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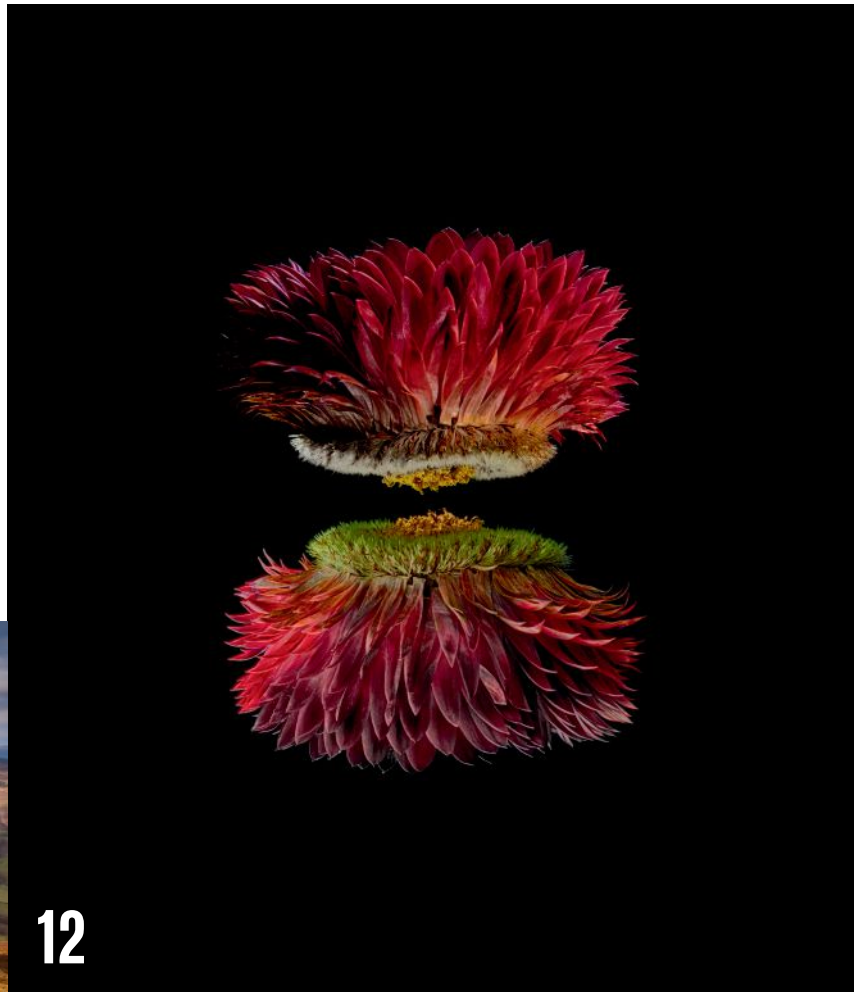

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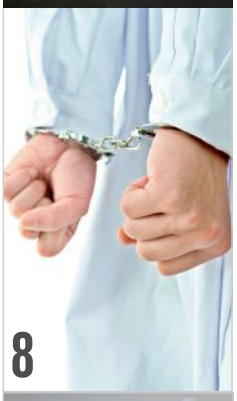
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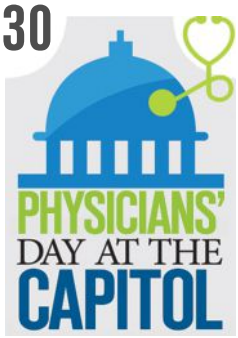

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Rahel Nardos, MD

How do we transform the healthcare system?

It is extremely timely that this publication highlights our medical colleagues who take the time to play. In her *New York Times* article in 2020, Kristin Wong wrote, "Play offers a reprieve from the chaos, and it challenges us to connect with a key part of ourselves that gets lost in the responsibilities of adulthood, especially during a crisis." Play has a way of turning off the busy mind that is always on a deadline and transporting us to the present moment in which we are released from our "productivity" mindsets and offered a purely joyous, colorful, and nonsensical mindset, one not motivated by results.

However, no amount of play and self-care can replace the need to radically transform the current system of healthcare, which increasingly is moving away from the shared universal values of humanity that brought many of us into medicine in the first place. In her book, *Radical Transformational Leadership*, Monica Sharma says that our humanity, irrespective of where we are born, thrives in the steadfast presence of dignity, compassion, and fairness. When these shared human values are challenged and sidestepped, particularly in a profession charged with the tremendous responsibility of alleviating human suffering, no amount of play and personal wellness tips will restore our full inner capacity to thrive as a community of practice. The problem we face today is not an individual- or a division- or a department- or even a hospital-level problem, it is a system-level problem that requires system-level solutions, solutions that re-center and restore our universal values.

Allison Holt, MD, vice chair of clinical affairs, University of Minnesota Department of Psychiatry and Behavioral Sciences, talked to me about the current crisis of overcrowded emergency rooms that are forced to house children and young adults in mental health and behavioral crisis because they have nowhere else to go. Emergency and mental health professionals are trying to rescue one person at a time downstream while many more bodies are falling into the water upstream. The rescuers are tiring and they are leaving this sacred profession at a time when they are most needed. The solution is not only to rescue faster, but to stop the falling into the water in the first place.

How do we build a community of practice of all stakeholders who want to safeguard our universal human values and are willing to bring their collective wisdom and resources to keep our communities healthy? I believe that with intentionality and vision, we can prioritize bringing together everyone who has a stake in keeping communities healthy and thriving to design a more holistic and complementary system of health. That includes those who profit from the current healthcare system in the short run but stand to lose in the long run unless they invest in building healthy communities.

We absolutely need to play and engage in our personal well-being but we also need to safeguard our shared human values and be agents of radical healthcare transformation. This starts with a diverse group of individuals like me and you daring to disrupt the status quo and insisting on building a culture of health, not a business of sickness.

We absolutely need to play and engage in our personal well-being but we also need to safeguard our shared human values and be agents of radical healthcare transformation. This starts with a diverse group of individuals like me and you daring to disrupt the status quo and insisting on building a culture of health, not a business of sickness. John Paul Lederach, a global peace maker, talks about the power of "critical yeast": "small groups of people in unlikely combinations, in a new quality of relationships" who have the unique capacity to turn what has been upended into long-term transformation. When the right kind of people come together, they make things grow exponentially beyond their small number as yeast does to bread. We can be the critical yeast of our time. **MM**

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

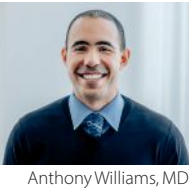
Fisch Awards nurture creativity

Medical students try or enhance their artistic interests

BY LINDA PICONE

From 2007 through 2017, the University of Minnesota offered Fisch Awards to medical students who wanted to explore artistic activities. During those 10 years, about 95 students won Fisch Awards, funded through an endowment established by the late Robert O. Fisch, MD, and selected through a program set up by Fisch and Jon Hallberg, MD.

Jennie Magner



Anthony Williams, MD

The awards ended when the funding ran out, but when the Center for the Art of Medicine (CFAM) was developed at the University of Minnesota Medical School in 2020, "this was one of the initiatives we wanted to restart," says Jennie Magner, center coordinator for CFAM.

"We were coming together as a center and we now had an umbrella for things to fit under," says Anthony Williams, MD, associate director for CFAM. "Jon Hallberg said that if we have budgetary room, we should bring the Fisch Awards back." Hallberg is creative director of CFAM.

A rejuvenated Fisch Awards program was announced in February 2022 and medical students were encouraged to apply. In April, 33 medical students, out of 65 applicants, were selected to get Fisch Awards of $250 to $2,500 to pursue artistic activities during the 2022-23 academic year. That is a much larger group of awardees than in any of the first 10 years of the program.

The process for awarding grants has been made more formal, but the idea behind the grants remains the same as when Fisch and Hallberg were doing the selections. "I really loved the baseline and the foundation that was there," Williams says. "We didn't change anything about the philosophy."

The Fisch Awards were promoted on both the Twin Cities campus and the Duluth campus. Williams said the first 10 years of Fisch Awards were while he was in medical school at the University of Minnesota—"and I never knew anything about it." He wanted to make sure all medical students would be aware of the grants.

Students applying had to submit a statement of purpose, what they hoped to do, and a budget. As the applications were reviewed, Magner says, sometimes the proposed budget amount was slightly reduced.

A committee of reviewers made up of CFAM staff, other physicians with artistic connections, former Fisch Awardees, and a couple of medical students reviewed the applications and selected the awardees. "The preference was really to give students the opportunity to acquire new knowledge," says Magner. "But we definitely have students who are building on existing knowledge and skills. We were looking for new ideas, ways that students can increase their creativity."

A number of the awardees have used their funds to take classes or workshops, Magner says. What they proposed was "pretty open-ended." "Our goal is just to get students started," she says. "It's really to get your hands messy, to get them involved in the creative process."

For more information, visit https://med.umn.edu/about/centers-institutes/center-art-medicine/award-opportunities

A welcome event was held in the spring of 2022 and there will be some kind of presentation for and about the awardees this spring, to see what everyone has done with their award. "We're working on what the final project unveiling will look like," says Williams. "When it was a smaller group, they used to meet at Dr. Fisch's house, but that's no longer feasible, so we're trying to reimagine it."

Williams, a medicine and pediatrics hospitalist at Regions Hospital and Minneapolis and St. Paul Children's hospitals, sees art as important in life and in medicine. He says that creativity nurtures certain skills that physicians don't necessarily get in other ways, including observation, challenging and reimagining views of the world, and community, when creative output is shared with others.

"In general, creativity allows us to be in touch with ourselves through critical reflection and it allows the integration of physical, psychological, emotional aspects of ourselves," he says. "That's even more important in a field like medicine, where a lot of us end up silo-ing ourselves to do our jobs. You have this field that's heavily rooted in evidence-based medicine, heavily rooted in scientific thought, and yet the job that we do is all about people and people interactions. Ignoring that aspect of ourselves is damaging and doesn't allow us to be the best versions of ourselves that we can be."

Linda Picone is editor of *Minnesota Medicine*.

Robert O. Fisch

Robert O. Fisch, MD, was a Holocaust survivor, a participant in the Hungarian Revolution in 1956, and a refugee from Communist suppression in Hungary. At the University of Minnesota, where he arrived as an intern in 1958 and retired as professor of Pediatric Medicine in 1997, he cared for patients, mentored medical students, and wrote or co-wrote more than 100 scientific papers.

Which would be a very impressive life's work and experience if it stopped there, but Fisch did not. He established Project Read, which had volunteers reading to children in pediatric clinic waiting rooms. He published five books. His paintings have been exhibited in the United States, Europe, and Israel, including *Light from the Yellow Star: A Lesson of Love from the Holocaust*, a gripping memoir with his own illustrations.

In 2007, Fisch and his wife, Karen Bachman, established the Robert O. Fisch Art of Medicine Awards for students at the University of Minnesota Medicine Awards to pursue creative activities they might not otherwise be able to experience.

Fisch died on his 97th birthday, June 12, 2022.

Fisch Awards 2022-23

For the academic year 2022-23, 33 medical students, including first-, second-, and third-year MD and MD/PhD students from both the Duluth and Twin Cities University of Minnesota Medical School campuses, were chosen to receive Fisch Awards.

The artistic efforts of these students ranged from creative writing to sculptural weaving to woodworking to recording music and almost everything in between.

Awards ranged from $250 to $2,500, for a total of just over $25,000.

Three students whose artistic proposal was funded or partially funded by Fisch Awards talked about why it was important to them.

Elizabeth Edlund, second-year medical student, University of Minnesota Duluth

Fisch Award: $485 for three classes in making stained glass

My grandmother was a nurse and a stained glass artist. She passed away when I was about 3 years old, but we still have all of her materials. So far, I have made a window panel and a lampshade and next I'm hoping to make a suncatcher. The challenge for me is getting the equipment. The grant doesn't cover tools, so I'm hoping to save up some money and buy tools.

It has felt lovely. The classes are three hours on Wednesday nights. I always go into the class very stressed about timing, but I always come out refreshed and balanced.

Hugh Burke, second-year medical student, University of Minnesota Twin Cities

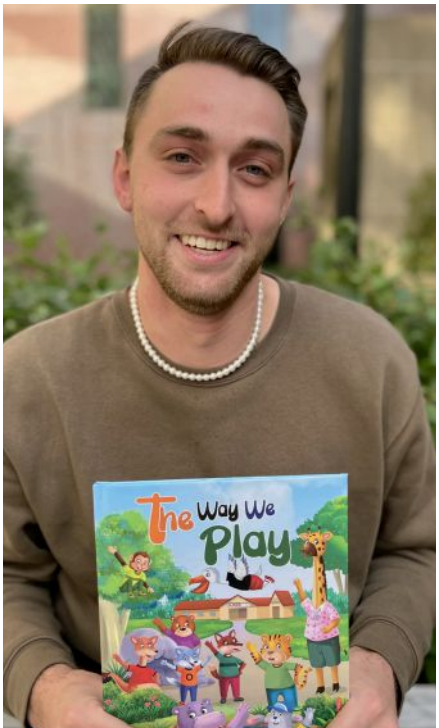
Fisch Award: $1,500 to pay for illustrations for a children's book

I had this idea to write a children's book and was talking about it pretty seriously with my co-author, Kylie Donohue. At first, it was kind of a joke, then the University announced the Fisch grants and that email felt like a sign.

I've always been interested in pediatric psychiatry; it's what I want to do after medical school. I'm in the Neurodiversity in Medicine Club, which is general education on how to work with the non-neurotypical patient. I took inspiration for the book from some of the topics we discussed in that club.

The book is *The Way We Play*, aimed at pre-kindergarten through maybe second grade. It's about animals at school who are playing outside at recess. They participate in three different tasks and they learn about each other by how they participate in the games. Some are built for swimming in the creek, but the hippo is not very good at jumping over the jump rope, for example. It wraps up with looking at what we learn from each other, that it's okay to be bad or good at some things.

We've gotten some good buys, especially in the first month. The money is going to a charitable organization. My advisor at the University works with a nonprofit that promotes literacy in Ethiopia; our next step is to get the book translated into Amharic.



The grant let me do what I wanted to connect with my future patient population. It's given me a window into a passion I didn't know that I had.

Shravika Talla, third-year medical student, University of Minnesota Twin Cities

Fisch Award: $1,000 to take Kathak dance classes

I grew up learning Indian classical dance and I danced a lot in cultural shows and competitively in college. I really missed dancing. It was kind of tough to do with med school and the pandemic. Learning Kathak (pronounced kah-thuhk) was something I always wanted to do. It is a graceful dance form characterized by intricate footwork and spins. The award was great opportunity for me; without it, I don't think I would have taken the classes. I have classes once a week in the evening. The day gets long, but I really enjoy it. I hope to continue into my fourth year of medical school and beyond.

For me, dance has always been very therapeutic and grounding. It helps me be more in tune with myself and connect with my roots. At the end of the day, I think that makes me be a better learner. I think it's great that the Fisch Awards encourage students to pursue something outside of medicine.

Restrictive covenants in Minnesota

Now is the time to end them

BY REBECCA YAO, MD, MPH; MICHAEL J. RIGBY, MD, PHD; AND AMIRALA S. PASHA, DO, JD

Noncompete: a feared term when nested within an employment contract, instilling feelings of powerlessness and subordinance.

Just after her husband matched at a residency program in Minnesota, Jane—a newly boarded family medicine physician—quickly came face-to-face with these feelings as she began her job search.

Two health systems (referred to here as Health Systems A & B) were available to her in the town they were moving to. Health System A had, unfortunately, just completed a round of hiring for the position she was looking for and could only offer a position at a satellite campus located an hour away. Health System B's employment contract contained a non-negotiable, noncompete clause prohibiting her from working as a physician within a 25-mile radius for two years if she were to leave.

She was left with two choices: take a less desirable position with Health System B or delay employment to wait for an in-town opportunity with Health System A. With looming student loan payments and a growing family to support, she signed a contract with Health System B, understanding that this effectively shut out any future possibility of working for Health System A, as the two-year waiting period required by the noncompete clause was not realistic. She also considered the possible fragmentation in patient care if she started work with Health System A but then decided to move to Health System B; her long-term goal was to establish relationships with patients she would take care of over many years.

Situations like this are all too common in the state of Minnesota. Indeed, an opinion piece published 10 years ago in *Minnesota Medicine* extensively detailed the harms of restrictive covenants to both physicians and patients. And yet, little has changed over the past decade.

Noncompetes: a primer

Noncompetes are a type of restrictive covenant that prohibit an employee from leaving to work for a competitor or starting a competitive business within a particular geographic area for a specified period of time. A 2007 survey across five states found that 45% of primary care physicians were bound by such agreements. For added context, it was estimated in 2020 that 18% of the labor force across all industries in the United States were tied to a noncompete agreement.

Since contract law is a creature of state law, the legality of noncompete clauses differs from state to state. While several states prohibit their use, others allow it with varying degrees of restrictions. At the time of this writing, Minnesota does not have a specific statute addressing physician noncompetes; courts assess noncompetes by their reasonableness. In practice, while there is an intention to avoid imposing hardship on the employee, it often doesn't work that way.

Ethics of noncompetes

By restricting where and when a physician can practice following employment termination for whatever reason, noncompetes can limit patients' choices in choosing a physician and compromise professional autonomy. In a backdrop of serially constrained professional autonomy throughout the medical training pathway, noncompetes serve as yet another limitation to a physician's capacity to negotiate and choose how to best provide care to their patients.

Examining this issue from an equity lens reveals additional consequences of these policies. Recent literature has shown that noncompete restrictions across industries may disproportionately harm women, who often have less geographic mobility and likely a heightened aversion to the risk of a noncompete lawsuit. This extends to women and people of color who are more often victims of sexual and workplace harassment; restrictions on post-employment options add yet another layer of complexity to the already immense psychosocial burden.

The harms of noncompetes extend far beyond just those bound by them. Physician relocation significantly impacts a patient's continuity and access to care. A physician who leaves a place of employment under the limitations of a noncompete generally

must also give up the ability to see the patients they have been caring for. This leaves patients, particularly those with difficulty traveling significant distances, unable to continue seeing a physician with whom they have established a long-term therapeutic relationship.

This toll on continuity of care leads to worse chronic disease management and health outcomes. Research has shown that patients who follow a consistent provider have increased adherence to medications, reduced hospital use, and higher likelihood of obtaining preventive care services such as cancer screenings and immunizations. In fact, multiple studies have demonstrated an association between increased continuity of care and overall lower mortality rates.

Within a noncompete region—particularly in rural areas—forcing a physician to move to a new geographic area can worsen physician shortages and further limit patient access to care due to the paucity of a particular specialty or expertise.

Economists have found that workers in states and industries with noncompetes have lower wages, decreased job mobility, and lower levels of job satisfaction—even for workers not bound by a noncompete agreement. These negative effects are exacerbated in states with greater noncompete enforceability.

Proponents argue that noncompete agreements exist to protect employers' legitimate business interests and investments in their employees. This, in and of itself, demonstrates that the true motivation for maintaining noncompetes is financial. By limiting post-termination employment options, institutions maintain a steady workforce and limit turnover and, within geographic constraints, sustain a steady patient population—all at the cost of patient care. Patients are, in effect, commodified and the physician-patient relationship is seen as transactional.

There is an argument that noncompetes protect proprietary information from leaving with workers who go to direct competitors. How much of medical practice is proprietary is debatable, and noncompete clauses prohibiting clinical work can be distinguished from ones prohibiting non-clinical work. Whatever short-term gain institutions receive with noncompete agreements is arguably outweighed by the long-term institutional and societal losses.

Looking ahead: next steps on employment contract reform

Spurred by a resolution brought forth by the Minnesota Medical Association (MMA), in 2014, the AMA Code of Ethics was amended, calling for physicians to avoid covenants that unreasonably restrict the right of a physician to practice medicine and that do not make reasonable accommodations for patients' choice of physician. Unfortunately, due to the flexible interpretation of "unreasonably," this policy does little and merely reiterates existing state law in jurisdictions that allow noncompete clauses. One need not look further for a stronger ethical rule than in the field of law: the American Bar Association has stated that for attorneys, noncompetes generally are prohibited.

Over the past decade, the MMA Ethics Committee and Policy Council have recommended language to redefine "reasonableness" of noncompetes to more appropriate standards, only to have faced later opposition against policy adoption. At the time of this writing, the MMA had just completed informational polling on a policy proposal brought by the MMA Committee on Ethics & Medical-Legal Affairs, with 90% of respondents opposing restrictive covenants in physician employment contracts.

In the 2022 Minnesota Legislative Session, a bill introduced by Rep. Jen Schultz argued for the ban of all noncompete agreements for employees earning a salary under the state median income for a family of four. The bill never became law and would not have addressed the noncompete clauses for physicians, but it was a step in the right direction. In recent years, other jurisdictions have taken steps to further restrict or eliminate noncompete clauses. Some have limited noncompete clauses for low-income employees while others have restricted the enforcement of such clauses for rural physicians and/or primary care physicians.

At the federal level, President Biden issued an Executive Order encouraging the Federal Trade Commission (FTC) to ban or limit noncompete agreements, although the effects of this Executive Order and the legal authority of the FTC to implement it remain unclear.

The renewed interest from lawmakers and policymakers at all levels of government shows that they recognize the potential for the deleterious effects of noncompete clauses on employment opportunities, competition, and fairness, and are willing to act. With the newly elected DFL majorities in both Minnesota legislative chambers, there is no better time than now for the MMA to lobby against the use of noncompete agreements and to advocate for physicians and patients. **MM**

Rebecca Yao, MD, MPH, is a resident in Internal Medicine at Mayo Clinic. Michael J. Rigby, MD, PhD, is a resident in Neurology at Mayo Clinic. Amirala S. Pasha, DO, JD, is an assistant professor of Medicine in the Division of General Internal Medicine at Mayo Clinic.

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The power of conversation

Project ECHO brings together community and experts

BY LINDA PICONE

Project ECHO (Extension for Community Healthcare Outcomes) sessions bring physicians together to learn and to share information, best practices, and frustrations but, more important, they often also bring members of the community into conversation with physicians and other healthcare providers.

"We try to use ECHO as a tool to facilitate conversations at the intersection of expert opinion and the reality of the front-line community," says Brian Gahan, MD, PhD, addiction medicine physician and Project ECHO co-lead, Hennepin Healthcare. "How do you fuse the academic and the street knowledge? How can we better fuse those narratives to help all involved come to a better healthcare outcome? Because goodness knows, the disparities are huge and real."

People from marginalized communities are hesitant to engage in healthcare "when healthcare has played a role in creating disparities and exacerbating stigma and not always treating people from marginalized communities well, particularly people of color," Gahan says. "Even if there is good, evidence-based practice, there is work to be done within the community, independent of healthcare providers—or at least only with safe healthcare providers who have had the same experience [as community members]."

Project ECHO had a focused series on the intersection of opioids, pain, and sickle-cell disease, Gahan says. "There is such a huge race component to the perceptions around care for sickle-cell disease that you can't not talk about race when you're talking about sickle-cell and interpretations of pain and opioid administration and presumptions of opioid-use disorder, whether it's real or not," he says.

Before that, there were several ECHO series where race equity was an integral part of the conversation and a series after the pandemic on disaster preparedness and how that exacerbates disparity and access to healthcare, but race equity was not a standalone topic, Gahan says. "So we had a theme [race equity] going through multiple series," he says.

That theme led to developing an ECHO series on race equity and opioid use that is designed to be a space for community members of color and healthcare teams to address disparities in opioid care. One session in the series is just for community members, Gahan says, "not outward facing to all healthcare professionals," and one is for healthcare professionals, most of whom are White.

Hennepin Healthcare and the Community-University Health Care Center (CUHCC) see the largest number of So-

mali and Indigenous patients, Gahan says, and both clinics have seen a rise in the number of Somali young people struggling with substance abuse disorder. "The family narrative is really hard," he says. "The older folks in that community often have come from refugee camps where the only medical care was that they were given antibiotics and then you get better or you don't; you take medication for a couple of weeks and you're done. So the concept of chronic disease management with long-term medication therapies is often problematic."

In talking with Yussuf Shafie, MSW, LICSW, the founder of Alliance Wellness center in Bloomington—the only treatment center in the Twin Cities specifically for East Africans—Gahan says he has learned more about what community-centered care might be for that community, and where to start the conversation with patients and their families.

Results

Has the ECHO approach been successful? Gahan says, "In early returns, yes, but it's a long haul." He says what develops from an ECHO session is always evolving. "Sometimes it's just finding what a resource is, in terms of who is saying what in the community. You get a sense for what the narrative is, where people are coming from, so it shifts where I meet people, where I start the conversation."

In late November, Grahan and other associates published paper in JAMA Health Forum: "Association of Project ECHO Training with Buprenorphine Prescribing by Primary Care Clinicians in Minnesota for Treating Opioid Use Disorder." The goal of the study was to see whether physicians who took part in Project ECHO training were more likely to prescribe buprenorphine to treat opioid use disorder. The retrospective study of 918 primary care clinicians found that those who attended ECHO sessions were more likely, by 23 percentage points, to obtain the required Drug Abuse Treatment Act waiver to prescribe buprenorphine than those who had not trained with ECHO. Buprenorphine is one of three medications approved for treating opioid use disorder, and often the more accessible medication.

The results suggest, "that Project ECHO training could be a useful tool for expanding access to medications for opioid use disorder."

Gahan says, "We were able to collaborate and show, for the first time, both in longitudinal and in engagement, that ECHO led to patient-level practice changes."

Benefits for physicians

ECHO is designed to help provide better medical care to challenged communities, but there are personal benefits for physicians who take part as well, Gahan says. "It's not just educating yourself and feeling better about it," he says. "Historically, most ECHOs show that they increase self-efficacy and improve the sense of community the provider has.

"Arguably, ECHO is one of the better things you can do for burnout. You're creating your own little community that's trying to do the right thing and you're learning from each other. You can share your difficult moments. It's a really collegial environment where you're also learning how to provide better care—which is why you got into the business in the first place." **MM**

Linda Picone is editor of *Minnesota Medicine*.

"We try to use ECHO as a tool to facilitate conversations at the intersection of expert opinion and the reality of the frontline community. How do you fuse the academic and the street knowledge? How can we better fuse those narratives to help all involved come to a better healthcare outcome? Because goodness knows, the disparities are huge and real."

Brian Gahan, MD, PhD
Addiction medicine physician
and Project ECHO co-lead
Hennepin Healthcare

Find Project ECHO sessions

Project ECHO sessions link experts to healthcare teams in any community via Zoom. Sessions are about an hour long. They are free to all participants and offer CME credits for physicians.

Minnesota Medical Association

Hennepin Healthcare and Stratis Health offer ECHO sessions with funding from the Minnesota Department of Human Services.

Project ECHO sessions through Hennepin Healthcare can be found at https://www.hennepinhealthcare.org/project-echo/ Recent topics have incuded viral hepatitis, perinatal substance abuse, geriatrics

Project ECHO sessions through Stratis Health, particularly aimed at rural health issues, can be found at https://stratishealth.org/training-events/ Recent topics have included opioid addiction in rural education and treatment and Midwest tribal opioid use disorder, facilitated by the Native American Community Clinic.

The MMA and MMA Foundation host a Project ECHO series on improving the transition from pediatric to adult care for youth with medical complexity, funded by COPIC. More information at www.mnmed.org/ECHO.

PHYSICIANS WHO FIND PASSION AND PURSUE IT

MOST OF THE NINE PHYSICIANS WE INTERVIEWED ABOUT THEIR OTHER-THAN-MEDICINE ACTIVITIES SAY THEY HAVE ENGAGED IN THESE ACTIVITIES SINCE THEY WERE YOUNG—MAYBE EVEN STILL IN ELEMENTARY SCHOOL.

But not all. Some found the activity that engages them as adults. All hope to keep doing whatever it is, from music to running to taking photographs, for as long as they are physically capable of it.

All of them also talk about how their chosen activity isn't just a way to avoid or reduce burnout, although it may be—it's something that they think helps them be better physicians. Not because of any direct connection between, say, gardening and infectious disease research, but because the focus on something outside of medicine helps them see their patients, their research, and their work in a different light. And that can mean better medical decisions.

Some activities allow time for meditation and personal challenge, some mean being part of a community, some provide both. The activity chosen seems less important in the long run than just having something to do that challenges you creatively and/or physically.

—LINDA PICONE, EDITOR OF *MINNESOTA MEDICINE*

MEDICAL RESEARCH AND PHOTOGRAPHY

NOT A JOB AND A HOBBY BUT A LIFE

To say that photography was Tim Schacker's first love is a bit of an understatement. "If you were to ask my mom when I started with photography, she would say I was born that way," he says. "Even in grade school I was taking apart slide projectors to make an enlarger, and I built a darkroom."

Schacker, MD, is vice dean for Research, professor of Medicine, and director of the Program in HIV Medicine at the University of Minnesota. He's also an exhibited photographer, with his latest show at the Phipps Art Center in Hudson, Wisconsin, coming up January 13 through February 19.

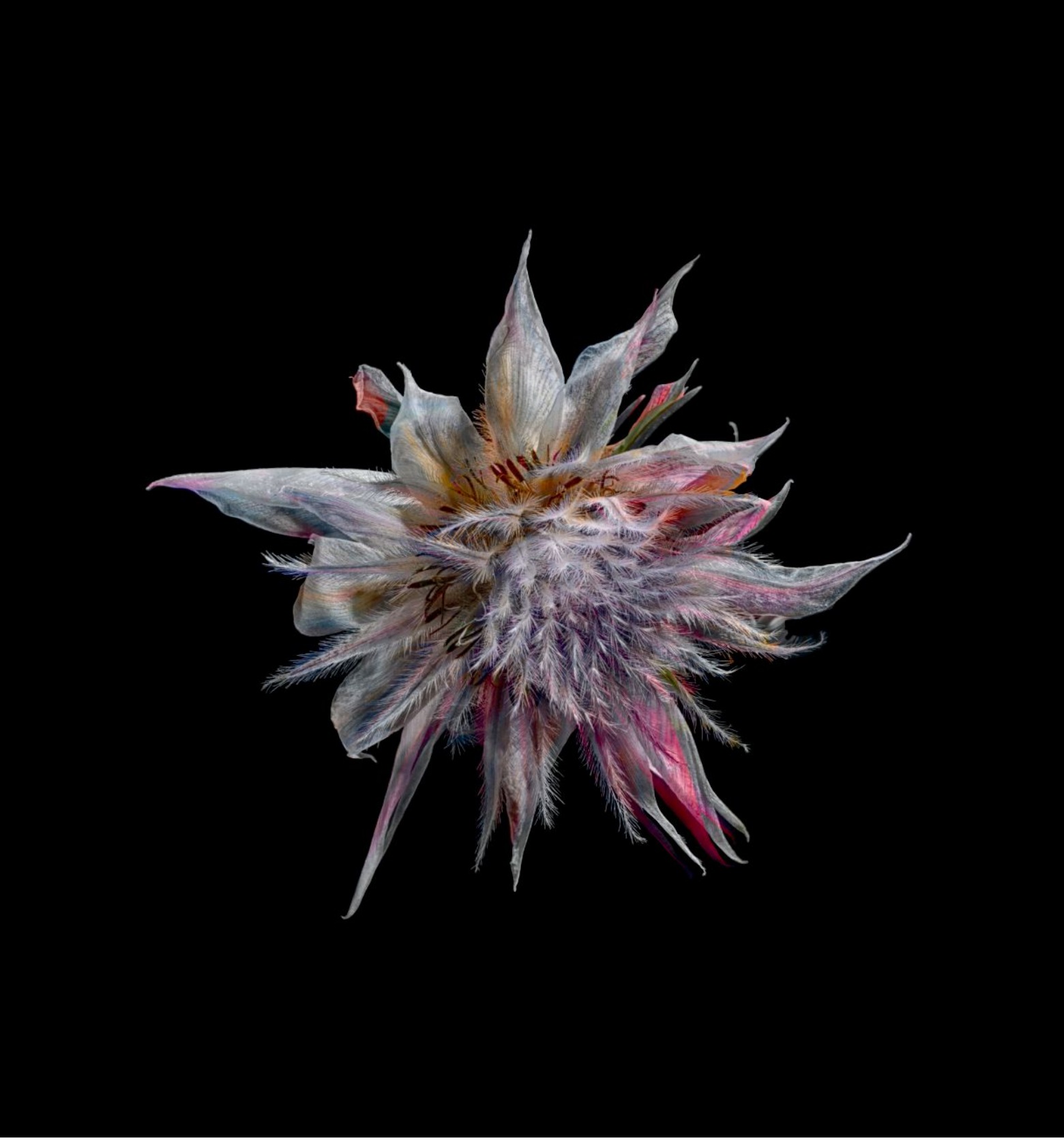
He didn't plan to go to medical school at all, in fact. He had been working as a commercial photographer, taking theater headshots, and was planning to go to graduate school in photography. "I decided to take a gap year," he says, "and then I ended up doing something else."

Many prerequisites later, Schacker was on his way to medical school and a successful career as a physician, researcher, and academic. The distance between photography and medicine might seem huge, but Schacker thinks it makes sense. "In the other part of my life, as a physician scientist, it's no huge surprise that most of the work I do involves image analysis," he says. "The techniques I've developed in the lab for doing image analysis really cross over and apply to my photography."

During his residency, Schacker had a communal darkroom he could use to process his film, but the demands of residency meant he didn't have as much time to do photography. "When the digital revolution happened, that just made things different," he says. "I found myself more engaged with it at that point."

He now has a photography studio in his basement, but says it's harder to do the photography he'd like because of time commitments. "These days, what I can do is take two weeks and do a project," he says. "But I've got my phone with me and I use that a lot; that's just an amazing tool."

Schacker's preference is to do photos in black and white, because he grew up with a darkroom and that's familiar. He is cur-



rently involved in a photo project with black and white images of wildlife from South Africa.

One recent photography project was to take flowers, then expose them to different light sources and combine the images. The resulting image is a composite of roughly 10 photographs. "When you do that, you really see things you didn't know were there," he says. Today, that combining happens on the computer; in the past, he did similar work but it took much more time and detailed effort when he was sandwiching negatives, rather than merging image files.

"Some people who have the career that I have and the job that I have will say that this, photography, is my release," Schacker says. "But honestly, this is just what I do. It's gratifying, I love it, it's how I think, it's how I see things."

WORKING OUT IS NECESSARY COMPETING IS JUST AN EXTRA

Candace Granberg, MD, a pediatric urologist at Mayo Clinic, has the kind of schedule you expect—and likely share. But no matter how busy she is with clinic, surgery, husband, children, and more, there's always time for exercise. Serious exercise.

"If I don't have time, I make time," Granberg says. "I try to get to the gym five days a week to do CrossFit. On other days, like when I have a big surgery day, I might just ride the bike or do some low-impact exercise. A rest day might mean just walking the dog, but I try to do something every day. It's basically an appointment on my calendar."

On clinic days, she usually exercises in the morning. On surgery days, she exercises in the evening. "It's absolutely integral to my life and well-being," she says. "If I have a rough day, I tell my husband, 'I need to go to the gym.' And he'll say, 'Absolutely.' For me, if I don't go to the gym, I'm not myself."

"My main fitness focus would be CrossFit, but as a result of CrossFit, I got into obstacle course racing and Ninja and CrossFit competitions," she says. "I was a two-sport college athlete and then did marathons up untiI I got into CrossFit 10 years ago."

She's been on the television competition American Ninja Warrior twice, in 2017 and 2019, but it hadn't been her intent to take part at all. She and three friends made up a team that applied for a different show, an obstacle course competition. "I was in Haiti on a mission trip and I got this email from NBC," she says. "They told me 'the producers really loved your application—but we don't want you to be on that show, we want you to be on American Ninja Warrior instead.'"

She had three and a half weeks to train and get ready for the competition, but found the challenge exciting, even though she didn't win. She's also done a number of Spartan Races and Hammer Races, the latter requiring racing with a sledgehammer and completing obstacles.

Granberg says she wouldn't be able to keep up with the demands of her practice, her family, and her need for serious exercise without her husband. "He's a saint," she says. "He stays home now and is the default pick-up and drop-off guy. Without him, I honestly would not have the time to do the things I do."

Her 12-year-old daughter and 9-year-old son are proud of her. "They see that I am strong," she says. "When I was on American Ninja Warrior, they were in the audience cheering for me and they have watched my CrossFit competitions. Showing them that this is just what you do, that working out is part of your life, sets them up for a lifetime of health and wellness."

Granberg says, "When you look at people who say, 'I don't have time to work out,' and you reframe that to 'Working out is not a priority for me,' if that doesn't sound good when it comes out that way, then you *should* be working out, it should be a priority for you. I just see it as a life necessity.

"We physicians already work too many hours and don't get enough sleep. Getting to the gym and exercising is one thing I can control."

FOLLOWING THE ROCKS AND WRITING ABOUT IT

One of the books written by Joel Carter, MD, is *Rockpeople: Beyond Chester Creek*. It's a thoughtful and lovely collection of his photos, his words, and some of his "rockpeople," structures of stacked rocks, made without glue or supports, that seem to defy gravity.

Carter, a former emergency medicine physician who now specializes in palliative care and pain management at Methodist Hospital in St. Louis Park, started his journey with rocks in a sweat lodge in Taos, "many, many years ago when I was going through lots of life transitions." He asked how men move from using their head to using their heart and was told, "The first thing is to learn from women. The second thing is to listen to the rocks."

The Inuit used stacked rocks—inukshuks—to serve as guides over the miles to the Arctic; the human-shaped structures pointed out where there might be lifesaving food portions, Carter says. "The tradition is that if anyone disturbs these, it's bad karma." The Jungians say that rocks represent the enduring human spirit, he says. In the Jewish Kabbalah, rocks have several important roles. "From the beginning of mankind, rocks have been important," Carter says.

Carter, who is originally from Winnipeg, made a trip to the concentration camp at Treblinka with his father, a Holocaust survivor, "sort of in search of my Jewish roots in a way I couldn't imagine." As the two rounded a corner to an open field where the extermination camp was, "I saw this huge field with nothing but rocks, and in the middle, this huge structure that was built in the shape of an inukshuk in many ways," he says. "For me, it was a sense of home, a sort of close encounter of the third kind, and it led me to begin a creative, artistic journey."

That journey started with stacking rocks where he could, generally near water. To create the structures, the rockpeople, requires concentration, almost meditation. "When you're present in the moment, what seems impossible with the rocks becomes possible," he says.

Although he doesn't have much opportunity to be with the rocks in his daily life in the Twin Cities, he sometimes goes to Duluth where he stacks

BALANCE POINT

I'VE BEEN STACKING ROCKS
ON THE SHORE OF LAKE SUPERIOR
FOR THE LAST NUMBER OF YEARS.
I'VE FOUND THAT THE ROCKS HAVE
BALANCE POINTS THAT YOU CAN FEEL.

I'VE ALSO FOUND THE HIGHER THE STACK
GETS THE LESS CONTROL YOU HAVE—
AND YOU NEED TO LET THE ROCKS FIND
THE BALANCE POINT THEMSELVES.
—Joel Carter, MD, from
Rockpeople: Beyond Chester Creek

rocks along the Lake Superior shore. In the past, he has even had a kind of rock stalker there, someone—or more than one someone—who would push down the structures he created. "Then I would do them again."

"When I'm back in Winnipeg, there's this amazing little spa that is surrounded by rocks," he says. "The last time I was there, someone came up to me and said, 'Are you the guy who does the rocks?' My rocks inspired others to try their hand at rock-balancing, with other rock sculptures appearing."

Carter began writing around the same time he first became engaged with the rocks. *Rockpeople: Beyond Chester Creek* is named after a creek near Duluth. The book, published in 2012, sold fairly well on the North Shore—and Carter began to frame himself as an interdisciplinary artist.

He is a believer in the power of storytelling, and stories are integral to his work as a physician: "Being an author gives me an 'in' to share important healing stories, amazing stories about what my patients have taught me about what's important. Stories can change symptoms."

The poems in *Rockpeople* are about "broken parts coming together in families, just as the small, unseen broken rock shards serve as shims to give balance and stability to the overall rock structure—a metaphor for life's journey and the broken parts of life we all encounter."

Creating rock structures and writing are "just part of taking care of myself," Carter says. After several difficult years, both simply as a part of the world and with some personal hardships, he says a friend told him to go back and read his own book for perspective.

RUNNING AS AN OUTLET...AND BEING A ROLE MODEL FOR PATIENTS

Britt Erickson, MD, uses running long distances as a way to burn off steam and stress. Sure, there are the regular runs during the week, but when we say "long" distances, we mean long. Like 100 kilometers (a little over 62 miles). Or her unique way of celebrating her 40th birthday in 2021 by running a full 40 miles.

Erickson is a gynecological oncologist at the University of Minnesota. She started running in college, "but I got into longer distances while I was in medical school and then it just sort of took off from there."

She's run 15 marathons, including seven Boston marathons, plus an Iron Man triathlon that included a marathon as part of it. She first ran Boston while she was in medical school at Mayo Clinic. "It was an annual tradition for me and my two brothers, to go to Boston and run Boston," she says.

"The longest distance I did was while I was in fellowship training, a 100K in Utah," Erickson says. "It was a trail run and I was invited by a group of doctors who challenged me: 'We don't have anyone in gyn onc,' they said. So I did it. I think it took about 19 hours; there was some walking involved."

After that run, Erickson's feet were so swollen that she couldn't get into any of her regular shoes and for a while had to wear sandals with operating room shoe covers over them while doing surgery.

She started running her birthday miles around the time she turned 30, she says, after a physician friend came up with the idea, and she tried to do that most years. But when she turned 40, she had a well-planned day of running. "I took the day off and I started running early in the morning," she says. "I ran with friends, co-workers, and family throughout the day who would join me for part of it—but I ran it all around the Twin Cities. I thought it was a really positive way to enter my fifth decade; I thought that if I could run this much on my 40th birthday, I am in a pretty good place."

Today, with a 4-year-old and a 9-month-old, Erickson still runs three to five days a week. "I sometimes run at 5am, before my day starts, sometimes at night, and almost always on the weekends." she says. "You have to try to fit it in with everything else." She lives near the Minneapolis lakes and often runs with her brothers. "We try to run together as much as we can."

Erickson ran through both of her pregnancies, for herself personally and because she thought it was important to do so as an OB/GYN. "I know not every pregnant woman feels comfortable running, but I found it a healthy way to stay active."

"Running for me is an outlet for all the of the high-stakes environment I'm in at work," she says. "I think our bodies internalize stress from the outside world and we have to do something with that stress. It can either gnaw away at us and affect our mental and physical health, or we can somehow actualize it, we can use that stress to power our bodies."

She also wants to model a healthy lifestyle for her patients. "Eating well and exercising are ultimately the best way to prevent most chronic illness, so I feel a sense of personal responsibility as a physician to stay as healthy as I can."

A LIFETIME OF MUSIC WITH A MEDICAL THEME SONG

Peter Nelson, MD, started playing in rock bands when he was "a small town boy from Thief River Falls, Minnesota," and he's kept it up ever since, through high school, college, and medical school. He admits that during his internal medicine residency, however, "I just didn't have time to play much music," but that was an anomalous blip in his life of music; during his gastroenterology fellowship at Mayo Clinic, he was in a rock band that played quite a bit.

In 1992, while he was in gastroenterology practice with CentraCare in St. Cloud, he and some friends started a band, The Receders. "We were kind of older guys," he says, explaining the name, "and some of the guys have hairlines that are more receding than others."

The Receders recorded two CDs of original music—almost all of the original songs written by Nelson—but in performance, the group mostly did covers of rock artists like Tom Petty and Bob Seger.

Writing and playing music "really grounds me and makes me remember who I am and where I came from," Nelson says. "I've been very happy as a gastroenterologist, but who I am is a kid from a small town in Minnesota. Music brings me back to my youth."

One of Nelson's musical accomplishments is something he would not have thought of on his own: an original song for a medical association. He was a member of the American Society of Gastrointestinal Endoscopy (ASGE) for many years. One year, at EndoFest, an annual ASGE event, the past-president asked Nelson if he would write a theme song for ASGE. And so he did; "Just Beyond Your Grasp" is a lovely 3-minute instrumental that he then heard played a number of times when he went to ASGE meetings.

Nelson retired in 2018—but, of course, is still playing. "I have an acoustic group that does a lot of acoustic folk rock," he says. "And my wife has an Irish band and I'm the default guitarist for that."

"It's just been emotionally very satisfying," he says of his life in music. "It's been fun to get together with the other musicians in the acoustic group, the Irish band, and the Receders. It's been a great outlet for me, separate from my time working as a gastroenterologist all these years."

FEET AND WHEELS ON THE TRAIL, HANDS IN THE DIRT, PADDLES IN THE WATER

MORE THAN ONE OUTDOOR PASSION

Dimitri Drekonja, MD, an infectious disease specialist with the University of Minnesota and the Minneapolis Veterans Administration healthcare system, doesn't have just one activity to engage in outside of the clinic and the lab, he has several, all outdoors.

"I've always enjoyed physical activity," he says. "I started as a distance runner and then I switched to biking because my kids are more bikers. To spend more time with them I've been learning mountain biking—although now I can't keep up with my 17-year-old and I barely keep up with my 13-year-old."

He and his wife picked a place to live (south Minneapolis) that was running or biking distance to work, so they could incorporate that kind of physical exercise into the day. "It takes some time out of your day, but if it's a 20-minute drive into work on city streets, now I can instead bike there in half an hour or run there in 40 minutes and it's a little bit of extra time but I can get some physical activity in. I really try to do that to find time to unwind, be outside, and get some exercise so I can enjoy eating and drinking the things I like to eat and drink."

During a recent trip to Colorado to look at colleges for his older son, Drekonja and his family made sure to get some family time hiking outdoors. He recalls that when he was a med student and funds were scarce, he enjoyed backpacking. "We could spend a week in the mountains with some dried food," he says. "It's a cheap way to live out in the wilderness and enjoy spectacular views." He and his wife have taken the family for a few overnight backpack trips, but not as often or as far as he'd like.

And, although there's a canoe in his backyard today, he misses the long trips in the Boundary Waters he used to take. The canoe gets put into local lakes, however. The family has a Father's Day tradition of canoeing all day on the St. Croix.

Drekonja has plenty of running under his belt, but, he says, "The honest truth is that when you get to your late 30s, inevitably you start to get slower. At some point, it gets a little tedious to just document how much slower you get doing the same 5Ks and 10Ks." The solution? Ultramarathons. "The ultramarathons I do are more trails," he says. "It's just getting out there and seeing interesting landscapes—my favorite is on the Superior Hiking Trail. It's a unique challenge to make yourself keep going, and it's a really friendly community and they are highly encouraging."

He now does a 50K race every year and he did one 100-mile race, just to try it. He finished, and "I told my wife afterward never to let me do that again. But the memory has faded enough that I think when I turn 50, I may try it again."

One passion that involves no travel is gardening. "Real gardeners would laugh at my description," Drekonja says. "I enjoy puttering in my yard. I've tried to grow some tomatoes but we have a walnut tree on our lot and it turns out that walnut trees poison tomatoes. I had to build a raised bed with a barrier to keep the tomatoes from the walnut tree's secretions, so this has been the first year we've had tomatoes."

"When you're spending a lot of the day wrestling with difficult decisions, patient care, or research, or administrative, I find it's really nice to go somewhere and just shut your brain off and let your mind wander to other things and do something with your hands like gardening, or do something physical," he says, whether that place is the path of an ultramarathon, a biking trail, or the garden in his backyard. "The solitude of being out and thinking about things other than medicine is a nice break."

ON THE ROAD

TIME TO REFLECT—AND READ

Dania Kamp, MD, knew that she wanted to take some significant time off from her family practice at Gateway Clinic in Moose Lake to do … something. But exactly what should that be?

"I thought about Doctors without Borders, but I have two girls that are still here, one in college and my 16-year-old is in the Twin Cities living with her dad, and I didn't want to be that far away," she says. "It evolved from 'I'm going to take time off and what do I want that to look like?' to 'What's the cheapest way to see all 50 states?'"

A "glamorized" Dodge Pro Master van she calls Gallagher turned out to be the answer. Kamp plans to travel around the country, starting March 1, through the end of 2023. She has what she calls "big loops" of travel planned, with the first one going south to the Carolinas, followed by a loop as she goes north into New England and Canada in late spring. She'll be joined by her partner, Kara Keel, for the second loop, then she'll be back in Minnesota for a wedding in July. Those first months of travel are well planned. After that is a bit looser: "I've already seen all the states out West, so that I'll play more by ear," she says.

The van has a bed, solar power, and water. "It's made to go off-grid," Kamp says. "I'm hoping to do some boondocking, to get off the path a little bit."

For at least the first loop, Kamp's dog, Cora, a 60-pound German Shepherd mix, will be along for the ride. But Kamp will spend quite a bit of time by herself, and she's okay with that. "I love being by myself; I'm sort of an introvert. I need that time by myself after a busy day at work." She and Keel did a trial run to Montana last summer and found themselves talking with people at the campground, their introduction to the community of people who spend weeks, months, or even years on the road. "I think I'll meet great people along the way, but I'll also have time to reflect."

She's also looking forward to having time to read. An important part of her preparation is deciding what books to take along, both in print and electronically—"You can't beat a real book, but from a space standpoint, the Kindle will be there." She wants books that will be fun, but she also wants to learn something, to expand her world. "When you take 10 months off from what you normally do, how do you maximize that?" she asks herself. "How do you make it worthwhile, but also realize that it's okay to rest and relax?"

Kamp's friends and family have been supportive. "They're really excited for me and ecstatic that I'm just doing what I want to do."

She is eagerly looking forward to getting on the road, but there is a hard part: leaving her patients. "I've been at my clinic for 18 years and I have long-term relationships with a lot of them, so I've been explaining to them what I'm doing and that I do intend to come back."

And she will be back. "I'm not running away from anything or trying to find anything," she says. "I love my house and my home and my community and I think I'll miss that after a while."

IT'S ALL DOWNHILL IN THE BEST POSSIBLE WAY

Joel Dunn, DO, has a passion outside of his rural family practice in Sauk Centre that he can only pursue during the winter: skiing and snowboarding.

But pursue it he does, as much as he can, and he's got his whole family with him most of the time.

"My dad taught me to ski when I was 5, so I've been skiing for a while." Dunn says. "I taught myself to snowboard when I was about 12."

From December through March, Dunn and his family are skiing—including a week at Winter Park in Colorado. "I usually get out between three and four times a month during the winter," he says. "One of the best things about it is that my family can do it with me. My wife skis, my two sons ski and snowboard, and my daughter, who has Down syndrome, also skis with us."

Most of the time Dunn skis at Powder Ridge in Kimball. He's on the Ski Patrol there—as is his father, who has been doing that for 30 years.

While the family is in Colorado each year, Dunn's daughter is able to take part in lessons and practice at the National Sports Center for the Disabled there. "It's perfect for Betsy; they have instructors who are adept at teaching her how to ski and it's something she really looks forward to."

Although Nelson has been skiing all of his life, he says it's clear that the way people ski changes over time. "When I was younger, I used to go to the training parks and do all the spins and the jumps and the rails," he says. "As you get into your 40s, you begin to realize that your body doesn't like those things anymore. But I look at my dad, who's in his 70s and still actively skiing, so I hope I can get at least into my 70s or 80s and this is just something I will always do."

Skiing and snowboarding give Dunn a needed break, even though he can't do them all year. "In general, as a doctor, I'm busy," he says. "Especially in rural family medicine, if I'm in town, I'm working. So I need something that's going to get me away. For me, in the winter, skiing, and snowboarding, that's what it is. It's so unrelated to what I normally do and it's a physical activity, something I can do with my family. Those are the drivers that make it energizing for me, that balance my work life."

Minnesota can be bleak in the winter, if you don't have anything you like to do, he says. "It's cold and it's dark. My job is inside all the time, so to get outside is great. Skiing allows me to enjoy the snow, to be in the moment—and to not think about all the work-related stuff."

MUSIC AS COMMUNITY FROM CHILDHOOD ON

Erik St. Louis, MD, a neurologist who specializes in sleep medicine and epilepsy at Mayo Clinic, has never given up on the passion that was first stoked when he was in the seventh-grade school band in Eau Claire, Wisconsin.

"Eau Claire is a fairly musical place, particularly having a rich tradition in jazz," St. Louis says. "My drum instructors were jazz players and turned me on to jazz via watching them gig with the locally famous Water Street Big Band; hearing that big, swinging sound lit my fire for jazz ensembles. There have been phases when I've fallen away from playing a bit, but I always find that I miss it so much. Music is such an integral passion and core part of my identity that playing music has always been an essential act."

St. Louis plays percussion—"drum set, timpani, snare drum, and a little bit of mallet, and tuneful percussion like the marimba, vibes, glockenspiel, and xylophone, plus other odds and ends like cajon, hand drums, tambourine, and others." His middle school experience segued into high school bands, then was continued—and considerably enhanced—at St. Olaf College, "a very musical place," where he did his undergraduate work. "My mentors and directors there turned me on to classical music and I played and gigged in a few campus pop and rock bands," he says. "I had the opportunity to tour internationally twice with the St. Olaf Band and I formed lifelong friendships with some of the 'Bandies.'

"All of my people were music people in college." That included the young woman who became his wife—Kerith Swanson St. Louis, then a soprano in the famed St. Olaf Choir.

Although it was harder to play with groups when he was in medical school, residency, and then fellowship, when he could, he did. It was essential. "At some level, I feel like pursuit of music in a variety of ways, whether it's playing or listening, is just an integral part of who I am and what I need to feel whole as a human being," he says.

St. Louis has played with several community music groups; while at the University of Iowa, he regularly gigged with the Medical Faculty Jazz Combo, and he has played with several Rochester ensembles including the Rochester Civic Music Concert Band, Mayo Chamber Symphony, and Choral Arts Ensemble Chamber Orchestra, which provided opportunities to play Bach's *B Minor Mass* and *Messiah*, his only "paying gigs of the last decade." He has also been active as a church musician, in his current home congregation of Zumbro Lutheran Church in Rochester. "I'm an irregular 10:30 Worship Band member, which is basically the church rock band," he says.

"Music is still where I find a lot of community, where many of my people still are," he says. "It's a different way of communication and, in spiritual terms, a way to try to express the ineffable."

Whether he's playing in the church or community settings, he thinks of his music as one form of lifelong service, not simply performance. "That kind of makes it an essential habit and practice," he says. "I'll keep doing it as long as I can do it capably." **MM**

AWAY FROM THE CLINIC, HOSPITAL, OR LAB

SPENDING TIME ON PURSUITS OUTSIDE OF MEDICINE CAN HELP YOU

BE A BETTER PHYSICIAN

BY SUZY FRISCH

Physicians' lives are often fast-paced and stressful, filled with long, challenging days. Add in the parts of medical practice that make work unpleasant and frustrating—dealing with insurance companies, electronic medical records, requirements for prior authorization, and more—and it's no wonder so many physicians feel overloaded and distressed about their work.

What if there were a simple way to alleviate some of the negative effects of working in this demanding but rewarding profession? The solution—and there is one—can improve mental health, relieve stress, boost self-confidence, and help you be a more creative thinker. No magic pill: it's just having something—call it a hobby, call it a passion, call it a necessity—to focus on outside of work.

Kevin Eschleman, PhD, associate professor of psychology at San Francisco State University, does research on employee well-being and job performance. His findings have helped dispel the notion that people with rich lives outside of work are less productive employees because they get distracted by these interests. In reality, those who devote time—even just a little—to non-medical pursuits become more engaged with their work.

In studies that asked people to track how they feel before and after work, researchers found that those who participated in outside activities were more renewed and ready to dive back into their jobs. "People reported feeling more excited, more energized, and finding more meaning in their work. It's really powerful when you can get someone who wants to be at their job that day because they feel more refreshed, rather than someone who is worn down and depleted," says Eschleman, who published this research in the *Journal of Occupational and Organizational Psychology.*

"For a long time, society didn't recognize that what you do in your free time—whether it's learning a new hobby or facing a new challenge—can have a positive effect on problem-solving and solving other challenges in the workplace."

While it certainly benefits physicians to have diversions outside of work, there are broader reasons for them to make time for these activities. When physicians have a steep imbalance between their professional and personal lives, it can lead to burnout, with trickledown negative effects on patient care, satisfaction, and outcomes, says Colin West, MD, PhD, an internist and director of the Mayo Clinic Program on Physician Well-Being.

These consequences prompted Mayo to create its well-being program in 2007. It was tasked with investigating and understanding factors that might be preventing physicians from operating at full strength and providing the best care possible to patients.

"The first major category of finding was just the understanding that physician distress or well-being has impact, and it affects every stakeholder in medicine. There are impacts on patients, impacts on access to care, and impacts on associated costs," West says. Though that finding seems obvious now, it wasn't the case when the program started. "We faced a lot of headwinds; as if everyone knew when they went into medicine that it would be a challenging career, but they have financial security and respect, and if they are distressed, their career is getting the better of them, but it's acceptable."

Finding a better balance between physicians' work and outside lives is an important way to mitigate burnout and bring more satisfaction to their medical careers. In Mayo's early studies on physician well-being, researchers found that those who recognized the give and take between work and other aspects of their lives fared better.

West likens it to having two bank accounts, one for work and one for home. "If you get overdrawn on your home account, at some point you have to pay that back out of your work account, and vice versa," he says. "The group that did best in our studies acknowledged that tension and worked to balance those responsibilities rather than always prioritizing one side of things."

Full-time focus

The process of becoming a physician requires years of intense focus during college, medical school, residency, and fellowship training. It means putting many aspects of your life on hold, including stepping away from interests that once were passions. As you settle into your new career, possibly with a young family, it feels like an unaffordable luxury to add anything else to your day.

It doesn't have to be that way, says Andrew Barnes, MD, MPH, a developmental and behavioral pediatrician at the University of Minnesota and a faculty member of its Center for Spirituality and Healing. Although many people say they just can't spare the time for one more thing, Barnes says, they shouldn't feel guilty when they do something for themselves. "You can tell yourself 'thank you' for sacrificing everything in your life for everyone else, and that it's okay to be a bit selfish—that you waited long enough for this," he says. "It's not selfish at all to set time aside on your calendar for your hobbies or yourself."

Barnes, who has a research focus on resilience and how people thrive in the face of adversity, says that one key approach to building fortitude involves self-care, including taking time for non-medical activities. Anything that helps people connect with others, gain meaning and purpose in life, or be a part of a community plays a role in carrying physicians through the inevitable bad days or weeks at work. An outside diversion can provide relief.

"It's important to connect with those parts of us that know how to play and have fun because that's where learning and healing and growing happen," Barnes says. "It's about cultivating outside interests so that we can come back to something meaningful in a different way, and it can make our load a little bit lighter from the human drama that was inflicted on us."

Many physicians struggle to find balance in their lives because they get trapped in a positive feedback loop of being admired for being a physician, doing good things for people that are appreciated, and knowing that their work matters to others, says Michael Maddaus, MD, a physician life coach who spent two decades as a cardiothoracic surgeon, professor, and vice chair of the University of Minnesota Department of Surgery.

Pair that vantage point with training that instills in physicians the integral qualities of discipline, perseverance, self-sufficiency, and saying "yes" to everything. It results in people who struggle to take their eyes off of the work ball, often to their own mental and physical detriment, Maddaus says.

But they should do just that. Finding time for other pursuits, especially creative activities, often brings people delight while helping them mute the volume on their high-pressure work lives. "Creativity resides in the freedom to think and the ability to contemplate; that's why it's so crucial to have the intention and discipline and courage to pursue creative hobbies," Maddaus says. "You get to rest your mind and focus on something else so your brain can get a break. Then you get relief, and you get enjoyment."

Maddaus, who researches resilience and coaches other physicians on how to make their lives more fulfilling, developed the concept of the resilience bank account. His paper, published in *Annals of Thoracic Surgery*, detailed eight ways to become more resilient, including exercise, meditation, finding connection, and saying "no." The last one is a vital tactic for physicians who argue that they just don't have time to add outside activities to their lives. He quotes motivational speaker Jocko Willink, who tells people, "All of your excuses are lies."

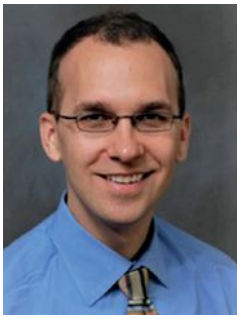
"Just make the time. Say 'no' to the things you are caught up in doing that are not adding value," Maddaus says. "The biggest thing is to focus on what really brings you a sense of meaning and purpose and joy at work and outside of work, and say 'no' to all the other things. Find two or three things at home or work that you really like—you'd almost do it for free—and focus on those things. It's not easy but like anything, it's worth it."

"IF YOU GET OVERDRAWN ON YOUR HOME ACCOUNT, AT SOME POINT YOU HAVE TO PAY THAT BACK OUT OF YOUR WORK ACCOUNT, AND VICE VERSA. THE GROUP THAT DID BEST IN OUR STUDIES ACKNOWLEDGED THAT TENSION AND WORKED TO BALANCE THOSE RESPONSIBILITIES RATHER THAN ALWAYS PRIORITIZING ONE SIDE OF THINGS."

COLIN WEST, MD, PHD, AN INTERNIST AND DIRECTOR OF THE MAYO CLINIC PROGRAM ON PHYSICIAN WELL-BEING

"YOU CAN TELL YOURSELF 'THANK YOU' FOR SACRIFICING EVERYTHING IN YOUR LIFE FOR EVERYONE ELSE, AND THAT IT'S OKAY TO BE A BIT SELFISH—THAT YOU WAITED LONG ENOUGH FOR THIS. IT'S NOT SELFISH AT ALL TO SET TIME ASIDE ON YOUR CALENDAR FOR YOUR HOBBIES OR YOURSELF."

ANDREW BARNES, MD, MPH, A DEVELOPMENTAL AND BEHAVIORAL PEDIATRICIAN AT THE UNIVERSITY OF MINNESOTA AND A FACULTY MEMBER OF ITS CENTER FOR SPIRITUALITY AND HEALING



For those who think they have no room for anything else, West suggests doing an inventory of how they spend their time. It might be surprising to find opportunities. For example, it's common to form the habit of scrolling through social media or zoning out in front of the television for an hour.

"If that is intentional and part of your renewal and recovery—great, that was time well spent. But if it's just brain-dead time, then it's wasted," West says. "There are actually pockets of time in most people's lives that they aren't advantaging. It doesn't need to be a lot of time either. It's sometimes just getting into the habit and being intentional about taking care of your whole self."

Another tactic is to schedule time on the calendar for a personal activity, like any other commitment, Barnes says. Slot in time for a hobby once or twice a week, even for short sessions, just to get in the habit of regularly reserving time for non-work interests. Then tell someone what you're doing and request that they ask you how it is going, giving yourself some accountability.

"THE BIGGEST THING IS TO FOCUS ON WHAT REALLY BRINGS YOU A SENSE OF MEANING AND PURPOSE AND JOY AT WORK AND OUTSIDE OF WORK, AND SAY 'NO' TO ALL THE OTHER THINGS. FIND TWO OR THREE THINGS AT HOME OR WORK THAT YOU REALLY LIKE—YOU'D ALMOST DO IT FOR FREE—AND FOCUS ON THOSE THINGS. IT'S NOT EASY BUT, LIKE ANYTHING, IT'S WORTH IT."

MICHAEL MADDAUS, MD, A PHYSICIAN LIFE COACH WHO SPENT TWO DECADES AS A CARDIOTHORACIC SURGEON, PROFESSOR, AND VICE CHAIR OF THE UNIVERSITY OF MINNESOTA DEPARTMENT OF SURGERY

What to do?

The key to gaining the benefits from outside pursuits is to land on something, anything, you can do consistently. Like physical activity, it's difficult to capture much value unless you participate in a diversion regularly. "Think of your mental health like your physical health. You have to engage in it consistently and with some kind of mindfulness and intention in order to see change," Eschleman says.

"You can't go to the gym once a month or for a week once a year and expect to see physical changes. Research shows that engaging in a hobby or activity can have a positive effect on your mental well-being. But it doesn't last more than a couple days."

Many people struggle with determining how to spend their time. Barnes suggests that they think back to what they enjoyed doing when they were young; perhaps they moved away from it as a career choice because it wouldn't pay the bills. Or they can do something with their children that they all enjoy, like reading a book, baking, or building LEGOs.

The choice of activity belongs entirely to each person—it's more about what it provides to the individual. Eschleman and team tracked study participants as they engaged in their hobbies, asking them to jot down what they did and how they felt. They discovered four underlying experiences that are beneficial to most people.

Relaxation. Any activity that puts you at ease, makes you feel calm, and physically relaxes you. For some people, that's going for a walk. For others it's watching Netflix or drinking a beer.

Sense of detachment. Physicians spend a lot of their day engaged in mentally challenging work, problem-solving, and thinking on their feet. Pursuits that allow you to mentally step away from work and turn off that part of your brain is very helpful. That can include reading, painting, or conversing with other people.

Sense of control. So often, free time is taken up by things outside of your control. From the routines of family life, like driving kids around, making dinner, or mowing the lawn, your time often is committed to needs and not wants. Set aside at least 20-30 minutes each week when you can do whatever it is you want to do.

Mastery experience. It's easy to fall into ruts and routines. Learning something new or honing existing skills provides a jolt of self-worth and self-esteem. It can be any activity, such as trying out a new recipe, learning a language, developing writing skills, or training to run faster. With a new or improved skill, many people find themselves with different and rejuvenating opportunities. Learning a new language opens doors to traveling abroad. Improved writing skills can lead to a new job. "The idea of doing an activity that provides the experience of mastery is that it's a boost to your emotions and a boost to your skill sets," Eschleman says.

West advises that you identify pursuits that help you live a more complete life, which is different for every person. It might be exercise, spiritual activities, being in nature, watching classic movies, or even online gaming. "It doesn't have to be viewed as an escape from work. You are nurturing other aspects of your being that will allow you to bring a restored presence to your work," he says.

"We're privileged in medicine that our work is meaningful and impactful. Not every profession has that. But we need to be well enough to allow that to happen by nurturing other aspects of being human. That allows physicians to be present for their patients. It's an upward spiral that makes people better in every domain." **MM**

Suzy Frisch is a Twin Cities freelance writer.

2023 LEGISLATIVE SESSION PREVIEW

With DFL in charge of all three branches, 2023 session should be progressive

The MMA heads into the 2023 legislative session with five top priorities geared at making Minnesotans the healthiest in the nation and Minnesota the best place to practice medicine.

The DFL won a majority in the Minnesota Senate for the first time since 2014 with a single-vote DFL majority (34 DFL, 33 R). Republicans have been in control since 2016.

DFLers maintained a majority in the Minnesota House of Representatives, but their majority there is also very slim (70 DFL, 64 R, pending two recounts).

The DFL's new control of the state Senate breaks Minnesota's four-year streak of a divided Legislature.

The 93rd Minnesota Legislature convenes January 3. DFLers, who now hold the "trifecta" of power, will be charged with approving a state budget with a likely $17+ billion budget surplus before adjourning May 22.

"With one party controlling the House, Senate, and the governor's office, it could make for a fast-paced session with a lot of progressive issues moving forward," says Dave Renner, MMA director of advocacy. "We wouldn't be surprised to see action on firearm safety, recreational cannabis, and the public option."

Last November, the MMA Board of Trustees approved the following priorities:

- ***Legislation to limit mid-year formulary changes.*** Patients are currently bound by the terms of their contract with a health insurer, yet insurers or pharmacy benefit managers (PBMs) routinely change the patient's drug coverage in the middle of that contract year. The MMA will advocate for legislation to stop insurers and PBMs from forcing a patient to change treatments in the middle of a contract year, when they have already begun their drug therapy.
- ***Passage of CANDOR (Communication and Optimal Resolution)***, which is a process used by healthcare facilities and professionals to respond to and resolve adverse events. Passing CANDOR in Minnesota will improve patient safety by encouraging open and honest communication with a patient and their family following an adverse event and reducing the burden of malpractice claims.
- ***Creation of a statewide electronic registry for POLST (Provider Orders for Life Sustaining Treatment) forms.*** Currently, there is no central database for POLST forms, so emergency providers may not know that a patient's POLST form exists. A statewide registry for POLST forms would help ensure patients' end-of-life wishes are respected and physician orders are enacted.
- ***Extension of permanent coverage of audio-only telehealth services for public and private payers.*** Minnesota passed a strong telehealth law in the 2021 legislative session, but it included a sunset clause, ending coverage for audio-only telehealth services after June 30, 2023. The MMA will advocate to continue these services, which are important for many patients, especially low-income patients, older patients, and patients who may live far from a healthcare provider or who have poor internet access.
- ***Expansion of Medical Assistance (MA) coverage for recuperative care services.*** This is a critical expansion for Minnesotans experiencing homelessness who need a safe and stable place to recover following both acute and/or post-acute services. MM

Save the Date: MMA's Annual Physicians' Day at the Capitol Set for February 8

Physicians and physicians-in-training from across the state will gather again in-person at the state Capitol on February 8 to advocate on behalf of medicine.

The annual get-together, which has been held virtually the last two years, is now referred to as Physicians' Day at the Capitol. It will include a review of top priorities and tips on how to interact effectively with elected officials.

The MMA is partnering with several specialty societies to promote the event, including the Minnesota Academy of Family Physicians; the Minnesota Academy of Ophthalmology; the Minnesota Chapter, American College of Cardiology; the Minnesota Chapter, American College of Emergency Physicians; the Minnesota Chapter, American College of Obstetricians and Gynecologists; the Minnesota Chapter, American College of Physicians; the Minnesota Osteopathic Medical Society; the Minnesota Psychiatric Society; and the Zumbro Valley Medical Society.

"The more white coats we get to the Capitol and in meetings with legislators, the louder our voice," says MMA President Will Nicholson, MD. "Now, more than ever, physicians need to be meeting with representatives and senators to continue advocating for the practice of medicine and patients."

News Briefs

Project ECHO series on transitional care to hold summit on March 13

With a grant from the COPIC Medical Foundation, the MMA and the MMA Foundation have been hosting a series of noon-time online sessions intended to develop a sustainable and collaborative knowledge-sharing community to improve the transition from pediatric to adult care for youth with medical complexity.

These sessions, which began in July 2022, will culminate with a day-long, in-person summit on Monday, March 13, in downtown St. Paul. "This summit will offer a combination of experts in transition care, patients, and those just starting out in this very important field," says project medical director Tori Bahr, MD.

"Because of clinical and technological advances, many children with medical complexity now live into adulthood," Bahr says. "Yet they face numerous practical hurdles in moving from pediatric care to adult providers." The project and the March 13 summit aim to improve the competence and confidence of Minnesota adult primary care clinicians to manage youth with complex conditions, thereby increasing the capacity and number of such clinicians willing to accept new patients.

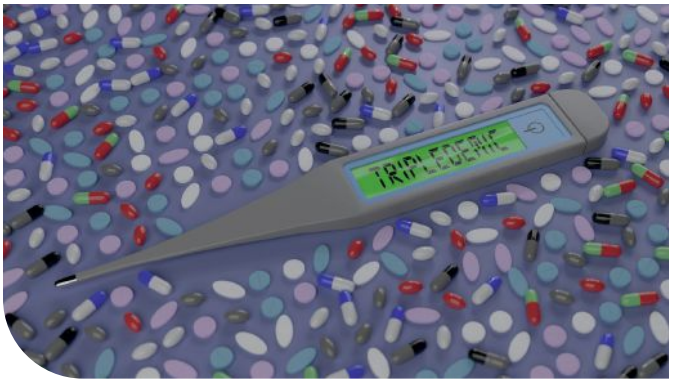
Look for further details including summit faculty, agenda and registration in MMA *News Now*.

Health commissioner steps down

In mid-November, Health Commissioner Jan Malcolm announced that she will retire from her position.

She has served as health commissioner under three governors. Her first stint, 1999 to 2003, was during the Jesse Ventura administration. Gov. Mark Dayton tapped her for health commissioner in 2018, where she has stayed until now, as part of Gov. Tim Walz's team.

In a statement, MMA President Will Nicholson, MD, said: "The MMA thanks Commissioner Jan Malcolm for her many years of service and excellent leadership of the Minnesota Department of Health. Throughout her career, she has steadfastly focused on protecting public health and defining good public health policy. Her steady, transparent, and science-driven guidance during the COVID-19 pandemic has helped Minnesotans fare better than most other states. We wish her the best in her retirement."



MMA urges Minnesotans to take preventive steps to stem tripledemic

The MMA sent a press release to media outlets across the state in November, urging all eligible Minnesotans to get their COVID-19 booster and seasonal flu shot.

"We've been lucky to have a mild fall so far, but soon the weather will turn colder, and the holidays will bring more people inside to gather in large groups," stated MMA President Will Nicholson, MD, in the release. "When that happens, we expect to see a rise in cases of influenza and other airborne diseases. Getting vaccinated is the best way to protect yourself and your family."

Later in the month, Nicholson also took part in a press conference addressing the rush of patients to the state's urgent clinics, hospitals, and emergency departments.

"We are already dealing with a rise in RSV (respiratory syncytial virus) cases, plus staff shortages at many clinics and hospitals," Nicholson said. "We need Minnesotans to step up by doing all they can to prevent illness now—get your shots, cover your cough, and stay home if you are not feeling well."

Three physicians now in Minnesota Senate

Three physicians, all with the DFL, are now in the Minnesota Senate following the November 8 election. Matt Klein, MD, was re-elected to a third term. Kelly Morrison, MD, had been in the House of Representatives but made the switch to the Senate. Alice Mann, MD, had served an earlier term in the House.

New map shows Minnesotans where to find treatment

The Minnesota Department of Health (MDH) and Hennepin Healthcare have unveiled a new map that will make it easier for Minnesotans experiencing chronic pain to find safe, opioid-free treatments, to help with healing, working, socializing, and managing daily tasks.

News Briefs *(continued from previous page)*

According to the CDC, about 20% of U.S. adults had chronic pain as of 2019. An important goal of treatment for people experiencing chronic pain is to provide options to help improve quality of life and function.

The NO PAIN MN map features several services that have been demonstrated to reduce chronic pain and improve quality of life, including psychotherapy, acupuncture, yoga, massage therapy, chiropractic care, and physical therapy. These alternative pain-management options can treat chronic pain with no risk of substance misuse, while improving quality of life.

CDC updates chronic pain prescribing guidelines

The Centers for Disease Control and Prevention (CDC) updated its recommendations for clinicians providing pain care for adult outpatients with short- and long-term pain and removed dose limits that have led to forced tapering for patients with chronic pain.

These updated clinical recommendations, published in the *CDC Clinical Practice Guideline for Prescribing Opioids for Pain* will assist clinicians in working with their patients to ensure that the safest and most effective pain care is provided. The publication updates and replaces the guideline released by the CDC in 2016.

The 2022 Clinical Practice Guideline addresses the following areas: 1) determining whether to initiate opioids for pain, 2) selecting opioids and determining opioid dosages, 3) deciding duration of initial opioid prescription and conducting follow-up, and 4) assessing risk and addressing potential harms of opioid use.

Some modifications to the guideline were made, including:

- The CDC no longer suggests trying to limit opioid treatment to three days for acute pain.

FROM THE CEO

Building on 170 years

The MMA was founded 170 years ago, in 1853. Although medical care today bears little resemblance to that of the mid-19th century, the commitment of physicians across the state—all specialties and all practice types—to unify their voices for the betterment of public health and the profession remains.

Yet none of us—staff or leadership—take our historic staying power for granted. We are continuously adjusting our work to address the most important issues facing you and your patients.

As a new year begins, we want to share the MMA's updated Strategic Map—the one-page summary of our strategic plan. It captures all the essential elements of what MMA is (mission/vision), what our core strategies are, and, most importantly, the outcomes we are working toward achieving on your behalf. I think you will find it an exciting and ambitious plan.

In my last column I shared some of the external forces and changes that informed the Board of Trustees as they worked to update the strategic direction. This revised Strategic Map reflects the Board's many months of thoughtful and informed deliberation. Based on a balanced scorecard model, it recognizes that the MMA must balance the work we do in the community, the work we do for physician members, and our work as good stewards of the organization.

As you engage with us over the course of the year and monitor our work and progress, I urge you to refer to this document and find the connections. As a professional association, our success requires your support and involvement.

Please reach out to us at any time (MMA@mnmed.org) to ask questions, share your ideas, or get involved.

Finally, with a new year comes a new membership season. We need your continued support to fuel our work. Our calendar year memberships and flexible dues options are designed to adjust with you as your career starts, grows, and changes.

Please renew today or check out the membership details online (www.mnmed.org/membership) for more information.

Here's to a great and productive 2023!

Janet Silversmith
JSilversmith@mnmed.org

- The agency is dropping the specific recommendation that physicians avoid increasing dosage to a level equivalent to 90 milligrams of morphine per day.
- For patients receiving higher doses of opioids, the CDC is urging physicians to not abruptly halt treatment unless there are indications of a life-threatening danger. The CDC offers suggestions on tapering patients off the drugs. It includes advice on ways physicians and patients can discuss tapering off drugs; a warning that clinicians should "weigh benefits and risks and exercise care when changing opioid dosage;" and a notice that they should "regularly reevaluate benefits and risks of continued opioid therapy with patients."
- The guideline recommends that clinicians try non-opioid approaches to pain control before initiating the medication.
- The guideline notes disparity in the care of people of color, some of whom are less likely to be referred to a pain specialist or receive postpartum pain assessments than White people.

"These updated guidelines will ensure that patients with chronic pain will continue to receive the medications needed to allow them to function," said MMA President Will Nicholson, MD. "The previous version of these guidelines was misused by some payers and pharmacies to establish hard practice standards that forced patients with chronic pain to taper their medications, even if tapering was not in their best interest."

The new recommendations are voluntary and provide flexibility to clinicians and patients to support individualized, patient-centered care. They should not be used as an inflexible, one-size-fits-all policy or law; applied as a rigid standard of care; or replace clinical judgement about personalized treatment.

Two MMA members receive rural health awards

As part of National Rural Health Day on November 17, the Minnesota Rural Health Association, the Duluth-based National Rural Health Resource Center, and the Minnesota Department of Health (MDH) presented the 2022 Minnesota Rural Health Awards to the following honorees:

Rozalina McCoy, MD, medical director, Community Paramedic Program, Mayo Clinic Ambulance Service, Rochester, received the 2022 Minnesota Rural Health Hero Award for her work establishing a Community Paramedicine Program that brought care out into the

MMA Strategic Map

Minnesota Medical Association

Mission/Vision

To be the leading voice of medicine to make Minnesota the healthiest state and the best place to practice

TAGLINE: *The voice of medicine in Minnesota since 1853*

Strategies | *How we will achieve our mission/vision*

*MMA advances its mission by **educating, convening, and collaborating** with members and others to effectively:*

Advocate	Engage	Empower	Inform
Anticipate and advance change to address critical and emerging issues	Connect, support, build trust, and foster physician community	Transform health and healthcare by developing effective physician leaders	Track and communicate issues affecting the practice of medicine to position physicians for success

Outcomes | *What we will see if we are successful*

Broader Community Impact	Recognition of MMA as a credible and valuable resource and leader	Physicians are valued and trusted	Improved patient and population health	Improved health equity
Member Impact	Improved professional satisfaction and well-being	Empowered physicians to navigate evolving systems and changing roles	Greater and more visible membership value	Increased member engagement within their communities and with MMA
Organizational Health and Sustainability	Increased and diversified membership and revenue	Effective membership communications	Engaged and effective board	Engaged and effective staff and efficient office infrastructure

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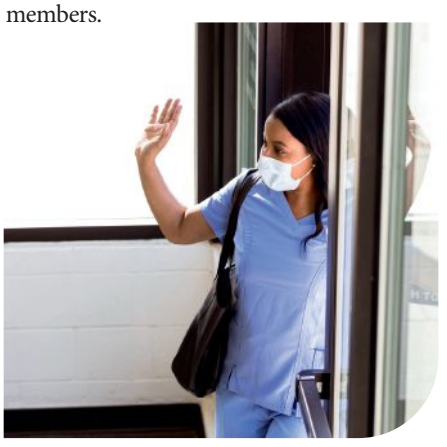
News Briefs *(continued from previous page)*

community and to residents in their homes, hotels, shelters, and other living situations.

Wesley O. Ofstedal, MD, medical director of Living Center, Essentia Health-Fosston, received the 2022 Minnesota Rural Health Lifetime Achievement Award for his devotion to his patients and his focus on geriatric care and preventive medicine. His work as a compassionate physician and mentor for multiple generations of local families benefited his entire community.

Wilderness Health, Two Harbors, received the 2022 Minnesota Rural Health Team Award for improving patient experience, advancing patient and community health outcomes, lowering costs, and enhancing the care team while serving a large area with some of the most remote parts of the state.

McCoy and Ofstedal are both MMA members.



One-third of a million providers left healthcare in 2021

According to a recent report from Definitive Healthcare, 117,000 physicians left the workforce in the fourth quarter of 2021. Overall, Definitive estimated that more than 333,000 healthcare providers left the field that year.

The top three specialties affected by the departures were internal medicine, family practice and clinical psychology.

Definitive looked at medical claims data to arrive at these workforce issues. Definitive's "mission is to transform data, analytics, and expertise into healthcare commercial intelligence."

This information was first reported in *Becker's Hospital Review*.

MMA board approves policy on healthcare for those with unstable housing

At its October meeting, the MMA Board of Trustees approved a policy proposal submitted through The Pulse on improving the effectiveness of healthcare given to people experiencing homelessness or unstable housing.

The policy proposal, which was submitted by the MMA's Medical Student Section, recommended that the Board:

- Support the creation and implementation of medical school curricula, continuing medical education, and information campaigns that educate physicians and trainees on how to screen for, and adapt medicine to, the housing status of patients.
- Pursue the collaborations, payment reforms, and legislation necessary to enable healthcare providers and institutions to screen for, and adapt medicine to, the housing status of patients.
- Support healthcare programs tailored to serving patients experiencing homelessness or unstable housing, including, but not limited to:
  a) recuperative care, a program that offers healthcare providers a safe place to discharge people experiencing homelessness when they no longer require hospitalization but still need to heal from an illness or injury.
  b) street medicine, a program through which healthcare professionals can provide medical care to people experiencing homelessness outside of the clinic, in places like encampments, parks, and under bridges.

Eighty-two members voted on the policy proposal, with 70 voting yes, six voting no and six not taking a position.

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

PHOTO BY KATHRYN FORSS

Edwin Bogonko, MD, MBA
MMA Board Chair

VIEWPOINT

Helping develop healthcare's leaders today

Growing up, most of us physicians were told at an early age that we were special. Teachers called on us more because they figured we knew the answers. Many times, we did. Many of our classmates looked at us with envy because we were getting attention. These grade school experiences supplied the foundation for us to become leaders, even if unwillingly.

As we matriculated, some of us took to leadership early and embraced the role. Others were asked to lead at their clinics or hospitals or as instructors and, because they wanted to continue to grow, learn, and earn more, they said yes. There also is a group of physicians who have all the skills they need to be great leaders but lack the confidence to do so.

That's where the MMA comes in.

We advocate for physicians on all levels. Whether it's supporting pro-medicine legislation at the state Capitol or fighting for physicians' rights in the courtroom or ensuring that individuals have access to the tools they need to be the best they can be, practicing at the top of their license. The MMA wants to provide a platform for physicians to grow professionally as well as in leadership roles. Our presence at the table has never been more important, lest we find ourselves on the menu!

Healthcare in Minnesota and across the country faces enormous challenges. It makes sense that physicians, who lead the healthcare team, should be called upon to help lead the change needed to make Minnesota the best place to practice, with citizens who are the healthiest in the nation.

The MMA strives to be a critical provider of education and experience for Minnesota physicians to be the leaders of today and tomorrow. That's why we have created the Minnesota Physician Leadership Institute (MPLI) as the newest visible example of how we are here to serve physicians.

The MPLI, when launched in 2023, will offer innovative, best-in-class, training to provide Minnesota physicians with the skills, insights, and competencies required to hone leadership ability.

As we face the ever-changing and increasingly challenging world of healthcare delivery, medicine has never needed physician leaders more. The MPLI will enhance physicians' confidence and competence as we lead medicine forward. It will provide training in the core skills physicians need to lead efforts that drive innovation in their practices, gain influence in the systems they work for or with, and elevate the health of our communities.

The MPLI will be a unique program designed *by* physicians and *for* physicians to help physicians realize their innate leadership potential. The MMA is excited to partner with the University of Minnesota Carlson School of Management and its world-class faculty to deliver such program content as negotiation strategies, project management, healthcare policy, mentoring and coaching, emotional intelligence and much more.

The MPLI will fill a void in the state. With it, the MMA seeks to be the organization physicians seek out and trust to provide ongoing effective and relevant leadership training. Challenge yourself or others in your practice and be part of the pioneer cohort. **MM**

There is a group of physicians who have all the skills they need to be great leaders but lack the confidence to do so. That's where the MMA comes in.

Empower-Patient Accounts

A way to redesign healthcare financing

BY ROBERT KOSHNICK, MD

The cost of healthcare in the United States has risen steadily for years. In 1950, the average person's yearly healthcare expenditure was less than $100 ($500 in today's dollars). In 2020, the national healthcare expenditure was $4.1 trillion or $12,530 per person, 19.7% of the gross domestic product (GDP).

This increase is driven by ballooning administrative costs, demands for services that often outstrip the available supply of providers, and the rise of managed and conglomerate medical care systems.

In 2020, according to government figures, 90.6% of healthcare spending was done through assorted third-party payers; only 9.4% was paid by patients. Third parties clearly control our healthcare system. They also are the source of the burdensome documentation, coding, billing, and complex regulatory requirements that make our healthcare expensive.

Third parties generally promote defined-benefit plans with open-ended benefits, which can drive patient demand for services that have limited resources, including the providers of medical care. Even though defined-benefit plans are highly inflationary, they have the support of powerful interests—employers and politicians—who have a personal stake in keeping them.

The way to address the systemic financing problem is to return the control of medical dollars to the patient and eliminate third-party payers for most medical spending.

Empower-Patient Accounts

The healthcare system should be designed to empower patients, rather than third-party payers. People could pay directly for their medical care, rather than funneling money through third parties. People could pay directly for basic primary care and incidentals through what I call Empower-Patient Accounts—accounts funded by the state or federal government that give people control over how and whom to pay for the medical care they need.

Empower-Patient Accounts (E-PA) would be like Indiana's Power Accounts, which Medicaid patients there have had since 2008. The State of Indiana funds Power Accounts for Medicaid recipients at $2,500 yearly through a Medicaid 1115 waiver.

I suggest that Medicaid-eligible patients would have $250 a month put into their E-PA accounts. Middle-income (middle income would have to be legislatively defined) Minnesotans could receive $125 a month for their E-PA accounts. These monthly rebates would be individually means-tested, so as not to discriminate against married couples who might lose their rebates by combining their incomes. Middle-income people would have the option of adding tax-deductible contributions to their E-PA account up to a set amount, perhaps $3,000 a year. The aver-

age person spends far less than $1,000 annually on primary care; E-PA money also could be used for other healthcare incidentals.

Higher-income people, those above the legislatively defined middle-income people, would not receive any rebates. They would be encouraged to fund their own E-PA accounts through tax-deductible contributions. In this example, that would also be $3,000 a year. Businesses would lose insurance tax deductions for employees who choose to fund their own E-PA.

E-PA would work much like the electronic-benefit transfers (EBT) of the Supplemental Nutritional Assistance Program (SNAP), except that it would be done through taxable financial institutions. These institutions would set up EBT-like smart credit cards and would be responsible for determining whether purchases were for approved medical care services or not. People with E-PA accounts would soon learn which purchases were allowed after payments for non-qualifying purchases were rejected.

Financial institutions also could set up ways for the funds to increase tax-free in the accounts, through savings accounts, money-market accounts, or other investment opportunities such as the bond or stock markets. Funds not spent could build up over time.

The same process could work for major medical events by funding high-deductible health plans (HDHP) or, alternatively, health savings accounts (HSA). Medicaid-eligible people would be provided an HDHP or HSA. Middle-income people would get monthly rebates based either on income levels or defined fixed amounts if they set up an HDHP or had an HSA. They would have to fund the rest of the cost of the HDHP or HSA themselves, but that amount would be tax-deductible. Higher-income people would not receive a rebate, but the funds they use to buy an HDHP and/or HSA would be tax-deductible up to legislatively set limits.

E-PA with HDHP/HSA would limit the liability of people with disabilities or pre-existing conditions for all their needed medical care, including catastrophic events. For this population, there is a role for free clinics, Federally Qualified Health Centers and rural health clinics, nonprofit organizations, community fundraising, and state high-risk pools. The Medicare disability program would continue to cover those who have become totally and permanently disabled, as well as those with end-stage renal disease (ESRD) and ALS.

E-PA with HDHP/HSA is by its very nature a defined contribution plan. Patients would be given a set amount of money to pay for their healthcare. People would oversee their own healthcare spending. Money not spent would accumulate in their E-PA and HSA. Patients could become cost-conscious about their medical care again.

> The healthcare system should be designed to empower patients, rather than third-party payers. People could pay directly for their medical care, rather than funneling money through third parties.

The E-PA/HDHP/HSA proposal is meant to cover Medicare-ineligible adults. Workman's Compensation Insurance for work-related disabilities would continue to help those who qualify. Parents and the Child Health Insurance program (CHIP) for the children of those who qualify would continue to cover the medical care for their children.

Direct Primary Care

Direct Primary Care (DPC) is another way to empower patients. Patients directly contract for their primary care with a primary care physician. The providers are obligated to provide acute and chronic care management, evidence-based preventive services, immunizations, basic mental health care, prenatal care, and child medical care, and oversee hospice care with no other copays or expenses.

DPC typically charges $75 to $100 monthly per adult or family rates. Physicians could form small clinics again if people paid directly for it or had DPC. The patient, not the dictates of corporate administration or third-party payers, would then be the sole concern of primary care physicians. E-PA might make this the dominant form of accessing primary care in the United States.

Impact on physicians

Researchers from Mayo Clinic, in a survey of 2,500 U.S. physicians, found that 62.8% of physicians had at least one manifestation of burnout in January 2022. Only 57.5% of physicians in that study said they would choose to be a doctor again.

During the last three years of my medical practice (2015-2018), I was the Resiliency Champion in the system where I was employed. It became clear to me that the high rates of burnout among physicians are due to systemic problems related to the third-party payment system. I concluded that unless we change the third-party-payer system, burnout rates will continue to be high.

E-PA accounts, by empowering patients, could give the country 264 million adult decision-makers (2022 numbers) who could accomplish the efficient allocation of medical care resources. Eliminating the third-party-payer system and using E-PA/HDHP/HSA could help medical care workers recapture the joy of medicine.

Paying directly for medical care is the most cost-effective way to get the medical care we need. This is the mindset change we, as a nation, need to make. It is also a way to reestablish the primacy of the patient physician relationship, desired by both patients and physicians. **MM**

Robert Koshnick, MD, FAAFP, is a retired primary care physician. He recently published *Empower-Patient Accounts Empower Patients!* He is the incoming chair of the Policy Committee of the Minnesota Medical Association. His ideas about E-PA accounts also appeared in an article in the October 2022 edition of *Minnesota Physician*.

Medicaid and Medicare reimbursement rate

Variations for the 20 most commonly ordered CT, MRI, US, and XR studies

BY DAVID KAHAT; STEPHEN KLAASSEN; DIEGO SANTIAGO, MA; CASSIANO SANTIAGO, MD; AND RONNIE SEBRO, MD, PHD

Medicare and Medicaid are crucial components of U.S. healthcare, serving over 30% of the U.S. population in 2019. Medicaid differs from Medicare in that reimbursements are determined on a state-by-state basis, and therefore may demonstrate greater variation. Lower and more variable reimbursement rates may create geographic disparities that may impact patients' access to imaging care. Radiological imaging is critical for disease diagnosis, treatment, and surveillance. The purpose of this study was to evaluate and characterize state variation in Medicaid and Medicare published reimbursement rates for the 20 most commonly ordered computed tomography (CT), magnetic resonance imaging (MRI), ultrasound (US), and radiograph (XR) studies.

Methods

The 20 most commonly performed CT, MRI, US, and XR studies (80 studies total) based on Medicare's 2019 National Summary Data File were included. Data from 2019 were used because the COVID-19 pandemic significantly altered healthcare utilization in the most recent dataset (2020). Global reimbursements were analyzed and divided into the technical component (TC), which covers the cost of equipment, supplies, and clinic personnel, and the professional component (PC), which reimburses physicians directly. Variability in reimbursements was quantified by the coefficient of variation (CV) which is the standard deviation divided by the mean. For each study, the mean Medicaid

FIGURE 1A

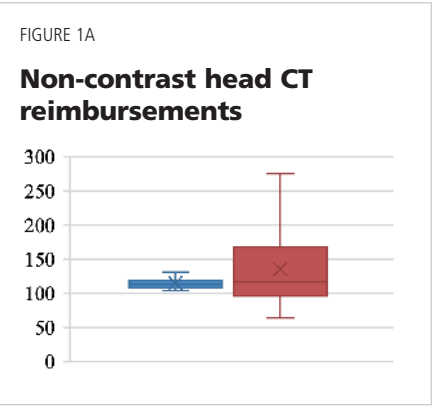


FIGURE 1B

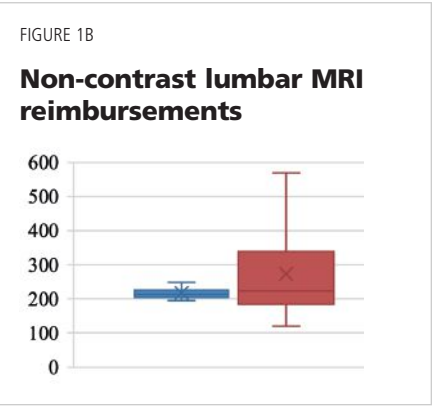


FIGURE 1C

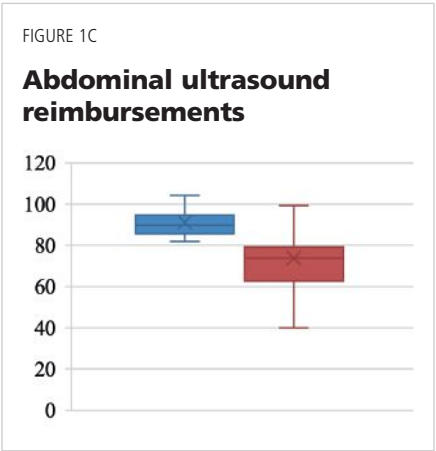


FIGURE 1D

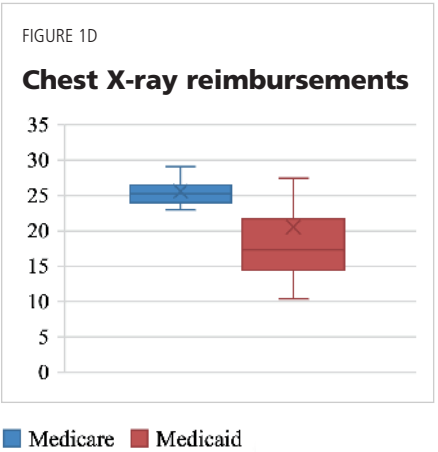


Figure 1 (a-d): Box plots were created based on each states' listed reimbursement rates for the most commonly ordered CT (a non-contrast CT of the head), MRI (a non-contrast MRI of the lumbar spine), US (an abdominal US), and XR (a chest XR) studies. Each plot represents national data, with the blue plots representing the listed Medicare reimbursement rates for each state and the orange plots representing the listed Medicaid reimbursement rates for each state. The interquartile ranges, median (indicated by a horizontal line), and mean (indicated by an "X") are shown.

and Medicare rates, CVs and the average professional components of each reimbursement rate were compared using a paired t-test.

Results

Medicare reimbursement rate variation between states (CV range: 0.07-0.08) was significantly lower than Medicaid reimbursement rate variation (CV range: 0.217-0.548) ($P < 0.05$ for all studies). For Medicaid, ultrasound had the lowest variation between states (CV= 0.280), then CT (CV= 0.328), radiograph (CV= 0.345) and MRI (CV= 0.398). Medicare dedicated a higher percentage to professional components than Medicaid for CT and MRI ($P < 0.001$); Medicaid proportionally paid greater professional component fees for radiograph ($P = 0.002$). Most between-state reimbursement variation was due to fluctuations in the technical rather than professional components.

Conclusion

This research demonstrates significantly higher between-state variation in Medicaid rates compared to Medicare rates for commonly ordered radiological studies. Of the global reimbursement, Medicaid typically paid a lower proportion to cover the professional component. Reimbursement rate variation on the low end may cause certain clinics to refrain from offering some imaging services below cost, while higher reimbursement rates could incentivize clinics to cherry-pick certain studies to offer beneficiaries. This may propagate geographic healthcare disparities in vulnerable populations. The variation should be investigated with more recent data when it is released, as well as in other specialties of medicine. Regarding radiology specifically, further research is needed to investigate why certain modalities (MRI) have reimbursement rates that vary much more than other modalities. MM

FIGURE 2A

CT reimbursement differences

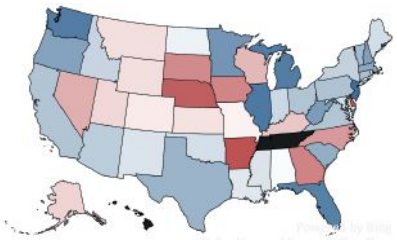
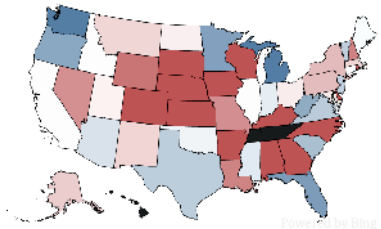


FIGURE 2B

MRI reimbursement differences



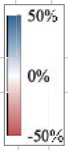


FIGURE 2C

Ultrasound reimbursement differences

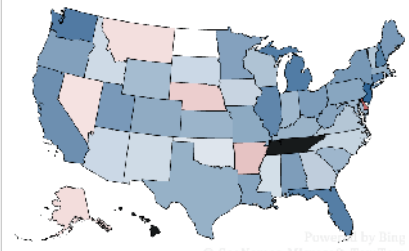


FIGURE 2D

X-ray reimbursement differences

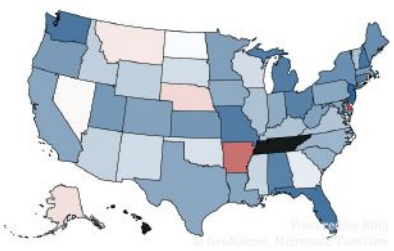


Figure 2 (a-d): State percentage differences for Medicare and Medicaid mean reimbursement rates for each imaging modality are displayed. Each state's mean Medicare and Medicaid reimbursement rate was calculated by averaging the Medicare and Medicaid listed reimbursement rates for the top 20 most commonly ordered scans of each modality. These two values were then compared to one another, with shades of blue indicating greater Medicare reimbursement rates and shades of orange indicating greater Medicaid reimbursement rates. No data was available for Hawaii or Tennessee.

David Kahat is a fourth-year medical student and MBA candidate at the University of Minnesota Medical School and Carlson School of Management. Stephen Klaassen is a fourth-year medical student at the University of Oklahoma. Diego Santiago, MA, is a statistician at Bahia Asset Management in Rio de Janeiro, Brazil. Cassiano Santiago, MD, is a third-year diagnostic radiology resident at the University of Minnesota. Ronnie Sebro, MD, PhD, is an attending radiologist at Mayo Clinic, Jacksonville, Florida.

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TABLE 1

CT Exams

	Medicare	Medicaid	Comparisons							
(FROM MOST TO LEAST COMMON)	Mean global reimbursement rate ($)	SD ($)	CV	% of global reimbursement rate covering PC	Mean global reimbursement rate ($)	SD ($)	CV	% of global reimbursement rate covering PC	% difference in mean reimbursement rate	P value between reimbursement rates
CT head, w/o contrast	115.56	8.35	0.072	37.8%	136.13	54.38	0.399	31.3%	-17.8%	0.01
CT abdomen & pelvis, w/ contrast	326.92	24.53	0.075	28.7%	260.19	72.96	0.280	28.4%	20.4%	0.00
CT thorax, w/o contrast	158.32	11.42	0.072	37.5%	171.29	63.68	0.372	31.1%	-8.2%	0.17
CT abdomen & pelvis, w/o contrast	200.57	14.09	0.070	44.5%	166.06	47.03	0.283	42.3%	17.2%	0.00
(FROM MOST TO LEAST COMMON)	196.13	14.47	0.074	32.6%	207.96	71.50	0.344	28.2%	-6.0%	0.27
CT cervical spine, w/o contrast	155.63	11.46	0.074	33.0%	173.77	58.73	0.338	28.7%	-11.7%	0.04
CT abdomen & pelvis, w/o & w/ contrast	367.39	27.62	0.075	28.0%	310.97	91.01	0.293	26.7%	15.4%	0.00
CT neck, w/ contrast	296.13	22.06	0.074	30.3%	300.48	101.27	0.337	28.0%	-1.5%	0.77
CT maxillofacial area, w/o contrast	139.19	10.33	0.074	31.7%	152.75	53.31	0.349	29.4%	-9.7%	0.09
CT lumbar spine, w/o contrast	154.92	11.40	0.074	33.1%	173.58	59.81	0.345	28.2%	-12.0%	0.04
CT angiography head, w/ contrast	296.48	22.09	0.075	30.2%	299.98	100.50	0.335	28.1%	-1.2%	0.81
CT lower extremity, w/o contrast	154.92	11.40	0.074	33.1%	166.09	50.62	0.305	28.0%	-7.2%	0.13
CT angiography, abdomen & pelvis, w/ contrast	404.56	30.46	0.075	27.7%	370.41	107.56	0.290	24.4%	8.4%	0.04
CT soft tissue neck, w/ contrast	202.67	14.78	0.073	35.0%	205.70	67.27	0.327	30.7%	-1.5%	0.76
CT thoracic spine w/o contrast	155.63	11.46	0.074	33.0%	175.20	61.60	0.352	27.9%	-12.6%	0.03
CT pelvis, w/o contrast	145.52	10.47	0.072	38.3%	158.60	59.46	0.375	32.5%	-9.0%	0.14
CT upper extremity, w/o contrast	178.55	13.39	0.075	28.8%	165.65	47.61	0.287	27.8%	7.2%	0.07
CT angio abd. aorta & bilateral iliofemoral, w/ contrast	443.29	33.38	0.075	27.4%	352.49	110.43	0.313	29.2%	20.5%	0.00

TABLE 2

MRI Exams

	Medicare	Medicaid	Comparisons							
(FROM MOST TO LEAST COMMON)	Mean global reimbursement rate ($)	SD ($)	CV	% of global reimbursement rate covering PC	Mean global reimbursement rate ($)	SD ($)	CV	% of global reimbursement rate covering PC	% difference in mean reimbursement rate	P value between reimbursement rates
MRI lumbar spine, w/o contrast	217.54	15.89	0.073	35.1%	273.07	119.74	0.438	28.0%	-25.5%	0.00
MRI brain, w/o & w/ contrast	364.87	26.94	0.074	32.2%	455.91	208.28	0.457	25.5%	-24.9%	0.00
MRI lower extremity joint, w/o contrast	228.69	17.03	0.074	30.4%	272.79	104.45	0.383	27.5%	-19.3%	0.01
MRI cervical spine, w/o contrast	217.19	15.86	0.073	35.1%	271.50	113.28	0.417	28.5%	-25.0%	0.00
MRI upper extremity joint, w/o contrast	229.66	17.14	0.075	30.7%	269.74	105.71	0.392	25.1%	-17.5%	0.01
MRI abdomen, w/o & w/ contrast	390.93	29.28	0.075	28.7%	510.35	220.45	0.432	22.5%	-30.5%	0.00
MRI lumbar spine, w/o & w/ contrast	366.99	27.12	0.074	32.0%	459.41	212.92	0.463	25.8%	-25.2%	0.00
MR angiography head, w/o contrast	244.70	18.65	0.076	25.1%	311.91	90.89	0.291	18.5%	-27.5%	0.00
MRI thoracic spine, w/o contrast	217.19	15.86	0.073	35.1%	280.81	124.42	0.443	28.3%	-29.3%	0.00
MRI pelvis w/o & w/ contrast	390.23	29.21	0.075	28.8%	500.70	204.17	0.408	22.6%	-28.3%	0.00
MRI lower extremity other than joint, w/o contrast	257.26	19.45	0.076	26.9%	303.39	96.93	0.320	21.8%	-17.9%	0.00
MRI cervical spine, w/o & w/ contrast	367.69	27.18	0.074	32.0%	461.35	214.41	0.465	26.2%	-25.5%	0.00
MRI abdomen, w/o contrast	225.27	16.57	0.074	33.4%	300.29	108.45	0.361	25.0%	-33.3%	0.00
MRI thoracic spine, w/o & w/ contrast	368.40	27.24	0.074	31.9%	462.24	214.86	0.465	26.2%	-25.5%	0.00
MRI pelvis, w/o contrast	265.79	19.99	0.075	28.3%	312.92	97.60	0.312	22.6%	-17.7%	0.00
MRI bilateral breast with CAD, w/o & w/ contrast	397.34	29.66	0.075	29.7%	372.54	156.38	0.420	28.9%	6.2%	0.32
MR angiography neck, w/o contrast	245.76	18.74	0.076	25.2%	318.65	103.55	0.325	20.1%	-29.7%	0.00
MRI lower extremity w/o & w/ contrast	389.81	29.27	0.075	28.1%	431.20	168.68	0.391	23.5%	-10.6%	0.09
MRI orbit, face, &/or neck, w/o & w/ contrast	389.10	29.21	0.075	28.2%	498.48	219.64	0.441	22.2%	-28.1%	0.00
MR angiography neck, w/o & w/ contrast	388.92	29.84	0.077	23.8%	500.75	169.18	0.338	18.4%	-28.8%	0.00

(continued on next page)

TABLE 3

Ultrasound exams

	Medicare	Medicaid	Comparisons							
(FROM MOST TO LEAST COMMON)	Mean global reimbursement rate ($)	SD ($)	CV	% of global reimbursement rate covering PC	Mean global reimbursement rate ($)	SD ($)	CV	% of global reimbursement rate covering PC	% difference in mean reimbursement rate	P valuebetween reimbursement rates
US abdomen, real time, limited	91.30	6.72	0.074	34.1%	73.83	16.24	0.220	33.9%	19.1%	0.00
US soft tissues, head and neck, real time	115.95	8.86	0.076	25.9%	82.17	19.96	0.243	29.3%	29.1%	0.00
US abdomen, real time, complete	123.26	9.06	0.074	35.1%	100.28	22.22	0.222	34.9%	18.6%	0.00
US breast w/ axilla, unilateral, real time, li *(FROM MOST TO LEAST COMMON)* mited	87.90	6.29	0.072	40.8%	72.74	22.47	0.309	39.5%	17.2%	0.00
US breast w/ axilla, unilateral, real time, complete	107.37	7.84	0.073	35.9%	88.51	27.43	0.310	34.5%	17.6%	0.00
US transvaginal	123.18	9.24	0.075	29.9%	92.92	24.28	0.261	33.0%	24.6%	0.00
US pelvic (nonobstetric), real time, complete	109.78	8.11	0.074	33.1%	87.43	19.38	0.222	34.3%	20.4%	0.00
US transrectal	157.09	12.10	0.077	22.9%	94.84	25.18	0.265	32.2%	39.6%	0.00
US joint, real-time, complete	77.99	5.54	0.071	42.6%	85.77	27.36	0.319	30.6%	-10.0%	0.05
US pelvic (nonobstetric), real time, limited	48.89	3.34	0.068	53.2%	49.53	13.84	0.279	41.8%	-1.3%	0.75
US abdominal aorta, real time, screening study	113.82	8.70	0.076	25.8%	83.95	30.33	0.361	28.1%	26.2%	0.00
US scrotum and contents	105.12	7.80	0.074	32.1%	79.09	23.29	0.294	36.3%	24.8%	0.00
US chest (includes mediastinum), real time	79.31	5.72	0.072	38.7%	69.71	18.31	0.263	33.8%	12.1%	0.00
US transplanted kidney w/ duplex, real time	156.31	11.95	0.076	26.2%	114.79	31.19	0.272	28.7%	26.6%	0.00
US pregnant uterus, real time, follow-up	113.53	8.16	0.072	39.5%	82.68	24.00	0.290	41.0%	27.2%	0.00
US transvaginal pregnant uterus, real time	96.11	6.87	0.071	41.2%	83.62	18.11	0.217	39.7%	13.0%	0.00
US pregnant uterus, real time, limited	84.33	6.10	0.072	39.5%	72.98	19.06	0.261	39.8%	13.5%	0.00
US elastography, parenchyma (i.e., organ)	107.88	8.20	0.076	28.1%	91.87	36.38	0.396	28.6%	14.8%	0.02
US pregnant uterus 1st trimester, real time	122.81	8.83	0.072	41.5%	101.03	27.40	0.271	43.1%	17.7%	0.00
US pregnant uterus post 1st trimester, real time	140.44	10.31	0.073	36.3%	114.26	28.45	0.249	37.9%	18.6%	0.00

TABLE 4

X-ray exams

	Medicare	Medicaid	Comparisons							
(FROM MOST TO LEAST COMMON)	Mean global reimbursement rate ($)	SD ($)	CV	% of global reimbursement rate covering PC	Mean global reimbursement rate ($)	SD ($)	CV	% of global reimbursement rate covering PC	% difference in mean reimbursement rate	P value between reimbursement rates
XR chest, single view	25.56	1.87	0.073	36.7%	20.55	11.09	0.540	41.8%	19.6%	0.00
XR chest, two view	32.67	2.40	0.073	34.3%	28.12	12.18	0.433	35.4%	13.9%	0.01
Screening mammography, bilateral two view w/ CAD	136.95	10.30	0.075	28.7%	111.61	43.95	0.394	29.3%	18.5%	0.00
Screening digital breast tomosynthesis, bilateral	55.38	3.74	0.067	55.5%	46.65	15.38	0.330	53.9%	15.8%	0.00
XR shoulder, complete, minimum of 2 views	32.97	2.49	0.076	29.6%	25.24	7.63	0.302	32.7%	23.4%	0.00
XR foot, complete, minimum of 3 views	32.60	2.48	0.076	26.6%	24.99	7.59	0.304	29.9%	23.4%	0.00
XR hip, unilateral, w/ pelvis, 2-3 views	45.02	3.44	0.076	25.7%	34.75	12.28	0.353	27.9%	22.8%	0.00
Dual-energy X-ray absorptiometry (DXA) study	39.34	3.00	0.076	25.8%	54.09	29.65	0.548	20.1%	-37.5%	0.00
XR knee, 3 views	38.96	3.00	0.077	25.0%	28.88	9.03	0.313	28.5%	25.9%	0.00
XR abdomen, 1 view	29.09	2.17	0.074	32.3%	25.09	11.09	0.442	33.0%	13.7%	0.01
XR lumbosacral spine, 2 or 3 views	37.96	2.84	0.075	30.5%	30.49	7.46	0.245	31.9%	19.7%	0.00
XR knee, 1 or 2 views	33.29	2.56	0.077	26.0%	24.97	7.26	0.291	29.2%	25.0%	0.00
XR knee, complete, 4 or more views	43.61	3.32	0.076	26.5%	32.24	8.96	0.278	30.1%	26.1%	0.00
XR ankle, complete, minimum of 3 views	34.72	2.66	0.077	26.0%	26.06	7.61	0.292	29.8%	24.9%	0.00
XR hand, minimum of 3 views	34.72	2.66	0.077	26.0%	25.44	7.79	0.306	29.7%	26.7%	0.00
XR wrist, complete, minimum of 3 views	38.60	2.99	0.077	23.4%	27.48	8.12	0.295	27.6%	28.8%	0.00
XR lumbosacral spine, minimum of 4 views	48.25	3.64	0.075	27.8%	42.49	11.87	0.279	32.2%	11.9%	0.00
XR pelvis, 1 or 2 views	28.37	2.12	0.075	31.8%	24.60	7.48	0.304	31.4%	13.3%	0.00
Diagnostic mammography, unilateral, including CAD	134.20	9.98	0.074	31.2%	108.44	42.66	0.393	30.7%	19.2%	0.00
XR cervical spine, 2 or 3 views	37.96	2.84	0.075	30.5%	29.15	7.70	0.264	33.1%	23.2%	0.00

ASHLEY NADEAU, MD *(MPH IN PROGRESS)*

- Co-chief resident in occupational medicine, HealthPartners Institute.
- MMA member since 2021.
- Grew up in Rochester, Minnesota. Undergraduate degree from Saint Olaf College, then worked at Mayo Clinic in research and development, basic science research, translational research, clinic, and cancer trials. Medical school at the National University of Ireland Galway. Post-graduate medical training in anatomical and clinical pathology at Penn State.
- Has a "fur toddler," a 3-year-old boxer mix, Duke, who lets her spoil him and keeps her on her toes.

Became a physician because…

As cliche as it sounds, I got the itch during sophomore year to choose a field that allows me to connect with people, absorb and apply knowledge, and approach the vulnerability of our humanity.

Greatest challenge facing medicine today…

Eliminating expensive and elaborate obstacles/barriers, rituals, and routines that do not lead to improved value or outcomes for patients or doctors. This is a huge subject, with side quests that are too numerous to go into details, but essentially we need to redesign the system to a better version.

How I keep life balanced…

It is awfully bold to assume my life is balanced as a resident. I attribute my balance to having a fantastic residency program director and colleagues who help me regulate, and a wonderful supportive family and friends. Also, keeping myself busy with traveling, volunteering, and having a great community and dog.

If I weren't a physician…

There was a time, when I was a little kid, that I wanted to be a marine biologist to study ocean creatures. Unfortunately, I was much better with mathematics, so I would say I would be a statistician had I not gone to medical school; I left my masters program in biostatistics early to pursue my medical degree. **MM**

Project ECHO®
Minnesota Medical Association

SAVE THE DATE

Project ECHO Transition Summit

Monday, March 13, 2023
317 on Rice Park event center
Downtown St. Paul
8:00 - 5:00pm

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