZING IN HOSPICE, HEALTHPARTNERS

IN PRACTICE 42 YEARS

I believe there are two major factors for a good physician: First, that they have mastery of their discipline of medicine. Second, that they have some sense of empathy in caring for their patients and their patients' families.

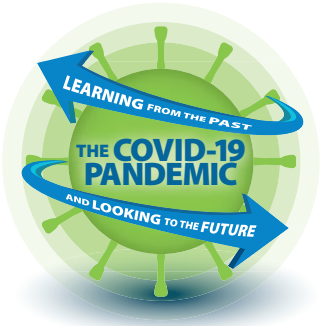
That has a number of parts to it. One is communication skills and the ability to be honest with patients and families, so they have a sense of being cared for. This is often referred to as bedside manner, but it's much more significant than that. It has some real importance in terms of patient healing. If they think what the physician tells them comes from a place of concern and compassion, they are more likely to do well.

Often, I hear from nurses who is a good physician. They observe communication skills and compassion. Physicians are often good to other physicians, but they also have to respect the others in the healthcare team they're working with. A physician has to have some humility; they have the expertise in medicine, but others may have expertise in other areas. They have to be able to listen to the nurses and take their input.



Expertise in medicine is acquired through your study and training, but the type of physician you become in terms of other qualities, I often wonder whether those skills can be taught. It's important that we take people into medical school who not only have an aptitude for medicine but also an aptitude for people. I think that's not emphasized enough in the selection. I'm on the faculty of the University of Minnesota for the fellowship in palliative medicine and I interview candidates for that fellowship. Their interpersonal skills are really important.

What I bring to medicine more than anything else is my ability to communicate and connect with families … and I probably learned that from my mother and father. **MM**



LESSONS LEARNED

Annual Conference faculty discuss how COVID-19 pandemic changed healthcare

More than two and a half years into the COVID-19 pandemic, there are still plenty of lessons to be learned. That's what Minnesota physicians heard at the September 23 virtual Annual Conference.

"We have a common issue," said José T. Montero, MD, MHCDS, director, Center for State, Tribal, Local, and Territorial Support, Centers for Disease Control and Prevention (CDC). "We don't know how to talk to elected officials." He said that CDC leaders learned along the way that they tried to be "too perfect" and "too scientific" in the information they shared with the public. It resulted in confusion and mistrust.

They also underestimated the "politicization of the pandemic," said Health Commissioner Jan Malcolm, noting that, although some leaders have declared the pandemic over, 400 people continue to die from it each day. "It's the fourth leading cause of death." She also pointed out that with each new booster that is rolled out, fewer people get shots.

Both Montero and Malcolm emphasized the need to improve communications to better handle the next public health emergency.

Glenda Eoyang, PhD, HSDP, the founder of the field of human systems dynamics, shared tools and techniques to help see patterns in chaos and how to react to them. She led a panel discussion with Lori Bethke, MD, chief medical officer at Entira Family Clinics; Jennifer DeCubellis, chief executive officer at Hennepin Healthcare; Krista Skorupa, MD, CPE, division chair, regional practices at Essentia Health; Cindy Firkins Smith, MD, senior vice president, rural health at CentraCare; and Prathibha Varkey, MBBS, president at Mayo Clinic Health System.

The panel shared lessons learned. Skorupa pointed out the "gift of COVID" and how the pandemic became a "change accelerator" for how medicine is practiced in Minnesota and across the country.

The conference was sponsored by COPIC, Army Medical Professionals, Advanced Brain + Body Clinic, Ferring and Minnesota Disability Hub.

2022 MMA Awards

In concert with the conference, the MMA honored four physicians, three physicians-in-training, a reproductive health researcher, and a pediatric advocacy organization. Each year, the MMA honors those in medicine for going above and beyond with these MMA Awards.

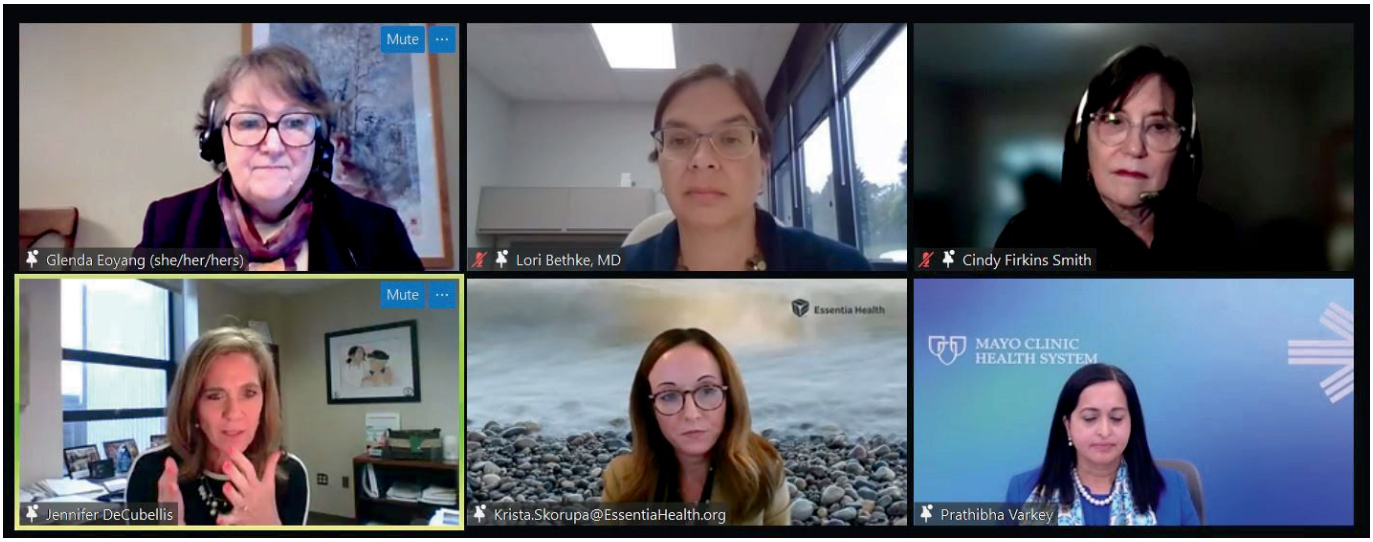
2022 winners include:

Distinguished Service Award

Bob Moravec, MD, received the MMA's highest honor, the Distinguished Service Award, for his years of service to the association and to medicine.

President's Award

Deb Dittberner, MD, and **Carolyn McClain**, MD, received the MMA's President's Award, which recognizes those who have given much of their free time to help improve the association.



Glenda Eoyang (upper left) led a robust discussion on how to deal with chaos with Lori Bethke, MD, Cindy Firkins Smith, MD, Jennifer DeCubellis, MD, Krista Skorupa, MD, and Prathibha Varkey, MD.

Medical Student Leadership Award

Michael Kelly and **Sinibaldo Romero Arocha** received the MMA's Medical Student Leadership Award, which recognizes medical students who demonstrate exemplary leadership in service to fellow medical students, the profession of medicine, and the broader community.

Resident and Fellow Leadership Award

Dan Pfeifle, MD, received the MMA's Resident and Fellow Leadership Award, which recognizes residents/fellows who demonstrate exemplary leadership in service to their peers, the profession of medicine, and the broader community.

James H. Sova Memorial Award for Advocacy

James H. Sova was the chief lobbyist for the MMA from 1968 until the time of his death in December 1981. This award is given to a person who has made a significant contribution to the advancement of public policy, medical sciences, medical education, medical care, or the socioeconomics of medical practice. **Rachel Hardeman**, PhD, MPH, is this year's recipient.

Eric C. Dick Memorial Health Policy Partner Award

This new award is given to an individual, a group of individuals, a project, or an organization that demonstrates commitment to pursuing sound public policy, building coalitions, or creating and/or strengthening partnerships with the goal of improving the health of Minnesotans or the practice of medicine in Minnesota. Dick was the MMA's manager of state legislative affairs from 2010 until his untimely death in January 2021. This year's recipient is the **Minnesota Chapter of the American Academy of Pediatrics**.

COPIC/MMA Foundation Humanitarian Award

Carolyn "Carrie" Stelter, MD, received the COPIC/MMA Foundation Humanitarian Award, which recognizes MMA members who go above and beyond to help address the healthcare needs of underserved populations in Minnesota.

To watch videos of the award winners, visit www.mnmed.org/education-and-events/Annual-Conference. MM

News Briefs

New Board members announced

Laurel Ries, MD, a family physician in St. Paul, has been elected as the MMA's president-elect. She assumed the role on October 1. MMA members voted for officials in August.

Ries will join the other 2023 officers on the Board: **Will Nicholson**, MD, a family physician and hospitalist in Maplewood, will serve as president (watch Nicholson's inauguration video at www.mnmed.org/education-and-events/Annual-Conference); **Randy Rice**, MD, a family physician in Moose Lake, assumes the role of immediate past president. **Kim Tjaden**, MD, a family physician in St. Cloud, continues as secretary-treasurer. **Edwin Bogonko**, MD, MBA, a hospitalist in Shakopee, continues as Board chair.

Other election results include:

Melissa Edgar, was elected as the medical student trustee.
Dionne Hart, MD, was re-elected as an MMA trustee.
Rebecca Thomas, MD, was re-elected as an MMA trustee.
Tjaden was re-elected as an MMA trustee.
Gaurav Mehta, MBBS, was elected as an MMA trustee.
Dennis O'Hare, MD, was elected as an AMA Delegate.
David Thorson, MD, was re-elected as an AMA Delegate.
George Morris, MD, was elected as an AMA Alternate Delegate.
Ashok Patel, MD, was re-elected as an AMA Alternate Delegate.
AMA delegates and alternate delegates take office beginning January 1, 2023.

Register now for December 8 Joy of Medicine Conference

Registration is now open for *Reclaim the Joy of Medicine: The 6th Annual Bounce Back Project Clinician Well-Being Conference* on December 8 from 9 am to 4:45 pm at the Crowne Plaza Minneapolis West, 3131 Campus Drive, Plymouth.

Featured speakers for the day include:

- Colin West, MD, PhD, will give the opening keynote, "From Burnout to Thriving in Modern Medicine."
- Conference founder Corey Martin, MD, will discuss well-being during the mid-day keynote.
- Taj Mustapha, MD, will close out the day with a talk on "The Intersection of Well-Being and Equity."

The day will also include breakout sessions in the morning and afternoon. For a full schedule and to register, visit www.mnmed.org/education-and-events/Reclaim-the-Joy-of-Medicine.

MMA Code of Conduct ensures that all are welcome

In order to create a welcome and inclusive environment for all physicians, trainees, staff, and guests, the MMA established a Code of Conduct. Each year, we remind members of the policy and encourage you to review it and help us create a space of belonging for all. View it at www.mnmed.org/MMA/media/Hidden-Documents/codeofconduct.pdf

MMA signs letter to Congress to fix Medicare payments

The MMA joined the AMA and more than 120 national specialty and state medical associations in a letter to Congressional leaders urging them to work on long-term solutions to fix the Medicare physician payment system.

"Instability is being driven by a confluence of fiscal uncertainties physician practices face related to statutory payment cuts, perennial lack of inflationary updates, significant administrative barriers, and the cumulative impact of the pandemic," said the letter sent in September to Speaker of the House Nancy Pelosi, Senate Majority Leader Chuck Schumer, Senate Minority Leader Mitch McConnell, and House Minority Leader Kevin McCarthy.

An AMA analysis found that Medicare physician payment has been reduced by 20%, adjusted for inflation from 2001 to 2021.

The letter urges Congress to do the following by the end of the year:

- Provide relief from the scheduled -4.42% budget neutrality cut in Medicare physician fee schedule payments.
- End the statutory annual freeze and provide a Medicare Economic Index (MEI) update for the coming year.
- Extend the 5% Advanced Alternative Payment Model (AAPM) participation incentive and halt the impossible-to-meet revenue threshold increase for five years to encourage more physicians to transition from fee-for-service into APMs.
- Waive the 4% PAYGO sequester triggered by passage of the American Rescue Plan Act.

MMA receives national awards for health-equity initiatives

The MMA recently received two 2022 Profiles of Excellence Awards from the American Association of Medical Society Executives (AAMSE) for its work on health equity.

These awards recognize the work of medical societies that make positive impacts on their members and in their communities. Each year, the Profiles of Excellence Awards program recognizes one member organization that has achieved excellence in a certain category.

The MMA received the Diversity, Equity, and Inclusion Award for its Minnesota Health Equity Community of Practice (CoP). Created in August 2021, the Health Equity Community of Practice is made up of health-equity champions and professionals who come together quarterly to exchange expertise, network, discuss health-equity issues and priorities, and identify opportunities for cross-organizational collaboration.

The MMA also received the Leadership Award for its Health Equity Time Out process. The MMA's Health Equity Time Out is an explicit policy and process used by MMA committees, task forces, and the Board of Trustees. Before taking action, a Health Equity Time Out is called to consider potential health equity implications. Like its surgical counterpart, the MMA's Health Equity Time Out is designed to create a safe space for any committee, Board member, or staff person to raise health-equity considerations each time decisions are made.

These initiatives are part of the MMA's ongoing commitment to promote health and racial equity and improve health outcomes for marginalized populations in Minnesota.

Physician toolkit to reverse overdose epidemic now available

The MMA, in partnership with the AMA and Providers Clinical Support System (PCSS), developed a physician toolkit designed to reverse the overdose epidemic. The physician toolkit gives Minnesota physicians resources, information, and tools to help treat patients dealing with substance use and substance abuse disorders, and provides opportunities to learn about better care for pain. The physician toolkit comes at a time when Minnesota public health officials have reported a record number of overdose deaths in 2021, most of which can be attributed to fentanyl. To learn how you can play a role in reversing the overdose epidemic, check out the physician toolkit at www.mnmed.org/MMA/media/Hidden-Documents/opioidtoolkit.pdf.

MMA comments on proposed changes to the Interstate Medical Licensure Compact rule

In September, the MMA submitted comments in support of proposed changes to Chapter 6 of the administrative rule, which clarifies the Interstate Medical Licensure Compact (IMLC).

The recent overturning of *Roe. v. Wade*, as a result of the U.S. Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* and subsequent state actions, resulted in inconsistency among state medical practice acts—legal action in one state is now illegal in another. This inconsistency raised many concerns with the IMLC, which was developed to provide an expedited pathway to licensure for physicians who already had a license in good standing in one state and were seeking licensure in another.

When the IMLC was formed, much effort was put into transparency and communication between state medical boards that were members of the IMLC. This was done to ensure that all states where a physician was licensed would be notified of any adverse actions taken against that physician in another member state. As part of this work, the IMLC Rule contained requirements for all member states to act against a physician licensed through the IMLC if that physician had action taken against their license in their state of principal licensure.

To help alleviate concerns and support state sovereignty, the IMLC commission has proposed amendments to the IMLC Rule clarifying that one member state cannot direct the actions of another member state against a licensee and that each member state has the discretion to choose when and how to discipline a licensee. There were additional amendments made to clarify that the IMLC does not authorize one member state to issue a subpoena for the appearance of a witness or testimony against a licensee for actions that are legal in that member state.

MMA submitted comments in support of the proposed amendments by the IMLC Commission and requested additional

amendments to clarify that a physician is only subject to the laws of the state in which the patient is located at the time of care.

Burnout rate for physicians spikes, study shows

Researchers found that 2020 marked the end of a six-year period of decline in the overall rate of work-induced burnout among physicians. By the end of 2021, after 21-months of the COVID-19 pandemic, the physician burnout rate spiked to a new height that was greater than previously monitored by researchers.

"While the worst days of COVID-19 pandemic are hopefully behind us, there is an urgent need to attend to physicians who put everything into our nation's response to COVID-19, too often at the expense of their own well-being," said AMA President Jack Resneck Jr., MD. "The sober findings from the new research demand urgent action as outlined in the AMA's Recovery Plan for America's Physicians, which focuses on supporting physicians, removing obstacles and burdens that interfere with patient care, and prioritizing physician well-being as essential requirements to achieving national health goals."

The new physician burnout research builds on landmark studies conducted at regular intervals between 2011 and 2021 by researchers from the AMA, Mayo Clinic, and Stanford Medicine. Together, these studies found the overall prevalence of burnout among U.S. physicians was 62.8% in 2021, compared with 38.2% in 2020, 43.9% in 2017, 54.4% in 2014, and 45.5% in 2011. Each study consistently demonstrated that the overall prevalence of occupational burnout among physicians was higher relative to the U.S. workforce.

Since 2012, the AMA has led the national conversation on solving the physician burnout crisis and advocated for new thinking and solutions that acknowledge physicians need support, system reforms, and burden reduction. The COVID-19 pandemic exacerbated many of the drivers of physician burnout. Research has shown that due to COVID-related stress, one in five physicians intend to leave their current practice within two years.

The AMA's ongoing work to mitigate physician burnout, as exemplified by the Recovery Plan for America's Physicians, strives to attack dysfunction in healthcare by removing obstacles and burdens that interfere with patient care. The AMA website offers physicians and health systems a choice of cutting-edge tools, information, and resources to help rekindle a joy in medicine, including:

STEPS Forward™ —a collection of more than 70 award-winning online toolkits offered by the AMA that help physicians and medical teams make transformative changes to their practices, covering everything from managing stress and preventing burnout to improving practice workflow.

Organization Biopsy™ —a set of measurement resources developed by the AMA that assess burnout levels within medical organizations to provide metrics that can guide solutions and interventions that mitigate system-level burnout rates and improve physician well-being.

International Conference on Physician Health—a biennial meeting held in October in Orlando, Florida, brought together the AMA, British Medical Association, and Canadian Medical Association to support health and well-being in the ranks of physicians and medical students.

Joy in Medicine™ ***Health System Recognition Program***—an AMA distinction, now in its third year, that recognizes health systems with a demonstrated commitment to pursue proven strategies that reduce work-related burnout among care teams.

Debunking Regulatory Myths—a series created by the AMA that provides physicians and their care teams with resources to reduce guesswork and administrative burdens and focus on streamlining clinical workflow processes, improving patient outcomes, and increasing physician satisfaction.

The AMA continues to work on every front to address the physician burnout crisis. Through research, collaborations, advocacy, and leadership, the AMA is working to make the patient-physician relationship more valued than paperwork, preventive care the focus of the future, technology an asset and not a burden, and physician burnout a thing of the past.

For more information on the MMA's work on physician wellness, visit www.mnmed.org/resources/MMA-Practice-Well-Collaboratory. Also, save the date for the Reclaim the Joy of Medicine: The 6th Annual Bounce Back Project Clinician Well-Being Conference on December 8 in Plymouth. Watch MMA *News Now* for future details.

BMP executive director to step down in February

Ruth Martinez, MA, the executive director of the Minnesota Board of Medical Practice (BMP), has announced that she will retire from the position in February 2023. A national search for her replacement is underway. Martinez has served as executive director since 2014 and was a supervisor of the Board's complaint review unit for 12 years before that.

Deadline approaching: legislatively mandated opioids CME needed by end of year

During the 2019 session, the Minnesota Legislature passed a law requiring individuals with licenses with the authority to prescribe controlled substances to obtain at least two hours of CME on best practices in prescribing opioids and controlled substances by the end of 2022. The MMA created an online, self-assessment activity that includes content on best practices in prescribing opioids and controlled substances, as well as non-pharmacological and implantable device alternatives for treatment of pain and ongoing pain management. Visit the MMA website (www.mnmed.org) for more information.

FROM THE CEO

The essential and hard work of adapting

If there is one thing the COVID-19 pandemic has taught all of us, it is that adapting to change is a necessary life skill. Physicians, and everyone else involved in healthcare, faced the need to adapt even more intensely than most. Adapting can be hard—it can mean changing old habits, disrupting established processes and systems, adopting new technology, and setting new expectations. Although adapting to change—both sudden change and predicted future change—is an ongoing process, the past two years have offered more than their share of sudden changes and events.

As is true for individuals, organizations also need to adapt or risk becoming irrelevant to their customers or, in the case of the MMA, their members.

The pandemic is not yet over and its impacts continue to ripple throughout the healthcare system and our broader economy. A September 2022 study, published in *Mayo Clinic Proceedings*, "Changes in Burnout and Satisfaction With Work-Life Integration in Physicians Over the First 2 Years of the COVID-19 Pandemic," found a dramatic 64% increase in symptoms of burnout between 2020 and 2021. The study found that nearly 63% of physicians had at least one manifestation of burnout in 2021, compared with 38.2% in 2020, 43.9% in 2017, 54.4% in 2014, and 45.5% in 2011.

The challenges faced in the early waves of the pandemic have given way to ever more concerning challenges—politicization of vaccines, workforce shortages, mistreatment and outright hostility toward healthcare professionals, and mistrust of physicians and science. The pandemic also further exposed racial inequities in Minnesota and across the county.

In the aftermath of the murder of George Floyd, physicians rightly pushed the MMA to intensify and accelerate its work to root out racism and bias in healthcare and to improve health equity.

Amid this dynamic, the U.S. Supreme Court in June, in its *Dobbs v. Jackson Women's Health Organization* decision, overturned nearly 50 years of precedent. The MMA, in partnership with several other Minnesota physician organizations, affirmed that abortion is a component of comprehensive medical care and that healthcare decisions, including whether to have an abortion, should be made between a patient and their physician.

These are just some of the inputs that informed the MMA Board of Trustees as it worked this year to revisit the MMA's strategic plan. Importantly, the Board reaffirmed its commitment to improving physician well-being and professional satisfaction; improving health equity; improving individual patient and population health; and empowering physicians to lead and navigate changing systems and roles. An unfortunate but critical new focus in our strategic plan is restoring trust in physicians and science.

There are plenty of uncertainties ahead of us, but also great opportunities. MMA leadership will continue to adapt our work to be laser-focused on the issues of greatest consequence to Minnesota physicians and their patients.

Janet Silversmith
JSilversmith@mnmed.org

VIEWPOINT

Together, we will make healthcare better

Will Nicholson, MD
MMA President

United as one profession, we make Minnesota the healthiest state in America and the best place to practice. This year, let's grow our ranks and expand our voice.

As you know, it has been a tough couple of years. Throughout the COVID-19 pandemic, we've seen facts lose to propaganda. We've seen science lose to conspiracy theory. And far too often, life and death decisions for our patients have been made far from the bedside. Each of us is working harder, risking more, and wondering when things are going to get better.

Healthcare is going to get better when physicians gang up and make it better. Together, we can work to steer healthcare back towards the things we hold most dear, the wellbeing of our patients, the wellbeing of our practices, and our own wellbeing.

As president, I'm excited to spend the next year working with the MMA staff to help make the practice of medicine in Minnesota better. Our team is working to improve things so you can focus on your patients.

- *Every physician doesn't need to become a social media influencer to fight back against propaganda.* The MMA communications team has your back.
- *Every physician doesn't need to build a relationship with leaders at the Capitol to steer our state towards better health.* The MMA legislative team has your back.
- *Every physician in Minnesota doesn't need to become a health policy expert to unravel the pros/cons of every new policy coming our way.* The MMA advocacy team has your back.
- *Every physician doesn't need to build a charitable foundation to help lift up our fellow physicians.* The MMA Foundation has your back.

Growing the team is imperative. The more members we have, the louder our voice! We are building an MMA that is bigger, more vibrant and more inclusive. Tell your colleagues and help us grow. **MM**

On October 1, Nicholson took over as the 156th president of the MMA. He is a family physician and hospitalist at St. John's Hospital in Maplewood. He has been a member since 2005.

Healthcare is going to get better when physicians gang up and make it better. Growing the team is imperative. The more members we have, the louder our voice! We are building an MMA that is bigger, more vibrant and more inclusive. Tell your colleagues and help us grow.

Minnesota Medical Association

FREE ONLINE COURSE FOR MEMBERS

PROGRAM ENDS 12.31.22

Best Practices for Prescribing Opioids

AND OTHER CONTROLLED SUBSTANCES

You need to earn 2 CME credits to fulfill the legislative mandate. Where better to turn than the Minnesota Medical Association, the state's largest physician advocacy organization?

During the 2019 session, the Minnesota Legislature passed a law that requires individuals with licenses with the authority to prescribe controlled substances to obtain CME on best practices in prescribing opioids and controlled substances.

To help physicians comply with this mandate, the MMA has developed an online, self-assessment activity that includes content on best practices in prescribing opioids as well as non-pharmacological and implantable device alternatives for treatment of pain and ongoing pain management.

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

Cost
MMA members are free, others pay $60.

Questions on the activity?
Email the MMA (cme@mnmed.org)

Questions about the mandate and how to provide documentation of course completion?
Email the Minnesota Board of Medical Practice (Medical.Board@state.mn.us)

For more information, visit
www.mnmed.org/opioidmandate

Medical student and resident work

Minnesota Medicine has invited and published abstracts and case studies from medical students, residents, and fellows for many years. Some of those submitting abstracts and case studies were invited to present posters at the Minnesota Medical Association Annual Conference.

This year was different. The MMA decided not to include posters in the Annual Conference, which was entirely virtual and, for whatever reason, the number of submissions was very small. Nevertheless, we feel it's worthwhile to publish what we can.

Three case studies are presented here. Another submission will be published in the January/February 2023 issue of *Minnesota Medicine*.

Male breast cancer

BY IBRAHIM ABDALLA AND NOELLE HOVEN, MD

A 60-year-old male presents with a suspicious breast mass on a contrast enhanced computed tomography (CT) chest examination. Subsequent evaluation in a breast imaging clinic with diagnostic mammography and targeted right breast ultrasound confirms an irregular mass in the upper outer right breast and right axillary lymphadenopathy.

Male breast cancer is rare, with a lifetime risk of 1 in 1,000 compared to women with a 1 in 8 lifetime risk of developing breast cancer, but the incidence is increasing. Men demonstrate worse long-term survival outcomes when compared to women in large pooled studies. The overall decreased survival in men relative to women has been attributed to delayed diagnosis or more advanced loco-regional disease. It also may be that male breast cancer is biologically different from breast cancer in women.

Invasive ductal carcinoma is the most common type of breast cancer in men, responsible for 85%-90% of cases, followed by ductal carcinoma *in situ* (DCIS). Risk factors for breast cancer include advanced age, germline genetic mutation (ex. BRCA2 gene mutation), chromosomal conditions (eg. Klinefelter syndrome), family history of breast cancer, high estrogen level, and history of chest irradiation.

It is important to differentiate male breast cancer from the more common clinical presentation of gynecomastia. This benign male breast proliferative process is commonly bilateral, subareolar in location and may present as a palpable concern with or without associated tenderness. Male breast cancer commonly presents as a palpable mass. Associated calcifications, nipple retraction, nipple discharge, suspicious lymph nodes, or skin thickening increase the level of suspicion for underlying breast malignancy. The treatment for male breast cancer is largely based on the treatment protocols for female breast cancer. Surgical treatment can include mastectomy with either axillary lymph node dissection or sentinel-node biopsy.

In this case, the diagnostic mammogram demonstrated a large irregular retroareolar mass in the right breast. Suspicious enlarged right axillary lymph nodes, right breast skin thickening, and right nipple retraction were also present. An ultrasound confirmed an irregular hypoechoic mass and suspicious right axillary lymph nodes with diffuse cortical thickening. Diagnosis of invasive ductal carcinoma grade 3 was established with an ultrasound-guided core needle right breast biopsy.

Conclusion

New or worsening breast symptoms, particularly in one part of one breast, should be further evaluated in a dedicated breast imaging center with diagnostic mammography and/or targeted ultrasound. Early detection is important to ensure appropriate treatment and improve overall survival. **MM**

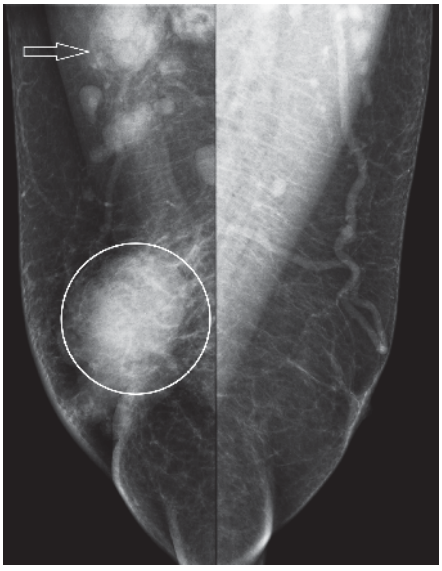


FIGURE 1

MLO view: Bilateral digital diagnostic mammography medial lateral oblique (MLO) views show right breast retroareolar mass (circle) and asymmetric right axillary lymphadenopathy (arrow).

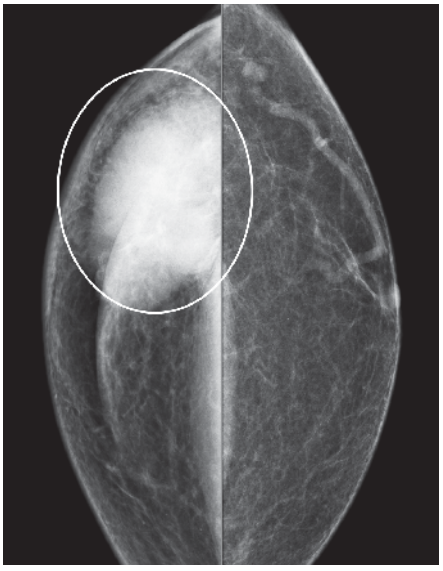


FIGURE 2

CC view: Bilateral digital diagnostic mammography craniocaudal (CC) views show right breast retroareolar mass (circle) and asymmetric right axillary lymphadenopathy.

Ibrahim Abdalla is a second-year medical student at the University of Minnesota Medical School and Noelle Hoven, MD, is an assistant professor in the Department of Diagnostic Radiology at the University of Minnesota.

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Rat-bite fever: A rare diagnosis in Minnesota

BY MICHELLE MCDONOUGH, MD, AND DOMINIKA A. JEGEN, MD

Rat-bite fever is a zoonotic illness caused by *Streptobacillus moniliformis* in North America and *Spirillum minus* in Asia. *Streptobacillus moniliformis* is a fastidious gram-negative rod found in respiratory and urinary flora in rodents. The infection is spread through contact with rodents (called Rat-bite fever) or through contaminated food or water (called Haverhill fever). The estimated incidence in the United States is 2,000 infections annually; the infection rate per rat bite is 10%, with 20,000 rat bites occurring each year. Susceptible populations include pet rat owners, those near rodent infestations, and veterinary workers. Children are more susceptible as their immune systems are not fully developed.

Typical presentation includes fever, rash, and polyarthralgias. Complications include abscesses, hepatitis, nephritis, pneumonia, meningitis, endocarditis, and pericarditis. The mortality rate ranges from 3% with early identification to 12% with delayed treatment. As blood cultures are unreliable due to the fastidious nature of this organism, increased awareness is needed for diagnosis. First-line therapy is Penicillin G. However, in most case reports, cephalosporins are started empirically and are effective. Alternative treatments include doxycycline and azithromycin.

Clinical presentation

Our patient is a 7-year-old female seen in clinic for finger pain, erythema, and reduced flexion two days after being bitten by her pet rat. She was diagnosed with cellulitis and started on amoxicillin-clavulanic acid (Augmentin), which she took for three days before stopping it prematurely. She returned to the emergency room nine days later with a fever of 102.2° F, headache, myalgias, pharyngitis, vomiting, poor oral intake, and rash reported for two days. The erythematous macular rash involved the extremities, but spared the axillae, face, and trunk (Figure 1). On inspection, the patient was lethargic, with conjunctival injection bilaterally. Cardiac and respiratory examination was unremarkable. She had no palpable lymphadenopathy. She had an unremarkable abdominal examination and active movement of all limbs. Her rat bite had healed. Kernig's and Brudzinski's signs were negative.

Laboratory investigations revealed a leukocytosis of 23.3, CRP 6.95, and ESR 18. Urinalysis, chest x-ray, and COVID-19 and influenza tests were all negative. She had hyponatremia with a sodium of 130. Liver enzymes and echocardiogram were unremarkable.

On hospital admission, she was given IV ceftriaxone at 20 mg/kg every 24 hours, IV normal saline at 20 cc/hr as multiple boluses, and antipyretics. She improved markedly within 12 hours. She remained afebrile thereafter and was discharged home two days later with 12 days of oral cephalexin. She showed a complete recovery by one-week follow-up. Blood cultures remained negative.

Discussion

In 2005, a similar case occurred in Minnesota in a 23-year-old who was critically ill. The case was sent to the Minnesota Department of Health for definitive diagnosis. This case demonstrates how Rat-bite fever can be missed owing to multiple non-specific symptoms as well as blood cultures that are often negative. As incidence is underestimated and presentation can involve severe illness with accessible treatment, we illustrate the importance of obtaining a detailed history and awareness of this illness. **MM**

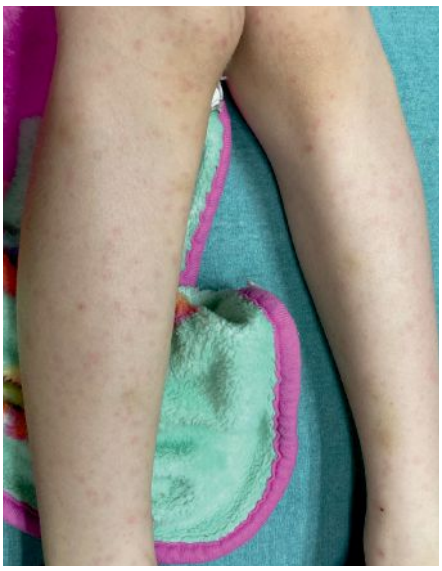

FIGURE 1

Erythematous macular rash present on extremities on Day 1 of hospitalization.

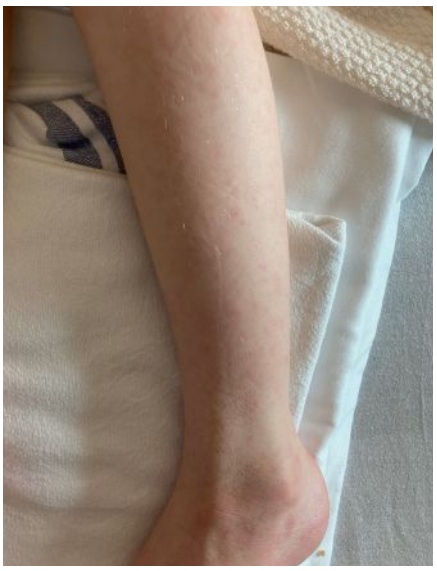

FIGURE 2

Improvement of rash after antibiotic therapy on day of discharge, Day 3 of hospitalization.

Michelle McDonough, MD, is a third-year resident in family medicine at Mayo Clinic. Dominika A. Jegen, MD, is in the Department of Family Medicine, Mayo Clinic Health System

The authors acknowledge Susan Laabs, MD, family medicine physician, who arranged for collaboration for this submission.

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Splenic infarct as a complication of a wandering spleen

BY SAVANNAH SEITER, AND KEITH STELTER, MD

A 14-year-old female presented to the Emergency Department with two days of abdominal pain, nausea, and vomiting. She reported diffuse abdominal pain that was most severe in the left upper quadrant. The pain was exacerbated by walking, talking, and lying down. She reported one episode of non-bloody emesis the previous day but said she had no fever, change in bowel habits, recent travel, alcohol use, or drug use. She had no relevant past medical history, had never been sexually active, and took no medications.

On exam, the patient was ill-appearing, pale, and lying in the fetal position on the bed. Vital signs demonstrated tachycardia to 173 bpm, a blood pressure of 110/64, respiratory rate of 22, and she was afebrile. The abdominal exam was notable for diffuse tenderness with guarding, worst in the left upper quadrant; heel-tap sign was positive. There was no rebound tenderness and bowel sounds were present.

Laboratory evaluation showed a leukocytosis to 24.6 and an elevated CRP. Lipase was normal. A CT scan of the abdomen was obtained and showed splenomegaly to 14.3 cm with a small amount of perisplenic fluid, and a total splenic infarct with moderate hemoperitoneum.

Following the diagnosis, the patient was transferred to a pediatric hospital, where she underwent a splenectomy. During surgery, torsion of the splenic vessels and anatomy consistent with a wandering spleen were found. She was discharged on the ninth post-operative day and followed up as an outpatient two months later to receive the pneumococcal, meningococcal, and Hib vaccines.

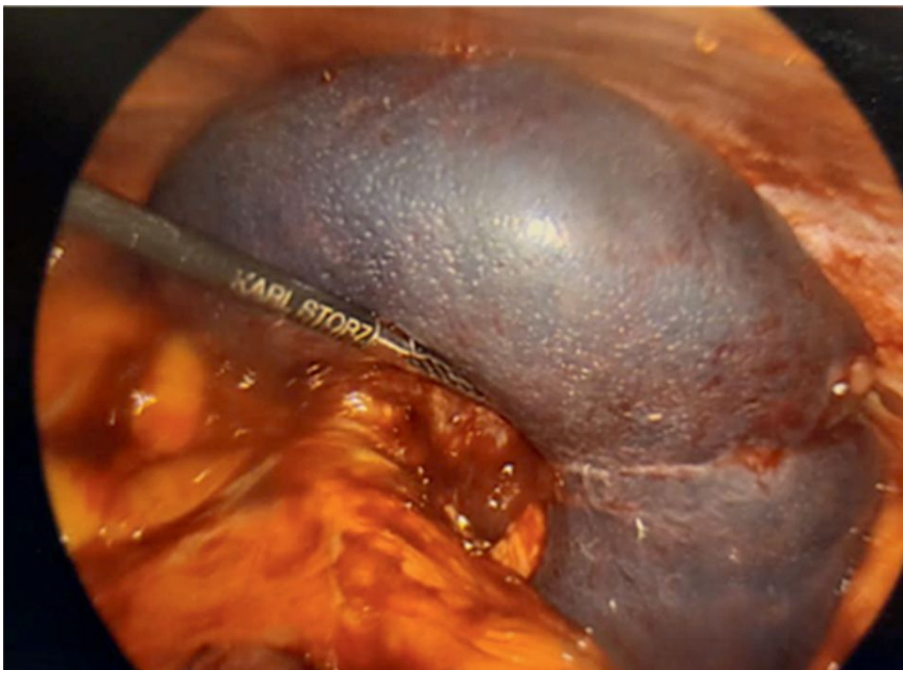
Discussion

The spleen is held in the left upper quadrant of the abdomen by four key ligaments—the gastrosplenic medially, the phrenosplenic superiorly, the splenorenal posteriorly, and the splenocolic inferiorly. A wandering spleen is defined as the absence or malformation of any one or more of these ligaments, which causes hypermobility of the spleen. This hypermobility results in an elongated vascular pedicle at the hilum, which is prone to torsion.

Wandering spleen has an estimated incidence of 0.2% and women of reproductive age are most commonly affected by the subsequent hilar torsion. It has been hypothesized that increased estrogen in women allows for additional ligamentous laxity, making the spleen more prone to torsion and subsequent infarct. Studies examining ACL tears in women support this hypothesis. Research has found that women are more likely to sustain ACL injuries during the follicular phase of their menstrual cycle when estrogen is the highest. *Ex vivo* studies provide additional support to this theory, having found that high estrogen levels are correlated with lower levels of lysyl oxidase, an enzyme that cross-links the collagen of ligaments.

This is one hypothesis as to why splenic infarct from a wandering spleen usually presents in women of reproductive age, and is a fitting explanation for this patient presentation as well. **MM**

Savannah Seiter is a fourth year medical student, University of Minnesota. Keith Stelter, MD, is a family medicine specialist, Mayo Clinic Health System.



FIGURE

Infarcted spleen during splenectomy.

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Carlson School of Management, University of Minnesota

Carlson Executive Education

Navigating Transition for Youth with Medical Complexity to Adult Care

The MMA is hosting a series of noon-time online sessions intended to develop a sustainable and collaborative knowledge-sharing community to improve the transition from pediatric to adult care for youth with medical complexity. Thanks to clinical and technological advances, many children with medical complexity now live into adulthood. Yet they face numerous practical hurdles in moving from pediatric care to adult providers. This project aims to improve the competence and confidence of Minnesota adult primary care clinicians to manage youth with complex conditions, thereby increasing the capacity and number of such clinicians willing to accept new patients.

ONLINE SESSIONS begin July 18, 2022, and running through March 2023.

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1. Publication Title	2. Publication Number	3. Filing Date
MINNESOTA MEDICAL ASSOCIATION/MINNESOTA MEDICINE	3 5 1 9 0 0	09/29/2022
4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
BI-MONTHLY	6	$45.00

7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4)
Addr 1: PO BOX 1150
Addr 2:
City, State ZIP: MINNEAPOLIS, MN 55480-1150
Contact Person: LINDA PICONE
Telephone: 612-362-3758

8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not Printer)
Addr 1: 3433 BROADWAY STREET NE STE 187
Addr 2:
City, State ZIP: MINNEAPOLIS, MN 55413-2199

9. Full Names and Complete Mailing Addresses of Publisher, Editor and Managing Editor (do not leave blank)
Publisher (Name and complete mailing address)
Name: MINNESOTA MEDICAL ASSOCIATION
Addr 1: 3433 BROADWAY STREET NE STE 187
Addr 2:
City, State ZIP: MINNEAPOLIS, MN 55413-2199
Editor (Name and complete mailing address)
Name: LINDA PICONE
Addr 1: 3433 BROADWAY STREET NE STE 187
Addr 2:
City, State ZIP: MINNEAPOLIS, MN 55413-2199
Managing Editor (Name and complete mailing address)
Name: LINDA PICONE
Addr 1: 3433 BROADWAY STREET NE STE 187
Addr 2:
City, State ZIP: MINNEAPOLIS, MN 55413-2199

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Full Name	Complete Mailing Address
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11. Known Bondholders, Mortgagees and Other Security Holders Owning or Holding 1 Percent or more of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → [X]

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12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
[X] Has Not changed During Preceding 12 Months
[ ] Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement below)

PS Form **3526**, July 2014

13. Publication Title		14. Issue Date for Circulation Data Below: 09/01/2022	
15. Extent and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to filing Date
a. Total Number of Copies (Net press run)		4,198	4,238
b. Paid and/or Requested Circulation	(1) Mailed Outside-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	3,847	3,883
	(2) Mailed In-County Paid Subscriptions Stated on PS Form 3541 (Include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)	0	0
	(3) Paid Distribution Outside the Mails Including Sales Through Dealers and Carriers, Street Vendors, Counter Sales ,and Other Paid Distribution Ouside USPS	0	0
	(4) Paid Distribution by Other Classes of Mail Through the USPS (e.g. First-Class Mail)	0	0
c. Total Paid Distribution [Sum of 15b. (1), (2), (3), and (4)]		3,847	3,883
d. Free or Nominal Rate Distribution (By Mail and Outside the Mail)	(1) Free or Nominal Rate Outside-County Copies Included on PS Form 3541	73	58
	(2) Free or Nominal In-County Copies Included on PS Form 3541	0	0
	(3) Free or Nominal Rate Copies Mailed at Other Classes Through the USPS (e.g. First-Class Mail)	0	0
	(4) Free or Nominal Rate Distribution Outside the Mail (Carriers or other means)	75	75
e. Total Free or Nominal Rate Distribution (Sum of 15d. (1), (2), (3) and (4))		148	133
f. Total Distribution (Sum of 15c. and 15e.)		3,995	4,016
g. Copies not Distributed (See Instructions to Publishers #4 (page #3))		204	222
h. Total (Sum of 15f. and g.)		4,199	4,238
i. Percent Paid (15c. Divided by 15f. Times 100)		96.30%	96.69%

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16. Electronic copy Circulation		
If present, check box →		X
a. Paid Electronic Copies	0	0
b. Total Paid Print Copies (Line 15c) + Paid Electronic Copies (Line 16a)	3,847	3,883
c. Total Print Distribution (Line 15F) + Paid Electronic Copies (Line 16a)	3,995	4,016
d. Percentage Paid (Both Print & Electronic Copies (16b divided bt 16c x 100)	96.30%	96.69%

[X] I certify that 50% of all my distribution copies (electronic and Print) are paid above a nominal price

17. Publication of Statement of Ownership
[X] Publication required. Will be printed in the **11/01/2022** issue of this publication. [ ] Publication not required

18. Signature and Title of Editor, Publisher, Business Manager, or Owner: *Linda Picone* — Title: EDITOR — Date: 09/29/2022

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DARON GERSCH, MD, FAAFP

- Trauma physician, ER medical director, CentraCare Long Prairie Hospital, and nursing home medical director, Mother of Mercy Nursing Home, Albany MN.
- MMA member since 1994.
- Grew up in St. James, MN. Graduated from Augustana University, Sioux Falls. Medical school at University of Minnesota Duluth and Twin Cities. Residency in Cedar Rapids, IA. Practiced the full spectrum of family medicine in Albany, MN 1994–2020, emergency medicine in Long Prairie since 2020.
- Albany City Councilmember 2009–2012 and mayor of Albany 2013–2018. President of the Minnesota Academy of Family Physicians 2013–2014.
- Wife, Patti Gersch, and adult children Nick, Molly, and Anthony. Family dog, Rocky.

Became a physician because…

I have always been interested in science and especially biology. I became interested in how the human body works and functions, what goes wrong with illness, and how to try and fix it. I have always been interested in all aspects of medicine and have always known that I wanted to live in a rural area. Putting those together made becoming a rural family physician a perfect fit for me.

Greatest challenge facing medicine today…

The greatest challenge/threat facing medicine today is that medicine and medical decisions are being made by third-party companies and not the doctors and patients themselves. They are basing these treatments on cost and not what is best for the patient. Physicians and healthcare providers are in danger of simply becoming widgets in a large medical industrial complex.

How I keep life balanced…

My family has always kept me grounded and balanced. I also like to read science fiction/fantasy novels and to run. I try to fish when I get a chance.

If I weren't a physician…

This is a hard question for me to answer since I've wanted to be a medical doctor since I was in seventh or eighth grade. Prior to that I wanted to be an astronaut. Given my interest in biology and human physiology, I most likely would've been working in a lab or as a professor at a university.

MATTHEW CARNS, MD

- Gastroenterologist, Mankato Clinic.
- MMA member since 2012.
- Grew up in Grafton, WI. Graduated from University of Minnesota with a BS in Food Science. Medical school at Medical College of Wisconsin, Milwaukee. Internal medicine residency, gastroenterology and human nutrition fellowship at University of Texas Health Science Center, San Antonio.
- Wife, Tina, whom he met while in Milwaukee. They lived in Texas for seven years while she was in the U.S. Army. Daughter, Lillie, 9 years old.

Became a physician because…

I always had an interest in science. As I advanced through school, I learned that lab work, in particular grant writing and focusing on getting published, was not for me. Medicine gives me the opportunity to continue to study science, but also allows me the chance to practice medicine as an art to restore and maintain health. I also enjoy performing procedures.

Greatest challenge facing medicine today…

Trying to digest the ever-expanding amount of information available. This is made more difficult by constantly changing computer technology and incompatible platforms that make transfer of records disorganized and often time-consuming to properly assess. I also think extra time requirements unfortunately contribute to the burnout that seems to be increasing as physicians try to balance work and home life.

How I keep life balanced…

I try to find little time slots where I can get a few of the tasks on my list done so that work doesn't pile up. Once there is a backlog, it is difficult to catch up. Using the remote features of the electronic record system is also a time saver. I can use that time to make sure I can fulfill my role as a "Dance Dad" for my daughter. We are usually on the go trying to keep up with Lillie's busy dance schedule! My family also likes to travel as a trio. We hike frequently and try to bike and ski as often as possible.

If I weren't a physician…

I would have continued in food science. Possibly as a cheesemaker.

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