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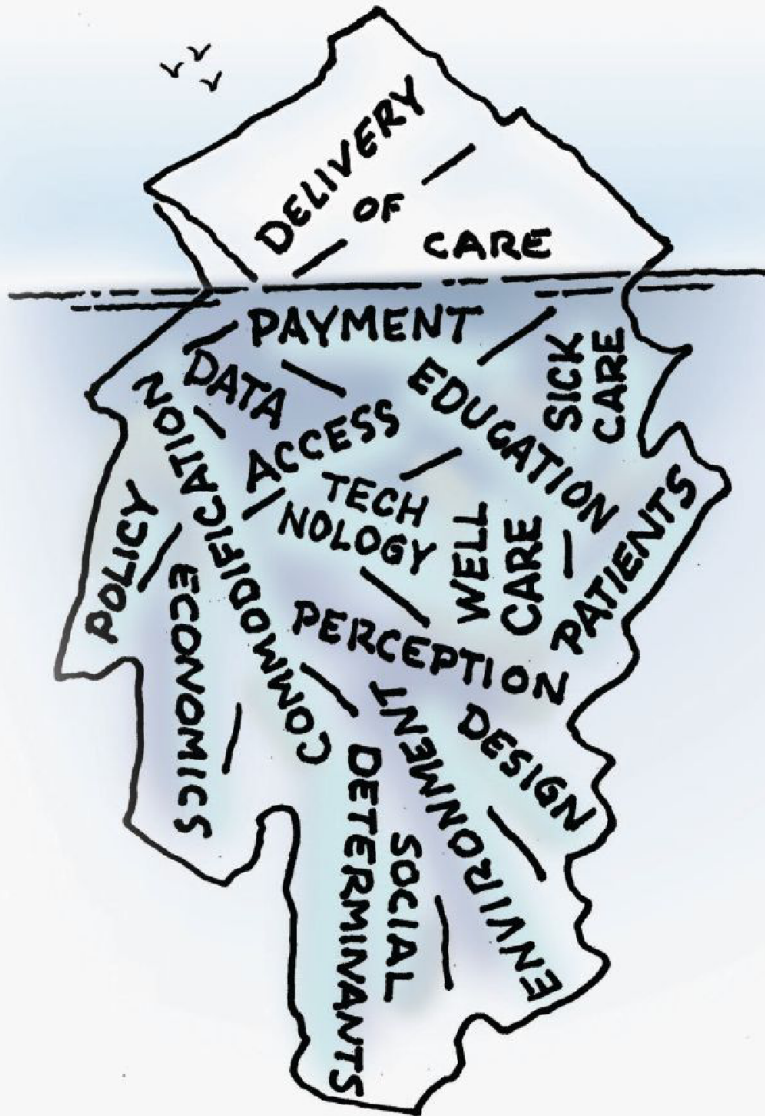
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*Victoza® 1.2 mg and 1.8 mg when used alone or in combination with OADs.

†Victoza® is not indicated for the management of obesity, and weight change was a secondary end point in clinical trials.

VICTOZA®
liraglutide (rDNA origin) injection

Indications and Usage

Victoza® (liraglutide [rDNA origin] injection) is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza® only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza® is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise.

In clinical trials of Victoza®, there were more cases of pancreatitis with Victoza® than with comparators. Victoza® has not been studied sufficiently in patients with a history of pancreatitis to determine whether these patients are at increased risk for pancreatitis while using Victoza®. Use with caution in patients with a history of pancreatitis.

Victoza® is not a substitute for insulin. Victoza® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings.

Victoza® has not been studied in combination with prandial insulin.

Important Safety Information

Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be ruled out by clinical or nonclinical studies. Victoza® is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Based on the findings in rodents, monitoring with serum calcitonin or thyroid ultrasound was performed during clinical trials, but this may have increased the number of unnecessary thyroid surgeries. It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate

human risk of thyroid C-cell tumors. Patients should be counseled regarding the risk and symptoms of thyroid tumors.

Do not use in patients with a prior serious hypersensitivity reaction to Victoza® (liraglutide [rDNA origin] injection) or to any of the product components.

If pancreatitis is suspected, Victoza® should be discontinued. Victoza® should not be re-initiated if pancreatitis is confirmed.

When Victoza® is used with an insulin secretagogue (e.g. a sulfonylurea) or insulin serious hypoglycemia can occur. Consider lowering the dose of the insulin secretagogue or insulin to reduce the risk of hypoglycemia.

Renal impairment has been reported post-marketing, usually in association with nausea, vomiting, diarrhea, or dehydration which may sometimes require hemodialysis. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment.

Serious hypersensitivity reactions (e.g. anaphylaxis and angioedema) have been reported during post marketing use of Victoza®. If symptoms of hypersensitivity reactions occur, patients must stop taking Victoza® and seek medical advice promptly.

There have been no studies establishing conclusive evidence of macrovascular risk reduction with Victoza® or any other antidiabetic drug.

The most common adverse reactions, reported in ≥5% of patients treated with Victoza® and more commonly than in patients treated with placebo, are headache, nausea, diarrhea, and anti-liraglutide antibody formation. Immunogenicity-related events, including urticaria, were more common among Victoza®-treated patients (0.8%) than among comparator-treated patients (0.4%) in clinical trials.

Victoza® has not been studied in type 2 diabetes patients below 18 years of age and is not recommended for use in pediatric patients.

There is limited data in patients with renal or hepatic impairment.

Please see brief summary of Prescribing Information on adjacent page.

Victoza® (liraglutide [rDNA origin] injection)**Rx Only****BRIEF SUMMARY. Please consult package insert for full prescribing information.**

WARNING: RISK OF THYROID C-CELL TUMORS: Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be ruled out by clinical or nonclinical studies. Victoza® is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Based on the findings in rodents, monitoring with serum calcitonin or thyroid ultrasound was performed during clinical trials, but this may have increased the number of unnecessary thyroid surgeries. It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate human risk of thyroid C-cell tumors. Patients should be counseled regarding the risk and symptoms of thyroid tumors [see *Contraindications and Warnings and Precautions*].

INDICATIONS AND USAGE: Victoza is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. **Important Limitations of Use:** Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise. In clinical trials of Victoza, there were more cases of pancreatitis with Victoza than with comparators. Victoza has not been studied sufficiently in patients with a history of pancreatitis to determine whether these patients are at increased risk for pancreatitis while using Victoza. Use with caution in patients with a history of pancreatitis. Victoza is not a substitute for insulin. Victoza should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings. The concurrent use of Victoza and prandial insulin has not been studied.

CONTRAINDICATIONS: Do not use in patients with a personal or family history of medullary thyroid carcinoma (MTC) or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Do not use in patients with a prior serious hypersensitivity reaction to Victoza or to any of the product components.

WARNINGS AND PRECAUTIONS: Risk of Thyroid C-cell Tumors: Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors (adenomas and/or carcinomas) at clinically relevant exposures in both genders of rats and mice. Malignant thyroid C-cell carcinomas were detected in rats and mice. A statistically significant increase in cancer was observed in rats receiving liraglutide at 8-times clinical exposure compared to controls. It is unknown whether Victoza® will cause thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors could not be determined by clinical or nonclinical studies [see *Boxed Warning, Contraindications*]. In the clinical trials, there have been 6 reported cases of thyroid C-cell hyperplasia among Victoza®-treated patients and 2 cases in comparator-treated patients (1.3 vs. 1.0 cases per 1000 patient-years). One comparator-treated patient with MTC had pre-treatment serum calcitonin concentrations >1000 ng/L suggesting pre-existing disease. All of these cases were diagnosed after thyroidectomy, which was prompted by abnormal results on routine, protocol-specified measurements of serum calcitonin. Five of the six Victoza®-treated patients had elevated calcitonin concentrations at baseline and throughout the trial. One Victoza® and one non-Victoza®-treated patient developed elevated calcitonin concentrations while on treatment. Calcitonin, a biological marker of MTC, was measured throughout the clinical development program. The serum calcitonin assay used in the Victoza® clinical trials had a lower limit of quantification (LLOQ) of 0.7 ng/L and the upper limit of the reference range was 5.0 ng/L for women and 8.4 ng/L for men. At Weeks 26 and 52 in the clinical trials, adjusted mean serum calcitonin concentrations were higher in Victoza®-treated patients compared to placebo-treated patients but not compared to patients receiving active comparator. At these timepoints, the adjusted mean serum calcitonin values (~1.0 ng/L) were just above the LLOQ with between-group differences in adjusted mean serum calcitonin values of approximately 0.1 ng/L or less. Among patients with pre-treatment serum calcitonin below the upper limit of the reference range, shifts to above the upper limit of the reference range which persisted in subsequent measurements occurred most frequently among patients treated with Victoza® 1.8 mg/day. In trials with on-treatment serum calcitonin measurements out to 5-6 months, 1.9% of patients treated with Victoza® 1.8 mg/day developed new and persistent calcitonin elevations above the upper limit of the reference range compared to 0.8-1.1% of patients treated with control medication or the 0.6 and 1.2 mg doses of Victoza®. In trials with on-treatment serum calcitonin measurements out to 12 months, 1.3% of patients treated with Victoza® 1.8 mg/day had new and persistent elevations of calcitonin from below or within the reference range to above the upper limit of the reference range, compared to 0.6%, 0% and 1.0% of patients treated with Victoza® 1.2 mg, placebo and active control, respectively. Otherwise, Victoza® did not produce consistent dose-dependent or time-dependent increases in serum calcitonin. Patients with MTC usually have calcitonin values >50 ng/L. In Victoza® clinical trials, among patients with pre-treatment serum calcitonin <50 ng/L, one Victoza®-treated patient and no comparator-treated patients developed serum calcitonin >50 ng/L. The Victoza®-treated patient who developed serum calcitonin >50 ng/L had an elevated pre-treatment serum calcitonin of 10.7 ng/L that increased to 30.7 ng/L at Week 12 and 53.5 ng/L at the end of the 6-month trial. Follow-up serum calcitonin was 22.3 ng/L more than 2.5 years after the last dose of Victoza®. The largest increase in serum calcitonin in a comparator-treated patient was seen with glimepiride in a patient whose serum calcitonin increased from 19.3 ng/L at baseline to 44.8 ng/L at Week 65 and 38.1 ng/L at Week 104. Among patients who began with serum calcitonin <20 ng/L, calcitonin elevations to >20 ng/L occurred in 0.7% of Victoza®-treated patients, 0.3% of placebo-treated patients, and 0.5% of active-comparator-treated patients, with an incidence of 1.1% among patients treated with 1.8 mg/day of Victoza®. The clinical significance of these findings is unknown. Counsel patients regarding the risk for MTC and the symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea or persistent hoarseness). It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate the potential risk of MTC, and such monitoring may increase the risk of unnecessary procedures, due to low test specificity for serum calcitonin and a high background incidence of thyroid disease. Patients with thyroid nodules noted on physical examination or neck imaging obtained for other reasons should be referred to an endocrinologist for further evaluation. Although routine monitoring of serum calcitonin is of uncertain value in patients treated with Victoza®, if serum calcitonin is measured and found to be elevated, the patient should be referred to an endocrinologist for further evaluation. **Pancreatitis:** In clinical trials of Victoza®, there have been 13 cases of pancreatitis among Victoza®-treated patients and 1 case in a comparator (glimepiride) treated patient (2.7 vs. 0.5 cases per 1000 patient-years). Nine of the 13 cases with Victoza® were reported as acute pancreatitis and four were reported as chronic pancreatitis. In one case in a Victoza®-treated patient, pancreatitis, with necrosis, was observed and led to death; however clinical causality could not be established. Some patients had other risk factors for pancreatitis, such as a history of cholelithiasis or alcohol abuse. There are no conclusive data establishing a risk of pancreatitis with Victoza® treatment. After initiation of Victoza®, and after dose increases, observe patients carefully for signs and symptoms of pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back and which may or may not be accompanied by vomiting). If pancreatitis is suspected, Victoza® and other potentially suspect medications should be discontinued promptly, confirmatory tests should be performed and appropriate management should be initiated. If pancreatitis is confirmed, Victoza® should not be restarted. Use with caution in patients with a history of pancreatitis. **Use with Medications Known to Cause Hypoglycemia:** Patients receiving Victoza® in combination with an insulin secretagogue (e.g., sulfonylurea) or insulin may have an increased risk of hypoglycemia. The risk of hypoglycemia may be

lowered by a reduction in the dose of sulfonylurea (or other concomitantly administered insulin secretagogues) or insulin [see *Adverse Reactions*]. **Renal Impairment:** Victoza® has not been found to be directly nephrotoxic in animal studies or clinical trials. There have been postmarketing reports of acute renal failure and worsening of chronic renal failure, which may sometimes require hemodialysis in Victoza®-treated patients [see *Adverse Reactions*]. Some of these events were reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration [see *Adverse Reactions*]. Some of the reported events occurred in patients receiving one or more medications known to affect renal function or hydration status. Altered renal function has been reversed in many of the reported cases with supportive treatment and discontinuation of potentially causative agents, including Victoza®. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment. **Hypersensitivity Reactions:** There have been postmarketing reports of serious hypersensitivity reactions (e.g., anaphylactic reactions and angioedema) in patients treated with Victoza®. If a hypersensitivity reaction occurs, the patient should discontinue Victoza® and other suspect medications and promptly seek medical advice. Angioedema has also been reported with other GLP-1 receptor agonists. Use caution in a patient with a history of angioedema with another GLP-1 receptor agonist because it is unknown whether such patients will be predisposed to angioedema with Victoza®. **Macrovascular Outcomes:** There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with Victoza® or any other antidiabetic drug.

ADVERSE REACTIONS: Clinical Trials Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. The safety of Victoza® has been evaluated in 8 clinical trials: A double-blind 52-week monotherapy trial compared Victoza® 1.2 mg daily, Victoza® 1.8 mg daily, and glimepiride 8 mg daily; A double-blind 26 week add-on to metformin trial compared Victoza® 0.6 mg once-daily, Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, placebo, and glimepiride 4 mg once-daily; A double-blind 26 week add-on to glimepiride trial compared Victoza® 0.6 mg daily, Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, placebo, and rosiglitazone 4 mg once-daily; A 26 week add-on to metformin + glimepiride trial, compared double-blind Victoza® 1.8 mg once-daily, double-blind placebo, and open-label insulin glargine once-daily; A double-blind 26-week add-on to metformin + rosiglitazone trial compared Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily and placebo; An open-label 26-week add-on to metformin and/or sulfonylurea trial compared Victoza® 1.8 mg once-daily and exenatide 10 mcg twice-daily; An open-label 26-week add-on to metformin trial compared Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, and sitagliptin 100 mg once-daily; An open-label 26-week trial compared insulin detemir as add-on to Victoza® 1.8 mg + metformin to continued treatment with Victoza® + metformin alone. **Withdrawals:** The incidence of withdrawal due to adverse events was 7.8% for Victoza®-treated patients and 3.4% for comparator-treated patients in the five double-blind controlled trials of 26 weeks duration or longer. This difference was driven by withdrawals due to gastrointestinal adverse reactions, which occurred in 5.0% of Victoza®-treated patients and 0.5% of comparator-treated patients. In these five trials, the most common adverse reactions leading to withdrawal for Victoza®-treated patients were nausea (2.8% versus 0% for comparator) and vomiting (1.5% versus 0.1% for comparator). Withdrawal due to gastrointestinal adverse events mainly occurred during the first 2-3 months of the trials. **Common adverse reactions:** Tables 1, 2, 3 and 4 summarize common adverse reactions (hypoglycemia is discussed separately) reported in seven of the eight controlled trials of 26 weeks duration or longer. Most of these adverse reactions were gastrointestinal in nature. In the five double-blind clinical trials of 26 weeks duration or longer, gastrointestinal adverse reactions were reported in 41% of Victoza®-treated patients and were dose-related. Gastrointestinal adverse reactions occurred in 17% of comparator-treated patients. Common adverse reactions that occurred at a higher incidence among Victoza®-treated patients included nausea, vomiting, diarrhea, dyspepsia and constipation. In the five double-blind and three open-label clinical trials of 26 weeks duration or longer, the percentage of patients who reported nausea declined over time. In the five double-blind trials approximately 13% of Victoza®-treated patients and 2% of comparator-treated patients reported nausea during the first 2 weeks of treatment. In the 26-week open-label trial comparing Victoza® to exenatide, both in combination with metformin and/or sulfonylurea, gastrointestinal adverse reactions were reported at a similar incidence in the Victoza® and exenatide treatment groups (Table 3). In the 26-week open-label trial comparing Victoza® 1.2 mg, Victoza® 1.8 mg and sitagliptin 100 mg, all in combination with metformin, gastrointestinal adverse reactions were reported at a higher incidence with Victoza® than sitagliptin (Table 4). In the remaining 26-week trial, all patients received Victoza® 1.8 mg + metformin during a 12-week run-in period. During the run-in period, 167 patients (17% of enrolled total) withdrew from the trial: 76 (46% of withdrawals) of these patients doing so because of gastrointestinal adverse reactions and 15 (9% of withdrawals) doing so due to other adverse events. Only those patients who completed the run-in period with inadequate glycemic control were randomized to 26 weeks of add-on therapy with insulin detemir or continued, unchanged treatment with Victoza® 1.8 mg + metformin. During this randomized 26-week period, diarrhea was the only adverse reaction reported in ≥5% of patients treated with Victoza® 1.8 mg + metformin + insulin detemir (11.7%) and greater than in patients treated with Victoza® 1.8 mg and metformin alone (6.9%).

Table 1: Adverse reactions reported in ≥5% of Victoza®-treated patients in a 52-week monotherapy trial

Adverse Reaction	All Victoza® N = 497 (%)	Glimepiride N = 248 (%)
Nausea	28.4	8.5
Diarrhea	17.1	8.9
Vomiting	10.9	3.6
Constipation	9.9	4.8
Headache	9.1	9.3

Table 2: Adverse reactions reported in ≥5% of Victoza®-treated patients and occurring more frequently with Victoza® compared to placebo: 26-week combination therapy trials

Adverse Reaction	Add-on to Metformin Trial		
	All Victoza® + Metformin N = 724 (%)	Placebo + Metformin N = 121 (%)	Glimepiride + Metformin N = 242 (%)
Nausea	15.2	4.1	3.3
Diarrhea	10.9	4.1	3.7
Headache	9.0	6.6	9.5
Vomiting	6.5	0.8	0.4
Adverse Reaction	Add-on to Glimepiride Trial		
	All Victoza® + Glimepiride N = 695 (%)	Placebo + Glimepiride N = 114 (%)	Rosiglitazone + Glimepiride N = 231 (%)
Nausea	7.5	1.8	2.6
Diarrhea	7.2	1.8	2.2
Constipation	5.3	0.9	1.7
Dyspepsia	5.2	0.9	2.6

Add-on to Metformin + Glimepiride			
	Victoza® 1.8 mg + Metformin + Glimepiride N = 230	Placebo + Metformin + Glimepiride N = 114	Gargine + Metformin + Glimepiride N = 232
Adverse Reaction	(%)	(%)	(%)
Nausea	13.9	3.5	1.3
Diarrhea	10.0	5.3	1.3
Headache	9.6	7.9	5.6
Dyspepsia	6.5	0.9	1.7
Vomiting	6.5	3.5	0.4
Add-on to Metformin + Rosiglitazone			
	All Victoza® + Metformin + Rosiglitazone N = 355	Placebo + Metformin + Rosiglitazone N = 175	
Adverse Reaction	(%)	(%)	
Nausea	34.6	8.6	
Diarrhea	14.1	6.3	
Vomiting	12.4	2.9	
Headache	8.2	4.6	
Constipation	5.1	1.1	

Table 3: Adverse Reactions reported in ≥5% of Victoza®-treated patients in a 26-Week Open-Label Trial versus Exenatide

	Victoza® 1.8 mg once daily + metformin and/or sulfonylurea N = 235	Exenatide 10 mcg twice daily + metformin and/or sulfonylurea N = 232
Adverse Reaction	(%)	(%)
Nausea	25.5	28.0
Diarrhea	12.3	12.1
Headache	8.9	10.3
Dyspepsia	8.9	4.7
Vomiting	6.0	9.9
Constipation	5.1	2.6

Table 4: Adverse Reactions in ≥5% of Victoza®-treated patients in a 26-Week Open-Label Trial versus Sitagliptin

	All Victoza® + metformin N = 439	Sitagliptin 100 mg/day + metformin N = 219
Adverse Reaction	(%)	(%)
Nausea	23.9	4.6
Headache	10.3	10.0
Diarrhea	9.3	4.6
Vomiting	8.7	4.1

Immunogenicity: Consistent with the potentially immunogenic properties of protein and peptide pharmaceuticals, patients treated with Victoza® may develop anti-liraglutide antibodies. Approximately 50-70% of Victoza®-treated patients in the five double-blind clinical trials of 26 weeks duration or longer were tested for the presence of anti-liraglutide antibodies at the end of treatment. Low titers (concentrations not requiring dilution of serum) of anti-liraglutide antibodies were detected in 8.6% of these Victoza®-treated patients. Sampling was not performed uniformly across all patients in the clinical trials, and this may have resulted in an underestimate of the actual percentage of patients who developed antibodies. Cross-reacting anti-liraglutide antibodies to native glucagon-like peptide-1 (GLP-1) occurred in 6.9% of the Victoza®-treated patients in the double-blind 52-week monotherapy trial and in 4.8% of the Victoza®-treated patients in the double-blind 26-week add-on combination therapy trials. These cross-reacting antibodies were not tested for neutralizing effect against native GLP-1, and thus the potential for clinically significant neutralization of native GLP-1 was not assessed. Antibodies that had a neutralizing effect on liraglutide in an *in vitro* assay occurred in 2.3% of the Victoza®-treated patients in the double-blind 52-week monotherapy trial and in 1.0% of the Victoza®-treated patients in the double-blind 26-week add-on combination therapy trials. Among Victoza®-treated patients who developed anti-liraglutide antibodies, the most common category of adverse events was that of infections, which occurred among 40% of these patients compared to 36%, 34% and 35% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. The specific infections which occurred with greater frequency among Victoza®-treated antibody-positive patients were primarily nonserious upper respiratory tract infections, which occurred among 11% of Victoza®-treated antibody-positive patients; and among 7%, 7% and 5% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. Among Victoza®-treated antibody-negative patients, the most common category of adverse events was that of gastrointestinal events, which occurred in 43%, 18% and 19% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. Antibody formation was not associated with reduced efficacy of Victoza® when comparing mean HbA_{1c} of all antibody-positive and all antibody-negative patients. However, the 3 patients with the highest titers of anti-liraglutide antibodies had no reduction in HbA_{1c} with Victoza® treatment. In the five double-blind clinical trials of Victoza®, events from a composite of adverse events potentially related to immunogenicity (e.g. urticaria, angioedema) occurred among 0.8% of Victoza®-treated patients and among 0.4% of comparator-treated patients. Urticaria accounted for approximately one-half of the events in this composite for Victoza®-treated patients. Patients who developed anti-liraglutide antibodies were not more likely to develop events from the immunogenicity events composite than were patients who did not develop anti-liraglutide antibodies. **Injection site reactions:** Injection site reactions (e.g., injection site rash, erythema) were reported in approximately 2% of Victoza®-treated patients in the five double-blind clinical trials of at least 26 weeks duration. Less than 0.2% of Victoza®-treated patients discontinued due to injection site reactions. **Papillary thyroid carcinoma:** In clinical trials of Victoza®, there were 7 reported cases of papillary thyroid carcinoma in patients treated with Victoza® and 1 case in a comparator-treated patient (1.5 vs. 0.5 cases per 1000 patient-years). Most of these papillary thyroid carcinomas were <1 cm in greatest diameter and were diagnosed in surgical pathology specimens after thyroidectomy prompted by findings on protocol-specified screening with serum calcitonin or thyroid ultrasound. **Hypoglycemia:** In the eight clinical trials of at least 26 weeks duration, hypoglycemia requiring the assistance of another person for treatment occurred in 11 Victoza®-treated patients (2.3 cases per 1000 patient-years) and in two exenatide-treated patients. Of these 11 Victoza®-treated patients, six patients were concomitantly using metformin and a sulfonylurea, one was concomitantly using a sulfonylurea, two were concomitantly using metformin (blood glucose values were 65 and 94 mg/dL) and two were using Victoza® as monotherapy (one of these patients was undergoing an intravenous glucose tolerance test and the other was receiving insulin as treatment during a hospital stay). For these two patients on Victoza® monotherapy, the insulin treatment was the likely explanation for the hypoglycemia. In the 26-week open-label trial comparing Victoza® to sitagliptin, the incidence of hypoglycemic events defined as symptoms accompanied by a fingerstick glucose <56 mg/dL was comparable among the treatment groups (approximately 5%).

Table 5: Incidence (%) and Rate (episodes/patient year) of Hypoglycemia in the 52-Week Monotherapy Trial and in the 26-Week Combination Therapy Trials

	Victoza® Treatment (N = 497)	Active Comparator (N = 248)	Placebo Comparator (N = 121)
Monotherapy	Victoza® (N = 497)	Glimepiride (N = 248)	None
Patient not able to self-treat	0	0	—
Patient able to self-treat	9.7 (0.24)	25.0 (1.66)	—
Not classified	1.2 (0.03)	2.4 (0.04)	—
Add-on to Metformin	Victoza® + Metformin (N = 724)	Glimepiride + Metformin (N = 242)	Placebo + Metformin (N = 121)
Patient not able to self-treat	0.1 (0.001)	0	0
Patient able to self-treat	3.6 (0.05)	22.3 (0.87)	2.5 (0.06)
Add-on to Victoza® + Metformin	Insulin detemir + Victoza® + Metformin (N = 163)	Continued Victoza® + Metformin alone (N = 158*)	None
Patient not able to self-treat	0	0	—
Patient able to self-treat	9.2 (0.29)	1.3 (0.03)	—
Add-on to Glimepiride	Victoza® + Glimepiride (N = 695)	Rosiglitazone + Glimepiride (N = 231)	Placebo + Glimepiride (N = 114)
Patient not able to self-treat	0.1 (0.003)	0	0
Patient able to self-treat	7.5 (0.38)	4.3 (0.12)	2.6 (0.17)
Not classified	0.9 (0.05)	0.9 (0.02)	0
Add-on to Metformin + Rosiglitazone	Victoza® + Metformin + Rosiglitazone (N = 355)	None	Placebo + Metformin + Rosiglitazone (N = 175)
Patient not able to self-treat	0	—	0
Patient able to self-treat	7.9 (0.49)	—	4.6 (0.15)
Not classified	0.6 (0.01)	—	1.1 (0.03)
Add-on to Metformin + Glimepiride	Victoza® + Metformin + Glimepiride (N = 230)	Insulin glargine + Metformin + Glimepiride (N = 232)	Placebo + Metformin + Glimepiride (N = 114)
Patient not able to self-treat	2.2 (0.06)	0	0
Patient able to self-treat	27.4 (1.16)	28.9 (1.29)	16.7 (0.95)
Not classified	0	1.7 (0.04)	0

*One patient is an outlier and was excluded due to 25 hypoglycemic episodes that the patient was able to self-treat. This patient had a history of frequent hypoglycemia prior to the study.

In a pooled analysis of clinical trials, the incidence rate (per 1,000 patient-years) for malignant neoplasms (based on investigator-reported events, medical history, pathology reports, and surgical reports from both blinded and open-label study periods) was 10.9 for Victoza®, 6.3 for placebo, and 7.2 for active comparator. After excluding papillary thyroid carcinoma events [see *Adverse Reactions*], no particular cancer cell type predominated. Seven malignant neoplasm events were reported beyond 1 year of exposure to study medication, six events among Victoza®-treated patients (4 colon, 1 prostate and 1 nasopharyngeal), no events with placebo and one event with active comparator (colon). Causality has not been established. **Laboratory Tests:** In the five clinical trials of at least 26 weeks duration, mildly elevated serum bilirubin concentrations (elevations to no more than twice the upper limit of the reference range) occurred in 4.0% of Victoza®-treated patients, 2.1% of placebo-treated patients and 3.5% of active-comparator-treated patients. This finding was not accompanied by abnormalities in other liver tests. The significance of this isolated finding is unknown. **Vital signs:** Victoza® did not have adverse effects on blood pressure. Mean increases from baseline in heart rate of 2 to 3 beats per minute have been observed with Victoza® compared to placebo. The long-term clinical effects of the increase in pulse rate have not been established [see *Warnings and Precautions*]. **Post-Marketing Experience:** The following additional adverse reactions have been reported during post-approval use of Victoza®. Because these events are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure: Dehydration resulting from nausea, vomiting and diarrhea [see *Warnings and Precautions*]; Increased serum creatinine, acute renal failure or worsening of chronic renal failure, sometimes requiring hemodialysis [see *Warnings and Precautions*]; Angioedema and anaphylactic reactions [see *Contraindications, Warnings and Precautions*]

OVERDOSAGE: In a clinical trial, one patient with type 2 diabetes experienced a single overdose of Victoza® 17.4 mg subcutaneous (10 times the maximum recommended dose). Effects of the overdose included severe nausea and vomiting requiring hospitalization. No hypoglycemia was reported. The patient recovered without complications. In the event of overdosage, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms.

More detailed information is available upon request.

For information about Victoza® contact: Novo Nordisk Inc., 100 College Road West, Princeton, New Jersey 08540, 1-877-484-2869

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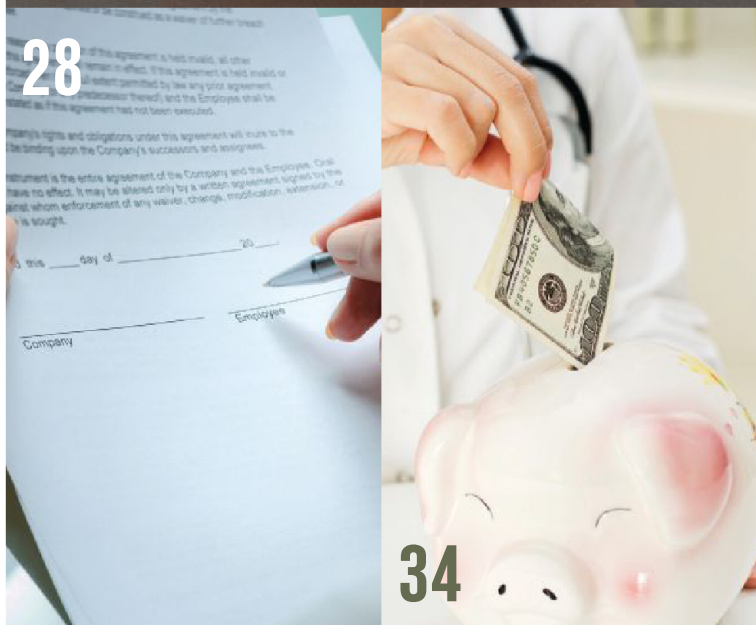
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PHOTO BY SCOTT WALKER

Charles R. Meyer, M.D., Editor in Chief

Becoming a physician has always been intimidating, and it isn't getting easier.

Not for the faint-hearted

I remember my first day of medical school, sitting in an auditorium with 160 other first-year students wondering if I could handle the work. I was intimidated. I remember my first day of residency, gathering with my fellow residents and our attending on the hospital ward, suffused with uncertainty about knowing enough medicine not to kill anybody. I was intimidated. I remember my first day of medical practice, donning my white coat in our little office, hoping my new partners wouldn't have second thoughts about hiring this young kid. I was intimidated. At every step of the journey through medical training and into practice is a Scylla of doubt and a Charybdis of anxiety. Today's medical trainees have to face the added hurdle of paying back mountains of educational debt. Becoming a physician has always been intimidating, and it isn't getting easier.

Medical education has never been cheap. Four years of college and four years of medical school are followed by three to seven years of residency, which usually pays a wage that buys sustenance but certainly doesn't help retire student loans, especially those for tuition, which seems to keep ballooning year after year. When I graduated from Northwestern Medical School in 1974, tuition was \$3,300 per year. Now tuition at Northwestern and other private medical schools hovers at around \$50,000 per year. Talk about intimidating.

And although money has always been a factor in students' decisions about education and profession, it now more than ever seems to drive many of the choices doctors-to-be make. Faced with \$150,000

to \$200,000 in loans coming out of medical school, newly minted MDs have done the math and increasingly chosen subspecialties that promise higher pay and quicker loan retirement. Looking for ways to pad their meager salary during training, young physicians wedge moonlighting gigs into an already stuffed life. Once they finish training, they face a health care system dominated by big—big medical groups, big health care corporations and big government. The once-lucrative option of private practice is evaporating in many U.S. markets, so doctors fresh out of residency need to understand how to read an employment contract more than how to build a practice.

As articles in this month's issue describe, help is available to the debt-encumbered. Although there is no free lunch, most programs ask young doctors to use their skills in a setting where they are needed. Their service pays for their loans.

The desire to be of service has always been part of what makes doctors tick, and hopefully the call to serve will always top the list of reasons to pursue a career in medicine. Indeed, commitment to service seems alive and well as our medical students and residents collect medical supplies for underdeveloped countries, practice in the inner city or travel abroad to tackle the world's dire problems. Stories about up and coming physicians like these suggest that the new cadre of physicians is not intimidated by the frightening-but-exciting medical world they are entering. **MM**

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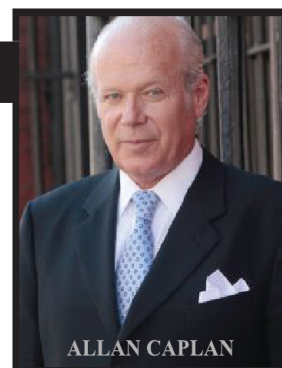


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Residency and drowsy driving

Long hours in the hospital may be responsible for more than stress and fatigue among residents. They also may be associated with motor vehicle crashes.

In a survey of approximately 300 Mayo Clinic residents, nearly half (43 percent) reported almost having an accident during their training and 11 percent had actually been involved in a crash. The residents attributed the incidents and near-misses to fatigue or distress, which includes feelings of burnout and depression.

“The mere fact that motor vehicle incidents are common among residents brings the issues of resident fatigue, sleepiness and distress to a new level of priority,” lead author Colin West, M.D., Ph.D., said in a statement.

Residents were surveyed quarterly between July 1, 2007, and July 31, 2010. The findings were reported in the December 2012 *Mayo Clinic Proceedings*.



Experience pays

Physicians with the least experience drive up health care costs, according to a recent article in *Health Affairs*.

Researchers from the RAND Corporation and Kaiser Permanente Center for Effectiveness and Safety Research, analyzed cost profiles created from health insurance claims for physicians in Massachusetts. They found overall costs for those with less than 10 years of experience were 13.2 percent higher than those for physicians with 40 or more years of experience. They found no associations between cost and other factors including having malpractice claims or disciplinary actions, board certification status, patient volume and practicing in a large or small group.

The authors identified two possible reasons why physicians with less experience have higher costs: 1) they have more costly practice patterns (they order more diagnostic tests, treat patients more aggressively, use newer, more expensive treatments), and 2) they may treat sicker patients with more complex medical problems than their more experienced peers.

They also warned that unless less-experienced physicians change the way they practice, they could be excluded from high-value networks or receive lower payments through Medicare’s proposed value-based payment program.

Source: Mehrotra A, Reid RO, Adams JL, et al. *Physicians with the Least Experience have Higher Cost Profiles than do Physicians with the Most Experience*. *Health Aff.* 2012; 31(11):2453-63.



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Making it “just happen”

A group started by medical students raises money for health projects in developing countries and awareness here at home.

BY KIM KISER

During spring break his first year of medical school, Curt Nordgaard traveled to Peru. His itinerary included visits to Universidad de San Martín de Porres, which has a relationship with the University of Minnesota Medical School, where he was studying, as well as several hospitals and clinics in and around Lima.

Although he wasn't planning on it, Nordgaard also stopped at an orphanage on the outskirts of town. There, he was struck by both the children and the dedicated people who served them. He found he couldn't ignore their needs—for supplies, for food, for everything. “When I came back, I felt like I didn't want to forget about it and leave it behind,” he recalls. “I wanted to do something to support them.”

That trip was the impetus for the Just Health Network, which was created in 2009 by Nordgaard and four other medical students who had also traveled overseas.

The network raises money for things that its founders say “should just happen” in order for people to be healthy—children ought to have food, for example. “The unifying idea was to generate support for community programs and to help people in Minnesota understand some of what's going on in the developing world,” he says.

Just Health's first project involved arranging for toothbrushes, toothpaste and other dental supplies as well as money for food and medical care to be sent to the orphanage in Peru. Another provided food for an orphanage in Zambia that cared for children with HIV. “Some of the children were unable to take their meds because they needed to be taken with food and they didn't have enough to eat,” Nordgaard says. And another helped a group of single mothers in Tanzania purchase livestock to raise and sell.

Thinking bigger

Nordgaard says he and his colleagues, Abe Markin, Evan Skow, Ben Pederson and Nathan Mustain, have raised money for these projects through Eat for Equity dinners (dinner parties for a cause) in the Twin Cities and other fundraisers. He says Just Health Network's donations have averaged about \$1,000 per project. “We might not generate much funding,” he says, “but we're reaching groups of young people and spending time talking to them about the issues and the projects we're supporting.”

The size of the donations may soon grow, however. Just Health Network is in the process of becoming a 501(c)(3) organization. Nordgaard, who is in his first year of a pediatrics residency in Boston, says having tax-exempt status will allow them to solicit contributions from donors.

With growth in mind, they have taken on a more long-term project aimed at increasing access to primary care in northern Uganda, which is still recovering from a three-decade-long war between government forces and rebels. Mustain traveled there after his first year of medical school to work on a documentary film. On that trip, he met a Ugandan physician, Ocan Francis, M.D., who was finishing up his



LEFT: Patients wait at a mobile clinic operated by Ocan Francis, M.D. ABOVE: Curt Nordgaard, M.D., and Francis. TOP RIGHT: Francis and Nathan Mustain.



PHOTOS COURTESY OF CURT NORDGAARD AND NATHAN MUSTAIN

medical degree at the time. He was impressed with how Francis would travel to camps in the northern part of the country every other weekend to care for people who had been displaced from their homes. “He and another guy would provide health care all day,” Mustain says. “I was struck by how noble that was and how they weren’t doing this through some big multinational organization. This was neighbor helping neighbor with a little boost of outside resources [for medications].”

Francis and his father, who is also a physician, have been building a health center in Patongo, a town in an isolated part of the region. “They had taken out personal loans to purchase a building,” says Nordgaard, who visited Uganda with Mustain last spring. Nordgaard and Mustain noted what was happening with the health center so they could share stories about its progress with people back home. Thus far, Just Health has contributed several thousand dollars to the project.

Far from finished

Nordgaard, who wants to return to Minnesota after his residency, and Mustain, who will begin his residency at North Memorial’s Broadway Family Medicine Clinic

The construction site of the Patongo health center, which will one day have surgical capacity. Mustain says the fact that 80 percent of area women who need emergent C-sections die before they reach a facility capable of performing the procedure convinced him of the need for the center.

in Minneapolis later this summer, remain committed to Just Health Network, along with a handful of undergraduate students at the University of Minnesota. Nordgaard is working with a Boston organization, The Child is Innocent, which provides education and leadership training to children in northern Uganda, to pool resources. Mustain says he will continue working on local fundraisers.

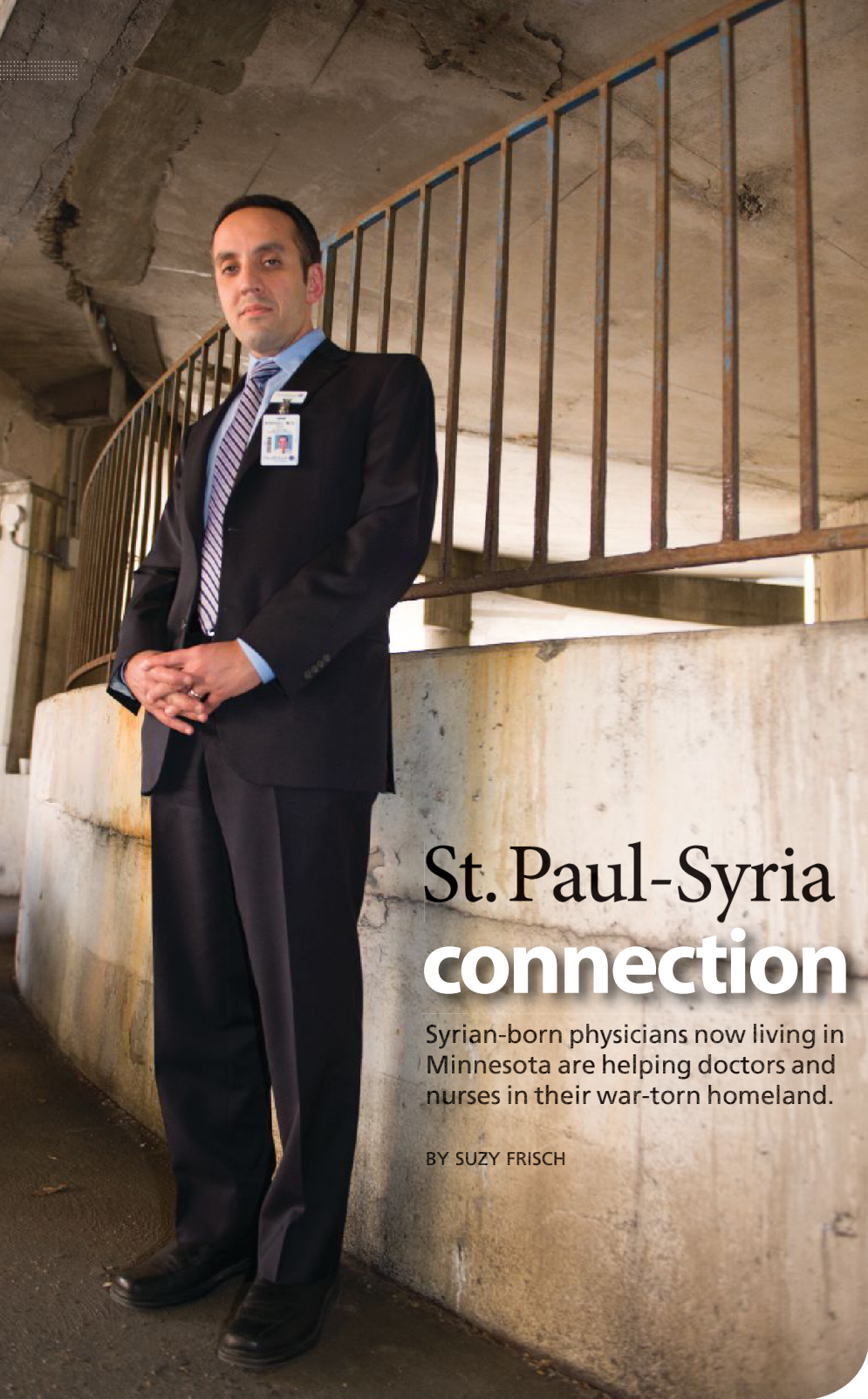
Although both want to return to Uganda in the near future, they emphasize to those who might give to the network that Ugandans are the ones providing the care there. “We’re hoping to show the advantage of utilizing the strengths of local communities,” Nordgaard says. “We don’t want to be the ones going and providing

care. We want to empower the local providers to do it.” MM

Kim Kiser is senior editor of *Minnesota Medicine*.



To learn more, search for Just Health Network on Facebook.



Wael Khouli wants to build a better system for getting medical supplies to the places where they're needed.

class project—he's enrolled in the executive MBA program at Yale University—and see firsthand what was happening there. "Many doctors and nurses started providing care secretly. If they get arrested, they will be tortured and killed for providing medical care."

As a result, many Syrian physicians have fled the country, while others try to care for patients in temporary field hospitals in homes, garages and vacant buildings. It's far from easy. They often lack the supplies and training needed to handle complicated trauma cases, and they must do their jobs while under the risk of attack by Syrian forces.

Khouli and another Syrian physician based in Minnesota, Mohammed Anas—who asked that his last name not be published to protect his family in Syria—are trying to help health care workers there.

Setting up a supply chain

Since September 2012, Khouli has been working to develop a better system for getting supplies to hospitals. Using both his medical and business knowledge, he is building a database containing information about what supplies hospitals have, what they need, their capacity for treating patients, and their access to resources such as water, electricity and the Internet. The hope is that it would be used by relief workers in Turkey to guide their decisions as they seek to provide support. Once that is operational, he plans to set up a virtual supply chain in order to better coordinate requests for supplies from hospitals with deliveries from those providing supplies. The goals are to make the process more efficient and to document the transactions.

Khouli, who has lived in the United States since 1997, when he went to Michigan for residency, has stayed on top of the situation in Syria through social media and involvement with two groups—the Washington D.C.-based Syrian Expatriates Organization (SEO) and the Syrian American Medical Society (SAMS) in Canfield, Ohio. When he started his project, he did phone interviews with medical relief organizers here and in the region. He also participated in weekly Skype conversations

St. Paul-Syria connection

Syrian-born physicians now living in Minnesota are helping doctors and nurses in their war-torn homeland.

BY SUZY FRISCH

PHOTO BY KATHRYN FORSS

Of the many tragedies unfolding during the Syrian civil war, the one that particularly incenses Wael Khouli, M.D., is how government forces repeatedly target doctors and nurses trying to provide medical care. Since the start of the uprising in his native country two years ago, more than 100 doctors have been killed while treating patients and hundreds more are jailed or missing.

"From the beginning, the regime drew the line that you cannot deliver medical care to protestors—and these were peaceful protestors. Five days into the uprising, one of my classmates was the first doctor to be killed by the regime," says Khouli, an internist who is director of care management for HealthEast's three hospitals in St. Paul and Woodbury. Last fall, he traveled to Syria and Turkey to do research for a

with representatives of relief organizations to hear updates from the ground. He decided to travel to Syria, where some of his relatives have been killed and jailed or are missing, to talk in person with Syrian doctors and nurses, see their working conditions and get a better understanding of the challenges they face.

He went first to Turkey, visiting Hatay and Gaziantep, the two largest cities near the Syrian border, where he met with staff from several medical relief organizations. Guided by another doctor from northwestern Syria, Khouli also went to the areas around Idlib and Aleppo in Syria. In addition, he visited several medical facilities and warehouses to see how supply distribution is handled.

Khouli learned that there was no good system for ordering and keeping track of supplies. In fact, he met a man who carried with him a notebook filled with a list of supplies that each field hospital in his area needed including CT scanners, ventilators and lab equipment. That way, if he came across someone from a relief organization he could easily share the wish list.

The lack of basic medical equipment became glaringly obvious to Khouli when he heard surgeons from a field hospital near Aleppo describe how they handled a trauma case. The team of vascular, orthopedic and general surgeons completed a six-hour surgery to repair a man's shattered leg, transfusing into him six to eight units of blood without equipment to monitor his blood levels or kidney function during surgery. Instead, they managed him as best they could by simply checking his vitals, watching his color and monitoring his urine output.

"It was unbelievable," Khouli says. "Here they were, half an hour from the Turkish border and you have this severe injury. They have to make a decision to do what they can with the resources they have."

The work the doctors do can be for naught, Khouli learned, when he visited a private hospital on his first day in Syria. Although there was supposed to be a cease-fire in honor of a Muslim holiday, five civilian women were injured when a shell hit their home. One was declared

dead at the hospital. Another had a severe head injury. The four women were put in an ambulance—really a van—to get across the Turkish border about an hour away. There, a Turkish ambulance would take them to the nearest tertiary hospital, which was 45 minutes away.

"In normal circumstances, they would have been able to get care in Aleppo in about 15 minutes. But that portion of the city is under regime control," Khouli says. "It was clear to me that one of them wasn't going to survive. We know many people are dying along the way to Turkey."

Critical lessons on critical care

Anas, a Twin Cities critical care physician, went to Turkey last fall to train nurses who had traveled there from Syria. He became motivated to help when he saw a video about nurses in Homs trying to do CPR on a young man. He noticed the nurses didn't know how to do it correctly. Anas joined a SAMS-sponsored trip in October to lead a course on trauma care for nurses. He chose to focus on nurses because there are far more of them than doctors in the opposition-controlled areas.

Anas spent seven days training about 30 nurses. At his request, SAMS and the SEO bought ventilators, central lines, CPR machines and medications in Turkey for the nurses to use during the training and later in Syria. They also equipped them with cameras, computers and Internet connections so Anas can continue consulting with the nurses about specific cases by Skype.

The nurses Anas trained experienced the worst of the war. Some were tortured for providing medical care, yet they refused to leave Syria. "They are very motivated, and they told their families, 'We don't want to leave with you.' They wanted to stay in the area where there was war so they could help," says Anas, who grew up in Syria, earned his medical degree there, and came to Chicago for his internal medicine residency in 2008.

The nurses work in a part of Syria where there are few doctors because many have fled for safer ground. At one of the four hospitals that Anas helps, there is one

surgeon and one medical student; others have no doctors at all. A physician might do a surgery, but it's the nurses who manage the patients before and after and see that they are transported to nearby Aleppo or into Turkey for follow-up care.

In January, Anas consulted with nurses over Skype as they treated a man whom they believed was poisoned by the nerve gas sarin during a bombing. As he tried to help others after the attack, the man became paralyzed and stopped breathing. It was touch and go—they didn't have an antidote or other medication; under Anas' direction, the nurses put him on a ventilator. After about seven hours, he could breathe on his own, and a few hours after that he could move again.

"The lack of medical support inside is terrible. After we started to run the first [intensive-care] unit, we realized there was no oxygen in the entire north of Syria," Anas says. "They can't even get a blood gas."

Subsequent support

Back in the United States, Anas and Khouli continue to raise awareness about and money for people in Syria in conjunction with SAMS, SEO and other organizations. In May, Anas helped organize a fundraising dinner featuring a Syrian journalist and a Syrian-Canadian trauma surgeon who has traveled to Syria to perform surgery. He also plans to continue consulting with doctors and nurses in Syria as needed. Now that Khouli is done with business school, he plans to redouble his efforts to create a supply-distribution channel.

Both doctors want to help Syrians who have been injured in the fighting or are just sick and need care. They're also dedicated to helping the doctors and nurses who continue to provide care for those in need, despite fear of being tortured or killed for doing so. "The efforts of doctors inside Syria are heroic," Khouli says. "I can't think of any other place where delivering medical relief means putting your life at risk." MM

Suzy Frisch is a Twin Cities freelance writer.



Learning by the light of the moon

Money and experience motivate residents to work extra hours.

BY HOWARD BELL

Watching that bag fill with blood in seconds was one of the scariest moments of my career,” recalls Amy Holbrook, M.D., chief internal medicine resident at Abbott Northwestern Hospital in Minneapolis.

Holbrook was moonlighting at the hospital during her third year when an elderly patient with a G-tube started vomiting blood. The patient also was tachycardic and hypotensive, and because he was congenitally deaf, he could only communicate with sign language.

Holbrook had learned basic sign language in elementary school and was able to ask him if he was having any pain. He said no. “We put a bag on the end of the G-tube and put the bag on the floor. It immediately filled with two liters of blood. For a few moments, I thought my heart would stop beating. I was with three of the strongest nurses in the hospital and all four of us turned pale. I knew he was bleeding to death in front of me.”

Holbrook was able to communicate to him that she thought something catastrophic was happening. “I needed to know how aggressive to be. He shook his head, took my hands in his hands, and then signed ‘make me comfortable.’”

Holbrook called in his family and a sign language interpreter, and they were able

to have “a very honest conversation” about whether to send him to the ICU or OR to try to stop the bleeding—or transition him to comfort care, which is what they did. The man died peacefully a couple days later.

“It would have been easier emotionally to just send him to the ICU and be aggressive,” says Holbrook, “especially since it was the middle of the night and the patient wasn’t mine. Moonlighting has taught me a lot about handling emotionally charged, acute changes in patient status.”

Holbrook is one of the 90 percent of residents in the Abbott Northwestern Internal Medicine Residency Program who moonlight. For Holbrook and her peers, moonlighting is not just a way to earn extra dollars, it’s an important part of their training.

A long tradition

Ever since residency programs as we know them began in the 1960s and ’70s, moonlighting has provided residents a way to gain experience and earn extra money.

Today, moonlighting is most common among primary care residents. It’s less so among non-primary care residents because they don’t have as much time after fulfilling their residency duties and because there are fewer opportunities.

“Moonlighting may be more common among primary care physicians because their training prepares them for more opportunities,” says Jeremy Springer, M.D., director of the University of Minnesota’s Family Medicine Residency Program at Methodist-Park Nicollet. “They can moonlight in urgent care, the ER, do hospital coverage and work in other settings where ACLS [Advanced Cardiac Life Support] is required.”

Yet program directors generally agree that moonlighting is a little less common today than it was a decade ago for four reasons: Residency salaries are higher than they used to be; residents place more value on free time; the hours they spend moonlighting count toward the 80-hours-per-week work restriction; and duties once performed by moonlighting residents such as those in urgent care are now regular MD jobs.

How it works

Legally, second- and third-year residents are allowed to moonlight if they have a Minnesota medical license and have passed their Step 3 exams (Complex 3 for DOs). International residents can moonlight after completing their second year of residency; they also must have a work visa, not a training visa. Many programs require

or at least encourage residents who want to moonlight to first complete life-support courses including Advanced Trauma Life Support, Advanced Cardiac Life Support, Neonatal Resuscitation Program and Pediatric Advanced Life Support.

In addition, residents must have their program director's permission to moonlight. And doing so can't interfere with residency program duties such as rotations and call. "If a resident is leaving rotations early in order to moonlight, is excessively sleep-deprived or in any way struggling with their residency duties, we won't let them moonlight," Springer says.

Residents schedule their own moonlighting activities but must report the hours they work to prevent them from violating an American College of Graduate Medical Education rule adopted in 2003 that says residents can't work more than 80 hours per week, averaged over one month. Originally, only hours spent moonlighting within the resident's program counted toward the 80 hours, according to Springer. "A 2011 revision changed the rule so that all moonlighting—internal and external—counts toward the 80 hours," he says.

"It takes the typical family medicine resident 50 to 60 hours per week to fulfill their residency program duties," says John McCabe, M.D., director of the University of Minnesota's Family Medicine Residency Program at Mayo Health System—Mankato. "So that does leave time for moonlighting."

Typically, moonlighting residents earn between \$70 and \$100 per hour, less for just being on call at home and more when working in a busy emergency department.

Different programs, different options

Medical students who'd like to moonlight during residency should find out how the programs they're interested in handle moonlighting because each one does it differently. In Minnesota, all primary care residency programs allow moonlighting. Some allow residents to moonlight only "in-program," meaning at the hospital or clinic where the residency program is based. Others allow them to work at

nearby clinics or hospitals not affiliated with their "home" hospital or clinic. In still others, residents must find work outside the program through a locum tenens agency.

Residents in Abbott Northwestern's internal medicine residency program, for example, may moonlight only at Abbott and during one of three shifts: the daily 5 p.m. to 8 a.m. shift, in which they admit new patients, cross-cover for attendings and serve as house officer, which is what Holbrook was doing when she got called to attend the patient with the G-tube; the 5 p.m. to 8 a.m. weekend shift, when they handle all admissions; or the 5 to 11 p.m. shift, when they cross-cover from home for the hospitalists.

Residents at Duluth's Family Medicine Program can moonlight either outside the program or at positions reserved for them at a local hospital, according to program director Kim Kruger, M.D. Some provide night and weekend coverage at Miller-Dwan Medical Center's psychiatric ward. "Residents get experience with a variety of psychiatric issues they might not otherwise get," Kruger says, "but some of these patients also come in with broken bones, head injuries, so it offers variety." In addition, a couple of Duluth residents moonlight in urgent care and emergency departments in Cloquet, Moose Lake, Two Harbors and Grand Marais. "We encourage moonlighting, but we don't require it," Kruger says. Of her 20 eligible residents, 10 moonlight.

At the St. John's Hospital Family Medicine Residency Program in St. Paul, the 12 eligible residents are allowed to moonlight inside or outside of St. John's, according to program director Bill Roberts, M.D. He says they usually choose to moonlight internally, covering the hospital on weekends and holidays, admitting patients and responding to emergencies. Those who are interested in rural medicine also moonlight at urgent care centers or rural emergency rooms.

Moonlighting at the hospital that is home to the program has its advantages, according to Roberts. "You're working in a system where everybody knows you and

are ready to help if you need it. You're also familiar with the protocols and electronic medical record."

At the University of Minnesota's program at Methodist-Park Nicollet, residents choose from four moonlighting options, two of which are outside of the hospital and clinic. Of the 12 eligible residents, 10 take advantage of them. Third-year resident Maria Carrow, M.D., has worked 12-hour weekend shifts at Park Nicollet's Melrose Eating Disorders Clinic in St. Louis Park. There, she does house officer duties and helps attending physicians write their daily notes and discharge summaries. At a Minneapolis allergy clinic, she covers for the physician, responding to any anaphylactic reactions to treatment. She also provides coverage for physicians at Park Nicollet's Imaging Center. "Having built-in opportunities to moonlight is extremely convenient," Carrow says. "It's one of the big reasons I chose this program."

The reasons they moonlight

The opportunity to earn extra income has always motivated residents to moonlight. The money brought in might enable a spouse to stay home with young children or the purchase of a house. But often the added income allows residents to make payments on their students loans.

The average primary care resident emerges from training a year's salary in debt, according to Roberts. "With that kind of debt," he says, "an extra \$1,000 a month goes a long way."

Being able to pay off her loans was the reason Carrow says she chose to moonlight. "I even have a little to invest. It's also helped me afford to travel to fellowship interviews," she says.

Getting experience with different types of patients and different types of problems beyond what they are exposed to during their rotations and ward duties is another benefit, says Thomas Lovinger, M.D., a third-year family medicine resident at Mayo Health System – Mankato. Lovinger works four-hour shifts evenings and weekends at a Mankato urgent care clinic and also moonlights at two low-acuity emergency departments in nearby small towns,

where his shifts sometimes last 48 hours. “The extra money’s nice,” he says, “but I started moonlighting mostly to work independently from a preceptor and improve my skills and confidence in condition diagnosis and management. In a broad specialty like family medicine, the more medical conditions you get experience with, the better physician you become.”

Thomas Mullin, M.D., a third-year resident at Methodist, says he likes the challenge of being on his own. “I don’t have a preceptor offering advice while moonlighting, which forces me to think critically, be efficient and face situations that are sometimes out of my comfort zone. It helps me realize what I’m strong at and what things I need to learn more about.”

Abbott Northwestern Internal Medicine Residency director Robert Miner, M.D., says the residents who moonlight gain a great deal of extra experience admitting and seeing patients. Holbrook would agree. “I’ve probably done 500 admissions while moonlighting,” she says. “I’ve learned a ton about cross-cover situations. I’ve gotten to know the flow of the hospital at night and become buddies with a lot of the night nurses. Moonlighting pushes your limits, while still having back-up available to help.”

A price to be paid

What moonlighters gain in experience and money, they lose in free time. For that reason, according to Kruger, moonlighting isn’t right for everybody. “Residency by itself is exhausting and time-consuming,” she says. “Many of our residents with spouses or children don’t do it because they treasure their family time.”

Carrow admits that physicians who moonlight do make sacrifices. “Some of my colleagues make an additional \$25,000 per year by moonlighting, but they give up what little free time they have left after residency obligations,” she says. “You sacrifice time with family and friends, time for exercising, time for being outside and time for recharging.”

That’s a trade off Duluth second-year resident Nicholas Vidor, M.D., who moonlights in an emergency department in Cloquet, says he’s more than willing to make at this point in his life. “Sure, I miss days off for R&R,” he says, “but the extra money makes me less stressed when I’m already living payday to payday. I just can’t make it on a \$50,000 salary when I’m making \$700 monthly loan payments, not counting interest.”

For those who do moonlight, the experience is positive overall. “Moonlighting can be life-changing,” Kruger says. “All of the time and work you’ve invested in your career can come to life in a powerful way. Our residents come back from moonlighting excited and enthusiastic, with stories to tell. It’s about doing things you thought you could never do.” MM

Howard Bell is a medical writer and frequent contributor to *Minnesota Medicine*.

10 tips for moonlighters

1 *“Don’t start your moonlighting career as a solo physician in an emergency department. Consider waiting until your third year before moonlighting in any emergency department.”*

Jeremy Springer, M.D., program director, Methodist-Park Nicollet

2 *“Do it, but don’t burn out. Use some of your extra money for student loans and some for happy hour.”*

Amy Holbrook, M.D., chief resident, internal medicine, Abbott Northwestern Hospital

3 *“Bring extra socks. They’ll rejuvenate you at 3 a.m.”*

Amy Holbrook, M.D.

4 *“Make sure you’re not being taken advantage of and that you’re fairly compensated.”*

Maria Carrow, M.D., third-year family medicine resident, Methodist-Park Nicollet

5 *“If you’re expected to respond to emergencies, make sure there’s a system in place that you’re comfortable with, including an updated crash cart, 911 activation system, medications, and someone who can get IV access if you can’t.”*

Maria Carrow, M.D.

6 *“Have colleagues available by phone for a quick consultation.”*

Nicholas Vidor, M.D., second-year resident, Duluth Family Medicine Residency Program

7 *“After you moonlight, debrief yourself. Share your experiences and ask colleagues what they would do in those situations.”*

Kim Kruger, M.D., program director, Duluth Family Medicine Residency Program

8 *“When moonlighting outside your program through a locums agency, make sure they provide [malpractice] coverage. If you’re moonlighting outside your program as an independent contractor, you must buy your coverage. There are two types: ‘occurrence’ and ‘claims-made’ coverage. Choose occurrence. It’s pricier, but it covers you if a claim is made after you’ve left that job, even if you are no longer insured by that company.”*

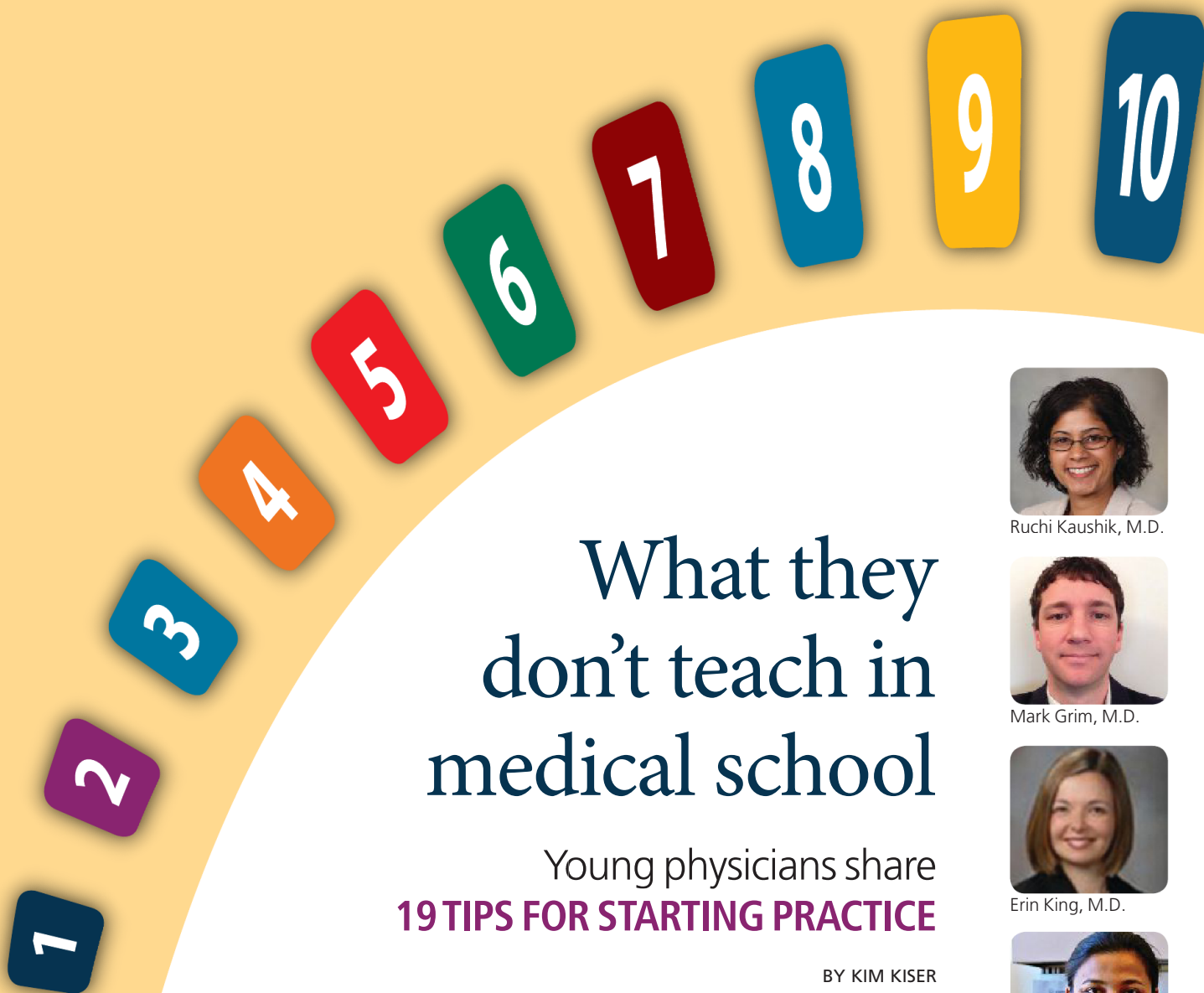
Jeremy Springer, M.D.

9 *“Especially if you moonlight outside your program, keep up to 40 percent of what you earn to pay taxes. You’ll receive 1099s at the end of the year from each place you moonlighted. I’ve seen residents who don’t plan for this and they have to scramble to pay their taxes.”*

Thomas Lovinger, M.D., third-year family medicine resident, Mayo Health System – Mankato

10 *“Make residency your priority—not making money. Locums agencies will call asking you to work. Know your limits.”*

Thomas Lovinger, M.D.



What they don't teach in medical school

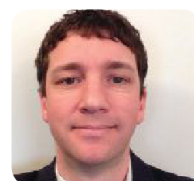
Young physicians share
19 TIPS FOR STARTING PRACTICE

BY KIM KISER

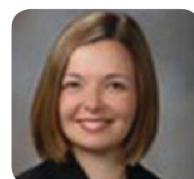
Medical school and residency go a long way toward preparing physicians for practice. But as they move into their first jobs, young physicians inevitably encounter situations that no one taught them how to deal with: What do you consider when evaluating a job offer? How do you find your place in an established practice? How do you juggle meetings and call duty with patient care? We asked physicians in and around Minnesota who began practicing in the last few years about the challenges of making the transition from training to practice. What surprised them? What do they wish they had learned but had not? We also asked what advice they would give medical students and residents to help them be better prepared for their first job. Here's what they had to say.



Ruchi Kaushik, M.D.



Mark Grim, M.D.



Erin King, M.D.



Soma Ghosh, M.D.



Keith Spears, M.D.



Kourtney Houle, M.D.

on preparing for practice

1 “The more clinical experience you gain in training, the easier it will be to work with many different types of patients. I highly recommend moonlighting as often as possible.”

MATT VIEL, M.D., FAAFP, FAMILY PHYSICIAN, EDGERTON

2 “Being an employee versus a physician owner are vastly different career tracks, so learn from each type of physician while in training so you can better decide which type of practice would better suit your personality.”

KOURTNEY BRADFORD HOULE, M.D., FAMILY PHYSICIAN, ST. CLOUD MEDICAL GROUP, ST. CLOUD

3 “Take time to learn about the ‘bigger picture’ in medicine and how you can have an impact on the coming changes in the health care community/industry.”

KEVIN BEST, M.D., FAMILY PHYSICIAN, PRESCOTT, WISCONSIN

4 “Residency and medical school are protected times for learning and making mistakes. Your preceptors will not be backing you up when you finish, so learn all you can.”

ERIN KING, M.D., PEDIATRICIAN, GRAND FORKS, NORTH DAKOTA

on finding your first job

5 “Know what you want from your job and your life ahead of time. Don’t be afraid to voice your desires (like wanting to work part-time or different hours) because you are never aware of what the employer has to offer you. Build your list of deal-breakers early, so you don’t feel walked on when you start working. And ask as many questions as possible about specific aspects of the job so there are no surprises.”

RUCHI KAUSHIK, M.D., GENERAL PEDIATRIC AND ADOLESCENT MEDICINE PHYSICIAN, MAYO CLINIC, ROCHESTER

My biggest challenge

“Lack of training in regards to the business/administrative aspects of medicine. I felt I went out of my way in residency to learn more about these challenges but still find myself underprepared.”

KEVIN BEST, M.D.

My biggest challenge

“Learning to practice independently. Even though I felt fairly certain of myself while in training, when I was on my own I felt a bit uncomfortable at times.”

KEITH SPEARS, M.D.

6 “Think about what kind of physician you would like to be and where your strengths and weaknesses lie.”

ERIN KING, M.D., PEDIATRICIAN, GRAND FORKS, NORTH DAKOTA

7 “Take time to inform yourself about nonmonetary compensation (benefits). Knowing about malpractice insurance and other benefits would have been helpful in my job search and job market analysis. Also learn about the different models of practice from a business standpoint (private, employed, etc.).”

MARK GRIM, M.D., ANESTHESIOLOGIST AND ASSOCIATE SECTION CHAIR FOR ANESTHESIA, ESSENTIA HEALTH EAST, DULUTH

8 “Understanding the culture and politics of your institution before signing a contract is vital. It’s very important that you feel valued as a physician and that what you do every day matters not only to your patients but to those making the policy and work environment you exist in. To walk into a situation where this isn’t fostered can be toxic and accelerate burnout. If you train in a supportive environment, the importance of this can be taken for granted when you venture out on your own. Also, find a clinic where the people have fun at work. You need to have fun or the days will get long and intolerable at times.”

CHRISTINE ATHMANN, M.D., FAMILY PHYSICIAN, CROSBY

9 “Before you take a job, be sure you take every opportunity to get to know those with whom you will be working. The people around you are more important than the terms of the contract. Talk to the other doctors in the practice to really get a sense of what day-to-day, week-to-week and month-to-month work is like. How are call trades and cross-coverage arranged? How do you ask for time off? What are the hours, really, not just the hours of operation? What is the dress code?”

MATT VIEL, M.D., FAAFP

on starting the job

10 “It’s OK to double-check the dose of amoxicillin on Up to Date for the hundredth time because this is the first time in your life that no one is looking over your shoulder. Patients have no idea that you just finished residency, so treat them appropriately and confidently and they’ll never have reason to doubt you.”
KOURTNEY BRADFORD HOULE, M.D.

11 “Don’t be too hard on yourself. You are going to screw up, as will those around you. Learn from each other, support each other during those moments and be thankful for those learning opportunities as they will stick with you. Never be afraid to know what you don’t know and ask for help.”
CHRISTINE ATHMANN, M.D.

12 “Your partners are your equals. They may be older, they may have been there longer, but they are not your superiors. Learn from them when it’s applicable, but hold your own and form your own ideas about your practice.”
KOURTNEY BRADFORD HOULE, M.D.

My biggest challenge

“Understanding coding and billing, managing time in a busy private clinic, keeping up with notes and dictation, meeting the expectations of patients, the employer and the community.”

SOMA GHOSH, M.D.

on money

13 “Learn about managing money. It is a strange transition from making a modest living one day and then literally making six figures. I would advise anyone to meet with a financial adviser.”
KEITH SPEARS, M.D., FAMILY PHYSICIAN, ARDEN HILLS

14 “Don’t spend money just because you’re making it. Save a much higher percentage than you did in residency. Give to charity a much higher percentage than you did in residency. Early retirement (or semi-retirement) is a realistic goal that can be achieved with proper planning from Day 1.”
MATT VIEL, M.D., FAAFP

The biggest surprise

“How much fun the actual practice of medicine can be.”

MATT VIEL, M.D., FAAFP

on housing

15 “Being in a smaller, less-desirable home for a finite time is better than being ‘house poor.’”
KOURTNEY BRADFORD HOULE, M.D.

16 “When relocating for a job, rent a house. A new job is very demanding and having house maintenance might become overwhelming.”
SOMA GHOSH, M.D., PEDIATRICIAN, DETROIT LAKES

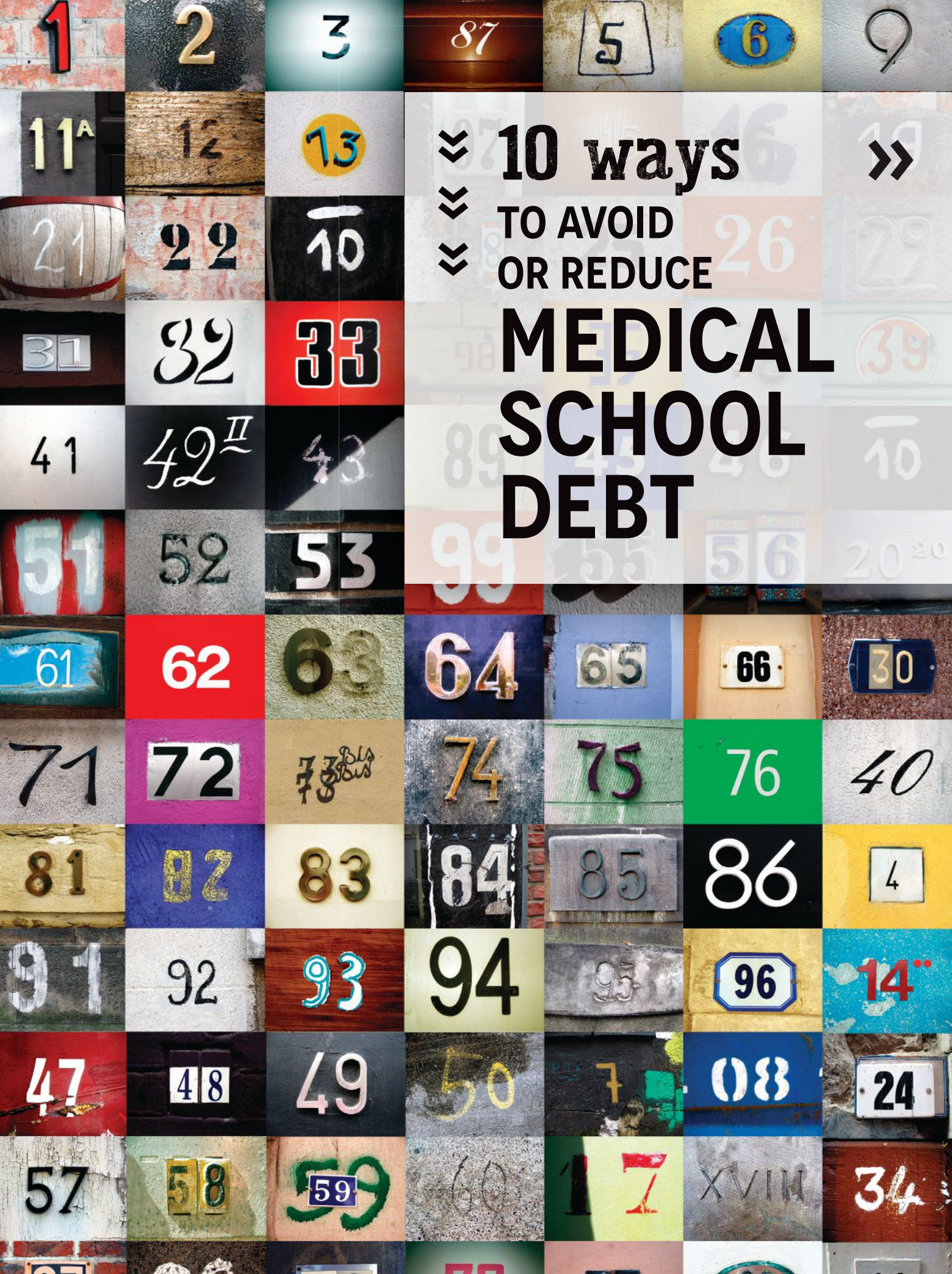
on balancing work and life

17 “When at work, work hard, take care of your colleagues (because they will then take care of you when you need it most). In your most sleep-deprived and challenging moments, treat your patients as you would want your most valued life members treated. Exercise and take care of yourself or your physical and mental health will suffer.”
CHRISTINE ATHMANN, M.D.

18 “If you haven’t learned it by now, medicine is a black hole for your time. It will take whatever you let it. Set aside time every day for God. Set aside a day every week for worship and rest. Set aside time every day for family. Set aside time every week for your spouse. Set aside time every week for your kids. Set aside time every day for personal fitness. If you are not prepared to keep time away from medicine, then it will devour you.”
MATT VIEL, M.D., FAAFP

19 “Be sure to make time for family and outside activities as your job is what you do, not who you are. You will be a better physician if you have a fulfilling home life.” KOURTNEY BRADFORD HOULE, M.D.

Kim Kiser is senior editor of *Minnesota Medicine*.



≈ 10 ways ≈
≈ TO AVOID ≈
≈ OR REDUCE ≈

MEDICAL SCHOOL DEBT

» » PROGRAMS THAT CAN HELP YOU PAY IT BACK— AND PAY IT FORWARD.

BY JEANNE METTNER



For most medical students, education debt is inevitable.

According 2011 data from the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine, 86 percent of graduates of allopathic medical schools and 91 percent of graduates of osteopathic medicine colleges leave school with some debt. The average amount they owe is roughly \$205,674 for osteopathic and \$162,000 for allopathic school. Needless to say, student debt weighs on the minds of today's medical students and young physicians.

But there are strategies for avoiding or dealing with debt. Certainly, numerous private scholarships are available, including one sponsored by the MMA Foundation (see box). Here, we provide information about some of the public scholarship and loan forgiveness programs that can help medical students and physicians avoid or deal with debt.



MMA Foundation Scholarships and Loan Forgiveness

The MMA Foundation (MMAF), the charitable arm of the Minnesota Medical Association, provides four-year partial scholarships to 10 students at Mayo Medical School and the University of Minnesota Medical School.

The MMAF also supports the loan forgiveness program offered by Minnesota's Office of Rural Health and Primary Care. This year, its contribution enabled four physicians to work in underserved parts of Minnesota.

The MMAF is a nonprofit 501(c) (3) corporation; gifts to the foundation are tax-deductible as allowed by law. To learn more, contact Dennis Kelly at dkelly@mnmed.org or 612-362-3767.



ELIZABETH GOELZ, M.D.

PHOTO BY STEVE WEWERKA

DEBT-DEFYING ACT

ELIZABETH GOELZ, M.D.

*Minnesota Urban Physician
Loan Forgiveness Program*

As she was nearing the end of her internal medicine residency at Hennepin County Medical Center (HCMC) in early 2011, Elizabeth Goelz was in a quandary: She loved her job but in a few short months would be facing payments on \$115,000 of student loan debt. She knew that if she took a job at the county hospital, she would be earning less than if she went to work for a large health system. How could she follow her heart yet not be overwhelmed by debt? As she searched for answers, she discovered she qualified for the Minnesota Urban Physician Loan Forgiveness Program, which erases a portion of student debt in exchange for practicing in an underserved urban community.

Goelz completed the paperwork and was accepted into the program. She then took the position she wanted at HCMC's Internal Medicine Clinic in Minneapolis. "What excites me about urban medicine is the variety. I see a whole spectrum of patients, from those with private insurance and full-time employment to those who are chronically homeless and without insurance, and everything in between," she says. "Many of the medical problems are the same, but the medical implications of social problems are vast and ought to not be underestimated. It is both complex and rewarding."

Since 2012, Goelz, who is married and has three young children, has been receiving \$25,000 a year for loan repayment. After she receives a check, she pays

Scholarships

National Health Service Corps Scholarship Program

The National Health Service Corps (NHSC) provides up to four years of tax-free payments for medical school tuition, fees and other qualifying educational expenses plus a living stipend to students who agree to serve in a Health Professional Shortage Area after they graduate. In return for every year or partial year of scholarship received, students complete one year of full-time service at an NHSC-approved site. The minimum service requirement is two years following residency. The NHSC works with scholarship recipients to help them find a practice site.

Who is eligible? A U.S. citizen or U.S. national who is enrolled in or accepted for enrollment in an accredited medical or osteopathic medicine school.

How competitive is it? Very competitive. In 2012, the program had 1,373 applicants and awarded 212 scholarships.

How to apply? The application is available at <http://nhsc.hrsa.gov/scholarships/index.html> and is due in mid-May for the following academic year.

For more information: Visit nhsc.hrsa.gov/index.html.

Indian Health Service Health Professions Scholarship

The Indian Health Service (IHS) offers scholarships to qualifying American Indian and Alaska Native students who have applied to or enrolled in a health professions program and commit to working in an IHS program after they graduate.

How it works: The IHS scholarship covers up to four years of tuition, fees and other educational and living expenses. For every year of scholarship provided, recipients must complete one year of service in an IHS program, a Tribal health program, an Urban Indian health program, or a facility that provides care for at least 75 percent of the American Indians or Alaska Natives living in the area. The minimum service commitment is two years after residency. Recipients must apply annually to continue their scholarship.

Eligibility: Applicants must be U.S. citizens, a member of a federally recognized Tribe, and have applied to or been accepted into a health profession program in the United States. To maintain the scholarship, recipients must have a minimum 2.0 GPA. Other eligibility requirements are listed at www.ihs.gov.

How competitive is the program? The program is extremely competitive. In fiscal year 2012, an estimated 280 awards were made through the program. The average award to a full-time student is \$48,056.

How to apply: New applications are usually submitted in March for the following academic year. Application information can be found online at www.ihs.gov/scholarship/apply_now.cfm.

For more information: Contact the IHS Scholarship Program branch office at 301-443-6197.

Military Scholarships

The U.S. Army, U.S. Navy and U.S. Air Force offer scholarships in exchange for military service.

How it works: The Health Professions Scholarship Program (HPSP) pays for tuition, books, supplies and equipment required for medical school and provides a monthly stipend for other nonqualifying expenses for up to four years. In return, students complete a minimum of 45 days of active duty and one year of service for every year of scholarship they receive. The minimum length of service is two years. Applicants can count one year of residency toward their service requirement.

Eligibility: The program is available for students pursuing degrees in medicine as well as other health professions. In addition to being enrolled in an accredited school, you have to be a full-time student, a resident of the United States, and qualify as a commissioned officer (through satisfactory completion of training and health exams).

How competitive is the program? The HPSP itself is provided to all students who qualify. However, the military has a greater need for primary care physicians than those who practice certain specialties.

How to apply: Students can apply any year they are enrolled in medical school; however, the best time to apply is the fall before your first year. Applications take 12 to 16 weeks to process and are accepted throughout the year.

For more information: Visit www.goarmy.com, www.airforce.com or www.gonavy.com for more information. Local recruiters can also provide details.

Loan forgiveness programs

Public Service Loan Forgiveness

Public Service Loan Forgiveness (PSLF) is a federal program that offers loan forgiveness to qualified students who work in education, health care and other areas following graduation. It was created by the College Cost Reduction and Access Act of 2007. However, participants won't see their loans forgiven until 2017 at the earliest.

How it works: Individuals employed full-time (30 hours a week or more) in a public-service position continue to make payments on their eligible federal student loans (Federal Direct Loans). After 120 monthly payments (10 years), the federal government forgives any remaining balance. The forgiven portion of the loan is tax-free.

Eligibility: The biggest concern is that the job you take qualifies as a public service position. Examples of PSLF-eligible jobs for physicians include positions at a Veterans Affairs medical center, a nonprofit public health organization or a nonprofit, tax-exempt 501(c)(3) organization (which includes most hospitals in Minnesota). To qualify for PSLF, you must be a full-time public-service employee at the time you apply, while you are making each of your required 120 payments and at the time the remaining balance of your loans becomes eligible for forgiveness.

How to apply: You can enroll in PSLF and track your public service by submitting the Employment Certification Form, which is available at <https://studentaid.ed.gov/sites/default/files/public-service-employment-certification-form.pdf>.

Cautionary notes: Most standard loans have a 10-year repayment schedule (120 monthly payments), so by the time you qualify for forgiveness, you will have already paid off most, if not all, of your loans. For this reason, getting the full benefit of PSLF usually requires you to have some type of income-based repayment plan, where you are not paying in as much as you would with a traditional loan repayment schedule.

Also, only qualifying payments made after October 1, 2007, count toward PSLF. Thus, the first forgiveness of loan balances will not occur until October 2017 at the earliest. The federal government does not guarantee that the PSLF program will still be in place at that time.

If you stop working full-time in a qualifying public-service position and have not yet made the mandatory 120 payments, your remaining debt will not be forgiven.

For more information: Learn more at Fed Loan Servicing (www.myfedloan.org) or the Association of American Medical Colleges (www.aamc.org).

her lender and submits evidence of loan payment to the program. Although the service obligation is three years, she is hoping to extend it for the optional additional year. If she completes four years of service, she will have only about \$20,000 left to repay on her student loans.

"The loan forgiveness program has allowed me to work with a population of patients whom I love working with, in an academic health center that serves absolutely everybody," she says.

Goelz would recommend the program to anyone who is passionate about working with an urban underserved population. Her advice to medical students searching for debt-reduction options: "Find the type of work you are interested in and pursue repayment programs that fit with that. These programs are often multi-year commitments—and that's a long time to be doing something you don't enjoy just for the repayment benefits."



SEAN ENGEL, M.D.

PHOTO BY STEVE WEWERKA

DEBT-DEFYING ACT

SEAN ENGEL, M.D.

U.S. Navy Health Professions Scholarship

Sean Engel had long felt called to serve in the military. Although he was interested in the Navy, he hesitated to apply for a military scholarship before entering medical school because he didn't know what specialty he wanted to pursue. He knew that residencies for specialties such as orthopedics and otolaryngology were sparse in the armed forces. "For a lot of specialties in the Navy, there are only a few residency programs that you can apply to, and if you don't get your selected specialty, you have to go into some other area where the Navy needs you or spend time as a general

medical officer. Whereas, if you are a civilian, you can broaden your search and ultimately settle on something that's a little closer to what you wanted," he says. "So that was my hesitation with doing it right away the first year of school."

Finally, in 2007, a year before graduating—and still without a firm decision about his career—he applied for and received a Health Professions Scholarship through the U.S. Navy. The Navy paid for Engel's final year of medical school—tuition, books and all other educational expenses—and provided him with a monthly stipend. In return, he was obligated to complete a minimum of three years of military service after graduation. "I opted for the scholarship instead of the loan repayment program because it seemed the right time to put in my service obligation," he says. "I was engaged, I didn't have any kids, and I felt that if I were going to be deployed to places all around the world, it would be better to do it now rather than after residency, when kids and careers could come more into play."

Immediately after graduation, Engel got married, completed his mandatory five weeks of officer training at Newport, Rhode Island, and then moved with his wife (a pediatrics resident) to Portsmouth, Virginia. There, he completed one year of an internal medicine residency at the Navy Medical Center, then worked three years as a trained undersea medical officer, providing primary care services to Navy divers, submariners and others in the Naval Special Warfare/Naval Special Operations community.

After meeting his service obligation in 2012, Engel and his wife moved back to the Twin Cities, where he is now a family medicine resident at the University of Minnesota-Methodist Hospital Program. Even with the Navy's one-year scholarship, Engel graduated with \$130,000 in debt, which he is working on paying down. With his salary and incentive bonuses from the Navy plus his wife's salary as a pediatric resident, the couple was able to pay off his wife's medical school debt—\$180,000—in just four years.

The financial incentives offered by the military are worth it, Engel says, if you are willing to be flexible with your postgraduate training prospects. He advises those who might be interested to remember the possible risks. "Your training and post-residency assignment will be where the military needs you, and some-

Minnesota Rural Physician and Minnesota Urban Physician Loan Forgiveness Program

Minnesota's loan forgiveness programs place physicians in areas of need within the state in exchange for loan forgiveness. The programs are administered by the Minnesota Department of Health's Office of Rural Health and Primary Care (ORHPC) and are partially funded by the Minnesota Medical Association Foundation.

How it works: Residents can receive up to \$25,000 of loan forgiveness annually for up to four years in return for full-time work (30 hours a week) in a qualifying rural or underserved urban area. Participants must serve a minimum of three years.

Eligibility: Physicians doing residencies in family medicine, obstetrics and gynecology, pediatrics, internal medicine and psychiatry in Minnesota are potential candidates.

How competitive is the program? According to the ORHPC, selection is based on professional experience, training and "other relevant factors." The number of awards made per year varies and is based on available state funding.

How to apply: Prospective candidates should submit their application to the ORHPC during their final year of residency. Applications are accepted between September and January. Participants must begin their service obligation no later than March 31 following completion of their residency.

Cautionary note: If the participant fails to meet his or her service obligation, he or she must repay the total amount of the loans forgiven—plus interest.

For more information: Go to www.health.state.mn.us/divs/orhpc/funding/loans/ruralphys.html or www.health.state.mn.us/divs/orhpc/funding/loans/urban.html.

Loan repayment programs

National Health Service Corps Loan Repayment Program

Since 1972, the National Health Service Corps (NHSC) has offered assistance with loan repayment to physicians who are willing to work in a Health Professional Shortage Area. More than 40,000 primary care physicians, nurse practitioners, physician assistants, dentists, dental hygienists and mental and behavioral health professionals have taken advantage of this program.

How it works: Eligible primary care physicians (MDs or DOs) can receive up to \$30,000 in loan repayment each year in return for a minimum two-year service obligation at an approved site located in a federally designated Health Professional Shortage Area. The amount of the loan repayment award depends on the score of the Health Professional Shortage Area and whether the clinician is working half time or full time. (Health Professional Shortage Area scores are calculated according to the needs of an area—the greater the need, the higher the score.) Those working in areas of greater need (a score of 14 or higher) can receive \$30,000 per year if they work full-time and up to \$15,000 if they work half-time. Those working in areas with less acute shortages (a score of 13 or less) can receive \$20,000 annually if they work full time and \$10,000 per year if they work half time. Additional awards for service beyond the initial two-year obligation may be available. In Minnesota, most areas in or around Tribal lands have a score of 14 or higher. Some of the hospitals and clinics in those areas include Mille Lacs Family Clinic, White Earth PHS

Indian Hospital in Becker County and Sawtooth Mountain Clinic in Cook County. For a full list, go to <http://hpsafind.hrsa.gov/HPSASearch.aspx>.

Program staff can help you find a qualifying site or if you're already working at one, you can apply.

Eligibility: Applicants must be U.S. citizens or U.S. nationals.

How competitive is the program? Applicants working in clinics with Health Professional Shortage Area scores of 14 or higher will receive priority consideration. However, funding varies from year to year, so a physician in a lower-scoring Health Professional Shortage Area may qualify for an award one year but not the next.

How to apply: Physician candidates may apply to the NHSC during the final year of residency. Applications are usually due in mid-April and must be submitted online at nhsc.hrsa.gov/loanrepayment/application-process/index.html. Awards are made the following September.

Cautionary notes: The NHSC is subject to the across-the-board funding cuts brought about by the Budget Control Act of 2011. The American Academy of Family Physicians has indicated that sequestration will reduce the NHSC trust fund by 5.1 percent. The U.S. Department of Health and Human Services' Health Resources and Service Administration, which funds the NHSC, will provide updates as information becomes available.

For more information: Visit nhsc.hrsa.gov/index.html.

Indian Health Service Loan Repayment Program

The IHS Loan Repayment Program offers physicians working for the IHS a way to pay down their debt if they did not qualify for a scholarship.

How it works: The program pays up to \$20,000 of qualifying medical school loans, plus 20 percent of the person's federal income taxes, in exchange for two years of full-time service after residency in any health program or facility administered by the IHS or that benefits American Indians and Alaska Natives. The Loan Repayment Program matches candidates to an IHS-approved site, and the term of service begins on the date the award is given (loan repayments are not made retroactively).

Eligibility: Priority is given to American Indians and Alaska Natives and those willing to work in the areas with the greatest needs.

How competitive is the program? The number of awards given depends on how much money the IHS has to offer in a given year and how many people apply. In 2013, the estimated amount available for the IHS loan repayment program is approximately \$20,179,074 to support approximately 455 competing awards, which average \$44,270 for a two-year contract. Applications continue to be considered until all funds have been exhausted for the year.

How to apply: Prospective candidates can apply online at www.ihs.gov/loanrepayment. The IHS accepts applications October 1 through the Friday of the second full week of August. Applications are reviewed monthly beginning in January or whenever funds become available.

For more information: Go to www.ihs.gov/loanrepayment/faq.cfm#indian_health or contact the IHS Loan Repayment Program office at 301-443-3396.

Minnesota State Loan Repayment Program

The Minnesota State Loan Repayment program could be considered the state's version of the National Health Service Corps' program. It is available to primary care physicians, nurse practitioners, physician assistants, dentists, dental hygienists, psychiatrists and a number of other mental

times you get very little input. Also, the Navy sends doctors wherever it has sailors or marines: on ships, overseas and in combat zones," he says, adding that his not being deployed was unusual. "I would say you should anticipate being deployed during your career as a physician in the Navy—at least with the current operational demands."

MICHELE THIEMAN, M.D.



PHOTO BY LEANN OVERBEEK

DEBT-DEFYING ACT

MICHELE THIEMAN, M.D.

Minnesota State Loan Repayment Program

Five years ago, Michele Thieman was settling into her job as a family physician for Essentia Health's Walker Clinic in Walker, Minnesota, when she started looking into loan-repayment options. She first explored the National Health Service Corps and then learned about the Minnesota State Loan Repayment Program and decided to apply for that. Along with completing her own application, she also had to arrange for the Walker Clinic to apply as a qualifying site. "That was the biggest hurdle, and I remember it was a bit of a headache," Thieman recalls. "There was a lot of paperwork, but I told my supervisors that it would be a good recruiting bonus to be able to show that within our medical group, we had sites that qualified for these types of loan-repayment programs."

The clinic qualified and Thieman received the award and completed her service from November 2009 to February 2012, which included an approved three-month maternity leave. For Thieman, service meant doing what she had been doing since she was hired at Essentia: "My job was and continues to be

seeing patients as a primary care physician. I see patients of all ages and with all problems, including obstetric care, pediatrics and geriatrics—and everything in between.” Thieman says the Walker Clinic serves summer tourists with acute illnesses and injuries, seniors who have retired “Up North” and are contending with chronic conditions such as diabetes and heart disease, and those who have always called Walker home. It also serves patients who live on the nearby Leech Lake Indian Reservation.

The program repaid \$40,000 of her student loan debt. “While I still owe the federal government \$90,000 for my education, the state government took a nice bite out of that total,” she says.

Her main word of caution is that stiff penalties apply to physicians who leave their job before they meet their service obligation. Says Thieman: “When working in rural health, the finances are shakier than in a large city, and there is a possibility that you could get transferred to another clinic, especially if your clinic closed. I had some important conversations with my supervisor before signing the service contract, essentially to ensure that there was no chance I would be transferred to another location that did not meet the requirements of the loan repayment contract.”



WILLIAM MANZEL, M.D.

PHOTO BY STEVE WEWERKA

DEBT-DEFYING ACT

WILLIAM MANZEL, D.O.

Income-based Repayment and Public Service Loan Forgiveness

In 2009, William Manzel, D.O., learned about income-based repayment (IBR) through the financial aid office at Mayo Clinic, where he was a first-year family medicine resident. Although the program looked attractive, he didn't apply to it until his third year.

and behavioral health professionals. Its purpose is to improve access to care in underserved communities.

How it works: The program is administered by the state Office of Rural Health and Primary Care and is funded by a grant from the National Health Services Corps and matching funds from the State of Minnesota. Participants must have a Minnesota license and agree to practice a minimum of two years at least half time at a program-approved site. The site must be located in a federally designated Health Professional Shortage Area and meet other requirements. Last year, the program funded five slots for eligible clinicians, including primary care physicians (internal medicine, family medicine, obstetrics/gynecology, pediatrics, psychiatry and geriatrics).

Eligibility: Physicians must be licensed in Minnesota and must not have any outstanding service requirements from other loan repayment programs. Individuals in the National Guard are eligible to participate.

How competitive is the program? Funding is limited and only one candidate is accepted per program-approved site.

How to apply: Application forms can be found online at the Minnesota Department of Health website (www.health.state.mn.us/divs/orhpc/funding/loans/state.html) and are usually due in August. Awards are issued in October, after federal and state funding has been appropriated. The Department of Health will continue to accept applications if there is money left over.

Cautionary notes: Because a portion of the program's funding comes from the federal government, the Minnesota State Loan Repayment Program could be affected by sequestration.

The penalties for not fulfilling your service obligation are steep. Participants who are placed in default are required to pay the State of Minnesota the total amount of loan repayments issued plus an unserved-obligation penalty of \$7,500 for each month of uncompleted service or \$31,000, whichever is greater.

For more information: See www.health.state.mn.us/divs/orhpc/funding/loans/state.html.

Income-Based Repayment

The idea behind the Income-Based Repayment (IBR) program is that borrowers can make loan payments based on their income. IBR, which was created through the College Cost Reduction and Access Act of 2007, requires that you demonstrate financial hardship, which is calculated by considering your adjusted gross income, your family size and the poverty guideline in your state of residence.

How it works: Borrowers who qualify for IBR make monthly loan payments that are roughly 15 percent of their discretionary income. For example, under IBR, a borrower with a spouse and one child and income of \$45,000 would make a monthly payment of \$205 on \$20,000 of eligible debt. If the same borrower were to repay that loan under the standard repayment plan, their monthly payment would be \$230. As your income changes, your monthly payments will change. You must submit documentation annually to determine your payment for that year. After 25 years of making qualifying repayments under the income-based repayment program, the federal government forgives any remaining balance on your qualifying Federal Direct Loans.

Eligibility: The servicer of your federal loans can help you determine whether you are eligible for IBR. To qualify, the annual amount due on your eligible loans, calculated through a 10-year standard repayment period, must exceed 15 percent of the difference between 1) your adjusted gross income and 2) 150 percent of the poverty guideline for your family size in the state where you live.

How competitive is the program? The program is open to anyone who is eligible at the time of application.

How to apply: It is best to apply for IBR after a discussion with the servicer of your student loan. If you are unclear who that is, check out www.nsd.edu.gov. IBR applications are available online at StudentLoans.gov.

Cautionary notes: Unless your IBR is connected with participation in the Public Service Loan Forgiveness program, any forgiven debt that exists after the 25-year repayment period is taxable. In some cases, the forgiven debt can amount to thousands of dollars of taxes owed—and it's payable immediately.

Direct PLUS Loans and Direct Consolidation Loans that repaid PLUS loans are ineligible for IBR.

For more information: The U.S. Department of Education's Federal Student Aid office has calculators and other resource to help borrowers determine whether they are eligible. Go to: <http://studentaid.ed.gov/repay-loans/understand/plans/income-based>.

Pay As You Earn

Pay As You Earn is a product of the Health Care and Education Reconciliation Act of 2010. Under the legislation, Congress reduced the monthly loan payments under Income Based Repayment—from 15 percent of discretionary income to 10 percent of discretionary income. IBR is still available to those who do not qualify for Pay As You Earn.

How it works: As with income-based repayment, Pay As You Earn allows you to make reduced monthly payments on your loans based on your adjusted gross income, the size of your family and the poverty guideline for your state of residence. In addition, with Pay As You Earn, the federal government forgives any outstanding debt on your Federal Direct Loans after 20 years of qualifying repayments. Any forgiven debt that exists after the 20-year repayment period is taxable.

Eligibility: This repayment plan is available only to "newer" borrowers—those who have at least one Federal Direct Loan disbursed on or after October 1, 2011. The borrower must not have loans that were disbursed before October 1, 2007. The servicer of your federal loans can help you assess your eligibility.

How competitive is the program? The program is open to anyone who is eligible at the time of application.

How to apply: It is best to apply for Pay As You Earn after a discussion with the servicer of your student loan. If you are unclear who that is, check out www.nsd.edu.gov.

Cautionary notes: Direct PLUS Loans and Direct Consolidation Loans that repaid PLUS loans are ineligible

For more information: A good place to start is <http://studentaid.ed.gov/PayAsYouEarn>. **MM**

Jeanne Mettner is a frequent contributor to *Minnesota Medicine*.

"I was skeptical at first when I heard about this program," Manzel admits. "Then we heard multiple lectures at Mayo, where they strongly advised us to look into it, and when I crunched the numbers, I realized that it made a lot of sense to enroll."

But because he did not like the idea of spending 25 years paying off his debt, he combined IBR with a 10-year service obligation offered through the Public Service Loan Forgiveness Program—allowing him to make 120 monthly income-based payments (instead of 300) before the government forgives the remainder of the loan amount in exchange for his practicing at an approved location.

Manzel says that although applying for both programs took some legwork, the effort was worth doing. He was able to complete part of his service obligation while he was still a resident at Mayo. He now works for the Stillwater Medical Group, which is affiliated with HealthPartners. Less than 15 percent of his monthly income now goes toward paying off his loans. Each year, his contribution is recalculated based on his gross adjusted income and family size (he and his wife have three children).

Manzel's only concern about the Public Service Loan Forgiveness and IBR programs is whether they can be sustained long-term. "The major risk is that you are trusting that the government is going to honor this, that it's not going to collapse." Yet he recommends the programs to medical students and residents. "It's crazy not to do it. You can save tens of thousands of dollars," he says. "Hypothetically, if the programs were to dissolve, it wouldn't be for naught because you would already have started paying off some of your loans—in a way that allows you to at least have a comfortable standard of living."



10 things to consider in a physician employment agreement

What to know before signing on the dotted line

BY CLAIRE H. TOPP, J.D., AND EMILY R. MENCHACA, J.D.

Negotiating an employment agreement can leave any physician riddled with anxiety. Young physicians especially may be concerned about trying to change the provisions of a contract for fear a potential employer might rescind their offer.

Although the task of reviewing an employment agreement and negotiating certain points may be daunting, it is important and now expected. Employers will respect that you are simply trying to understand your employment agreement and are working to be sure that its terms are fair.

Here are 10 things to consider when evaluating and negotiating an employment agreement. One overarching theme is that you must understand the content of your employment agreement; the better you understand its content, the better you will be able to negotiate its terms.

1 **Duties**

Employment agreements typically require you to provide services at an employer's "offices" on a "full-time" basis. Although these phrases in and of themselves are not harmful, they could be inherently unfair to

you if they are not appropriately defined. Depending on your specialty, "full time" might mean five days per week or four-and-a-half days per week or three days of clinic time and one day of surgery per week, etc. You need to be sure that your understanding of "full time" matches the employer's definition. This also will help you as you compare compensation for two jobs, which may have different definitions of full time. Although it is typical for an employer to assign you to the office where your services are most needed, you should request that the employer consult with you

before assigning you to a different location. This is particularly important if your compensation is based on your production and some offices are less productive than others.

2 Policies and procedures

Most employment agreements require you to comply with the employer's policies and procedures, which can be amended from time to time by the employer. Although the employer can change the policies and procedures after you sign your employment agreement, you should request a copy of the current ones to make sure you find them acceptable before you sign the contract. For example, there might be a policy on compensation that states, "Employer shall pay Employee the compensation and provide to Employee the employment benefits to which Employee is entitled pursuant to the Compensation Policy, as is in place from time to time. Employer expressly reserves the right to modify the Compensation Policy at any time." Or, a policy might suggest that an employer does not trust the employee to report income from outside activities, for example, "Employee shall, no later than April 20 of each year, submit her federal income tax return for the purposes of a review of the Employee's other gross professional income."

3 Term

Be sure to carefully review the term of the agreement in light of the termination provisions. For example, an employment agreement may indicate that the term begins January 1, 2014, and continues for three years. This appears to be a three-year agreement, but if the agreement allows the employer to terminate your employment without cause on 90 days prior written notice, the term is actually 90 days.

4 Termination

Although termination provisions are present in every physician employment agreement, they vary greatly. There are two types of termination provisions: 1) "for cause" and 2) "without cause." Most physician employment agreements contain both

for cause and without cause termination provisions.

For cause. Both you and the employer should be able to terminate for cause (meaning some sort of breach or violation of the agreement or other specifically defined action or inaction). If the employer can terminate your employment for cause, the employer should be required to give you notice of the problem and an opportunity to fix the problem within a reasonable time period (also called a "cure" period). In addition, the definition of actions that would qualify as "for cause" termination by the employer should a) be narrowly defined (for example, delete the phrase "including, but not limited to"), b) include materiality thresholds (for example, that a breach must be significant) and c) not include the phrase "in its sole discretion" for determinations of cause that are made by the employer.

Without cause. Both you and the employer should be able to terminate the contract without cause (meaning one party can terminate for any reason or no reason but not an illegal reason). Termination without cause typically requires notice, which generally is 60, 90 or 120 days. Where either party can terminate without cause, you should carefully think about the implications. For example, if the employer terminates you without cause, you should not have to pay for tail insurance and the covenant not to compete should not apply or at least should not apply within the first six months of the agreement (see below for discussion of tail insurance and covenant not to compete).

5 Compensation

Although most physician employment agreements establish base compensation, more and more also include productivity compensation based on relative value units performed by you and billed by the employer (realized at the time the service is provided) or cash receipts/collections (collected up to three or four months following the date the service is provided). If bonuses are based on a cash receipts/collections basis, the employer only collects nine months' worth of billings during the

first year. Thus, you should try to negotiate a pro-rated bonus for the first year (for example, you will receive a bonus if you achieve 75 percent of the threshold required for the first year) and should specify that, upon termination, the employer must pay you for any receipts collected within three months after termination.

6 Malpractice insurance

Insurance coverage is a crucial issue that you must carefully consider before signing any employment agreement. There are two kinds of insurance: 1) occurrence-based insurance and 2) claims-made insurance.

Occurrence-based insurance. Occurrence-based insurance covers malpractice incidents that allegedly occur while you are covered by the policy as an employee of the practice. If you are covered by a policy and someone is allegedly harmed by you but does not bring a claim until after you terminate your employment, the incident will still be covered by the policy even though you no longer have the insurance coverage because the alleged act occurred while you had coverage.

Claims-made insurance. Claims-made insurance covers claims made while you are covered by the policy. This could include claims stemming from harm allegedly caused by you before you were covered by the policy, as long as those claims are filed while you are covered. It also means that if harm allegedly occurs while you are covered by a policy but a claim is made after you have left employment and are no longer covered by the policy, you will not be covered unless you purchase "tail insurance" (also known as an extended-reporting endorsement). Expressed mathematically: Claims-made insurance + Tail insurance = Occurrence-based insurance.

Some employment agreements simply mention that you will be provided professional liability malpractice insurance without addressing whether the policy is occurrence-based or claims-made. Be sure to ask which type of insurance the employer is offering.

If you have occurrence-based insurance, it will continue to cover you after

you terminate and you do not need to discuss tail insurance. The same is true if your employer self-insures. If you have claims-made coverage, someone will need to purchase tail insurance to cover any claims that come in after you terminate your employment. Who pays for tail insurance should be negotiated in your employment agreement. Some employers split the cost of tail insurance with the physician. Others pay the entire cost of tail insurance or require that the physician pay the full cost. In some cases, the party that bears the cost of tail coverage depends on who terminates the employment agreement and for what reason. It may also vary depending on how long you actually work for the employer.

7 Outside activities

Many employment agreements prohibit you from providing outside services without the employer's consent. You should carefully review the scope of the provision because it also may prohibit you from conducting research, speaking or publishing without the employer's consent and may indicate that any money earned from such activities belongs to the employer. If you intend to provide any such services outside of your employment, try to negotiate the employer's consent for those activities you know you will be conducting as part of the contract so you can keep any compensation you may receive, provided that you performed the services on your own time (eg, vacations, weekends, etc.). Also, keep in mind that you will need your own malpractice insurance for outside professional activities, including volunteer activities.

8 Covenant not to compete

Almost all physician employment agreements contain a covenant not to compete (although it would be ideal for physicians if they didn't). These provisions usually run one to two years following termination, and they can be complex. When reviewing a covenant not to compete, be sure to ask these questions:

Is it reasonable under state law based on geographic area and duration? The geographic range should focus on areas

from which the employer draws patients and should relate to the employer's offices where you provided services (this is particularly important for employers that have offices spread across a geographic radius and you only provided services in a few of those offices).

What sort of events trigger the covenant not to compete? Typically, the covenant not to compete is triggered if the employment terminates "for any reason." However, you should not be prohibited from working for a competitor if the employer terminates you without cause or if you terminate because of the employer's material breach. In contrast, you may be subject to a covenant not to compete if you terminate without cause or if the employer terminates you for cause.

Certain items typically are excepted from covenants not to compete. They include:

- Performing periodic hospital rounding
- Employment as a hospitalist
- Teaching at a university medical school or other academic institution
- Providing medical director services
- Providing review services to any agency, third-party payer or other organization for payment, quality, medical necessity or peer-review purposes
- Conducting scholarly or academic research and/or writing
- Performing volunteer services.

9 Call coverage

It is crucial to understand the call coverage obligations required by the agreement. Although it is important to make sure patients' needs are met, it is also important to ensure that your health and well-being are protected. You should know that call coverage is shared equally or that you understand the circumstances under which call would not be shared equally among the staff (both junior and senior physicians). Keep in mind that if the division of labor for call coverage is based on the number of physicians in an office, your obligation will increase if other physicians leave the employer.

10 Integration provision

Most contracts have an integration provision that shows up in the miscellaneous section of the contract. The integration provision specifies that the contract is the entire agreement between the parties and supersedes any and all prior agreements, understandings, promises and representations made by either party concerning the subject matter in the agreement. In other words, the signed agreement is the final statement of the arrangement, and any previous agreements, even those made in writing before you signed the contract, are replaced by the agreement and are not enforceable. So, ensure that any promises made about the contract are written into the version that you sign.

Accordingly, if your potential employer tells you that it won't enforce a particular term in the employment agreement or that you don't have to worry that the agreement indicates that the employer won't provide tail insurance because the employer always provides it even if not contractually required to do so, you must make sure those terms are reflected in the agreement or in a side letter that is dated the same date as the employment agreement.

Conclusion

Although this isn't everything you need to know about physician employment agreements, we have touched on a number of important issues to consider when negotiating with a potential employer. Smaller and newer practices and those in rural areas will be more likely to negotiate than large health care systems, which use standard template employment agreements that are applicable to all physicians they employ. Even if you will not be able to negotiate the terms of your employment agreement, it is still worth having an attorney review it so that you can understand its benefits and limitations and take the terms into consideration when evaluating a job offer. **MM**

Claire Topp and Emily Menchaca are attorneys in Dorsey and Whitney's health group in Minneapolis.



PRACTICING MEDICINE IN AN IMPERFECT WORLD

FIVE TRUTHS ABOUT PREVENTING OR SURVIVING A LAWSUIT

BY LAURIE DRILL-MELLUM, M.D., M.P.H.

We physicians are human beings and, as such, we make mistakes. When patient outcomes are different from what was expected, we sometimes get the blame even though we've done the best we can. Yet most of us engage in magical thinking. We assume that we are different from our peers—that somehow we can be more careful than others and dodge the bullet of a lawsuit. Sure, there are ways to mitigate that risk, and some physicians will make it through their whole career without being sued. More likely, it is just a matter of time before you are named in a medical malpractice claim.

Harvard researchers found that by age 65, 75 percent of physicians in low-risk specialties such as family medicine, pediatrics or psychiatry will have faced a malpractice claim; the rate for high-risk specialties is reported to be 99 percent.¹ In high-risk specialties such as neurosurgery and cardiovascular-thoracic surgery, approximately 19 percent of practitioners face a claim each year.¹ The same investigators also found the average physician spends almost 11 percent of a presumed 40-year career with an open, unresolved malpractice claim.² That doesn't include the time from the date of the injury to when a claim is actually filed, which is nearly two years on average. That period

can be extremely stressful, as the physician must deal not only with the emotional impact of the adverse outcome but also with the fear of a possible lawsuit.


Because we can't eliminate the risk of being sued, we need to develop healthy ways to think about this inevitability and to embrace practices that will promote resiliency and minimize the negative impact of unanticipated events on both you and your patients. Here are five principles to take to heart.

1 Communication is all-important

A review of the malpractice literature suggests that a breakdown in the patient-physician relationship, as evidenced by communication problems, is one of the leading reasons for malpractice claims.³ In addition, poor communication is consistently cited as the third most common reason for sentinel events.⁴

Communicating in a compassionate, empathetic manner is as important as relaying accurate, understandable information. People may or may not remember what you say, but they will definitely remember how they felt when you said it. The importance of establishing good rapport with patients, families, colleagues and other members of the care team cannot be over-emphasized. Good rapport involves

communicating with the goal of ensuring that your words and intentions are understood. It also requires treating people with kindness, dignity and respect. If you remember the "favorite uncle rule" (treat each patient as you would your favorite uncle), you will make the patient feel as if he or she is the most important person in the world and lessen your chance of being sued.

Small actions such as calling patients the day after surgery or checking in with those who had worrisome complaints when you saw them in the clinic or emergency department will make a huge difference to them. Such gestures may nip a problem in the bud if things aren't progressing as you would have expected. Sitting down with your patients, asking about their lives, extending a caring touch or making an empathetic remark also go a long way toward establishing trust and encouraging good communication. Routinely asking if their concerns were addressed or whether they have additional questions shows that you are committed to their well-being. And, if you keep the concept of "communicate for understanding" front and center, people will feel comfortable asking you questions. This applies to interactions with patients, their family members and your staff. 

Another aspect of communication is the informed consent process. Obtaining informed consent is the legal duty of any physician performing a procedure or delivering treatment. As such, it should not be delegated to another health care professional, such as a nurse preparing the patient for the procedure. It's important that you take the opportunity during the informed consent conversation to create realistic expectations about the likely results of the procedure. Be sure to document discussions about the work-up, differential diagnosis, recommendations, and risks and alternatives and note the patient's concerns, questions and understanding. The outcome of a medical malpractice claim may be significantly affected by whether all of these things are included in the patient's record.

2 Humility is an important virtue in the practice of medicine

The days of the "lone wolf" are over. We are practicing in a time when no one physician can possibly know all the answers. We also are living during a time when many resources are available to us. It is imperative that we use them all. We can obtain prior medical records, review literature and consult with colleagues when faced with clinical challenges or conundrums. You will be hard-pressed to explain why you didn't take advantage of these resources if something goes wrong.

New technologies and procedures will always be a part of medicine, but you must make sure you are technically competent before using them. Know your limits and get help when you need it; always put your patient's best interest ahead of your ego.

Also, avoid "jousting" or criticizing another clinician's care. It won't help the situation. In a case where there was a mishap, there is little chance that you will fully understand what transpired and what resources were available to the physician who was caring for the patient. Jousting only makes patients and families feel worse, in addition to inviting lawsuits.

3 Patients and family sue because they want information

One of the most commonly held myths about medical malpractice is that patients sue because they want money. More often, what they want is an explanation about and an acknowledgement of what happened, an apology, information about the consequences they may experience and reassurance that everything will be done to make sure the same thing does not happen again.⁵ That said, when it's clear that mistakes have been made and that the patient suffered adverse consequences as a result, that patient is justified in seeking compensation for their injuries.

A relatively new approach to dealing with unanticipated outcomes, pioneered at the University of Michigan Health System, is gaining traction in the medical community and improving physician, patient and family satisfaction.⁶ This approach involves committing to being honest and apologizing when an adverse event happens. Proponents of apology cite data that show it can result in fewer lawsuits, lower insurance premiums, decreased defense costs and lower settlements.⁶ Opponents contend that it may do more damage than good by making a defense case weaker. In any event, when you sincerely say, "I'm sorry this has happened to you," it does not imply that you are responsible or liable for the outcome; it just implies that you have appropriate and natural feelings of regret. In fact, the absence of these simple words when medical care goes wrong can do damage, as the silence can be deafening.

Saying you are sorry can help repair your relationship with the patient, decrease the amount of time spent in resolution, and help both you and your patient heal and move forward. It also opens the door to allowing both parties to better understand what went wrong and how it could be prevented in the future.

Thirty-four states and the District of Columbia have passed laws preventing apologies by health care professionals from being used in a lawsuit.⁷ Minnesota does not currently have a health care apol-

ogy statute. Because the scope of these laws differs by state, you should seek professional advice about the situation in your state.

Transparent communication does not mean telling patients and families all the details of an event while in the acute setting. Rather, it means sharing information when it becomes available and when patients are able to absorb it. This requires working with patient safety and risk management personnel to set a stage in which open, honest and empathetic conversations can occur. Promising to get back to patients when you have more information and following through on this promise can make or break a relationship that has been rendered fragile by an unanticipated outcome. The truism that "people will fill in the blanks" when they aren't kept in the loop is especially true when medical care goes awry.

In addition to apologizing and making a commitment to open, honest disclosure, you may need to communicate with your clinic or hospital business office so that bills are not sent to a patient in the midst of an adverse event. Depending on the event, it may be appropriate not to bill the patient at all. Exercise the same sensitivity around other expenses the patient and their family may incur related to the event such as those for parking, meals, hotel stays and missed days of work. Insensitivity to financial concerns can irritate patients and further damage your relationship with them.

4 Caring for yourself is imperative

Burnout is characterized by emotional exhaustion, depersonalization and a sense of low personal accomplishment; it leads to decreased effectiveness at work. Studies show that burnout is prevalent among physicians at all stages of their careers. In a study of almost 8,000 practicing surgeons, Mayo Clinic researchers found that major medical errors were strongly related to a surgeon's degree of burnout.⁸ A survey of residents by the same group from Mayo

found that 76 percent of the 115 respondents met the criteria for burnout.⁹ Those residents were significantly more likely than residents who weren't experiencing burnout to report at least one episode of providing suboptimal care per month, including discharging a patient early to make the workload more manageable, making a medication error for reasons other than lack of knowledge, not performing a test because of a desire to discharge a patient, paying little attention to the social or personal impact of an illness on a patient, and having little emotional reaction to the death of a patient.⁹

The problem of burnout and its effect on patient care and safety is garnering more attention these days. Medical schools, hospitals and clinics are developing programs to promote well-being and resiliency; they also are attending to the emotional needs of providers affected by unanticipated outcomes. Participating in physician wellness programs, many of which teach stress-management techniques, may be one of the best investments you can make to help you cope with the stress associated with an adverse event and possible malpractice claim.

5 Surviving, even thriving, after a lawsuit is possible

Physicians want to help people, so it's not surprising that an adverse event knocks us off kilter. Studies show that after such an event, physicians often experience post-traumatic stress-like symptoms, a phenomenon known as the "second victim" response.¹⁰ They may feel numb, fearful and isolated from others. And they may become depressed or have symptoms such as headaches and difficulty sleeping, eating and concentrating. Many report feeling personally responsible for the adversity, as though they have failed the patient. And most replay the scene over and over in their minds, and second-guess their skills and knowledge going forward.¹¹ This makes them vulnerable to another unanticipated outcome.¹²

Second-victim response is normal. But far too often, we are reluctant to admit how much stress we are experiencing. We

tend to retreat and isolate ourselves when we feel the shock, sadness, shame, sense of failure and overwhelming guilt that go along with an unanticipated outcome. When this happens, our colleagues and other care providers may be afraid to approach us. Ultimately, this is damaging not only to us but also to our community of care providers.

Health care organizations are starting to recognize the impact of the distress felt by physicians involved in unanticipated outcomes and related lawsuits; some are even developing clinician-support programs. For your sake—and that of your current and future patients—take advantage of these programs. The University of Missouri Health System has developed an in-depth program to support second victims and documented six stages of recovery after an adverse event. Its creators note that outside forces such as malpractice claims, root cause analyses or disciplinary investigations can trigger new memories of the original event.¹³ During the final stage of recovery from an adverse event or lawsuit, "moving on," physicians either drop out, survive or thrive.¹³

Several factors seem to influence how a physician comes away from an adverse event. Personal resilience is a key predictor of thriving. And recovery often requires us to forgive a colleague, another member of the health care team or ourselves, which is much easier said than done. When physicians don't take time to heal and they merely survive, they put themselves at risk for burnout and all that goes along with it including depression and an increased likelihood of committing further errors.

Conclusion

In spite of our best efforts, adverse outcomes and subsequent lawsuits are a part of medical practice. Both cause physicians to experience significant stress. Fortunately, more and more resources are becoming available to support distressed physicians and help them realize that their response to such events is normal. If your patient experiences an unanticipated outcome, remember that you are not as alone as you might think. Reach out and

ask for support. And in turn, offer support to peers who might be in a similar situation. In addition to accepting and providing support, adopt practices that promote wellness and resiliency as well as good relationships with patients and other health care providers. As we remove the stigma associated with being involved in an adverse event, being sued and seeking help, we will become healthier, happier and better able to take care of ourselves and others. **MM**

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FIVE SECRETS TO FINANCIAL SUCCESS FOR YOUNG PHYSICIANS

How to pay off your debt and achieve your goals.

BY DAVE DENNISTON, CFA

Now that you are starting your medical career, you may feel relieved to finally have all those years of schooling and training behind you. But then reality sets in and you wonder how you are going to deal with the educational debt you've accrued. According to the American Medical Student Association, 86 percent of medical school graduates carry educational debt; the

TIPS FOR FINANCIAL PLANNING

- Remember that your situation is unique, so you will need your own plan.
- Take time early in your career to reflect on your circumstances and set goals.
- Work with a professional who can guide you as you make choices.
- Make establishing a rainy-day fund and paying off debt priorities.



a colleague (see Financial plans for two physicians).

To develop a plan, you will need to take time to ponder and reflect upon your situation. The best time to do that is now, early in your career. Here are some things to consider as you do that.

1 Establish a “rainy day” fund

In my opinion, one of the most important things you need to do is start a contingency fund. During your first months on the job, make sure you set aside money for the “stuff happens” factors in life such as the car breaking down or the furnace going out. I would suggest saving a minimum of \$6,000 within your first few months of employment. If you make more than \$200,000 a year, double that. Continue to save that amount annually to keep building a cash reserve.

Keep these funds in a money market or checking account until you have more than \$15,000. Then, consider a low-risk investment account that allows you to pull out money without penalty.

2 Reduce your debt

Once you’ve accumulated a cash cushion, focus on reducing your debt. In doing so, consider the following:

- Make sure that you consolidate your debt and lock in the interest rates. You can do this with both student debt and consumer debt. Interest rates are at an all-time low and are likely to rise within the next two to three years. The interest rate for consumer debt such as credit cards and car loans typically is higher than the rate for educational debt. Pay off any consumer debt before paying down your student loans. Also, if you only have \$5,000 or less left on a loan, consider paying it off in full in order to increase your monthly cash flow and give yourself a sense of accomplishment.
- If you are a resident or fellow, defer your student loan payments (interest will compound during this time) until after you start working or seek forbearance such as paying a reduced amount through an income-based repayment

or a pay-as-you-earn plan. Note that a pay-as-you-earn plan requires a lower monthly commitment than an income-based repayment plan.

- Look into federal and state debt-forgiveness programs. These programs help professionals pay off educational debt in exchange for serving in an area of need for a certain amount of time. To learn more about these opportunities, go to https://services.aamc.org/fed_loan_pub/ and <http://NHSC.hrsa.gov/loanrepayment/studentstoserviceprogram/> or <http://studentaid.ed.gov/repay-loans/forgiveness-cancellation/charts/public-service>.
- Assuming you are not enrolling in a debt-forgiveness program, consider paying back your student loans in 10 years or 15 years instead of 30 years. If you’re paying 5 percent interest on a \$150,000 student loan over 30 years, you’ll pay nearly \$140,000 in interest. If you pay the loan back in 15 years, you will reduce the amount of interest you pay to about \$64,000. You could use the \$76,000 you would save to buy a cabin or RV, for example, or add to your retirement account. At a minimum, consider putting at least an extra \$500 to \$1,000 per month toward your debt.
- Pay down your student loans before you pay down your mortgage. The interest on student loans is not likely to be tax deductible once you are making more than \$90,000 a year, whereas the interest on a mortgage is.

Physicians have big hearts and big dreams. They may want to pay for their kids’ college education, buy the cabin or second home, buy a boat or RV, or give money to worthwhile charities. My advice: Hold off on these things until you are debt-free. Remember that once your debts are paid, you’ll have the cash to fund these other projects.

3 Live within your means

As a physician, you will be able to enjoy a nice lifestyle. But be reasonable. Living comfortably means different things to different people. I consider it to mean that you aren’t just squeaking by and are able to

median debt burden for a graduate of a public school is \$119,000 and the burden for a graduate of a private school is nearly \$150,000.¹ So how do you balance paying off such debt with buying your first home, saving for retirement, buying a new car and enjoying life?

Successfully doing so requires consideration of your circumstances, priorities and income. You may or may not be married and have children. You may or may not be in a highly paid specialty. Depending on your personal situation, your financial plan will look very different from that of



do the things you like to do—dining out, going on a vacation—while still keeping your expenses within limits. To help keep an eye on your living expenses, use free budgeting and wealth management tools such as Mint.com, Emoneyadvisor.com and creditkarma.com.

4 Save for retirement

How do you balance living the way you want to with paying off debt and saving for retirement?

First, contribute to your 401k. It not only counts toward retirement, but it lowers your income taxes.

Second, contribute at least up to the maximum match that your employer provides. If your employer matches dollar for dollar, this is like an automatic 100 percent return. Even if your employer matches 50 cents or 25 cents on the dollar, that is still like a 50 percent or 25 percent return just for contributing.

Finally, max out your contribution, if possible, as doing so can lower the amount you pay in both federal and state income taxes. If you are younger than age 50, the maximum you can put in a 401k in 2013 is \$17,500.

5 Be smart about big-ticket items

After years of living in small houses or apartments or driving older vehicles, many young physicians feel they're more than ready to purchase a new home or car when they get their first "real" job. Instead of rushing out to buy such big-ticket items, take a moment and think about how those purchases might affect your ability to achieve your long-term financial goals. And bear in mind that your lifestyle can change as you pay off your debt.

Here are a few of things to consider when you are ready to make those purchases:

- When buying a home, make sure you can put at least 20 percent down on the property. If you put only 5 or 10 percent down, you may be required to have private mortgage insurance (PMI), the cost of which could raise your monthly pay-

Financial plans for two physicians

	PHYSICIAN 1	PHYSICIAN 2
Income	\$150,000	\$220,000
Taxes*	\$26,537	\$53,073
Rent/mortgage	\$18,000	\$18,000
Living expenses	\$60,000	\$80,000
Student debt payment	\$9,600	\$9,600
Rainy day/further debt paydown	\$12,000	\$21,000
Save for first home	\$17,000	\$25,000
Save for retirement/ 401k	\$6,863	\$13,327
Expenses	\$150,000	\$220,000

*Assumes married filing jointly, 2012 tax brackets with standard deduction of \$11,600, payroll taxes of 7.5% up to \$110,000 of compensation

ment by a couple hundred dollars. Note that there are some physician-specific loan programs that may not require PMI. However, getting in the practice of saving toward a goal is a wonderful form of financial discipline.

- Instead of buying a new car, buy a used one and hold onto it as long as possible. Remember that cars are depreciating assets. The second you drive a new car off the lot, it typically lose \$5,000 to \$10,000 of its value. Why put a significant chunk of your hard-earned dough into something that you know will depreciate? Financially speaking, buying a low-mileage used car (say with 20,000 to 50,000 miles on the odometer) and keeping it for five years or more makes much more sense than leasing or buying new.
- If you do decide to get a new car, remember that buying can be a better deal than leasing, especially if you keep the car for five years or more. If you lease a \$20,000 car over three years at 6 percent interest and pay \$1,000 down, the total cost over three years will be \$12,600 plus the down payment. At the end of the lease, you will have paid \$4,200 toward the principal of the loan and can either purchase the car or return it to the dealer. If you purchase the same \$20,000 vehicle with the same down payment and finance it at 6 percent interest, you will pay \$7,500 per year (\$22,500, plus the down payment over three years). At the end of the loan period, you will own

the car.²The cost of leasing for 10 years (let's say that you renew your lease every three years and get the latest model car) will be at least \$42,000, plus down payments. Whereas, if you buy the car and hold onto it, the cost will be \$22,500 plus the cost of regular maintenance. Buying rather than leasing would save you nearly \$20,000.

Final thoughts

As a physician, you've made a commitment to helping others and your community. Now you need to make a similar commitment to your finances. If you focus on paying off your debts, save for a rainy day, live within your means and put money away for retirement, you can then do the things you've long dreamed of doing and be well down the road to financial independence. ■■■

Dave Denniston is a wealth manager and financial advisor in Bloomington. He is the author of *5 Steps to Get Out of Debt for Physicians Workbook* and *45 Secrets to Financing a College Education*. He can be reached at ddenniston@macthig.net or telephone 800-548-1820.

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A case for professional community doctors

As young physicians, how can we engage our communities while caring for our families?

BY STEFAN POMRENKE, M.D., M.P.H., M.A.T.S.

A few weeks ago, I built a ball pit for my daughter. It's filled with the kind of balls that are perfect for juggling, a skill I am trying to learn. I'm also attempting some juggling in my professional life. I'm working half time in a clinic and half time in the community where I live and work. And although I consider my duties both inside and outside the clinic to be part of my job as a physician, no one has yet offered to pay me for my work in the community.

For me, the call to become engaged in the community where I practice was nearly deafening when I was studying public health. That call is being heard more and more often by those working in health care systems and in county or state health departments, as we have become more aware of the social determinants of health. Many young physicians, especially, have come to understand how the problems in communities relate to the health of individuals. And many more of us could be investing our time working on society's or our communities' problems.

Today's young physicians have been taught to see the patient within the context of their environment. We have been trained to assess situations and solve problems. We have knowledge, skills and talents that are unique in our communities. Many of us are natural leaders. Many of us

are articulate speakers. Many of us have studied public health. And many of us would like to work on larger social issues. But we are more than busy with our more-than-full-time clinic and hospital jobs and with our young families. And we are only paid for the time we spend with the individual patient at the point of care.

Still, I'd like to suggest that we physicians begin to think more creatively about our career paths. And I'd like to propose that others find a way to help us financially when we take an alternative route.

Our professional calling— vocation, vocation, vocation

Medicine, the ministry and law are the three original professions. Historically, members of these professions were viewed as leaders in their communities. The country doctor, the country minister and the country lawyer would make frequent public appearances. Their expertise was sought out and applied to problems affecting their community. They not only met with individual patients or parishioners or clients, they improved the health of the public, helped people apply faith to daily life, and promoted the rule of law and a responsible citizenry. Doing such things was considered part of their professional responsibility.

Today, we tend to think of professionalism as something that applies only in our daily clinical practice. We have forgotten that we have a professional obligation in the public sphere. Our thinking about the issue is further confused by the fact that we feel pressured by our own financial needs and by the demands of our health care system.

My community doc experiment

My thinking about my role as a physician began to change while I was a resident in the St. Joseph's Hospital Family Medicine program in St. Paul. Although I truly appreciated working with patients in the clinic and hospital, I found I wanted to do more to help them achieve long-term, sustainable behavior change.

I wondered how I could continue to apply lessons learned in public health school with those learned in medical school. Yet, the pace and demands of the full-time clinic job discouraged me from even thinking about community work. I could see burnout on the horizon.

When I completed my residency, I decided to do an experiment: I would practice in the clinic only half time and engage in the community during my non-paid "off" time. I now see patients half time at Westside Community Health Services, a

very supportive Federally Qualified Health Clinic in St. Paul.

My wife and I had already laid the groundwork for this experiment years earlier by deciding that we could live simply. We bought an older house in Dayton's Bluff, an inner-city neighborhood in St. Paul. My wife is a pastor at a church in north Minneapolis, and she too works half time in order to spend time raising our child. We both have found we better understand the challenges faced by the people we serve (congregants for her and patients for me) by living in the type of community they live in. And although the bills for my medical school debt keep on coming in monthly, with a small mortgage payment and a simple lifestyle, we are doing very well.

I've been amazed at what I have done in the past year. The chief accomplishment for our family was going through the adoption process. After nearly two years of waiting and planning, we have been blessed with a two-and-a-half-year-old daughter from Poland. And I got involved in a number of neighborhood organizations. I joined the Dayton's Bluff Community Council, which has submitted a proposal to the city of St. Paul for a bike route through our neighborhood. I'm helping with the Eastside Prosperity Campaign, which is starting to address transportation and food access issues on the east side of St. Paul. I serve on the board of Urban Roots (previously Community Design Center), which offers youth internships in gardening and conservation. I'm on the Dayton's Bluff Seniors Board, part of the Living at Home Block Nurse program.

I've mentored a low-income teenager, toured neighborhood buildings being prepped for renovation and discussed future building plans with my city council member, and completed some pretty big renovations on our house, which was previously a problem property. I volunteered on a committee working to establish a food co-op in our neighborhood, spoke to University of Minnesota family medicine residents about food systems issues, and interned with the Institute for Agriculture

and Trade Policy in south Minneapolis. I worked with the Minnesota Medical Association and the American Medical Association's Young Physician Section on agricultural policy (the U.S. Farm Bill) and its impact on public health. In addition, I'm the associate medical director of the Twin Cities Medical Society's Honoring Choices initiative, focusing on nurturing connections between the clergy and physicians.

It has been a great year. I've both staved off burnout and contributed to lasting changes in the health of our community. Knowing that my time has been fruitful is personally and professionally rewarding. I wonder, would others do the same if given some payment?

A challenge

I share all this because I hope it might inspire others to think creatively about how they might serve their communities. Leaders with more public platforms have recently reminded us to do the same. In January, the president of the Twin Cities Medical Society, Edwin Bogonkio, M.D., highlighted Dr. Martin Luther King's dream of the "beloved community" in his inauguration speech. President Barack Obama, in his second inauguration address, called on us to be citizens of this community.

We young physicians have much to offer our communities as well as our patients. We are industrious; we are efficient; we are connectors; we have energy. We need to get back to understanding that caring for our communities is part of our professional identity. Working part-time as a volunteer is one way to fulfill this obligation. I would hope that someday we might have community physicians who are paid for the work they do. For now, we young physicians will have to find creative ways to juggle our roles as professionals in the clinic and the community. MM

Stefan Pomrenke is a family physician at Westside Community Health Services in St. Paul and a community activist in his St. Paul neighborhood.



Call for Papers

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Articles due June 20

Health information technology (the possibilities and problems)
Articles due July 20

Mental health
Articles due August 20

Challenges to professionalism
Articles due September 20

Past and future (a look back and ahead)
Articles due October 20

Manuscripts and a cover letter can be sent to cpeota@mnmed.org. For more information, go to www.minnesotamedicine.com or call Carmen Peota at 612-362-3724.

The 2013 session

Despite the DFL's control of state government, the MMA still had to fight for health and human services funding.

BY DAN HAUSER

With one party controlling the House, the Senate and the governor's office, some observers might have assumed that the 2013 legislative session would have gone smoothly.

"The world of politics isn't that simple or straightforward, however," notes Dave Renner, the MMA's director of state and federal legislation. "While it was a very successful session overall, it was not without its bumps and bruises."

The largest bump came in March when House and Senate leaders released their budget targets with \$150 million in cuts to Health and Human Services general fund spending. By the end of the session that number had changed to \$50 million thanks to budget maneuvers that brought in more federal money. "Getting that amount revised was a considerable improvement but still below what the MMA would have liked to have seen," Renner says.

Cutting the HHS budget is nothing new. "It has been a frequent target for lawmakers," Renner says. "Between 2009 and 2012, the state cut more than \$2 billion in HHS spending. Fortunately, we were able to convince House and Senate leaders that you can't cut your way to a healthier Minnesota."

Another bump was felt in April when Senate leaders proposed rescinding the provider tax repeal during budget discussions (the tax is scheduled to go away at the end of 2019). This move would have kept the tax indefinitely. The proposal quickly met resistance from the MMA, the Minnesota Dental Association and other health care provider organizations, and was soon withdrawn.

Ensuring the continued phase-out of the provider tax was among the MMA's six top priorities for the session. The others were:

- Establishing a Minnesota health insurance exchange
- Expanding Medicaid (Medical Assistance) in Minnesota
- Promoting collaborative care delivery, not independent practice for advanced practice registered nurses
- Investing in medical education
- Increasing the tobacco tax to reduce smoking rates.

The MMA also kept an eye on a number of other issues including legislation dealing with prescription opioid abuse, the state's newborn screening program, repackaging of medications at clinics, cuts to workers' compensation health care reimbursements and prohibiting tanning for minors.

Following, we examine the hits, the misses and the unresolved issues from the 2013 session.



THE HITS

Medical Assistance expansion

On February 19, just a little over a month into the session, Gov. Mark Dayton signed legislation that expanded Medical Assistance to include anyone earning up to 138 percent of the federal poverty level (approximately \$15,800 per year for an individual) as permitted by the Affordable Care Act.

The Legislature moved quickly on this bill because the governor wanted the federal funding it would generate to be included in the March budget forecast.

The expansion and associated changes are expected to save the state more than \$1 billion over the next two biennia. The federal government will pay 100 percent of the cost of the expansion for new enrollees for the first two years, then phase down to 90 percent after that. Currently, Minnesota and the federal government share costs for Medicaid 50/50.

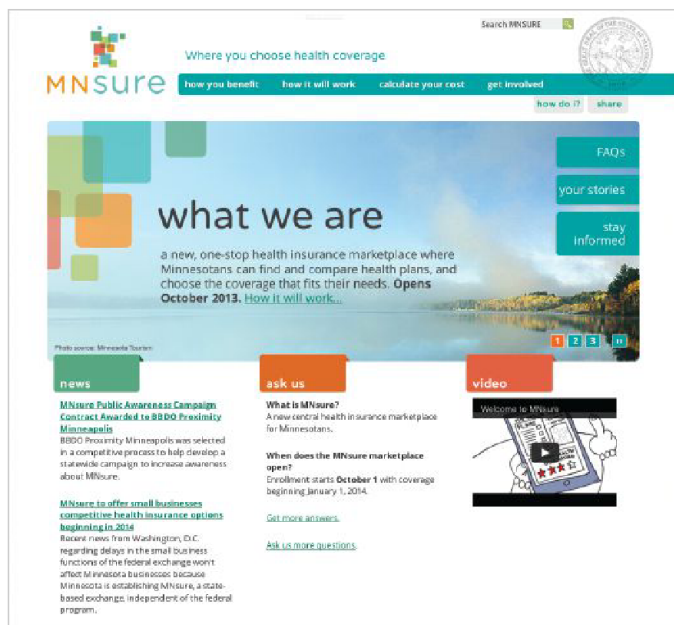
The expansion is expected to provide coverage to 87,000 Minnesotans, according to the Department of Human Services. MinnesotaCare already covers 53,000 of those people; 34,000 are currently uninsured.

Although the MMA supported the expansion because it increases access to care, it expressed concern about physician reimbursement rates. "The long-term sustainability of the Medical Assistance program requires the state to adequately pay for physician services provided to Medical Assistance enrollees," MMA CEO Robert Meiches, M.D., told a House committee in January. "Minnesota physicians have had their fee-for-service rates frozen for 13 years," he continued, pointing out that Medical Assistance fee-for-service payment rates for physicians are among the lowest in the nation. Minnesota currently ranks 47th out of 50 states.

In the end, lawmakers increased the fee-for-service rate by 5 percent.



Gov. Mark Dayton



Minnesota-based health insurance exchange

A month after signing the Medical Assistance expansion bill, Gov. Dayton signed the bill creating the Minnesota health insurance exchange, which was quickly christened MNsure.

MNsure will allow individuals and small businesses (those with 50 or fewer employees) to compare and purchase health insurance online. In order to utilize federal tax credits to help pay for private insurance, Minnesotans will have to purchase their coverage through MNsure. Eligibility for the Medical Assistance program also will be run through the exchange, which is expected to serve up to 1.3 million Minnesotans or about 20 percent of the state’s population.

The legislation passed largely along party lines, with all Republicans opposed. “We would have liked to have seen both sides of the aisle embrace this legislation, but we’re just happy it moved forward,” says Eric Dick, the MMA’s manager of state and legislative affairs. “The MMA has long supported a state-based exchange rather than having a one-size-fits-all federal exchange imposed upon the state. We believe that the new law will capitalize on Minnesota’s expertise and reflect our unique health care landscape.”

Minnesota is one of 17 states plus the District of Columbia that will run their own exchanges.

A little more than a month after the exchange became a reality, the governor announced a seven-member board that will oversee its operations. The board includes MMA member Kathryn Duevel, M.D., a retired ob-gyn from Willmar.

MNsure is scheduled to launch on October 1.

Fighting the provider tax

The provider tax issue reared its ugly head again in mid-April during Senate budget deliberations. The rescinding of the provider tax repeal was buried deep within a budget bill.

“We are shocked that less than two years after a bipartisan agreement was passed and signed by Gov. Dayton that Senate leadership is proposing to extend the provider tax,” MMA President Dan Maddox, M.D., told the *St. Paul Pioneer Press*. “This is a regressive tax on health care that falls most heavily on the sick and adds to the overall cost of care.”

MMA Board Chair Dave Thorson, M.D., also spoke out against the bill when he testified in mid-April before the Senate’s Health and Human Services Finance Division committee. “Physicians and other health care providers have witnessed years and years of fund diversion—hundreds of millions of dollars taken from the Health Care Access Fund and used to shore up the general fund,” Thorson testified. “This bill, sadly, does more of the same.”

Thanks to the efforts of the MMA’s legislative team and more than 70 members who sent emails to their senators in response to an MMA Action Alert, the Senate tax committee deleted the language that would have rescinded the provider tax repeal. “This was a great example of how working together we can make a real impact on policy at the state Capitol,” Renner says. “With our members help we were able to remind senators of the promise they, state representatives and the governor made two years ago to repeal the tax.”

Raising the tobacco tax

When lawmakers began the session, Minnesota ranked 28th in terms of how much it taxes tobacco. On July 1, it will rank sixth. That’s because the Legislature approved increasing the tobacco tax by \$1.60 per pack of cigarettes.

“I’d say that’s a huge success,” Dick says. “We’ve long advocated for increasing the tobacco tax because study after study has shown that raising the price of tobacco is the most effective way to prevent young people from starting and to get adults to quit smoking.”

It appeared from the beginning of the session that it was a matter of how much, not whether or not a tax increase would come.



The governor as well as House and Senate leaders all supported raising the tobacco tax; it was just a matter of reaching an agreement at the end of the session.

The MMA was also pleased with legislators for reclassifying “little cigars” as cigarettes. “These little cigars are very appealing to youths,” Dick says. “Nearly identical to conventional cigarettes, they are often available in appealing flavors like grape and chocolate. Given a tax loophole, they are far less expensive than cigarettes. With the new legislation they will be treated like cigarettes and, as a result, kids will be discouraged from buying them.”



The Botax bill

A proposal to extend the state’s sales tax to “cosmetic” surgical procedures received attention in both the House and Senate this session.

Under the proposal, sales tax would be levied on procedures directed at “improving the subject’s appearance, body image or self-esteem and which does not meaningfully promote the proper function of the body or prevent or treat illness or disease.”

The bill would exempt reconstructive surgery and “any surgery performed on abnormal structures ... including procedures to improve function or give a more normal appearance.”

The MMA opposed the proposal, noting the subjective line between a cosmetic procedure and one intended to give a more normal appearance. Testifying in opposition during a House hearing, MMA member Mike Tedford, M.D., warned that the bill could undermine a patient’s privacy as tax compliance questions could lead tax officials to audit patient’s medical records. Tedford, board chair of MEDPAC, the MMA’s political action committee, also noted that such procedures are already subject to the 2 percent provider tax.

The proposal was included in the original version of the Senate’s tax bill, but was quickly dropped. It was not included in the final tax legislation.

Restoring Medical Education and Research Costs (MERC) funding

A few days before the end of the session lawmakers agreed to provide \$12.8 million in funding for MERC. This amount will be matched by federal funds and restores funding to 2011 levels, before cuts to the program were made.

“With Minnesota’s aging population and more individuals receiving care under the ACA and related reforms, the demand on the physician workforce—particularly primary care physicians and those in rural and other underserved areas—is growing dramatically,” Renner says. “That’s why restoring MERC funding was so important. We need to invest in the next wave of Minnesota physicians.”

See Viewpoint on page 48 for more on MERC.



Health and Human Services funding

Budget targets for Health and Human Services (HHS) started out in a dismal position. Both House and Senate leaders were forced to cut \$150 million from HHS general fund spending. However, by the end of the session, the target had changed to a \$50 million cut.

“Thankfully, we were able to move the needle significantly,” Renner says. “However, we’d prefer not to have to make our case every session for more health care funding.” Since 2009, more than \$2 billion has been slashed from HHS programs.

The MMA and more than 50 other Minnesota health care-oriented organizations asked legislative leaders to reconsider their initial budget proposals. The group sent a letter to Sen. Majority Leader Thomas Bakk (DFL-Cook) and House Speaker Rep. Paul Thissen (DFL-Minneapolis). “These budget targets are even more perplexing in light of \$2 billion of proposed new revenues and, more important, the fact that the HHS budget is one of the few areas with actual expenditures below projections in the February forecast,” the letter said.

In addition to signing the letter, the MMA sent an Action Alert to its members in late March urging them to send emails to their representatives and senators asking them to stop the cuts.

In the end, these efforts plus meetings with Gov. Dayton led to the revised budget target for HHS.



Newborn screening

The MMA, along with the Minnesota Chapter of the American Academy of Pediatrics, sought changes to the state's newborn screening program as part of an omnibus data practices bill introduced in early May. However, those efforts were unable to garner the votes needed.

The MMA had advocated for postponing destruction of test results collected as part of the program until June 1, 2014. Current law allows them to be destroyed two years after they have been collected. This would dictate that destruction begin this November. Delaying destruction until June 2014 would have provided the Department of Health enough time to craft long-term storage solutions. The MMA also supported a request for the health department to conduct a comprehensive review and study of the newborn screening program.

"We're disappointed to say the least," Dick says. "Preserving the data until the Department of Health could complete a proposal for long-term storage was a small ask. We are disappointed that opponents of the program were able to scuttle the bill."

Prohibiting indoor tanning for minors

MMA leaders were disappointed when a bill that would have prohibited anyone younger than 18 years of age from visiting a tanning facility failed to move forward at the Capitol. Although bills

were introduced in both the House and Senate, neither received hearings.

"There's clear evidence of the link between rising skin cancer rates and artificial UV exposure," notes Dick. "Minnesota needs to treat this carcinogen just as we do tobacco, and that means prohibiting minors from using artificial tanning facilities."

Current Minnesota law allows children under the age of 16 to use tanning facilities with parental consent, and there are no restrictions on those 16 and older. Eleven states ban children from using tanning beds. According to the American Cancer Society, each year, approximately 120 Minnesotans die from melanoma, the most deadly form of skin cancer.



THE UNRESOLVED

Advanced practice registered nurses' push for more independence

One bill that caused the MMA concern would have granted advanced practice registered nurses (APRNs) the right to practice independently. It would have expanded the scope of APRNs to include: "performing acts of advanced assessment, diagnosing, prescribing and ordering." The legislation would have APRNs acting as primary care providers and give them authority to practice and prescribe outside of a prescribing or collaborative agreement with a physician.

The MMA believes that APRNs are an integral part of the health care team but should continue to work in a collaborative practice context to help meet the needs of patients.

In the end, the bill did not receive a hearing; but it is expected to come back next year. The MMA plans to meet with proponents of expanding APRNs' scope of practice this summer to discuss the issue, Renner says.

Nursing ratios

Legislation that would have mandated a patient-to-nurse staffing ratio proved controversial at the Capitol this session. As originally introduced, hospitals would have been mandated to provide a nursing staff ratio based on standards set by both nursing organizations and internal hospital committees. The proposal was the chief legislative priority for the Minnesota Nurses Association. The Minnesota Hospital Association (MHA) vigorously opposed it, arguing that the ratios are arbitrary, burdensome and unnecessary given that Minnesota's hospitals already provide high-quality care. The MMA agreed that placing required staffing levels in statute was not good policy.

As the proposal moved through the Legislature, it was pared back significantly. Signed into law in early May, the bill does not contain mandated ratios but rather instructs the Minnesota Department of Health to study the correlation between nurse staffing levels and patient outcomes. It also requires each hospital to

develop a “core staffing plan” detailing the projected number of full-time equivalent, nonmanagerial care staff that will be assigned in a 24-hour period to an inpatient care unit. Plans must be submitted to the MHA, which will post them on their hospital quality report website.

Compounding legislation

A scaled-back version of legislation proposed by the Minnesota Board of Pharmacy to regulate compounding pharmacies was included in the final HHS budget bill and signed into law. The MMA worked to focus this legislation on the issues related to poorly regulated out-of-state pharmacies that produce large quantities of compounded medications for use in physicians’ offices. The MMA also worked to remove language from earlier versions of the bill that would have prohibited physicians from compounding. The final bill provides more authority for the Minnesota Board of Pharmacy to ensure that entities that are compounding mass produced amounts of medications are meeting high standards. Additional discussions are taking place at the federal level about the growing issues of compounding pharmacies.

Criminal background checks for new licensees

Included in the HHS budget bill is a requirement for all health licensing boards, including the Board of Medical Practice, to begin requiring criminal background checks for all applicants for initial licenses and for those applying for reinstatement of a suspended license no later than January 1, 2018. These background checks must be sent to both the state Bureau of Criminal Apprehension (BCA) and the FBI. Applicants will have to submit to fingerprinting. In addition, the bill requires all licensing boards to work with the BCA to develop a plan to eventually implement background checks for all licensees. The plan on how to proceed must be developed by January 1, 2017. Currently, 37 state medical boards require criminal background checks for physician licensees.

Editor’s Note: Keep track of legislative events through MMA News Now — delivered to your email box free each Thursday. To subscribe go to the MMA website and look for “MMA News Now” under the “Publications” tab.

You can also keep track of MMA news on your smartphone or tablet by listening to the MMA Podcast. Find it on iTunes or at mnmed.org/publications/TheMMAPodcast.

News briefs

MMA member selected to MNsure board

MMA member Kathryn Duevel, M.D., was named to the seven-person MNsure board of directors by Gov. Mark Dayton in late April. She and five others will join Lucinda Jesson, commissioner of Human Services. Duevel, a retired ob/gyn with Affiliated Community Medical Center in Willmar, is the lone physician on the board that will oversee Minnesota’s health insurance exchange, which is scheduled to launch this October.

“We are very pleased to see Dr. Duevel on the board,” says Dave Renner, MMA director of state and federal legislation. “The MMA worked hard to ensure that physicians were part of this important group.”

Other members are:

- Thompson Aderinkomi, founder of RetraceHealth, a firm created to make high-quality care more affordable
- Pete Benner, former executive director of the Minnesota State Employee Union, AFSCME Council 6. He is a board member for the Institute for Clinical Systems Integration
- Brian Beutner, a consultant. Previously, he was the CEO of mPay Gateway, a health care software company. Beutner also worked for UnitedHealth Group
- Tom Forsythe, vice president of global communications with General Mills. He has served on health care committees under Govs. Arne Carlson and Tim Pawlenty
- Phil Norrgard, director of human services for the Fond du Lac Reservation.

Resolutions for House of Delegates due July 12

All resolutions for this year’s Annual Meeting must be submitted by July 12. Late resolutions will be considered only if they are of a truly urgent nature.

If you have questions about the deadline, contact the MMA Annual Meeting office at am@mnmed.org. Additional information can be found on the Annual Meeting page at mnmed.org/AbouttheMMA/2013AnnualMeeting.aspx.

This year’s meeting takes place September 20-21 at the Minneapolis Marriott Northwest (formerly the Northland Inn) in Brooklyn Center.

New MMA blog is now live

The MMA launched a new blog, Digital Rounds, on April 26 with a note from MMA CEO Robert Meiches, M.D.

“With this blog we hope to open a two-way dialogue with our members and those interested in issues affecting physicians in Minnesota,” Meiches wrote in the first post. “[The blog] is another example of how the MMA is striving to engage members.”

Blog topics will range from general health care to legislative to legal matters. Member input is highly encouraged. The blog can be found on the front page of the MMA website. Or you can go directly to: www.mnmed.org/Publications/DigitalRounds.aspx.



Task force digs into primary care physician shortage

Concerned about a projected shortage of primary care physicians in the state, the MMA has convened a 13-member task force to explore ways to grow Minnesota's primary care physician workforce.

"This is a very serious issue," says MMA President Dan Maddox, M.D. "The number of patients is growing while the number of physicians is decreasing. That adds up to trouble for any of us who will need care in the future."

The numbers are definitely troubling. Between 2000 and 2030, the portion of Minnesota's population 65 and older is expected to increase from 12 to 24 percent. And next year alone, when the Affordable Care Act kicks into full gear, more Minnesotans who previously have not been eligible for or have not purchased insurance coverage will become eligible and will be required to do so. Meanwhile, primary care physicians in Minnesota are getting older and closer to retirement. In 2011, more than a third were 55 years of age or older.

The task force includes 11 physicians, one resident and one medical student representing the traditional areas of primary care —family medicine, pediatrics, internal medicine and geriatrics. Also on the task force are representatives from the state's medical schools, residency programs and hospitals.

The group's charge is to:

- Plan and convene a summit to identify and share strategies for increasing Minnesota's primary care physician workforce
- Understand the factors affecting the capacity and future supply of Minnesota's primary care physician workforce
- Identify strategies for increasing the workforce in the state
- Determine roles for the MMA, as well as other potential stakeholders, in advancing specific strategies to increase the size of the workforce
- Recognize the relationship between workforce expansion efforts and other nonphysician primary care workforce initiatives
- Partner with others, as needed, to increase visibility and importance of the issue of workforce capacity among policy makers and the public.

The task force is expected to convene six times over the next 12 to 15 months.

Task force members

- Julie Anderson, M.D., family medicine
- Emily Borman-Shoap, M.D., pediatrics
- Kathleen Brooks, M.D., family medicine
- Amy Burt, M.D., pediatrics
- Raymond Christensen, M.D., family medicine
- Eric McDaniel, medical student
- George Morris, M.D., family medicine and sports medicine
- Anne Pereira, M.D., internal medicine
- Jacob Prunuske, M.D., family medicine
- Mark Rosenberg, M.D., internal medicine
- Nicholas Schneeman, M.D., geriatrics
- Paul Schutt, M.D., resident
- Jeremy Springer, M.D., family medicine (chair)

Election process underway for 2013 Annual Meeting

The MMA's current exploration of governance changes will not affect this fall's election of officers and AMA delegates but will alter the trustee election process.

The MMA president-elect, speaker and vice-speaker of the House of Delegates as well as AMA Delegates and Alternates will still be named at the 2013 House of Delegates on September 20-21 in Brooklyn Center.

MMA members were asked for nominations earlier this year. The MMA Nominating Committee met in May to review potential nominees; they will prepare a slate of candidates for



election that will be shared with all members this summer. All registered delegates are authorized to vote.

At its May meeting, the Board of Trustees recommended decreasing its net size by five to six trustees each year over the next three years to achieve the 12- to 14-member size as dictated by the 2012 HOD. The reduction will focus on current trustees whose three-year terms are concluding. This year, eight trustees' three-year terms are ending. In accordance with the recommended board size reduction, the HOD will only elect three trustees during the Annual Meeting in September. One of the trustees must be from the Northwest District (to meet Bylaw requirements). The other two may come from any trustee district.

To accommodate the reduced board size, the process for nominating trustees has changed. All recommendations for trustees—from individuals, from component societies, or from specialty societies—will be reviewed by the MMA Nominating Committee. Following the review, the committee will recommend a slate of candidates to the HOD no less than one month before the Annual Meeting. The HOD will elect three trustees from the proposed slate and from any members nominated from the floor during the meeting.

If you have potential nominees for MMA trustees please forward their names to Shari Nelson at snelson@mnmed.org by July 5.

Members making a difference

Jon V. Thomas, M.D., has been named chair of the Federation of State Medical Boards (FSMB). He has been a member of the Minnesota Board of Medical Practice since 2001 and has served on the FSMB board of directors since 2009.

John Noseworthy, M.D., CEO of the Mayo Clinic, and Reed Tuckson, M.D., executive vice president and chief of medical affairs for UnitedHealth Group, were named to *Modern Healthcare's* "50 Most Influential Physician Executives in 2013" in April. Noseworthy is No. 2 and Tuckson is 41.

In May, Rajini Katipamula-Maliseti, M.D., was recognized with an Award of Excellence at the 19th Annual Convention of the Telugu Association of North America in Dallas for her work with the health and well-being of Telugu people in Minnesota and India. The Telugu is an ethnic group originating in India.

Resident Ryan Brady, M.D., was elected as secretary of the Resident Fellow Section of the American College of Radiology.

HOD to decide on its future this September

The MMA Board of Trustees voted in May to draft a resolution for consideration by the 2013 House of Delegates (HOD) that



PHOTO BY DAN HAUSER

A candid conversation

Drug abuse expert and author Carol Falkowski discusses prescription opioid abuse, addiction and diversion with a group of physicians and students at a May 9 policy forum in Rochester. The event was one of three MMA-sponsored meetings on the fastest-growing drug problem in the United States. Similar forums were held in Minneapolis and Duluth during May.

would significantly change the MMA's governance structure, including eliminating the HOD.

The resolution will be based on a series of recommendations that were brought to the Board by the Governance 2.0 task force. The recommendations were:

- Continuing an Annual Meeting but replacing the HOD with a policy council
- Formalizing a process to gather member input through multiple avenues, including listening sessions and policy forums and present that input to the Board, MMA committees or the policy council
- Creating a process that will allow all MMA members to vote for future board members and officers
- Conducting a formal review process in three years to determine whether these governance changes should remain in place.

If the HOD ends up approving the resolution, the policy council, appointed by component medical societies and sections, would hold at least two meetings a year, one of which would be at the Annual Meeting. These council meetings would be designed to solicit input from the entire membership on the public policy issues facing physicians. The council meetings would be in addition to the listening sessions and policy forums currently taking place.

The Board also approved the Committee on Leadership Effectiveness and Development's recommendation to reduce the MMA board size by five positions this year. All of these positions are held by board members whose terms are coming to an end in 2013. At the 2012 Annual Meeting in Minneapolis, the HOD voted to reduce the board's size from 32 trustees to 12 to 14



Jon V. Thomas, M.D.



Rajini Katipamula-Maliseti, M.D.

members over a three-year period. The reduction of five positions would be the first step in that process.

The Governance 2.0 Task Force has been meeting since November 2012 to carry out the directive of the 2012 House to continue working on needed governance changes.

For more information on the proposed governance changes, please visit the MMA's Governance & Leadership page found under the "About the MMA" tab at www.mnmed.org/.

Physicians invited to celebrate writing at September event

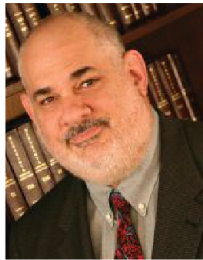
Minnesota Medicine will celebrate the 10th anniversary of its Medical Musings writing contest with a special celebration on September 19 as part of the Hippocrates Cafe program.

Hippocrates Cafe is a live, made-for-radio "show" that explores themes related to health and medicine through story and song. *MPR's* Jon Hallberg, M.D., the creator and host of the show, will be accompanied by some of the Twin Cities' finest actors and musicians as they interpret samples.

Look for more information as it becomes available.



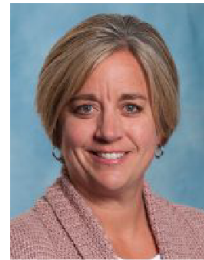
Eric Dick



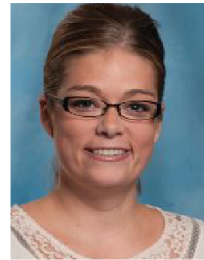
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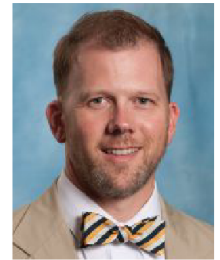
Terry Ruane



Janet Silversmith



Jaime Olson



Brian Strub

MMA in action

Eric Dick, the MMA's manager of state legislative affairs, welcomed MMA Vice Speaker of the House of Delegates **Mark Liebow**, M.D., and a group of Mayo Medical School students to the Capitol in mid-April. Every year, Liebow teaches a course on health care policy advocacy to Mayo students. As part of the course, students travel to St. Paul and Washington, D.C., to meet with elected officials and health care advocates. During their visit to the state Capitol, Dick informed the group about the MMA's work as an advocate for physicians at the Legislature.

In late April, **Robert Meiches**, M.D., MMA CEO, spoke with University of Minnesota medical students about their potential impact on the future of organized medicine.

Carmen Peota, editor of *Minnesota Medicine*, attended the Fisch Art of Medicine Student Awards in Minneapolis in mid-April.

Terry Ruane, MMA director of membership, marketing and communications, led listening sessions with Ob/Gyn Specialists and the Stearns Benton Medical Society Board in May.

Janet Silversmith, MMA director of health policy, gave a presentation to the Midwest Independent Practice Association in mid-May about the MMA's strategic priorities and legislative issues affecting physicians.

In April, **Jaime Olson**, MMA manager of continuing education, attended the Accreditation Council for Continuing Medical Education's "CME as a Bridge to Quality Accreditation Workshop" in Chicago.

Brian Strub and **Kathleen Baumbach**, MMA managers of physician outreach, conducted a listening session with physicians at the Buffalo Clinic in Buffalo. Strub also held listening sessions with the residents and physicians of the Duluth Family Practice Residency Program and with the physicians and staff at Northland Ear Nose and Throat Associates in Duluth.

Strub and **Dennis Kelly**, MMA Foundation CEO, attended the 2013 Honors and Awards Program at the University of Minnesota Medical School in April. MMA Board chair **David Thorson**, M.D., received the Exceptional Community Faculty Teaching Award as part of the event, which was sponsored by the University of Minnesota Foundation.

In mid-April, Ruane, Strub, Kelly and Baumbach attended the Minnesota Academy of Family Physicians 2013 Spring Refresher in St Paul.

Strub met with Clayton Tenquist, executive director of the Minnesota Veterans Medical Research and Education Foundation, in late April.

In May, Ruane and Strub met with Richard Schmidt, M.D., to discuss issues important to physicians at the Minneapolis Veterans Affairs Medical Center and VA Health Care System.

MMA is all ears at new listening sessions

BY DAN HAUSER

How is health care reform going to change our priorities?

If physicians didn't have so many administrative burdens to worry about they would have much more time to spend with patients.

These are among the concerns and suggestions the MMA has heard from physicians and medical students since launching its listening session program in March. So far, staff have conducted nine sessions, reaching more than 130 physicians from 25 cities.

"We want to see if MMA initiatives are on target or if there are other important issues facing physicians that we should be working on," says Terry Ruane, MMA's director of membership, marketing and communications, who is leading the effort along with his outreach staff. "These issues are too important for us to just guess what is keeping physicians up at night. We need to hear it from them directly."

Listening sessions provide both member and nonmember physicians with the chance to give feedback on MMA activities, share their ideas and concerns, and help shape future policy discussions. They are being offered to individual physicians as well as larger practices. "We want to make them available to all Minnesota physicians," Ruane says.

The idea for listening sessions grew out of discussions regarding the MMA's House of Delegates (HOD) at last September's Annual Meeting. Participation in the event has been declining over the years and the people who attend are older and less diverse than the membership as a whole. One solution was to have the MMA reach out to more members and get feedback in order to set policy that represents all members. Thus, listening sessions were born. "You may not be an active member in the MMA, but your voice is important, nonetheless, in the MMA's decision-making," Ruane says.

So far, physicians have embraced the concept and have not held back in sharing their opinions.



What are the important issues facing your practice?

Tell us about them.

MMA Listening Sessions give you the chance to provide feedback on MMA activities, share your ideas and concerns, and help shape the future of Minnesota health care.

Sessions are offered for individual physicians and larger practices.

Call 612-362-3728 to arrange your session.

Always working for Minnesota physicians.



MINNESOTA MEDICAL ASSOCIATION

"We are hearing a lot about administrative burdens," says Brian Strub, manager of physician outreach. Many physicians have expressed their concerns about prior authorization, electronic health records, quality measurement and other issues.

Some have voiced concern about how technology doesn't always help the way it was intended. One group of physicians said they get frustrated documenting their work on computers. If they do not enter the information correctly, it is assumed that they are not doing their job. One physician noted that if they don't code for a discussion on obesity with patients, the electronic system assumes that they have not had the conversation.

Other recurring topics include fair reimbursement, the primary care physician workforce shortage, physician autonomy and parents' resistance to immunizing their children.

"The sky's the limit when it comes to topics," Ruane says. "Whatever is of concern to Minnesota physicians is important to us. We really want to keep the listening sessions as open ended as possible so that physicians know that their voices are being heard."

If you are interested in a listening session, call the MMA membership department at 612-362-3728.

VIEWPOINT

MMA scores with MERC at Legislature

Each fall, the MMA's leaders and its legislative team members huddle together to decide on the priorities for the upcoming legislative session. It's kind of like drawing up a playbook before the big game. Some priorities/plays are defense-oriented while others are pure offense.

This year, we came up with six priorities: establishing a state-run health insurance exchange, expanding Medicaid in Minnesota, the phase-out and repeal of the provider tax, opposing independent

“My preferred play this season was our push to restore MERC funding because it means so much to the future of health care in Minnesota.”

APRN practice, increasing the tobacco tax to reduce smoking rates and restoring the state's investment in medical education.

All are important issues and all support the MMA's strategic direction. But some become favorites. My preferred play this season was our push to restore Medical Education and Research Costs (MERC)

funding because it means so much to the future of health care in Minnesota.

You will likely recall that MERC, established in 1996, helps teaching hospitals and clinics offset a portion of the costs of clinical training. It's crucial for the future of our profession. This hit home when we recently heard from one University of Minnesota medical student who is participating in the Rural Physician Associate Program in Bigfork, Minnesota. This 446-person community 90 miles east of Bemidji receives MERC funding to host students.

“Without MERC money for hosting students, I would not be here,” wrote Barret Myers Wolfson, a third-year student. “The Duluth students who come and spend weeks here in their first and second years may not get the opportunity to come either. And they may not be able to host interested students like me prior to starting medical school. MERC money makes exposure to high-quality rural medicine in Bigfork possible and is keeping future students interested in working and living in rural communities, which are in dire need of quality medical services.”

MERC is funded by three principal means: a portion comes from the state's cigarette tax; a portion from Prepaid Medical Assistance Program (PMAP) funds; and a portion from the University of Minnesota. All of these are matched with federal dollars.

I'm happy to report that we scored a touchdown with our MERC strategy this session. We were able convince lawmakers to restore MERC funding to its pre-2011 level of \$12.8 million, which is matched by federal dollars. In 2011, the Legislature



Dave Thorson, M.D.

PHOTO BY STEVE WEVERKA

reduced MERC funding by 50 percent as part of the budget agreement that ended the state shutdown. We have spent the past two years trying to get it back.

Without MERC funding, clinics and hospitals like the one in Bigfork may no longer find it viable to accept students like Wolfson. I'm sure you already are well aware of the primary care physician workforce shortage. An effective way to address the shortage is to ensure that MERC funds are targeted to primary care training sites, so they can expose medical students to the rewards of caring for a community early in their schooling. With an aging population needing more health care, investments in the state's medical education system are critical if Minnesota hopes to remain being one of the nation's healthiest states. That's why our efforts to restore MERC funding were so important this session.

MERC alone won't fix the primary care physician workforce shortage problem, but it's an excellent start.

Score one for the home team.

Management of Bloodless Surgery in a Trauma Setting

Balancing Patient Wishes with Safety

BY KAITLIN GADDIE, P.A.-C., CRYSTAL MONTGOMERY, C.N.P., SHERRIE MURPHY, R.N., JED GORLIN, M.D.,
MICHAEL B. MILLER, J.D., BRENDA ANDERSON, R.N., RACHEL M. NYGAARD, PH.D., CHAD J. RICHARDSON, M.D.,
AND ARTHUR L. NEY, M.D

Many patients refuse blood or blood products because of religious beliefs or fear of complications. At Hennepin County Medical Center, a multidisciplinary team developed a Bloodless Surgery Medicine Guideline (BSMG) to help identify those who refuse blood products, guide medical decision-making, improve documentation of informed consent or refusal, and ensure continuity of care for patients. To our knowledge, this is the first documentation of a guideline for managing informed consent for or refusal of blood or blood products in trauma patients. This article discusses the development of and legal rationale for two key components of the BSMG: an informed consent/refusal algorithm and a blueprint for discussing the use of blood or blood components with patients and documenting their decisions.

Blood-product transfusions can save the lives of patients with blood loss or blood disorders. However, some patients refuse blood transfusions for religious and personal reasons. For example, Jehovah's Witnesses' beliefs do not allow the use of allogeneic blood products, even in life-threatening situations.¹ Other patients, influenced by well-known cases such as that of Ryan White (a U.S. teenager infected with HIV from coagulation factor concentrates), may refuse transfusion for fear of contracting a communicable disease. These fears persist despite improvements in screening of blood donors and testing of blood products that have reduced the risk of contracting HIV and hepatitis from donated blood to less than one in a million.² When patients refuse transfusion, physicians and other providers are faced with an array of decisions about alternative treatments and potential ethical and legal dilemmas.

Although the number of patients who refuse blood products is small, when

someone does, it creates a difficult situation. We recognized a need for a systematic process to guide providers through the complex medical decisions they face when caring for these patients and developed a guideline to ensure standardized management of such patients that meets medical and legal requirements.

Creation of a Guideline

To help us write the guideline, we formed a multidisciplinary team that included trauma surgeons, other physicians, nurses, pharmacists, staff from the transfusion and trauma services and Jehovah Witness elders. The team met multiple times between December 2010 and June 2012. Team members who were health care professionals offered their perspective and assisted with the protocol development. The Jehovah Witness elders offered their insights and reviewed materials and provided feedback. The team's goal was to create a process that would a) identify those refusing blood products, b) guide medical

decision making, c) improve documentation of informed consent or refusal, and d) ensure continuity of care through use of an electronic medical record (EMR). The outcome of these meetings was the Bloodless Surgery Medicine Guideline (BSMG), which consists of an informed consent/refusal algorithm (Figure 1) and a blueprint for discussions with patients (Figure 2). Although the guideline was developed for use in the surgical setting, it has been available institutionwide since June 2012.

Informed Consent or Refusal Algorithm

A patient's right to refuse life-saving measures depends on his or her legal status and current state of health. Thus, the starting point in our algorithm is determining the answers to two questions: Is the patient a legal adult or an emancipated minor? And is the situation emergent, urgent or elective? The answers to those questions have an impact on next step.



In elective situations where the patient is an adult, the patient can state his or her wishes regarding specific product usage after being informed about alternatives to blood products. In urgent or emergent situations, emergency physicians, nurses and/or surgeons use the algorithm to guide discussions with patients and family members.

The common-law right of bodily self-determination gives any adult or emancipated minor with decision-making capability the right to refuse medical or surgical treatment, including blood transfusions, even if he or she is likely die without it.³ For unconscious and impaired individuals, federal case law generally shifts the decision to the physician and/or the state.^{4,5} (Note, informed consent/refusal cannot be given through a medical-alert card or by a family member attesting on behalf of the patient.⁶) Legal surrogates may refuse blood products or any medical treatment.

Any patient under the age of 18, unless emancipated, is considered to be a minor. In the United States, some parents believe the Free Exercise Clause of the First Amendment establishes their right to refuse medical care on their child's behalf.⁷ However, the reigning legal principle from *Prince v. Massachusetts*⁸ is that parents and/or guardians cannot legally prevent life-saving medical care for their child. If a minor's condition necessitates an emergent transfusion of blood, the provider is legally obligated to proceed with the transfusion, regardless of the parents' wishes.⁹ When the child's condition is not emergent and the parents refuse treatment, providers should obtain legal and ethical counsel before proceeding.

Regarding the question of whether the case is emergent, urgent or elective, most federal, state and local regulations classify patients as emergent if they require treatment within 12 hours to avoid adverse consequences.^{10,11} "Urgent" services are usually defined as those that may be delayed more than 12 hours after presentation without adverse consequences.^{3,4} Elective procedures are planned in advance.^{3,4} Ultimately, the determination as

FIGURE 1

Bloodless Surgery and Medicine Informed Consent Algorithm

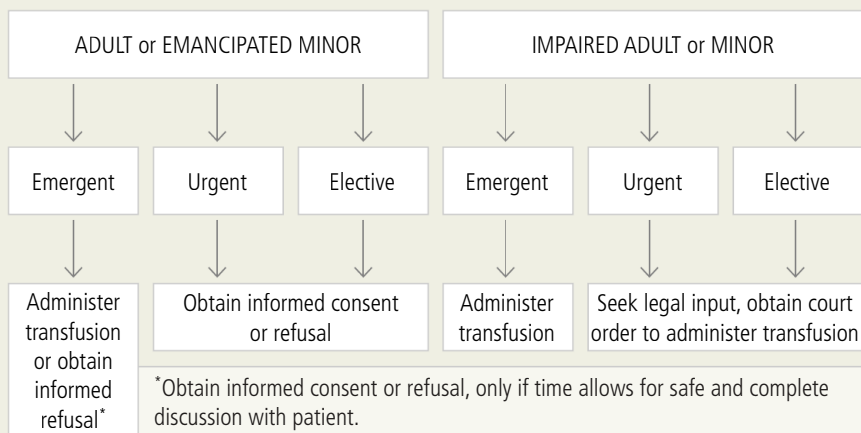


FIGURE 2

Bloodless Surgery and Medicine Discussion Pocket Card

Bloodless consent/refusal discussed with:

- Patient
- Parent/guardian
- Spouse
- Surrogate decision maker
- Jehovah's Witness elder
- Interpreter

Patient is a(n):

- Adult with decision-making capacity
- Emancipated minor with decision-making capacity
- Impaired adult, without decision-making capacity
- Minor

Patient accepts the following blood products

- Whole blood
- Red blood cells
- Plasma
- Platelets
- None

Spiritual care contact:

Ethics consult:

Legal input:

Page on-call hospital administrator

Patient accepts the following alternatives to blood products:

- Cell salvage/washing
- Non-blood-derived synthetic materials
- Hextend
- Erythropoietin
- Recombinant (manufactured) coagulation factors
- Factor VIIa
- Factor VIII
- Factor IX
- Chemicals that prevent clot breakdown
- Tranexamic acid
- Amicar
- Human-derived proteins/clotting factors
- Cryoprecipitate
- Albumin
- Profilnine
- Beriplex
- Autologous blood transfusions
- None

Patient accepts the following extreme alternatives:

- Amputation
- Organ: partial resection or removal
- Organ: partial or complete angioembolization
- None

The risks, including death, of refusing blood products for this surgery/hospitalization have been discussed.

to whether the situation is urgent or emergent must be made by a physician, and the physician is responsible for acting in the patient's best interest.

Discussing Alternatives, Documenting Decisions

The decision to refuse blood products must be based on a clear understanding of the consequences of not receiving blood or blood products.^{6,9} If a patient declines blood products, then the provider activates the BSMG, which is embedded in our EMR. We also made it available as a pocket-sized card (Figure 2).

The BSMG guides the physician and patient through the informed-consent discussion and documentation of the patient's refusal to undergo an intervention. The process involves

- assessing the patient's capacity to make decisions
- discussing with the patient the purpose of the treatment, possible alternative treatments, potential risks and benefits of the treatment, and the potential consequences of refusing treatment.

Upon a patient's refusal of whole blood, packed red blood cells, white blood cells, plasma and platelets, specific details of bloodless alternatives, operative techniques and general management decisions are reviewed. Details about this conversation and the patient's reason for refusal of blood or blood products are then recorded in the EMR.

Once the patient refuses any major blood products, a banner appears on the EMR to alert providers of the patient's status. This banner also triggers a hard stop. For example, if a provider attempts to order blood products, it forces additional documentation for the order. It is important to note that the order set can be changed at any time if the patient decides to accept blood products; it is not a permanent part of the patient chart and, in fact, must be resubmitted upon each hospital encounter. This procedure recognizes the need for continual reassessment based on changes in the patient's medical condition. In addition, the EMR provides alerts that help prevent potentially serious interac-

tions between blood alternatives should they be administered concurrently.

Understanding Patients' Beliefs and Managing their Care

Discussing transfusion and alternatives is essential to understanding a patient's beliefs and providing him or her with the best care possible. We have learned, for example, that although most Jehovah's Witnesses do not accept autologous blood transfusions, most patients with other concerns about blood products will accept this measure once they are assured of the products' safety.¹ In addition, we've found members of the Jehovah's Witness community do not consistently allow or refuse blood plasma derivatives such as albumin, clotting factors VIIa or IX, tranexamic acid, prothrombin complex concentrates (some or all of the vitamin K-dependent factors, such as II, VII, IX, X) or autotransfusion using cell saver. As with all religious communities, not every believer fully accepts all teachings, and decisions to accept these alternatives are made on an individual basis. Finally, medical measures such as amputation, partial organ resection or removal, and/or partial or complete organ angioembolization should be discussed, as they may be required if a patient declines blood products or alternatives.

Surgical strategies need to be modified if a patient chooses bloodless surgery. Surgical approaches should include using a cell saver (if permitted by the patient), liberal use of tourniquets, optimization of nutritional support and minimal blood draws. Traditional methods of volume expansion should be used before surgery. In addition to volume expansion, we include erythropoietin (EPO) (300 u/kg IV daily until lab work improves; given with iron), iron sucrose (200 mg IV q48 hrs x 5 doses—in combination with EPO), folic acid (2 mg IV or PO daily until laboratory volumes improve) and Vitamin B12 (1,000 mcg/day IM x 5 days).^{12,13}

Conclusion

We developed the BSMG to help physicians and other providers broach what can be a difficult topic in a way that respects

patients' beliefs. In doing this, we believe we have created a professional and practical process for working with patients who refuse blood or blood products and documenting their preferences.

We've both observed and heard anecdotally that use of the BSMG guideline has dramatically improved the informed consent/refusal process. Once we have gathered more data, we plan to study how use of this guideline affects patient outcomes. **MM**

Sherrie Murphy and Brenda Anderson are in trauma services; Kaitlin Gaddie, Crystal Montgomery, Rachel Nygaard, Chad Richardson and Arthur Ney are in the department of surgery; and Jed Gorlin is in transfusion service at Hennepin County Medical Center. Michael Miller is in the civil division at Hennepin County Attorney's Office.

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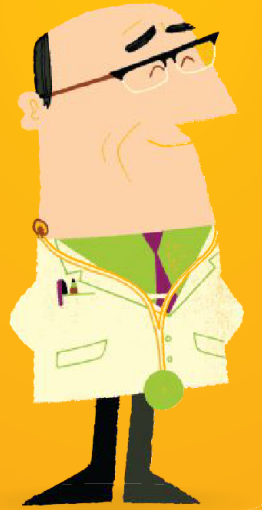
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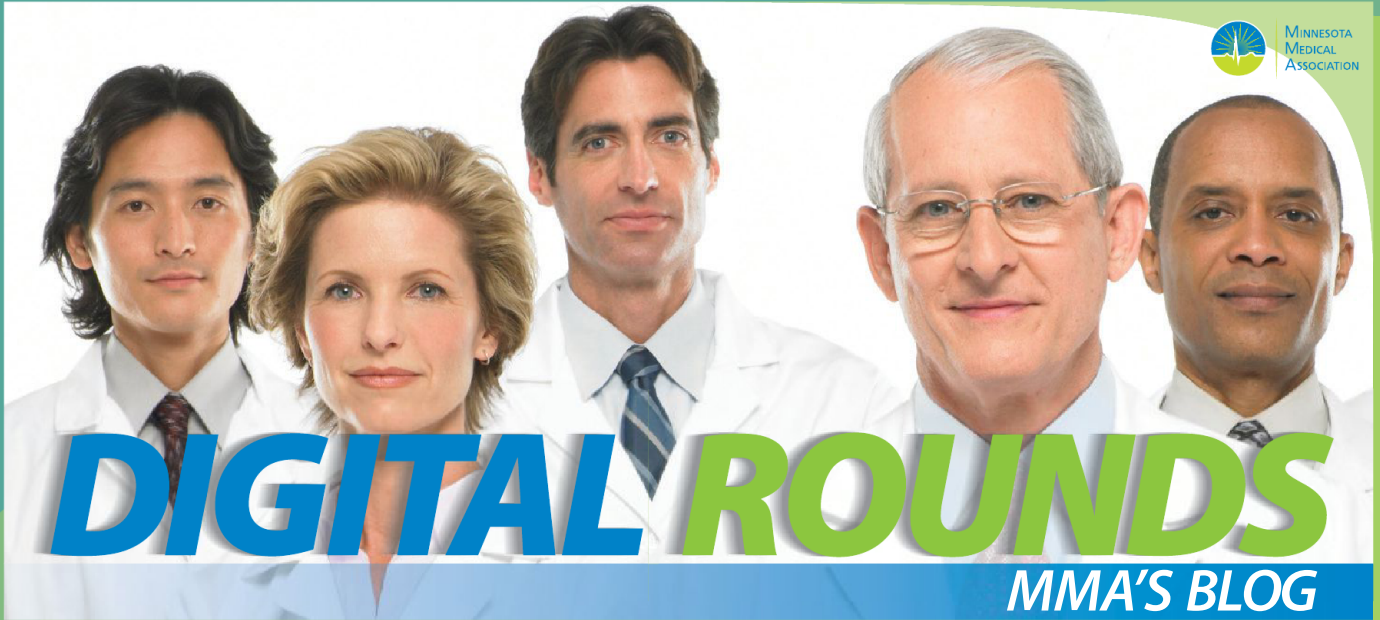
The other side of the curtain

BY JAMES COLLETTI, M.D.

A beautiful end-of-summer holiday
At home with my family
Outside playing tag with my children
Blue skies
A gentle breeze
Time with those who matter most
Chasing my son
Man, he is fast
Uneven ground
A sudden pop in the back of my leg
Immediate pain
Immediate swelling
Immediate fear of what this means
That didn't happen
I can stand
I have to stand ... I have a lot to do
The look on my son and daughter's faces as
 I repeatedly fall to the ground
Lying in the grass unable to stand
My tiny daughter trying to help me
My son running inside screaming
 "Mommy, Something is wrong with Daddy"
My calf doubling in size
Pain increasing
The look on my wife's face
My beautiful wife taking me to
 the Emergency Department —
 The Emergency Department where we both work!
The look on the triage nurse's face
 when I hobbled up to the desk
How kind and considerate she was
Passing by my colleagues and friends in a wheelchair
How embarrassed I was
How helpless I felt

Sitting in a patient room
 on the other side of the curtain
My friend and colleague's face
 when he entered the room
The excellent, compassionate
 and efficient care he provided
Time stands still in the room
Stains on the sheet
Odd smells emitting from the corner
The hustle and bustle of the ED
Loud noises from outside
Feeling bad about taking up a room
 on a busy holiday evening
Pain
But more than pain; worry
Concern that I will not be able to help
 my pregnant wife at home
Concern that I will be not able to work my shifts
Concern that I will let my colleagues down
Concern that I will not meet my commitments
Concern that I will not be able to
 play with my children
Concern that I will not be contributing
Concern that I will not be able to care for others
Wishing not to be on
 the other side of the curtain
Realizing that at some point we will all be
 on the other side of the curtain

James Colletti is the emergency medicine residency program director at Mayo Clinic in Rochester.



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