

THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

minnesota **MEDICINE**

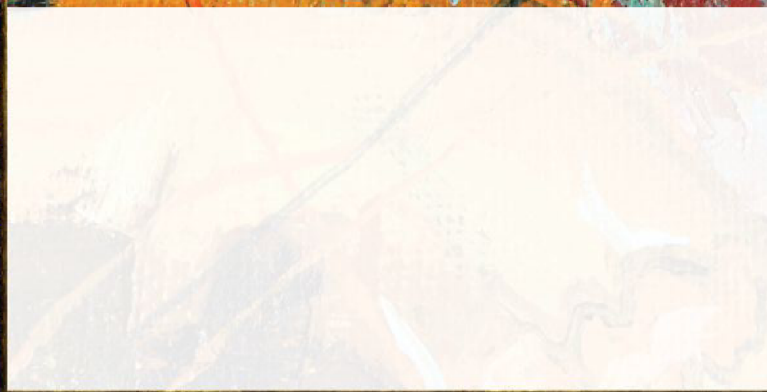
THE
ARTS
ISSUE

Is health care the
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selecting art for your facility

PLUS:

Writing and photo contest winners



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JULY 2012 VOLUME 95 ISSUE 7

JULY 2012

CONTENTS



PULSE

- 6 In brief**
Insights into mental illness, couture for a cause, a surgeon's shoes, health policy *haiku*.
- 8 Tales from "The Waiting Room"** | By Kim Kiser
The human condition meets the medical condition in a student production.
- 10 Small steps** | By Jeanne Mettner
The therapeutic benefits of dance.
- 12 Practical art** | By Kim Kiser
It's wearable, it's rideable, it's functional—and it's made by medical students.



WRITING CONTEST

- 26 Medical musings**
The call for entries for our ninth annual writing contest gave some the nudge they needed to put their stories on paper.
- 28 PHYSICIAN WINNER**
Better than this
| By Dave Dvorak, M.D.
- 30 STUDENT WINNER**
LOA
| By Annie Jespersen
- 32 HONORABLE MENTION**
The raising of Lazarus
| By Elizabeth Raskin, M.D.
- 56 HONORABLE MENTION**
Painted fingernails
| By Kimberly Schoonover, M.D.

CLINICAL & HEALTH AFFAIRS

- 38 Five Things to Consider When Selecting Art for Your Facility**
| By Gary Christenson, M.D.

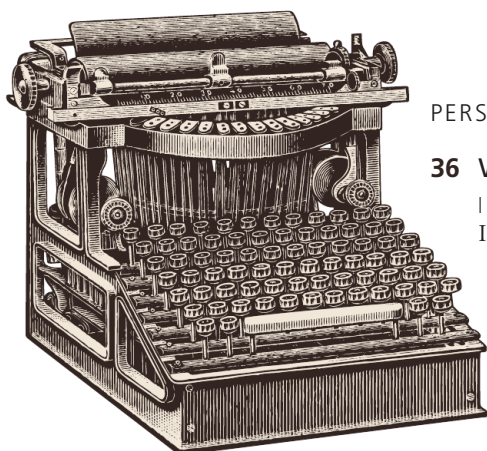
THE PHYSICIAN ADVOCATE

The MMA's monthly report on policy, people and politics

43

AT THE CAPITOL
Legislators call
for several studies

- 44 MEET A MEMBER
Maya Babu, M.D.
- 46 MMA IN ACTION
Happenings around the state
- 47 VIEWPOINT
Our value
- 48 VITAL SIGNS
MMA news in review



PERSPECTIVE

36 Where writing meets medicine

| By Kate Ledger
Insights from The Examined Life Conference

ALSO INSIDE

- 4 Editor's note
- 5 Letters
- 51 Index of advertisers
- 51 Employment opportunities

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Subscriptions

Annual subscription - \$45 (U.S.), \$80 (all international)

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Photo by Scott Walker

Good fiction can pull you into another universe, blocking out what is dim or disastrous in your life.

The power of fiction

In 1968, the United States was embroiled in the Vietnam War and I was enmeshed in organic chemistry. As my political and social beliefs crumbled, I memorized the arcana of alkenes and benzenes. My “orgo” professor would pace across the front of the lecture hall, filling the chalkboard with equations and chemical structures that we students dutifully and madly copied into our notebooks before he erased them for another round. The class was held early in the morning; but our inclination to nod off was forestalled by our fear of missing anything and by the occasional exploding experiments set off by the professor.

The year 1968 was truly all-consuming. I had little mental or emotional space for anything besides being a pre-med student and a confused college sophomore. Yet one day I picked up a book by William Styron that I didn't have to read for a class. *The Confessions of Nat Turner* was an elegant, lyrical historical novel telling the tale of the slave revolt led by Nat Turner. I remember lying on the couch in my dorm room turning page after page of Styron's classic while my orgo books languished on the table next to me. Styron's prose transported me to 1831 and dramatized the plight of the slaves and the mounting division within our country. Suddenly, Vietnam, orgo and my “identity crisis” faded into the background. With that book, I discovered the emotional power of fiction. I soon branched off into Thomas Wolfe, inhaling his flowing, poetic descriptions of the North Carolina mountains. Then I moved on to James Joyce, starting with the approachable *Dubliners* and *A Portrait of an Artist as a Young Man*

and tackling *Ulysses* the next year with the help of a literature course.

I still pursued my sciences with modest success and, though I questioned whether to pursue a career in medicine many times during my undergraduate years, applied and got accepted into medical school in 1970. I continued to struggle with my political and cultural beliefs. But my outside fiction reading somehow held me together and broadened my perspective during what was otherwise an unsettling time. Fiction reading is more than just a diversion such as watching a Twins game or doing a crossword. Good fiction can pull you into another universe, blocking out what is dim or disastrous in your life. Reading about the wider human condition makes your seemingly dire condition seem not so bad.

The last 50 years have ushered in the heyday of what has been termed “creative nonfiction,” which applies the art and techniques of fiction to true stories. Spearheaded by authors such as Norman Mailer and Tom Wolfe, real-life events come alive with dialogue and character development. The winning entries in our writing contest fit this genre as they nicely dramatize the intrigue some of us experience daily in medicine.

Recently, financial and professional travails have consumed my life, making each day a series of challenges surpassing anything I experienced in orgo class. Long talks with my wife help. A good night's sleep is a blessing. Now maybe I need to pick up Bill Styron again.

.....
Charles R. Meyer, M.D., can be reached at meyer073@umn.edu.



MMA Board overreached on marriage

I must say that I was quite surprised to see that the MMA Board of Trustees had adopted a policy on marriage. The author of “Marriage and Health Disparities” (May, p. 35), Peter Amadio, M.D., indicates rightly that “data documenting the health benefits of marriage specifically in same-sex couples remains limited.” Long-term and longitudinal data will take much more time to gather than one to two years, the amount of time same-sex marriage has been legal in certain states.

My father taught me that definitions are always of great benefit in discussions that are, in Dr. Amadio’s own words, “politically charged.”

I assume that the impetus to act before solid data and definitions are available was based on the upcoming ballot measure regarding the marriage amendment. The Board of Trustees has taken this step of adopting policy without consulting the membership of the MMA, and I feel that in doing so the Board overreached its mandate to represent Minnesota physicians to our legislators.

Greater clarity is needed, not less. Once marriage is defined, we can begin to determine the role it plays in the lives of the citizens of Minnesota. As a child, I was taught that all of the goods of marriage are for the benefit of the family, which is the primary cell of society. The

fact that these goods could benefit other groups of people does not mean that they are a right of every possible group.

James J. Joyce, M.D.
Sleepy Eye, Minnesota

Why I will vote against the same-sex marriage ban

When I was in medical school, my now husband and I lived with three men. Two were and are a couple and one was and continues to be involved with a wonderful man who divided his time between New York where we then lived and another state. We were all friends prior to living together. Sharing a kitchen and breaking bread together, we became a makeshift family.

My husband’s and my relationship paralleled that of our housemates I met my husband a few years before we began dating. After withstanding goading by mutual friends, we had dinner together at a restaurant and then later he graciously suffered through a meal I prepared. My aforementioned housemates watched in horror as I smothered the moderately edible meal with A1 sauce. I recall with fondness the stories my housemates told about their initial meetings and first dates. Our relationships followed fairly similar trajectories. We all had our first arguments; met parents, extended families, and each others’ friends; shared successes and grief; and had the “what is our relationship and what does it mean talks.” However, our paths sharply divided when my husband proposed to me.

My husband and I were able to legally codify our relationship because he is a man and I am a woman, and in New York state at the time (and in Indiana, where we legally married), that pairing was the only one accepted by the state. And so, in the midst of our joy, we were deeply angered and saddened by the fact that marriage was unavailable to our colleagues, housemates and friends.

A friend later told me her idea of marriage: In addition to the commitment that two people make to each other, the community makes a commitment to

guide and care for the couple. I can say that my husband and I survived our first year of marriage thanks in no small part to such support from our friends and family.

Shortly after we moved to Minnesota to start our residencies last year, we learned that New York had legalized same-sex marriage. We also learned that in Minnesota, an amendment to ban same-sex marriage would be put up for a vote. This juxtaposition had a powerful effect on us. My extended family includes people who would not have been allowed to marry and raise children were it not for the termination of the anti-miscegenation laws struck down by the Supreme Court in the late 1960s. To my husband and me, the same-sex marriage bans feel like our generation’s anti-miscegenation laws.

As new physicians, my husband and I are learning to evaluate research. We’ve found extensive quality literature that shows the health benefits of marriage. As stated in Dr. Peter Amadio’s article, the AMA and the MMA have developed policies recognizing that exclusion from civil marriage contributes to health care disparities affecting same-sex households. His commentary nicely lays out some of the evidence that the AMA and MMA reviewed as they formed their policies.

My grandfather, who just turned 86 years old this month and who has been married to my grandmother for “decades upon decades,” says none of us choose who to love. It just happens. Please join me in voting “no” in November. All Minnesotans should have the freedom to love and to formalize that love in marriage.

Calla Brown, M.D.
Resident, University of Minnesota

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Send your comments to
cpeota@mnmed.org.



The audience laughed, cried and cheered during a performance of "Minds Interrupted."

■ Theater

Insights into mental illness

Seven Minnesotans took the stage at the History Theater in St. Paul on a Monday evening in June to help tear down the stigma associated with mental illness—one story at a time.

One man described for the audience of more than 500 what it's like to hear voices 24/7. A woman shared her experience with bipolar disease, explaining that "when you're manic or depressed, there is no moderation in life." Another talked about how her mother suffers from paranoid schizophrenia and how she feels "like the doctors practice medicine and my mother is their guinea pig." Others told how writing, dance and music have helped them cope with their illness or that of a loved one.



Heidi Nordin rehearses her story.

Their insights were the focus of "Minds Interrupted: Stories of Lives Affected by Mental Illness," which was co-produced by the National Alliance on Mental Illness (NAMI) of Minnesota and the Compassionate Touch Network.

Minds Interrupted was created by two New Mexico women who wanted to use their own experiences to help others understand what it's like to live with mental illness. Since 2007, they have worked with individuals involved in NAMI programs throughout the United States to craft eight-minute monologues and bring them to the stage.

The June performance was the Minnesota premier.



■ Fashion design

Couture for a cause

For the second year, the fields of health care and design came together to elevate the lowliest of garments—scrubs—to the fashion runway. At an event billed as "Scrubbed into Fashion: Africa," University of Minnesota medical and dental students modeled clothes made from scrubs by design students.

The event is the brainchild of fourth-year medical student Phillip Radke, who last year came up with the idea of having a "Project Runway"-like contest to benefit medical missions. This year's show, which was held in April, raised more than \$12,000 for Smile Network International, a Minnesota organization that provides reconstructive surgeries for poor children and young adults in developing countries.

The winning creations and their designer Mai See Her. Models from left to right are dental hygiene student Nellie Pooler and dental students Alyssa Werner and Tyler Geyen.



Photos by Richard Fleischman

Photo courtesy of Phillip Radke

check this out

Eyes glaze over when you see a lengthy article on health care policy? Perhaps you'd be more interested in smaller daily doses of information delivered as *haiku*.

Since January, the Kaiser Daily Health Policy Report (www.kaiserhealthnews.org/Daily-Report) has included a 17-syllable poem. Editor Stephanie Stapleton says the staff were looking for ways to engage readers when they came up with the idea for the daily *haiku*. Most are written by readers.

"Sometimes they're really cutting, sometimes they're really poignant, sometimes they're laugh-out-loud funny," she says. Here's a favorite:

Ode to ICD10

Dolphin bite, space junk

Skis in flames, parrot attack

There are codes for those

— Anonymous

Research

OK to crank up the tunes

We know cell phones distract drivers. But a recent study from the Netherlands explored whether a decades-old distraction does. Drivers everywhere will be happy to learn that listening to music does not.

Researchers tested 69 subjects in a driving simulator. All reported their mental effort while driving, and the researchers measured how well the drivers performed both in complex and monotonous situations. Those who listened to music did as well as those who drove in silence, although they said it required them to exert more mental energy. No word on what kind of music was used in the test or how loud it was played.

Source: September 2012 issue of *Accident Analysis and Prevention*.

Medical history

A surgeon's shoes

Among the objects on display in the tiny museum known as the Hennepin Medical History Center is a pair of tattered white oxfords belonged to Samuel G. Balkin, M.D., a plastic surgeon who was on the staff at Swedish and Mt. Sinai hospitals in Minneapolis in the middle part of the last century (the hospitals are among those that eventually merged to become Hennepin County Medical Center).

Balkin's shoes were somewhat legendary, according to Ruth Rosen, R.N., who worked with him at both hospitals. "He always wore them in surgery," she says. And according to his daughter, a



Shoes belonging to Minneapolis surgeon Samuel Balkin, who lived from 1906 to 1973.

group of nurses eventually removed them from his locker, mounted them on a plaque and presented them to him.

Balkin's shoes and other artifacts, historical documents and photographs from former Minneapolis hospitals are on display at the museum, which is located in the lower level of Hennepin County Medical Center in Minneapolis. For more information about the collection, go to www.hcmc.org/medcenter/historycenter/index.htm.

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Jacob Feigal, a recent University of Minnesota Medical School graduate, describes how caring for a young boy in an HIV clinic in Tanzania changed his perspective on the disease.

about the medical condition described in the story the audience just heard, conditions such as post-traumatic stress disorder, HIV/AIDS and cystic fibrosis.

Park says the idea for the performance grew out of his love for film and medicine. After earning a degree in psychology from the University of Minnesota and taking film classes at the Minneapolis College of Art and Design, he went to New York to figure out whether he wanted to become a filmmaker or a doctor. While there, he came across a book by author Joan Didion. “The first line of her collection of essays called *The White Album* is ‘We tell ourselves stories in order to live.’ I realized then that medicine and film overlapped in my love for stories,” he says.

Although he ended up pursuing medicine, Park did not lose his love for storytelling. He got inspired after attending a production of *The Moth Radio Hour* at the Fitzgerald Theater in St. Paul last fall. “I watched the stories told live, and it had a profound effect on me,” he says. “At the time, I was just starting my rotations and was flooded with all these great stories from docs, classmates, patients, that were so personal. It made the light bulb go on.”

Working with Hippocrates Café Productions, a venture of University of Minnesota assistant professor Jon Hallberg, M.D., Park assembled the five storytellers for the live reading, which was recorded and is being prepared for release as a podcast.

Park, who will spend the next academic year earning a master’s degree in public health before starting his final year of medical school, is planning another production later this summer. “What makes this special is the unique lens we bring to every story,” he says. **MM**

To learn more about future productions and how to share your story, check out “The Waiting Room” on Facebook or contact Brian Park at brian.jh.park@gmail.com.

Photos by Jay Lansford

■ Storytelling

Tales from “The Waiting Room”

The human condition meets the medical condition in a student production. | BY KIM KISER

Five storytellers recently gathered at the Mill City Clinic in Minneapolis to share their experience of being a patient or caring for one with an audience of friends and family members—as well as potential listeners from around the world.

Between each reading, host Brian Park, a third-year University of Minnesota medical student who conceived the event, called “The Waiting Room,” presented a few facts



Brian Park



A patient and caregiver take part in the Parkinson's Dance, a program designed specifically for people with Parkinson's disease.

bility explore movement. This morning, they do kicks while seated, tap their feet, move their arms, and perform a flamenco dance. "The goal is to encourage an interactive experience and to socialize; many participants tell me that this class is one of the things they look forward to all week," says Erin McGee, outreach coordinator for the Capistrant Center.

Therapeutic benefit

The weekly dance class is not therapy, nor is it intended to help patients achieve measurable health outcomes or even to improve function. Rather, it helps them find ways to express themselves, says Suzanne Costello, artistic co-director of Stuart Pimsler Dance and Theater in Minneapolis, which has held similar classes for people with Alzheimer's disease and other forms of dementia, stroke survivors and those with other chronic conditions at Mayo Clinic in Rochester, North Memorial Medical Center in Robbinsdale and in several other cities including Columbus, Ohio; Torrance, California; and Chattanooga, Tennessee. "That is not to say that there isn't therapeutic benefit, because there is," she adds.

Indeed, some evidence points directly to the benefits of arts programs that include dance. In the landmark Creativity and Aging Study published in *Geriatrics* in 2006, Gene Cohen of George Washington University's Center on Aging in Health and Humanities examined the effects of arts participation on adults age 65 and older in Washington, D.C.; Brooklyn, New York; and San Francisco. At the 12- and 24-month marks, those who participated in arts activities—including painting, pottery, dance, music, poetry and drama—reported better health, fewer visits to health care providers, less medication use, improvement in mental health and more social involvement than those who were in a control group. In June 2003, the *New England Journal of Medicine* published results of a study on leisure activities and risk of dementia in

Photo by Kathryn Foriss

■ Participatory arts

Small steps

The therapeutic benefits of dance. | BY JEANNE METTNER

On a sultry Friday morning in May, a windowless banquet room in the Maplewood Community Center is transformed into a dance hall. Chairs are placed in a circle in the middle of the tile floor. In one corner, a man plays a jazz tune on a digital piano. Two dance instructors mingle with students before the start of the 60-minute lesson. Finally, the students—people with Parkinson's disease and their caregivers—take a seat and begin stretching and moving to music

ranging from Pachelbel's *Canon* to *The Charleston*. Smiles abound.

Welcome to Parkinson's Dance, a weekly event sponsored by HealthEast's Passport Program and the Capistrant Center for Parkinson's Disease and Movement Disorders at Bethesda Hospital in St. Paul. Modeled after the Dance for PD program produced by the Mark Morris Dance Group in Brooklyn, New York, the class uses specially trained dance instructors to help participants with limited mo-

“The classes allow people to be creative and successful in the moment.”

—Maria Genné, Kairos Dance

the elderly. The research team, led by Joe Verghese at Albert Einstein College of Medicine, found that among 469 adults 75 years of age and older, participation in activities such as reading, playing board games, playing musical instruments and dancing was associated with a reduced risk of dementia. Interestingly, of the nine “physical” activities analyzed (including doing housework, swimming, walking and bicycling), only dancing was associated with the reduced rate of dementia.

Something about dance

Dance often is being combined with other activities. At North Memorial Medical Center, for example, Costello and her team developed a class for stroke survivors that involved not only dance and movement but also writing and storytelling. In one session, instructors asked participants to write down (or have their caregivers write down) their memories of the exact moment they had their stroke. After describing the feelings connected to that memory, participants then worked with instructors to translate their emotion into a nonverbal gesture, which eventually led to more creative movement. “Because we come from an artistic focus rather than a therapeutic focus, it was interesting for us to have them find some expression for the moment of change in their life,” Costello says. The company has applied for a grant to offer the class at other sites in the Twin Cities. Although they didn’t measure outcomes, “there were beautiful stories that came out of that program,” Costello says. “One woman was in a wheelchair, not able to move, and by the end of the six-week program, she was out of her wheelchair.”

For the Dancing Heart program developed by Kairos Dance Company in Minneapolis, which was piloted at six long-term care facilities in the Twin Cities, instructors chose a theme (for example, weather) and then explored it during the class using music, movement and storytelling. Researchers from St. Catherine University in St. Paul studied how the program affected participants, some of whom had had strokes or heart attacks or were living with Parkinson’s or Alzheimer’s disease. Data gleaned over 36 weeks indicated they saw improvement in balance and stabilized memory and depression scores. Participants and their caregivers also reported increased socialization, improved “physicality” and an enhanced sense of personhood.

“There are interesting theories being investigated as to why dance is effective—we may be helping create new neural pathways,” explains Maria Genné, artistic director at Kairos Dance. “But one of the revealing things from the St.

Kate’s research—and one of the reasons I believe the classes are successful—is that they allow people to be creative and successful in the moment; there’s a timelessness about it.” Kairos is currently offering classes at Fairview Ridges Hospital, Park Nicollet’s Struthers Parkinsons Center and Carondelet Village in St. Paul.

All about the fun

When the Friday morning Parkinson’s Dance draws to a close, instructor Marsha Ovitz has participants stand up and hold hands. Silently, she turns and bows to the dancer next to her, who returns her bow before turning and bowing to his own dance partner. The gesture is passed along to each person in the circle. It’s a simple-but-powerful ritual that seems to further bind the participants. “In the medical model, we so often push physical therapy, push rehab, push ‘get better.’ Here, we’re having fun and enjoying dance,” McGee says. “It’s making a big difference in the quality of participants’ lives.” **MM**

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Katie McKenzie shows off the dress she made.

Wearable art

The night of the awards celebration, Katie McKenzie stood by a dressmaker's form, on which a purple-and-blue dress with a fitted bodice and ruffled collar was displayed. The dress is her own creation—she painted and dyed the fabric and made it into the garment.

McKenzie, a third-year student who is finishing the Rural Physician Associate Program in Owatonna, has been sewing since the first grade. "I love to buy fabric and find pieces that speak to me," she says.

When she applied for a Fisch award, she did so with the idea of learning more about screen printing. But her plans changed after she met Dr. Fisch. She mentioned that she enjoyed the printing process but didn't like having to create images to print. He suggested she learn to paint or dye fabric instead. "He told me he had worked with fabric early on. He painted it like a canvas," she explains.

McKenzie used the award money to take classes in fabric dyeing and surface design at the Textile Center in Minneapolis. For her project, she bought white cotton fabric and painted it with blue, green and purple dyes, then sprinkled salt on it to create a textured look. "I knew I wanted to make a wearable garment, so I washed it and put it in the dryer to set the paint." But when she pulled the fabric out of the dryer, the bright jewel tones had faded. Not knowing what else to do, she combined her leftover dyes and let the fabric sit in the concoction overnight. It produced the deep purple tone. "I washed it the next morning, and it turned out to be lovely. I was pleasantly surprised."

She chose the dress pattern for its cut and for the ruffled collar, which shows off the patterns she created on the fabric. McKenzie says she's waiting for the right occasion to wear the dress. "The first big decision was cutting the fabric," she says. "Because then I was committed to making it into the dress. The next is deciding where to wear it."



Photos by Libby Frost, University of Minnesota

■ Fisch Awards

Practical art

It's wearable, it's rideable, it's functional—and it's made by medical students.

| BY KIM KISER

For the last five years, a few lucky University of Minnesota medical students have received monetary awards to use in pursuit of an artistic interest. This last year saw more than 40 applicants—the most ever—for the Fisch Art of Medicine Student Awards, named for retired pediatrician and artist Robert Fisch, M.D., who established the fund that launched the awards. The 10 recipients included painters, potters, pianists and performers. At a program honoring their accomplishments at the Mill City Clinic in Minneapolis in April, a few stood out for their more functional forms. Here are their stories.



LEFT: Juan Reyes Genere talks about building the wheels for his bicycle.
BELOW: Andrew Merryman describes the joinery he's using on the dresser he's building.



Rideable art

Biking became a passion for Juan Reyes Genere after he transferred to the University of Minnesota from the University of South Dakota as an undergraduate. “I found biking was a good way to get around,” he says. “Then I got into the bike culture.” Minneapolis has shops, cafés and trails all catering to bicyclists, which contributed to its designation by *Bicycling* magazine as the top city in the United States for riders.

But for Genere, who recently finished his second year of medical school, riding wasn't enough. He wanted to build his own bicycle. Using a 1970s-vintage frame and used parts, he constructed a single-speed “fixie” (with fixed gears, the pedals never stop moving). “I built it from the ground up with the exception of the wheels,” he says. But he still wasn't satisfied. “I had used my hands to put together every other part of that bike but felt disconnected from the wheels,” he says.

He applied for a Fisch award with the idea of learning to build wheels and used the funds to take classes from the wheel builders at Freewheel Midtown Bike Center in Minneapolis. “They showed me the basic anatomy of a wheel and taught me the physics of a wheel and then showed me the technique of how to build it,” he says.

Genere then took a different bike—his old nine-speed that, he says, is better for riding longer distances, stripped it and powder coated it bright orange. He built the wheels using a tangential spoke pattern, in which each spoke crosses three other spokes to give it strength to handle the greater load when the rider pedals.

Genere rode the bright orange bike to the awards ceremony. He says the wheel-building experience gave him insight into the importance of having interests outside of medicine and a greater appreciation for physics. “I found there was a lot more physics involved than I could comprehend,” he says.

Functional art

After returning from a 16-month deployment to Iraq in 2007, where he served as a medic with the Red Bull Infantry Division, Andrew Merryman turned to woodworking as an outlet. “Over there, things are taken care of for you—your bills are paid, someone grocery shops for you, your laundry gets done. But when you come back, you suddenly have all these responsibilities and the adjustment to cope with,” he says. “It gave me much-needed stability in a world I couldn't control.”

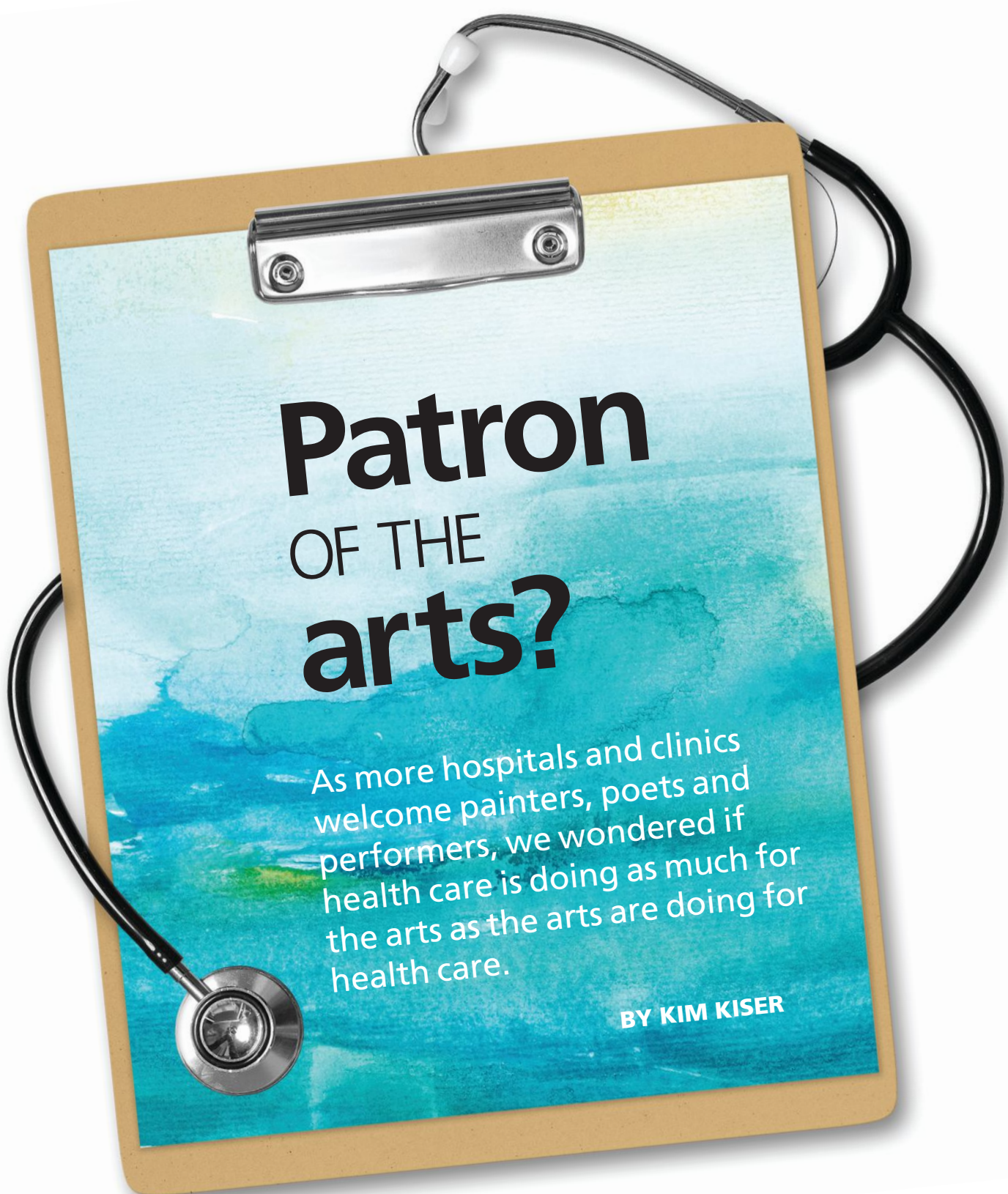
Working in his garage, Merryman, who finished his second year of medical school this spring, started making smaller pieces—jewelry boxes and end tables. But time, money and space limited what he could do.

Merryman applied for a Fisch award with the idea of taking on a bigger, more complex project. “I wanted to make an actual fine piece of furniture and make it how it used to be made,” he says. His plan was to construct a 70-inch-long dresser using wood-wood joinery—sliding and interlocking dovetails.

Merryman used the money for materials and to join North Country Woodshop in Burnsville, where he has access to the tools he needs, more space than in his garage, and advice and guidance from professionals.

At the awards program, Merryman shared photos of his project and examples of the types of joinery he used. He says he is about a third of the way finished with the dresser, admitting that between medical school and boards, he hasn't been able to devote much time to it lately.

Even so, he says that woodworking provides him a sense of accomplishment. He notes that it will be years before he sees the fruits of his academic labors. Of going to the wood shop, he says: “It makes me feel like I'm making progress in my life.” **MM**



Patron OF THE arts?

As more hospitals and clinics welcome painters, poets and performers, we wondered if health care is doing as much for the arts as the arts are doing for health care.

BY KIM KISER

For the last decade, *Minnesota Medicine* has done an annual issue on medicine and the arts. When we started, it seemed interest in exploring the relationship between the arts and medicine was a new phenomenon. We stretched to find examples of programs or efforts in Minnesota to illustrate our idea that there were points of intersection. Now, as the examples in this article show, the arts are everywhere in health care—and research is starting to prove their value. Artists, physicians, therapists and health care administrators have even formed their own organization, the Minnesota Arts in Healthcare Network, to find new ways to integrate the arts into health care settings.

All this has prompted us to wonder: Has health care become the latest patron of the arts?

We asked representatives from the arts community and from health care organizations to share their thoughts on this as well as whether they feel the incorporation of the arts into health care is here to stay. Here's what they had to say.

My belief is that the relationship between the arts and health care is one of partnership rather than patronage. I think the arts work with health care to treat the whole person. At their roots, they have the same purpose: the healing of the indi-

“The relationship is one of partnership rather than patronage.”

vidual. I've been researching what facilities are doing around the country, and they're starting to measure how the arts help patients—for example, they don't need as much pain medication. The arts also support the hospital staff, reducing stress. Those are all reasons I think of the arts as being a partner to health care.

If health care decided to stop incorporating the arts, it would be like the medical community deciding to stop believing in microscopic organisms. Once you know what you know, you know it. There's too much evidence now that shows not only how the arts help the patient and the families and staff but also how they can save money.

CANDICE SIMPSON
Visual artist

Her work can be seen at Health Foundations Birthing Center in St. Paul; Roberts Medical Clinic in Roberts, Wisconsin; and PrairieCare Hospital in Maple Grove.

Photo courtesy of Fairview Red Wing Medical Center



Fairview Red Wing Medical Center (now part of Mayo Health System) has partnered with the Sheldon Theatre to present an **Arts for Your Health** series. In April, violinist Chad Hoopes (pictured) performed in Fairview's Garden View Café and for patients in the hospital's units. Others who have performed there include pianist Butch Thompson, the Mu Daiko drum group and the Sheldon Theater Brass Band. The medical center also works with the Red Wing Arts Association to bring the work of local artists to its cafeteria.

Although it might seem as though health care has become the latest patron of the arts, it was really one of the first. Before we understood microbes, anatomy and physiology or had the procedural, pharmacological and technological tools that derive from such knowledge, medicine was very much enhanced by ritual characterized by music, dance, magical drawings and convincing tales that promoted healing. Health care is simply rediscovering that we are artistic organisms that are bound to create and express through myriad artistic behaviors. If we truly embrace a holistic view that considers all aspects of health including body, mind and spirit, then art must also be considered.

However, there is still significant progress to be made. As great art and health programs are born, other long-established programs are closed down. Art is too often demoted by health care to the role of decoration, amusement or luxury, while its power to motivate, soothe, comfort and heal is ignored. When song helps an aphasic

to speak, dance restores movement in Parkinson's disease and the process of painting provides an outlet for a patient to express fear and anxiety when faced with a debilitating

“Health care is simply rediscovering that we are artistic organisms.”

illness, doctors should take pause and consider that perhaps prescribing some art might make for a better prognosis.

GARY CHRISTENSON, M.D.

Chief medical officer,
Boynton Health Service, University of Minnesota
President, Society for the Arts in Healthcare



Photos courtesy of Candice Simpson

Hudson Hospitals and Clinics in Hudson, Wisconsin, has a partnership with the Phipps Center for the Arts through which artists from the region display their works throughout the hospital.

These works by visual artist Candice Simpson were included in a recent traveling exhibit.

The Guthrie Theater has partnerships with Mayo Clinic, HealthPartners and Children's Hospitals and Clinics of Minnesota. In May, the Guthrie hosted a Mayo Clinic conference on depression and mania that featured a performance of *Stopping Traffic*, a one-woman show about actress Mary Pat Gleason's struggle with bipolar disorder. Last month, the theater worked with HealthPartners to present *Play What's Not There*, a play by gerontologist William Thomas, M.D., about the need for balance in a physician's life. The first Saturday of each month, the Guthrie and Children's present *The Hero's Journey*, a program that uses storytelling to help young people who



Photo courtesy of the Guthrie Theater

have recently been discharged from the hospital. The photo above shows participants from one of those sessions.

Hospitals and clinics are coming to understand what many of us in the arts have known for a long time: that the arts are for everyone, not just the well-to-do and the well-dressed. And the power of art doesn't happen in just a museum or concert hall. Our work in health care and healing settings has shown that people can become better physically when they are surrounded by—or better yet, when they create—art that calms, inspires and helps them see things and themselves in a different light. Be-

“People can become better physically when they are surrounded by art.”

cause health care facilities often don't have funds for art and arts programs, they rely on partnerships with organizations like ours to help garner funding from private sources who understand and believe that treating the whole person isn't the same as just treating the disease.

BOB OLSEN
Executive director, COMPAS

COMPAS brings performers and artists to Children's Hospitals and Clinics of Minnesota and the Penny George Institute for Health and Healing.

“We must continue to advocate for the value of art.”

The health care system still struggles with the value of the arts. However, more and more, people are learning to appreciate the human development that comes from music and arts participation across the lifespan. We must continue to advocate for the value of art—for the artistic expression, joy and the extrinsic benefits it brings to our own individual and community development. The health care system is starting to become a player in the world of arts patrons, but it is far from replacing the current benefactors.

PAUL BABCOCK
President and chief operating officer,
MacPhail Center for Music

MacPhail is working with Children's Hospitals and Clinics of Minnesota.



Photo courtesy of Mayo Clinic

Mayo Clinic makes professional artists, musicians and writers available to patients through its Humanities in Medicine program. Here, Brian Sampson, a member of the Lyle, Minnesota, group Six Mile Grove, performs on one of the units. In addition, the Rosemary and Meredith Willson Harmony for Mayo program sponsors free concerts at Mayo every Monday.

In the 1980s and early '90s, when I was a health care management consultant, the arts weren't much on the radar. Artwork was seldom in the budget for clinic facilities. The arts have certainly become more integral to health care. And as it is demonstrated through outcomes research that the arts do indeed play an important role in healing and wellness, I believe their role will continue to grow.

Numerous health care facilities have developed truly nurturing and healing environments with skillful use of art and design. However, art for art's sake is not in and of itself healing; there is an entire profession that has arisen from the need for experts who truly understand how to create a healing environment.

“Art for art's sake is not in and of itself healing.”

Certainly, the arts are valued in health care. Many health care organizations collaborate brilliantly with artists in exhibitions, offering authentic opportunities for promotion of the artist and the sale of their works in exchange for a meaningful exhibition. But from my perspective as an artist, I see examples of artists themselves sometimes being undervalued in that their work is desired but adequate compensation for the work is not offered due to a lack of budget—in which case they are solicited for donations for facilities or fundraisers, asked to deeply discount their pricing, or invited to exhibit at a facility purely in hopes of making a sale.

LESLIE PILGRIM

Visual artist, writer, director of communications for the Midwest Arts in Healthcare Network

Her pieces are on display at HealthPartners and Allina clinics and the Phillips Eye Institute.

“Creative expression can aid in recovery.”

As health care in the United States continues to evolve, providers are becoming increasingly convinced of the important role the arts can play in the healing process. Visual artists such as myself are being regularly commissioned to create art that will brighten the walls of medical facilities because it makes the space more comfortable and, therefore, more conducive to healing. Musicians and actors are being hired to perform in medical lobbies and waiting areas because it reduces patient anxiety and contributes to a better overall health care experience. Hospitals and

long-term care facilities are also finding that hiring artists to teach patients various methods of creative expression can aid in recovery.

KAROLYN STIREWALT

Visual artist

Her work can be seen at Gillette Children's Specialty Health Care, Boynton Health Services, and J.A. Wedum Residential Hospice. She also paints for patients at Pathways Health Crisis Resource Center.



Photo courtesy of Children's Hospitals and Clinics of Minnesota

In November, Children's Hospitals and Clinics of Minnesota celebrated Arts and Health Month. As part of the celebration, artists from COMPAS came to Children's Minneapolis and St. Paul facilities to do a community art project with patients and their families.

I am excited and encouraged by the momentum around the arts and health care. This way of connecting across sectors and treating patients holistically is a positive sign for both the arts and the medical field. For artists, it's an important way for them to contribute something of value to their community and also an important source of support and income.

“Connecting across sectors is a positive sign for both the arts and the medical field.”

I do wish that the issue of artists' health care was more integrated into the conversation around the arts in health care. The vast majority of artists who work in partnership with hospitals and clinics are doing so as contract employees. It would be wonderful to see those hospitals and clinics take the lead in ensuring that the artists doing this important healing work have access to high-quality health care themselves. Artists in Minnesota are twice as likely to lack health insurance as the general population, and there is a great opportunity for the arts in health care movement to build partnerships of reciprocal benefit between artists and health care providers.

LAURA ZABEL

Executive director, Springboard for the Arts

Springboard is an economic and community development agency for artists.

“We see the arts as a patron of healing.”

Rather than view health care as a patron of the arts, we see the arts as a patron of healing. The goal is to promote healing, not the arts, however noble the latter goal may be. In actuality, our arts and healing project, which brought the arts into an extensive renovation and expansion of Children's Hospitals and Clinics of Minnesota's Minneapolis and St. Paul facilities, is funded by private philanthropy, corporate and state grants. So if anyone is the financial patron of the arts, it is our community. Given the overwhelmingly positive results of our program so far, we believe the healing power of the arts is an important development. We built a research and evaluation component into our program, and as more research results become available and as long as we keep seeing positive outcomes, we expect this trend will spread and flourish.

THERESA PESCH, R.N.

Vice president of development, Children's Hospitals and Clinics of Minnesota; executive director, Children's Foundation

Children's has partnerships with COMPAS; MacPhail Center for Music; the Minneapolis Institute of Art; the Children's Theater Company; the Guthrie Theater; Minnesota Children's Museum; and the Science Museum of Minnesota.

The University of Minnesota's Boynton Health Service has long incorporated the work of local artists into its facility. Painter Karolyn Stirewalt created this and other pieces that are mounted on ceiling tiles in exam rooms.



Photo courtesy of Karolyn Stirewalt

The French physician Ambroise Paré is credited with the aphorism “The task of medicine is to cure sometimes, to relieve often, and to comfort always.” Science is pre-eminent in the world of medicine; but when science falls short, the art of medicine provides comfort and more.

The incorporation of art into health care has been evolving for nearly a century in Rochester, longer in other locations. The first Mayo

Recognition of a role for the arts in health care is increasing, but for it to be more widely accepted, more and better research is needed regarding its benefits.

PAUL SCANLON, M.D.

Director of the Center for Humanities in Medicine, Mayo Clinic

“Expenditures for art can be a sensitive issue.”

Clinic building, completed in 1914, was a Greek revival designed by the firm Ellerbe and Rounds in conjunction with Dr. Henry Plummer. It had Tiffany glass skylights and Rookwood tile accents. In *Twenty-Eight Years at the Mayo Clinic*, Dr. Leda Stacy wrote, “Dr. Plummer thought it ought to be beautiful in its exterior and interior aspects, for he felt that perhaps in many instances the patients and their relatives would be surrounded by architectural beauty for the first time and would thus be helped to find some measure of peace and solace while waiting for their appointments with the physician.”

Mayo Clinic has since adhered to that philosophy. The practice of exhibiting a permanent art collection began in 1955. The Center for Humanities in Medicine evolved from a series of theatrical performances by Jason Robards and friends in the 1980s and now provides lectures, musical performances, art exhibits, and theater and dance performances.

Expenditures for art can be a sensitive issue, particularly when funding for clinical practice, education and research is tight. For that reason, most of the finest art is funded or donated by individual benefactors.

This fall, the University of Minnesota Amplatz Children's Hospital will launch an artist-in-residence program. Those chosen for the residency will work with children recovering from cancer and participate in community outreach activities.

More than 25 years ago, as a community musician working in nursing homes, I was told to disguise the phrase “healing effects of the arts” in my grant applications to arts organizations. Now, the same funders are encouraging the intersection of arts and health. Times have changed.

Bethesda Hospital has become a learning lab for the arts in health

“Funders are encouraging the intersection of arts and health.”

care. We have a vibrant therapeutic recreation program that supports patient participation in art initiatives, and we have experimented with a variety of art forms and community partners to discover what works or doesn't work. For example, Northern Clay Center and COMPAS both piloted artist residency programs at Bethesda. They worked with a variety of patients including those with traumatic brain injury, Parkinson's disease, and geriatric behavior and complex medical issues. Programs involved use of clay, dance, writing and the visual arts. Learning from this experience, these organizations have developed larger programs that serve hospitals, nursing homes and senior centers.

Arts programs easily get seed money from grants. But then they need to identify new sources of funding to sustain and grow their commitments. The arts in health care depend on the generosity of donors. Potentially, the arts may save dollars by reducing patients' need for pain medication. But more research is needed to monitor and document those benefits. This is the next phase for Bethesda, as we are now seeking to evaluate whether our new music intervention program for patients on ventilators leads to decreased use of medication for anxiety and earlier weaning. **MM**

BOB PAYTON

Collage artist, musician, therapeutic recreation specialist, HealthEast Bethesda Hospital

Kim Kiser is an editor of *Minnesota Medicine*.




Call for Papers

Minnesota Medicine invites contributions (essays, poetry, commentaries, clinical updates, literature reviews, and original research) on these topics:

- Finding Common Ground: What Unites MDs in an Age of Specialization?** | Articles due July 20
- Genetics** | Articles due August 20
- Health Care Delivery** | Articles due September 20
- Food and Nutrition** | Articles due October 20

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



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Mark Your Calendar!

A Thousand Words

Winners of our second annual photography contest.

What makes a good photograph?

To St. Paul photographer Steve Wewerka, it first has to be technically sound—the lighting, framing and structure need to work. But photographs that go to the next level do more. “They capture a moment, so that the picture has a sense of poignancy.”

Wewerka says creating that kind of image requires having both the ability to see beyond the obvious and the willingness to take extra steps—to look for the right angle, anticipate an action, wait for a moment and make decisions about what to exclude.

The winning images in *Minnesota Medicine’s* second annual photography contest show such effort and forethought. We received 30 entries this year. Our art director Kathryn Forss and Wewerka judged them. Here are their top picks and a few of Wewerka’s comments about what made them winners.

Steve Wewerka’s photography can be seen at www.stevewewerka.com.



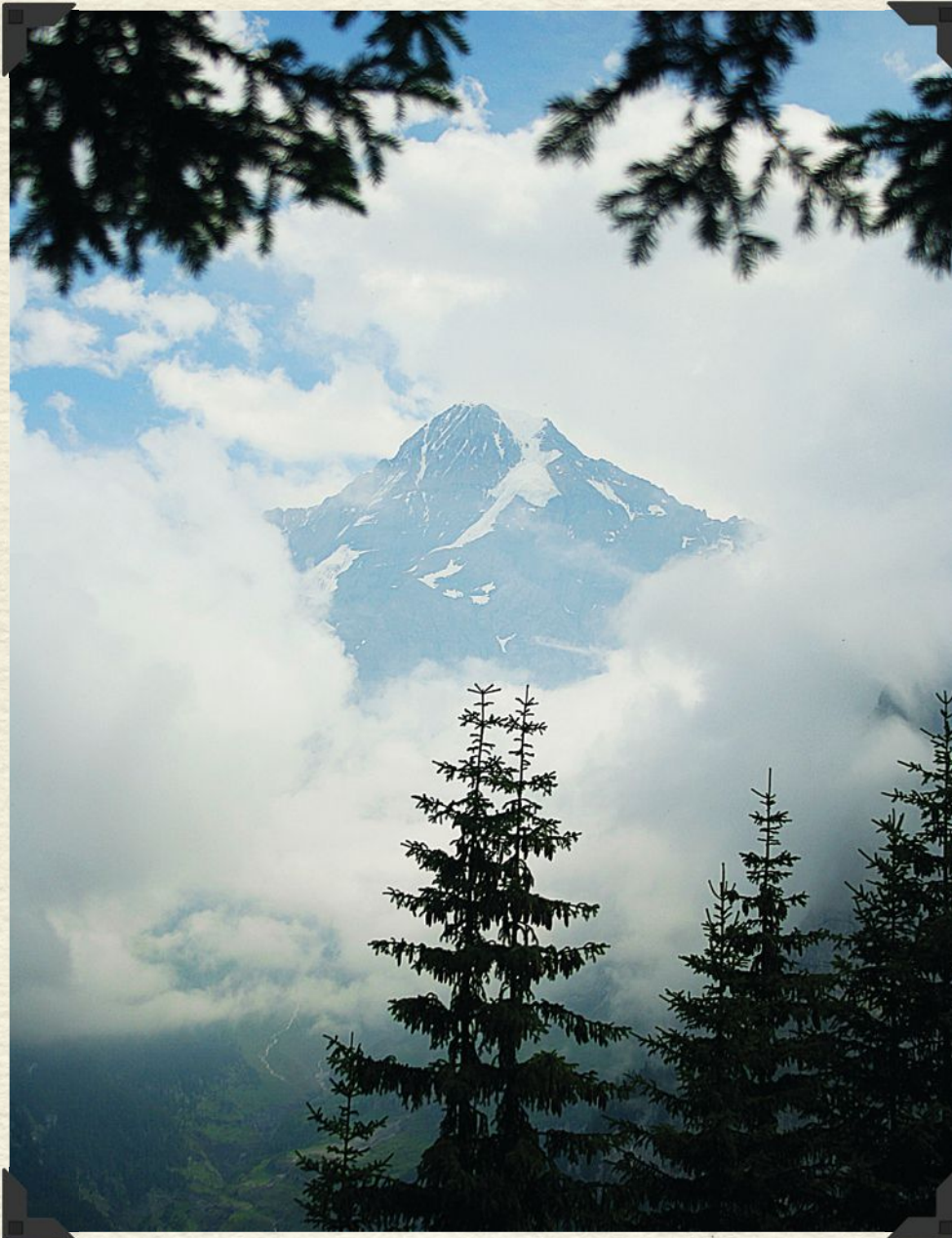
1st Place

Boy and birds in flight in fog

LISA ERICKSON, M.D.

WHAT INSPIRED THIS PHOTO? The mystique of the foggy day at Captiva, Florida. It allowed for no depth of field, no horizon and nice natural effects.

WEWERKA: *The photographer took the time to be aware of what was happening around her—the flock of birds gathered, the boy and the fog—and waited for the right moment. The image follows the rule of thirds, which always makes for a successful photograph. It essentially has three elements—the beach, the boy and the birds.*



2nd Place

Jungfrau Peak in the Swiss Alps

TIMOTHY JAY, MEDICAL STUDENT

WHAT INSPIRED THIS PHOTO? The clouds opened up at the perfect time, allowing a great view of Jungfrau Peak.

WEWERKA: *This photograph is successful because of the way the photographer framed the mountaintop with the trees. The human eye is always drawn toward light in a photograph, but this image almost traps the viewer's eyes.*



Honorable Mention

Gumbo, my 18-year-old eyeless, toothless boy

JEAN CRAIG, M.D.

WHAT INSPIRED THE PHOTO? My beloved Gumbo is a remarkable feline who demonstrates time and time again that cats have adaptability not disabilities. He is a frequent subject of my photography.

WEWERKA: *The strength of this picture is not what is in it but what's not in it. What's bugging the cat? What's happening that's making him agitated? The absence of information keeps me wondering.*

Honorable Mention

Angry bird

KRISTI HULTMAN, MEDICAL STUDENT

WHAT INSPIRED THIS PHOTO? This little bird kept following me around the beach and had such a great angry expression on his face. It was shot in the Galapagos Islands.

WEWERKA: *The focus on the bird's eye is what makes this image so successful. It is as if you can see straight through it into the bird. This is all about point of focus.*



MEDICAL MUSINGS

The call for entries in our ninth annual writing contest gave some the nudge they needed to put their stories on paper.

Profiles by Carmen Peota



This year, we wondered whether Minnesota Medicine ought have a writing contest. We questioned whether our readers were still interested. Would writers once again be willing to send us their essays and poems? Would our readers want to read them? Despite such misgivings, we decided to do it and proceeded to promote it.

It wasn't until we learned that several of our submissions were written only after the authors had seen the announcement about the contest that we knew we had made the right decision. Our promo, it turns out, provided just the nudge they needed to get an idea that had been brewing in their minds onto paper.

The real value of the contest, we now realize, is that it prompts individuals to focus the mind, make the time and put in the effort it takes to turn a memory or idea—and the emotion it conjures—into a form that will mean something to a reader. If a story is well-told or a poem is well-crafted, the writer's insight is passed along to the reader. Writing is simply sharing.

Rereading the submissions confirmed that providing the little prompt to get physicians to share their stories is worth the effort. Many of this year's writers offer new insights into big problems that medicine as a profession and we as society are grappling with.

Thank you to all who submitted entries. We intend to publish many of your pieces in the coming year. And thank you to our judges: Zubin Agarwal, Maria Carrow, M.D., Dan Hauser, Patricia Lindholm, M.D., Anjali Wilcox, Barbara Yawn, M.D., and Therese Zink, M.D., M.P.H., in addition to Minnesota Medicine editors Kim Kiser, Charles Meyer, M.D., and Carmen Peota.



writing contest |

PHYSICIAN WINNER

Dave Dvorak, M.D., M.P.H.

This year's physician winner Dave Dvorak is not new to writing. Over the years, his stories, letters to the editor and essays have appeared in medical journals (including *Minnesota Medicine*) and newspapers. In fact, Dvorak started writing long before he went into medicine. He was editor of his high school newspaper in Oak Park, Illinois, and a columnist for the University of Notre Dame's student paper *The Observer*.

During medical school, however, Dvorak realized that medicine was fertile ground for a writer. And practicing in the emergency department at Fairview Southdale Hospital for 18 years has confirmed that. He's a daily witness to much human drama. "You can see the entire spectrum of human emotions play out in a single exam room," he notes. "You see despair and heartache. There's also hope and love and courage, and families at their best and at their worst." Not surprising, most of his writing is inspired by patient encounters.

The encounter described in his winning piece "Better Than This" was a particularly poignant one for Dvorak. And as he mused about it, he realized the story not only conveyed an individual's tragedy but also illustrated a larger problem with the health care system in this country. Passionate about the plight of the uninsured, Dvorak thought sharing this story might be an effective way to get people thinking about the issue.

For Dvorak, writing is a way to persuade, a creative outlet and a form of therapy. "I think the tragedies we sometimes encounter in medicine, as much as you try to keep a healthy emotional distance, I think they affect us in small-but-real ways. There's a lot of sadness you may or may not realize you carry inside when you regularly see people suffer," he says. "Writing is a healthy way to process that."

DAVE DVORAK at a glance

EDUCATION

Undergraduate studies at the University of Notre Dame, medical school at the University of Illinois at Chicago, emergency medicine residency at Hennepin County Medical Center, master's in public health at the University of Minnesota.

FAVORITE AUTHORS

Abraham Verghese—"I admire physicians who are also good writers, who can convey the experience of illness and health care in a poetic way." Also Jonathan Franzen and Khaled Hosseini.

OTHER INTERESTS

Travel—"I like to travel—who doesn't?" and music—Dvorak plays in a band called Golly Llama that covers artists from Johnny Cash to Lady Gaga.

Better than this

BY DAVE DVORAK, M.D.

“How much will this cost?” he asks. It’s the question at the heart of any business transaction: Is this new car, this plane ticket, this iPad worth the asking price?

But the man sitting before me is not a customer in an automobile showroom or an electronics store. He is my patient in the emergency department, and he is weighing whether to undergo the chest CT scan I have just recommended.

“I’m uninsured,” he says. “I lost my health coverage when I got laid off from my job three years ago. This is all coming out of my pocket.”

An ex-smoker in his late 40s, he has been coughing up increasing amounts of bloody sputum over the past month. What began as occasional, tiny red flecks has progressed to thick crimson streaks he can no longer ignore.

“I can only give you an estimate,” I say, “but I’m guessing a chest CT scan plus the radiologist’s fee will run in the neighborhood of \$2,000.”

Like most emergency physicians, I have catalogued in my brain an endless litany of precise numbers—physiologic parameters, normal lab values, weight-based drug doses. But when it comes to knowing the costs of the myriad tests, medications and treatments that I routinely order for patients, I can offer little more than a rough estimate.

“I was afraid you’d say something like that,” he says. “I figured CT scans don’t come cheap.” He sighs quietly. “I’m raising my 8-year-old daughter on a pretty lean budget.” He looks thin in his hospital gown and a shade pale, a few days of gray-stubble on his chin.

“But I’ve been worried about this for too long,” he says. “I know I need to have it.”

.....

An hour later, I am seated at my computer scrolling through digital CT images while the radiologist on the phone describes the findings.

“In the hilum of the left lung there is a 4.5 centimeter lesion very likely to represent malignancy,” she says. My gaze falls on the irregularly shaped white mass, its tiny tentacles invading the delicate lattice-work of the surrounding lung tissue.

“Unfortunately, it gets worse,” the radiologist says. “There are also multiple scattered smaller lesions throughout both lungs, highly suspicious for metastases.”

There was a time during medical school and residency when I regarded abnormal clinical and radiographic findings with intrigue. I remember the excitement of hearing my first heart murmur. Of palpating a thyroid nodule. Of visualizing an ovarian mass on pelvic ultrasound.

But after years of clinical practice and countless patient encounters, I now find it difficult to view abnormal findings separately from the human lives they affect. I see an elderly woman’s hip X-ray, knowing that the fracture line coursing through the femoral neck likely spells the end of her days of independent living. A peculiar bright patch lighting up in the brain’s left hemisphere on an MRI scan signifies that a man will no longer be able to grasp a pen or a coffee mug in his right hand, will never again be able to speak a meaningful word to his family.

I hang up the phone, my eyes lingering on the CT images, the sinister white lung mass and its small-but-ominous satellites. And I am aware of their significance—that a middle-aged man will not live to see his daughter’s wedding.

.....

I return to the patient’s room and sit down on the bedside stool. Before I

speak, I feel his gaze upon me, anxiously searching my face for any subtle indication of the words to come.

“I’m sorry to have to give you this news,” I say, “but your CT scan shows findings concerning for lung cancer. It’s possibly spread to both lungs.”

He stares ahead, unblinking, his facial pallor seemingly more apparent. After a few moments, he speaks.

“On some level, I was expecting something really bad like this,” he says. “But, of course, you always hope that everything will turn out fine.”

My mouth, having grown dry, lacks the appropriate words to console him in this moment of utter sorrow. So I put a hand on his arm.

“I’ll talk to our on-call oncologist,” I tell him. “We’ll figure out a plan for you.”

.....

He waits patiently until I return to his room once more, armed with an action plan.

“The oncologist is going to admit you to the hospital and start the workup,” I explain. “He’ll order a PET scan to see if there’s been spread to other parts of the body. Then they’ll do a biopsy of that main lesion in your lung to determine the best treatment options—whether it be radiation, chemotherapy or some combination of the two.”

A long period of silence follows, time for my patient to process the information I have conveyed. I anticipate forthcoming questions.

“I suspected that you’d want to do all those things,” he says, finally. “But I’ve already been thinking this through, and I’ve decided that I’m going to have to pass on your recommendations.”

(continued on page 34)

STUDENT WINNER

Annie Jespersen

Our winning medical student writer Annie Jespersen has her parents to thank for her writing habit. They made her and her siblings keep a journal and write in it every evening when they were young. "They wanted us to have good language skills—to be able to communicate in writing and in person," Jespersen explains.

Her brother and sister didn't take to writing, but Jespersen did and ever since has used journaling as a way to "sort through things" she doesn't fully understand. "Writing kind of forces me to slow down and think about stuff," says the second-year University of Minnesota, Duluth medical student.

As her winning story "LOA" reveals, Jespersen has been doing a lot of thinking lately. In November, she decided to take a leave of absence from medical school to catch her breath emotionally. Jespersen entered medical school at age 21 after skipping two years of high school (she never earned a diploma) and graduating from Concordia College in Moorhead, where she majored in biology and chemistry. During her first year in Duluth, she found herself torn between the demands of medical school and those of family. "I don't think they quite understand how much time it takes to commit to medical school. And I had a hard time coming to terms with the fact that I needed to be selfish and do medical school."

A month into her leave, Jespersen realized that her fellow medical students and friends didn't quite know what to make of her decision. So she decided to explain herself by writing about it. "My plan is to write a book called *Sabbatical*," she says, predicting that the memoir about her medical school experiences likely won't be finished until long after she graduates. Toward that goal, she wrote "LOA." A friend who read the piece encouraged her to enter it in *Minnesota Medicine's* writing contest.

Although her writing habit waned in college and during her first year of medical school, she's realized that it's something she needs to do and plans to keep it up when she returns to medical school at the end of August. "I think it is part of what I need to do to keep sane, so I'll keep writing and journaling," she says. "It's part of who I am."



Photo by Jeff Frey

ANNIE JESPERSEN at a glance

EDUCATION

Undergraduate studies at Concordia College, Moorhead; medical school at University of Minnesota, Duluth.

FAVORITE AUTHORS

Bill Bryson—"he has a nice tone"—and Jane Austin. *Wuthering Heights* is her favorite book.

OTHER INTERESTS

Music—In college she sang in choirs and was one class shy of a minor in music. And fitness—She's training for a triathlon. "They dump you in Lake Superior, then you bike to Two Harbors, and then you do a half marathon around Duluth. We'll see what happens. I don't know if I'll survive."

LOA

BY ANNIE JESPERSON

It's Tuesday, 6:45 p.m. Most of my evenings these days are spent working at a store that sells camping equipment and outdoor clothing. I can't say I expected to be in this particular position a year ago, or even six months ago. Hell, six months ago my job was to absorb knowledge I would someday use to tell the difference between a STEMI and non-STEMI. As I struggle to remember which one can be treated with thrombolysis, I feel frustration growing like a knot in my chest. Instead of dwelling on that, I decide to throw myself into the task at hand, which happens to be removing cream-colored raffia ribbons from a mountain of neatly folded linen shirts we received earlier that day. I think it's strange the shirts come packaged in this way. It's impossible to determine what it looks like, let alone try it on, without destroying the artfully tied bow. I stand behind a large counter that houses the register, snapping the delicately tied ribbons one by one. The bluegrass music playing in the background is interrupted by snippets of conversation as shoppers casually pass the front door.

No one is in our store, and I decide Tuesday night must not be a peak time for Duluth shoppers. One of my co-workers sighs, slumps over the counter next to the register and cranes his neck in an attempt to read the clock on the computer screen facing me.

"Is it seven yet? If it is, this shift is going to go by really fast."

I glance at the clock, 6:48.

"It's almost seven, does that count?"

"Better than six for sure."

We stand in silence. I continue to tear ribbons apart, and he yawns extravagantly.

"Do you think this is someone's job?"

I motion to the raffia bows I am intently destroying.

"What, raffia tying?"

"Yeah. Do you think this is someone's job, or is it done by some sort of machine that was created just to make raffia bows?"

My co-worker carefully considers one of the delicate bows.

"Well, I'm not sure. There's probably a machine that does it; but I do know that there are some horribly simple things machines and computers can't do."

I stop my work for a moment, picturing someone very far away, feverishly tying raffia. I wonder if the raffia tie-ers are aware that I am unceremoniously destroying their hard work minutes after unpacking the box. It occurs to me my life could be very different. I was once a medical student. I am still a medical student—on a leave of absence, and feeling pretty sorry for myself. Comparing my current circumstances with those of the raffia tie-ers, I tell myself that I am still very lucky. But this thought makes me feel not better but nauseated. GERD, perhaps? I find it very hard to feel lucky at this moment.

"So I heard you want to get into rock climbing?"

Part of me is glad to have my thoughts interrupted. I feel guilty when I indulge in negative thinking about the direction my life has taken.

"Umm, yeah. I was thinking about it. Is it weird to go by yourself?"

He laughs and shakes his head a little.

"Kinda. You can come with me sometime if you like."

"Maybe I will. I don't want to look like a fool if I'm no good though."

He pops a raffia ribbon off a shirt and looks at me thoughtfully.

"You care a lot about what other people think of you, don't you?"

The question startles me, and I think for a moment before I reply.

"I didn't think so, but I guess I do. I just don't like being incompetent."

"You've got to start somewhere, Annie."

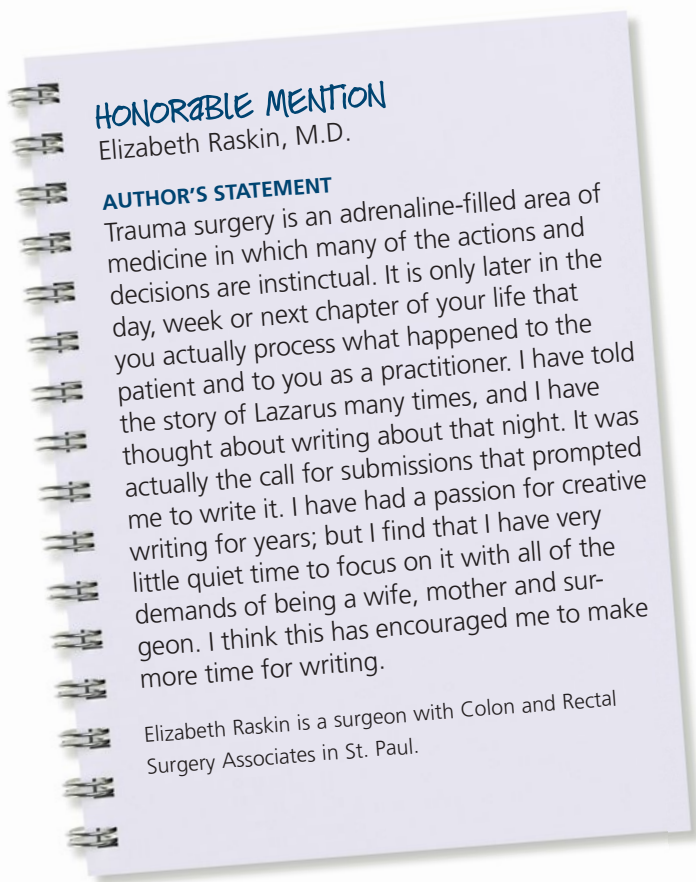
As my co-worker shuffles off to greet a customer, his words seem to linger, suspended in the air with the dust particles that float by, glowing in the evening sun. My hands are now idle, a small raffia graveyard surrounding me. From order, I've created chaos.

While surveying the mess, I wonder if I've always been this transparent. In a single brief conversation, someone I have known for less than a month has been able to identify the reason I chose to take a leave of absence from medical school.

I think back to a clinic day roughly a year ago, when I was stitching an elderly woman's arm in the emergency room. I was working with a male medical student; both of us were excited and humbled to be given the opportunity to place stitches in a human being instead of a lifeless pig's foot. After we finished, the patient patted my classmate on the shoulder and said, "You'll make a wonderful doctor." I thought these kind words were intended for both of us until she looked at me and said, "Oh, and you'll be a lovely nurse, honey." My chest hurt. Despite my white coat, she could not perceive me as the professional I was striving to become: a physician. I laughed as I left the room, but her words stung.

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(continued on page 34)



The Raising of Lazarus

I knew the statistics well. In the summer alone, 26 homicides were recorded, marking 2006 as one of the deadliest years on record for Boston. Most of the victims were 20-something black males from the Roxbury and Dorchester neighborhoods who had been beaten, stabbed or shot. Boston Medical Center became the repository for those who survived long enough to be picked up by the paramedics—the “innocent bystanders” who were in the wrong place at the wrong time and the bravado-laden retaliators. I met one of those victims in the emergency room. He arrived with a single gunshot wound to the chest. We futilely opened his chest while still in the trauma bay. Twenty minutes later, we drew a clean white sheet over his body

and went to find his family in the waiting room. Their screams and wails still haunt me. The young man’s mother clung to my sleeve as she slumped to the cold linoleum. Tears streamed down his older brother’s cheeks as he frantically paced back and forth.

“Why him? Why him?” she pleaded. We had no answers, only condolences.

A week later, in the same trauma bay, I almost met another casualty.

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The Red Sox were off their game that night. Huddled in the residents’ lounge, we watched disappointedly as Beckett let three runs come in during the fourth inning. Two years after their curse-breaking World Series win, the Sox had found redemption from the dark cloud that hung over Fenway Park. But the second chance they earned didn’t guarantee against the occasional lackluster performance. I was thumbing through a throwaway journal, downing another cup of watered-down nurses’ station coffee when the words “GSW: ETA 1 minute, Trauma Bay 1” came across my pager.

We hopped off the dilapidated couch and darted down four flights of stairs, racing toward the emergency room. As we descended on Trauma Bay 1, another page rang out announcing a second gunshot wound victim arriving in Bay 2. The staff surgeon, Dr. Agrawal, attended to the first patient while I grabbed the intern and headed toward the second.

“Twenty-two-year-old male found down on Dorchester Avenue. Gunshot wounds to the legs, abdomen and chest. Pulse 120, blood pressure 50 over palp,” announced the paramedic who wheeled in the bloodied patient. “He’s got lactated Ringer’s pouring in, and we’ve given a few rounds of epi.”

Wide-eyed and gasping for breath, the patient was panicky and restless—like an injured animal. As we stripped off his clothes with a pair of shears, I made note of more than 20 bullet holes from his thighs to his neck. I passed my stethoscope over his chest, only to hear muffled breath sounds. As the nurse dumped a container of betadine across the young man’s chest, the intern and I slid in chest tubes, which were quickly bathed in crimson. His blood pressure dropped precipitously and he lost consciousness. With blood spraying out of the endotracheal tube, the anesthesiologist bagged him.

“Let’s go!” I shouted, motioning to a medical student to hold the elevator to the second floor operating room. As we rolled out of the alcove, a third page came across reading, “GSW: ETA 2 minutes, Trauma Bay 3.” The intern and medical student looked up at me in disbelief. We held our breaths as we ascended one floor.

In the OR, I drew a 10-blade scalpel across the patient’s bloated abdomen, sinking the knife through layers of fat and fascia. We expected to encounter an abdomen full of blood, but as I passed my hand across the patient’s liver, spleen and intestines

we found neither blood, stool nor bile. Dr. Agrawal joined us as we extended the incision over his chest, quickly dragging across the sternal saw. As we pried open his ribcage, a fountain of blood poured out around the destroyed parenchyma of his right lung. I grabbed a large clamp and tried to get ahold of the hemorrhaging pulmonary vessels. Sam, the medical student, held the suction tip in the chest cavity as liters of blood were evacuated.

“We’re losing him,” the anesthetist uttered matter-of-factly. “We’re slamming in blood, and we’ve given rounds of epi and a slug of vasopressin.”

We looked up at the monitors. His pulse was essentially nonexistent except for when epinephrine was bolused through his veins. Flaccid and quivering, his heart lay deflated within the mediastinum.

The phone rang across the room.

“Dr. Agrawal, Bay 3 is bringing up another patient.” Defeated, the staff surgeon stepped away from the operating table. As he broke out of his bloodied gown, he muttered, “Sew him up and meet me next door.”

I stared across the table at Sam. I knew what came next. When the patient flatlined, we would remove the sponges and instruments and then whipstitch the gaping wound closed before taking him to the morgue.

Instinctively, I reached into the patient’s chest and cradled his heart in my hands. Weakly contracting, it felt like a frightened dove, wishing it could take flight. I methodically squeezed the weakened muscle between my palms.

“Look, Sam. With cardiac massage, you can artificially create a pulse.” We looked up at the monitors. We saw a correlating spike on the electrocardiograph when I compressed the heart. “And when you stop,” I paused, ceasing compressions, “the pulse disappears.”

I guided Sam’s hands around the heart. He received it delicately, recognizing the gravity of holding another man’s heart. With my hands around his, I instructed him in how to perform cardiac massage. Both well-aware that as soon as we ceased compressions our patient would die, we lingered in the rhythmic motion. I asked the anesthetist to draw up some epinephrine. Plunging the needle into the myocardium, I demonstrated to Sam how the stimulant caused the muscle fibers to contract. There was a brief burst of myocardial activity that slowly drifted away. As I asked for another milligram of epinephrine, we both watched as the patient flatlined. He was dead. Silence overcame the room as the monitors registered no signs of life.

I handed the syringe to Sam and had him inject the inert heart one last time.

Surprisingly, a few beeps broke the silence. I surrounded his heart with my hands once again and resumed compressions. “Please, please, please,” I silently begged as I watched the spikes re-form on the electrocardiograph. After a few minutes, I stopped. Then, independently, a pulse registered on the screen.

“Oh, my God,” I said out loud. “He’s alive.”

The anesthetists continued their efforts and we did the same. I asked the nurse to call Dr. Agrawal.

“Are you joking?” he asked in bewilderment.

We temporarily closed the patient’s abdomen and chest, knowing that we would be back in the operating room at some point in the next few hours for re-exploration. He was taken to the trauma ICU for resuscitation with his 15th unit of blood being transfused. We were invigorated, but knew that the patient would likely succumb to the sequelae of cardiac shock. Even if he could make it through the next 24 hours, he had likely sustained a severe anoxic injury. Organ failure was imminent.

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Two days later, I passed a newsstand on Harrison Avenue on my way to the hospital. The front page detailed the altercation in Dorchester that brought two young adults and one teenager to Boston Medical Center. I took the elevator up to the ICU where we would make Monday morning rounds with the chief of trauma, Dr. Erwin Hirsch. Iconic and revered, Dr. Hirsch’s name was synonymous with trauma surgery in Boston. A veteran of the Vietnam War and Operation Desert Storm, it seemed he had seen it all. He reminded his disciples that no two traumas were alike, stating, “You’re always dealing with the unknown.” We rolled a cart full of charts from room to room to discuss the inhabitants of the ICU, paying specific attention to the three that arrived Friday night.

With a wry smile, Dr. Hirsch turned to me and said, “Dr. Raskin, please present your patient ... Mr. Lazarus.”

I rotated to another hospital at the end of the week. Expecting to hear that our patient had died after a few days in the ICU, the fate of many individuals with similarly morbid injuries, I didn’t keep in touch after I left. A month later, I received an email from the nurse practitioner on the trauma service. I scrolled down the message to find no content except for an attached photograph. The photo revealed a young black male in a hospital gown, sitting in a wheelchair in front of Boston Medical Center. Smiling, he held a sign that read, “Thank you, Liz.”

I had no words for this gesture.

Reflecting on that night in the operating room, I am reminded of how little control we have over our patients’ lives. Despite our best efforts as physicians, some patients live and some patients die. As we approach the limits of science, we hold out for miracles, root for the underdog, and pray for second chances. We are simply midwives in this world, escorting the injured along their journey.

Milan Kundera wrote in *The Unbearable Lightness of Being* that “surgery takes the basic imperative of the medical profession to the outermost limits, where the human makes contact with the divine.” Surgery is an interface between life and death. It is a window into the sacred. **MM**

BETTER THAN THIS...

(continued from page 29)

It is not a reply I was expecting. “Why is that?” I ask.

“As I said before, I’ve got no health insurance,” he says. “But there’s one thing I do have—my house. And it’s fully paid for. I guess I’m not willing to mortgage it—and ultimately lose it—to pay off endless medical bills. My house is the only thing...” His voice trails off.

After a pause, he continues. “My house is the only thing I’ll have to leave my daughter when I’m gone.”

Tears have gathered in the corners of his eyes. I offer him a box of tissues, and he takes one.

We sit together in a room in a modern emergency department in a rich country, a land where highly trained specialists confidently wield the newest technologies and expensive pharmaceuticals. But these treasures are not accessible to all, for ours is also a land where private health insurance is bought and sold as a commodity. Ours is a system known to shake down sick people for money they don’t have. Ours is the only wealthy democracy that fails to guarantee health coverage to all of its citizens.

Just as it is failing now.

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He looks down at his watch. “Thanks for all you’ve done. I really appreciate it. But I’ve gotta leave now,” he says. “I have to go pick her up from school.”

As I watch him reach behind his neck to untie his hospital gown, I can’t help but feel that we owe him so much more. I can’t help but feel that we—health care providers, hospital administrators, insurance company executives, politicians, all those who strenuously fight the changes that our system desperately needs—we all have failed him.

I can’t help but feel that we are better than this. **MM**

LOA...

(continued from page 31)

A pair of customers are browsing the shoe selection, backs toward me. I wander over to them, thankful to have an activity to keep my mind busy. As the words “Can I help you?” leave my mouth, I realize these people are not strangers but members of my old medical school class. My stomach churns, and I am now convinced I suffer from GERD.

“Annie?”

I swallow and force a smile.

“Hey, guys! How’s it going?”

“Good, we’re just taking a study break, you understand. Do you work here?”

Their teeth seem too perfect as they both smile at me. I run my tongue over a snaggle tooth next to my lower left canine as I nod.

“Mmm hmm. I’m just keeping busy until I start up again next year. I love camping, and I needed a second job, so I just went for it.”

One glances at the time on an iPhone, while the other stares over my shoulder, nodding as if trying to pay attention to my words.

“You two seem busy, I’ll be over at the register if either of you need anything, O.K.?”

“Sure thing, Annie. Take care, and keep in touch!”

I wave goodbye awkwardly and begin reciting my favorite mantras as I walk back to the register:

You’re young. Who starts med school at 21 anyway?

Taking time off is what you needed to do.

You’re going to be a better person because of this.

I rip the ribbons off with extra flourish this time, feeling a little better as I watch the raffia pile grow. I watch my former classmates leave, laughing and seemingly carefree. It occurs to me the repetitive activities I do while working in retail give me an opportunity to sort through things I would not normally think about. I imagine the far-away raffia tie-ers have a lot of time to contemplate their lives.

During my contemplations, one thing I have come to realize is how little I really know about anything. When I began medical school, I was full of confidence. The day a white coat was draped across my shoulders was the day I thought I would begin to morph into a physician. From the outside, I certainly looked the part. With my ID badge, white coat and new medical vocabulary, I wore my future profession on my sleeve. With those tools, I could surely convince anyone I was someone to be taken seriously. As the days went by, it became clear there was one person I was unable to convince: myself. The blows to my confidence were small at first. A backhanded comment from a peer. A less-than-pleasant phone conversation with my parents. A barely passing exam grade. These small burdens began to grow heavy. I listened to my mother tell me she needed another surgery. And as I watched my relationships deteriorate, I felt doubt untying my confidence, rapidly undoing years of

feverish work toward a single goal.

I knew medical school would change me. I knew medical school would be hard. I didn't know how quickly relationships could change, and, in fact, seemingly vanish. Parents and friends offered support, but they were far away and had struggles and burdens of their own. It suddenly occurred to me that, despite their encouragement, I was on my own.

I notice the lonely banjo song has ended and a bluegrass rendition of *Auld Lang Syne* has begun. I wonder for a moment why the radio station is playing a holiday song in the middle of April. As I sing along under my breath, I'm swept back to the last day of my rural preceptorship, an uncharacteristically snowless Friday in late December.

I remember feeling wholly satisfied after removing a particularly juicy cyst and sending my patient on his way. I recounted the details of the procedure to my preceptor while perched on a stool at her expansive kitchen counter. She laughed, and said something along the lines of, "There's nothing like a good cyst." During that final week, I realized there really wasn't anything like a good cyst. It occurred to me that although I'd had to make sacrifices in my personal life and taken significant blows to my self-esteem and pride, medicine still held a special place in my heart.

I like to consider my leave a sabbatical. When I began medical school, I was academically prepared. Emotionally, I was not. A medical student several years ahead of me told me, "Life doesn't stop while you're in med school, it keeps going." I know now she was right. Life—relationships with family members and friends, my mother's illness and need for another surgery—don't go on hold when you are a student. Learning to cope with life is as

much a part of the process of becoming a doctor as studying anatomy.

Sometimes I wonder what kind of physician I would have been if life had indeed stopped during medical school. I doubt I would have taken a leave of absence; and I certainly wouldn't have developed any of the fantastic coping skills I now possess. If absence makes the heart grow fonder, then I will surely return to medical school in the fall a little bit more humble, and a little bit more in love.

My thoughts are interrupted again when my hands are unable to find another ribbon to untie. I look at the clock, 6:57. As I begin to sweep up the pile of raffia, I start to feel better. Yes, life happened to me while I was in school. Yes, it will take me longer than most to become a physician. But I am lucky. It has taken a long time for me to realize this, but I am glad the events of my life have led me to this sabbatical. Taking time off has turned out to be the best thing I could have done. After a year and a half of medical school, I had lost sight of why I wanted to be a physician. I now remember why.

Another co-worker arrives. As he punches in on the computer, he says, "Hey Annie, what's good in your life today?"

I smile. For the first time in a while, I can honestly say "Everything. Someday, I'm going to be a doctor." **MM**

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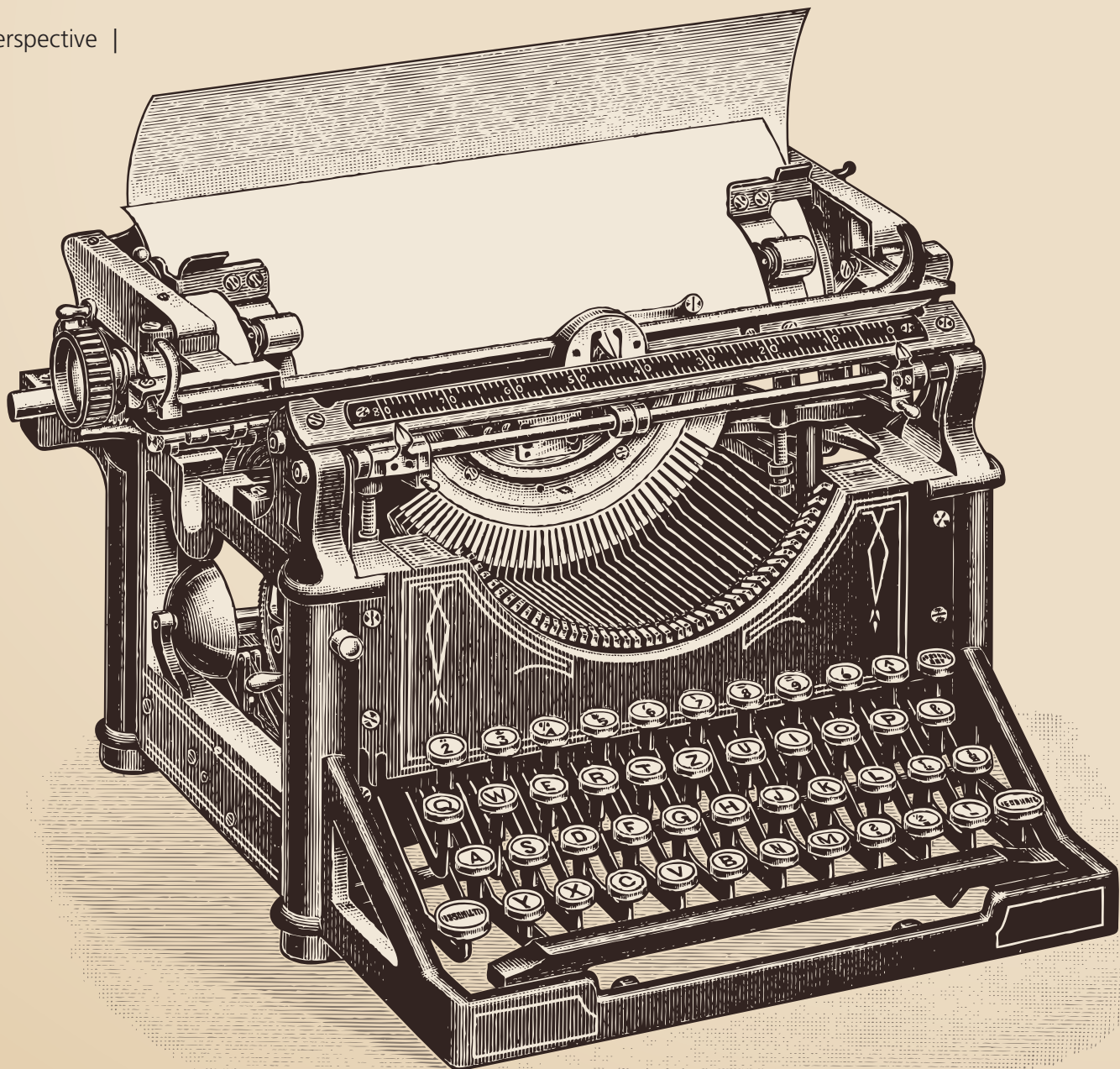
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Where writing meets medicine

Insights from The Examined Life Conference

By Kate Ledger

For Omer Sanan, M.D., a general surgeon at United Hospital in St. Paul, a life in medicine and a love of literature have long been intertwined. For 18 years, he's been part of an all-physician book club that meets several times a year to discuss histories, biographies and literary classics. He says reading has enhanced his work by heightening his awareness of detail. "Every day, patients tell us their stories. We make a great effort to pick out a few morsels that we believe are going to be useful in making a diagnosis and to understand how this patient is being affected by this illness," he explains. Moreover, reading

also teaches how to look at the big picture: "The patient's problem that brings them in is never totally isolated from their whole being."

Recently, however, Sanan became curious about engaging with literature in a new way. To reflect on his experiences in medicine, he decided to try his hand at writing. Eager to learn new techniques and to fuel his inspiration, he attended this year's Examined Life Conference at the University of Iowa Carver College of Medicine in Iowa City. The four-and-a-half-day gathering is offered by the medical school's writing and humanities program

and draws on the expertise and renown of the university's creative writing offerings. Workshops are specifically designed for health professionals (for example, "Turning Challenging Patients into Interesting People with the Magic of Creative Writing"). In addition, a variety of presentations explore the role narrative medicine can play in physicians' lives, both professionally and personally. Since it was initiated six years ago, the conference—which uses the tagline Writing, Humanities, and the Art of Medicine—has become a spring ritual for many who merge creative written expression with health care.

I drove the four and a half hours from St. Paul to attend the conference, eager to enhance my own writing. Aside from working as a health journalist, I'm also a novelist who focuses on medical topics. My conference fees were paid by a Minnesota State Arts Board grant toward the writing of my second novel, which is in progress. I hoped the conference would expose me to a side of medicine I don't always have access to in the interviews I conduct for magazine articles. In particular, I hoped it would offer a view of storytelling about the medical world—its hardships, exasperations and triumphs, and the ways those experiences affect both caregivers and patients.

As it turned out, Sanan and I were among several Minnesotans who made the trip (participants came from as far away as New Zealand). Although most were physicians at various stages of their careers, nurses, medical students, social workers, psychologists and even former patients attended the conference. Some were already published, such as the critical care doctor from New Jersey who'd recently completed a book of poetry and the family physician from Australia who'd written a play about a day in the life of a rural clinic. Some had drawn inspiration from the hardships of their own lives, such as the pediatrician from Boston who had published a memoir about helping her son recover from a traumatic brain injury.

What was immediately clear was how writing can help health care practitioners. The act of writing, even more so than reading, helps reveal the important elements of a story. Such awareness can increase a doctor's skill in taking patient histories. It can also change their perspective: One study mentioned during the conference showed that engaging with fiction, as opposed to scientific articles, increased medical students' empathy.

Writing certainly can help physicians address the emotions they experience on the job. Yuko Taniguchi, a Rochester-based poet, gave a session about the writing class she teaches for students pursuing health careers at the University of Minnesota-Rochester and members of the medical community at Mayo Clinic. In the class, she asks students to think back to an early experience with death, then write about the experience from a Taoist perspective. "Taoism says it was better that this person existed than not," Taniguchi explains. "Maybe there are other ways to think about this death." She then asks the students to distill the experience to a mere 55 words, paring the writing to reveal core emotions.

“The act of writing, even more so than reading, helps reveal the important elements of a story. Such awareness can increase a doctor's skill in taking patient histories.”

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For some, the conference provided access to practical information about being a physician-writer. Rachel Hammer, a student at Mayo Medical School, says the importance of writing became clear during cadaver dissection in first-year anatomy class. "You could look around the room and see in people's eyes who was O.K. and who was having trouble," she recalls. She and a few others gathered after class and channeled their emotions into the writing of a play about the history of dissection. The group continues to meet a once a month to read an excerpt of literature, which provides a writing prompt, Hammer explained in a session she led.

Hammer, who anticipates a career in primary care, is currently taking a year off from medical training to complete a Master of Fine Arts degree in creative nonfiction. She came to the conference with a burning question for other doctors who write: "When?" she says with a laugh. She found doctors' writing habits vary. "Some of them get up at four in the morning and write before going to work," she says. "And then there are those of the William Carlos Williams variety who grab a moment between patients."

The conference helped me understand some of the unique pressures of medicine (a phrase from a neurosurgeon that's stuck with me is that it's "a career of extremes"). Some of those I met even inspired new characters for my novel-in-progress. Sanan says he found the conference provided a distinct launching point for his new endeavor. "I've tried to write a few things since then, nothing profound," he says modestly. "I'm actually reflecting on my career, how I used to deal with things and how I'm dealing with them now. Writing is a process, and I'm just getting started." **MM**

Kate Ledger is a St. Paul writer and frequent contributor to *Minnesota Medicine*.



Carl Olvedt, *Taking the Bend*, 2004, oil on masonite.

This painting exemplifies the type of representational landscape that research most strongly supports as aiding in healing.

All images courtesy of Boynton Health Service, University of Minnesota.

Five Things to Consider When Selecting Art for Your Facility

By Gary Christenson, M.D.

■ Increasingly, visual art is being recognized for its ability to enhance healing. Yet often, those wishing to incorporate artwork into hospitals, outpatient clinics or long-term care facilities are at a loss regarding where to start when selecting pieces or have well-meaning but erroneous assumptions about what is appropriate for a health care environment. Fortunately, guidelines to assist with the selection process have been derived from the experience of hospitals with established art programs as well as a limited-but-growing body of research. Here are five things to consider when choosing artwork for your facility based on what we currently know.

.....

1. Do No Harm

It may come as a surprise to see a basic principle of medicine applied to selecting art for a clinic or hospital. However, as with other healing interventions, there can be a risk of doing more harm than good with art. For that reason, many hospitals focus on what they shouldn't display rather than the type of artwork they should display.¹

When looking for pieces, two major attributes, medium and thematic content, must be considered. Thematic content refers to the subject depicted in the artwork. With regard to theme, representational art can be more challenging to viewers than abstract art. However, one should never underestimate the mind's ability to perceive potentially objection-

able and anxiety-producing content in abstract works. For example, a reproduction of Picasso's cubist portrait of a woman, *The Dream*, may be colorful and well-recognized, but it includes an image of a phallus, which may offend those who discern it. Art featuring references to illness or death, violent imagery, nudity, and political and religious themes (unless the facility is a religious institution) should be avoided. Pieces with a medical theme may seem like a natural for a health care setting; but they are more appropriate for a medical school than a clinic or hospital, where the purpose of art is to provide an opportunity for the viewer to transcend, even if briefly, the medical setting.

Color needs to be considered as well. For example, an over abundance of red in

a piece can remind patients of blood and injury, and bilious greens can provoke nausea.

Medium refers to the materials from which the artwork is constructed. Most materials are acceptable for use in a health care setting; but there are some things to keep in mind. For example, textiles present a challenge to infection control, as they cannot easily be disinfected. Fabric works should be framed or otherwise placed behind glazing. Unfortunately, this may compromise the visual strength of a piece.

Safety also needs to be considered. Pieces of sculpture need to be firmly secured to a base or the floor to prevent them from being knocked over and injuring someone. Shatter-resistant glazing is

Bob Payton
Gamma Kappa,
2008,
cotton fabric collage.

This whimsical, colorful and kinetic work catches the eye and draws the observer in for reflection and interpretation. Its abstract nature may be less-suited for certain medical settings, such as an acute psychiatric service.



required for framed works in psychiatric and other settings where a patient could use broken glass to harm him or herself or another. Mobiles have the potential to gather dust and germs, compromising the cleanliness of a room. In addition, water elements should be avoided, as they have been associated with outbreaks of Legionnaire's disease.²

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2. Choose a Healing Image

Select artwork with healing potential. A limited body of research suggests two-dimensional works that depict landscapes, flowers and figures in nature, and are more representational than abstract, are most healing.^{3,4} In a study of patients in an intensive care unit, landscapes that

include water elements were found to be particularly beneficial. Compared with patients exposed to abstract art and control conditions, patients viewing landscapes with water elements reported less anxiety while they were in an intensive care unit and required less pain medication later on.⁴ These findings are consistent with research that has demonstrated that views of natural settings from hospital windows have a positive effect on patients' pain and anxiety as well as the length of hospital stays.⁵

However, the notion that representational work is superior to more abstract work is being challenged, as many health care facilities are displaying abstract pieces and patients are indicating appreciation

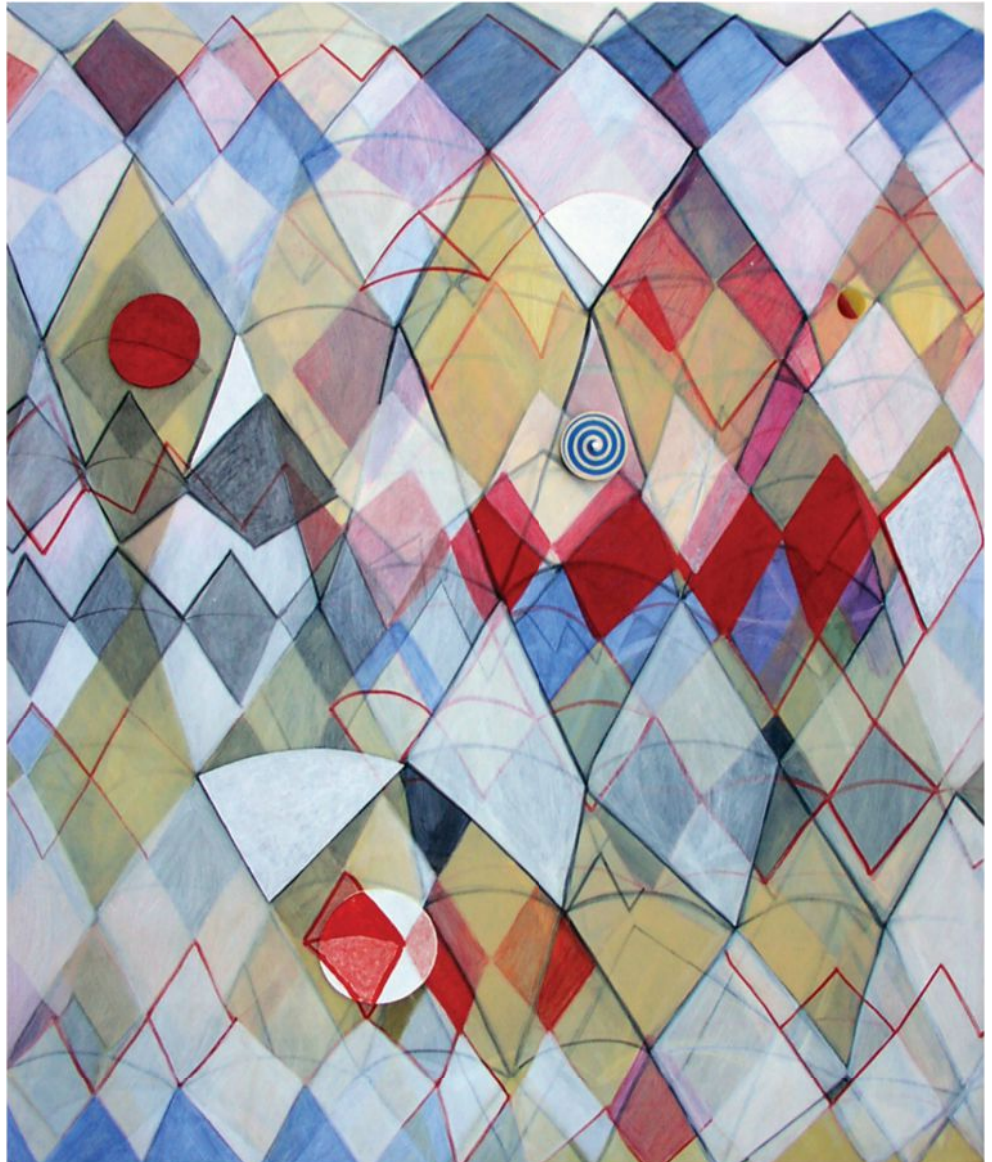
for them. Plato's conjecture, which is often paraphrased as "beauty is in the eye of the beholder," still holds true, and it is likely that any piece of art may be both beloved and despised. This reality supports the idea of periodically rotating art pieces within a facility. You can use an inexpensive cable hanging system to make frequent changes easier.

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3. Make It Noticeable

Artwork that goes unnoticed is like a prescription that goes unfilled. Works should not be too familiar, cliché or merely make an empty nondescript wall a decorated nondescript wall. Rather, they should draw attention, evoke positive feelings and allow for discovery. When possible,

Barbara Evan, *Caliope*, 2006, acrylic on masonite with collaged objects.

Abstract but whimsical, this large painting brightens one of the hallways of Boynton Health Service.



original pieces should be selected over reproductions.

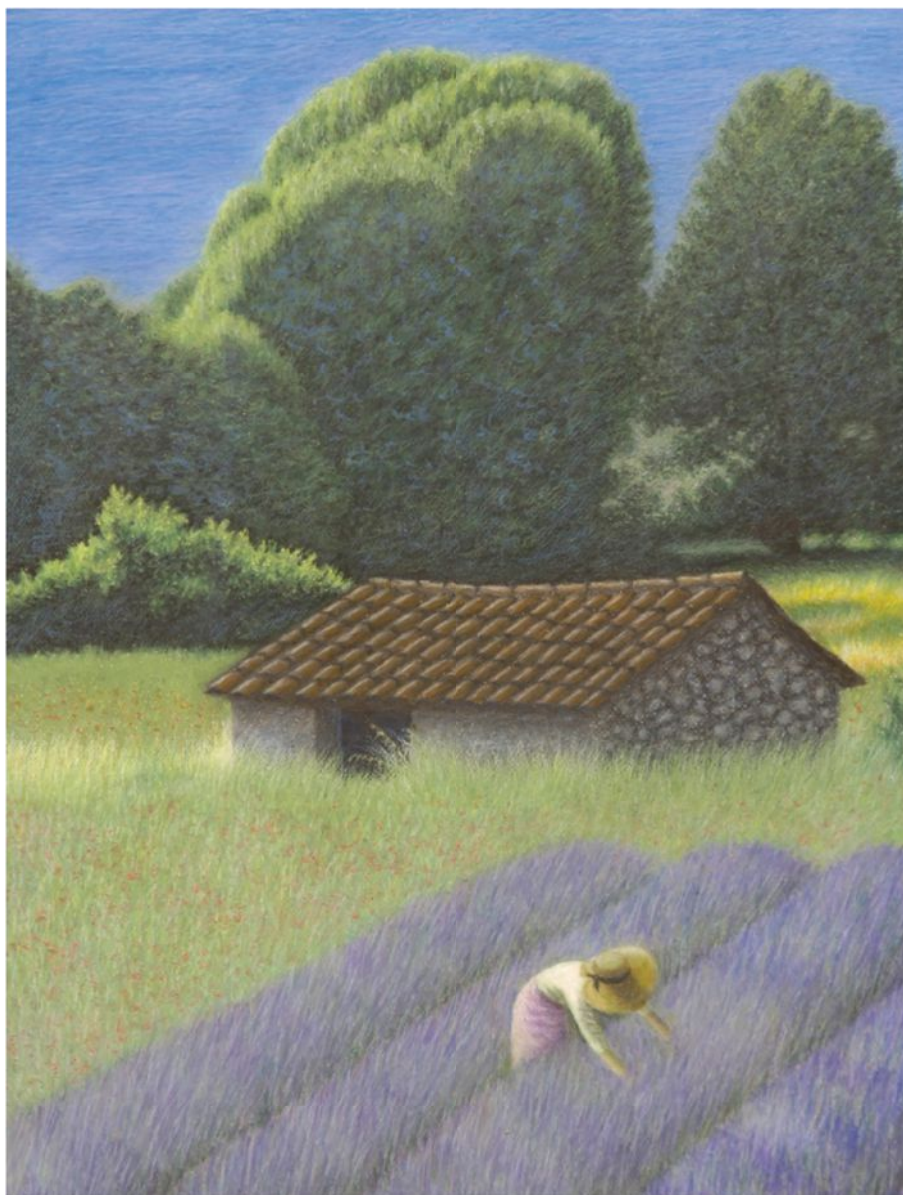
One of the ways art contributes to healing is that it can distract the patient from an otherwise stressful environment and/or situation. Artwork is also useful for helping patients and visitors navigate a facility. An exceptional example of art's ability to enhance wayfinding can be seen at Children's Hospitals and Clinics of Minnesota in Minneapolis, where visual artworks are organized according to theme, with each floor having pieces that reflect a different art form (music, theater, painting and drawing, etc.).

Art should be labeled. The label should include the name of the artist and the title of the piece and recognize the donor, if appropriate, as this can increase interest in the artwork. If there is a healing story behind the imagery or about the artist who created it, include it, as this information may make the viewing of the piece even more interesting, inspiring or moving.

4. Find the Right Location

Patients are asked to surrender varying degrees of control when visiting a health care facility. For example, a patient experiences a high degree of control when walking down a hallway, less control when sitting in a waiting area, and the least amount of control in an exam or hospital room, where he or she is essentially held captive. With that in mind, note that artwork for hallways can be a bit more challenging, edgy or abstract, as the viewer can walk away from it if he or she doesn't like or appreciate it. However, if a patient is in a hospital room where he or she may be confined for days, the artwork should have more universal appeal and feature a calming subject matter.

It will never be possible to find pieces that everyone appreciates. With that in mind, several hospitals including Bethesda Hospital in St. Paul have initiated art cart programs that bring artwork to the bedside. Patients can choose pieces they find most appealing, and those pieces are then displayed in their room throughout their stay. ↪



Laura Jackson, *Lavender Field, Provence, France*, 2008, pastel on paper.

A representational landscape with a small figure is considered universally appealing, particularly in health care settings. The colors in this painting are soft and the mood calm. It was the grand prize winner of the 2008 Boynton Health Service employee art contest.

Art need not only be placed on walls. The discovery of a painting as one reclines for an examination can be particularly pleasing and can distract a patient from their immediate concerns. Boynton Health Service at the University of Minnesota has installed ceiling panels with paintings on them in several locations including exam rooms. Among the paintings are one of birds in a woodland setting and another of a labyrinth.

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5. Present It Appropriately

Appropriate presentation of artwork maximizes its healing benefits and protects it from damage. Often, when artwork is purchased directly from the artist, it may be in an inexpensive frame that does not compliment the image. Professional framers are trained to select matting and frames that best highlight a work. If a piece of art is matted, the matting should be acid-free to prevent discoloration. Glazing should offer some protection against the effects of light.

A work of art should be hung under light that is adequate for viewing it; but it should be installed so that direct exposure to sunlight is avoided. Also, artwork should not have to compete with notices or navigation signage. Pieces of art should not be crowded, either. Each should have breathing room. This is not only true for two-dimensional works but also for sculpture, ceramics, carvings and other three-dimensional pieces.

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Conclusion

You can use art to enhance any physician's office, clinic, hospital or long-term care facility. Purchasing artwork often requires an up-front investment; but that investment can have a big payback. Not only can displaying artwork promote healing, it also can make a statement about the importance you place on the aesthetic needs and the comfort of patients, visitors and staff. Art also can be used to enhance your relationship with the community, as it can make a hospital or clinic not only a destination for excellent care but also a showplace for the artistic and creative elements that make us all human. **MM**



Gary Christenson is chief medical officer of Boynton Health Service at the University of Minnesota. He is also president of the Society for the Arts in Healthcare.

Josephine Lewis, *Mandala*, 2007, collage on board.

This four-foot-square composition is placed near other abstract pieces with organic elements displayed at Boynton. Reminiscent of a slice of Lake Superior agate or a cross section of an old tree, it is actually a mosaic made of thousands of paper strips cut from old *National Geographic* magazines.

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MINNESOTA
MEDICAL
ASSOCIATION

THE PHYSICIAN ADVOCATE

The MMA's monthly report on policy, people and politics

AT THE CAPITOL Legislators call for several studies

It may be summer, but there's plenty of homework to be finished before the start of the 2013 Legislature.

Last session, state lawmakers requested that a number of studies be conducted, some of which are noteworthy for Minnesota physicians. The MMA will work closely with the parties responsible for those studies to provide perspective and information.

"In particular, the MMA will be closely monitoring studies regarding the Medical Practice Act, managed care programs and the release of health records," says Dave Renner, MMA director of state and federal legislation.

Health licensing board studies

A request for several studies came out of the health licensing disclosure bill (often referred to as the Board of Medical Practice bill).

In one study, health-related licensing boards and the Commissioner of Health will evaluate ways to implement criminal background checks for licensees, how to pay for those checks, the

circumstances under which federal background checks are to be conducted and the standards to be applied to determine whether a criminal record may disqualify an individual from licensure or working in a regulated occupation. This work, including drafting legislation, must be completed by January 15, 2013.

In addition, the health commissioner

must convene a work group to evaluate whether the state's Medical Practice Act "effectively protects the safety and well-being" of citizens using an open and transparent process. The 15-member group will include two current BMP members, two practicing physicians appointed by the MMA, two medical educators, two state senators, two state representatives, the health commissioner,

(continued on next page)



AT THE CAPITOL*(continued from previous page)*

two consumers and two experts in the field of medical practice. This group must submit its report by January 1, 2013.

Finally, the Office of the Legislative Auditor will conduct an investigation of the BMP itself and its enforcement of the Medical Practice Act. Its findings are due January 1, 2013.

“The MMA supports review of these items to ensure that we have an effective regulatory system for health professionals,” Renner says. “We also want to ensure that we maintain a level of due process for physicians before the BMP.”

Study of managed care

In an effort to determine the value of the state’s Medical Assistance managed care programs, the human services commissioner has been asked to contract with an independent vendor with demonstrated expertise in evaluating such programs. This is just one item that came out of recent discussions about the need for increased transparency within the state’s public programs.

The study must examine the managed care programs with regard to the following, as compared with fee-for-service Medical Assistance: the satisfaction of participants and providers; the program’s ability to measure and improve health outcomes; ac-

cess to health services; the availability of additional services such as care coordination, case management and disease management; costs to the state; level of alignment with state and federal health reform policies; and the ability to use different provider payment models.

The evaluation also must consider the need to continue Rule 101, the requirement that HMOs participate in Medical Assistance and MinnesotaCare as a condition of licensure. Although Rule 101 also applies to physicians and other health care providers, the study will only review the HMO requirement. A preliminary report is due to Health and Human Services committee leaders February 15, 2013. A final report is due July 1, 2013.

Health records study

The Commissioner of Health, in consultation with the Minnesota e-Health Advisory Committee, has been tasked with studying a number of issues including audit procedures to monitor consent and unauthorized access to a patient’s health records; the feasibility of informing patients if intentional, unauthorized access of their records occurs; and the feasibility of providing patients with a copy of a provider’s audit log showing who has accessed their records. This is the result of concern that hospitals and clinics have not implemented enough protections to prevent



Maya Babu, M.D., at the AMA meeting in Chicago in June, when she launched her bid for an AMA RFS Board of Trustees seat.

MEET A MEMBER**Maya Babu, M.D.**

| By Dan Hauser

Maya Babu, M.D., always seems to be doing two things at once.

And we’re not talking simple tasks. No, it seems as though Babu seeks out a challenge and then adds to it with another equally difficult one. For example, as an undergraduate at the University of Minnesota she studied not only neuroscience but also psychology. Following graduation, she headed east to Harvard, where she earned medical and business degrees at the same time. (She was in the first group of students to go through the Ivy League school’s combined M.D./M.B.A. program.)

“I thought I’d go to law school because I wanted to do health policy,” Babu says. “I thought I would work for the Centers for Medicare and Medicaid Services or something like that. But then the business school program opened up [at Harvard].” And so she took that path instead.

She continued her two-things-at-once approach after graduating and coming back home to Minnesota (she grew up in Eagan). Now in her second year of a neurosurgery residency at Mayo Clinic, Babu is engaged in advocacy work on behalf of both the AMA and the MMA.

She sits on the AMA’s Resident and Fellow Section (RFS)

unauthorized access to electronic patient records. The study findings are due February 15, 2013.

Other studies

In addition, the MMA will be keeping tabs on the following:

- Two studies regarding autism. One will examine autism spectrum disorders within the Somali community, another the housing and service needs of children with autism. The Somali study is due February 15, 2014. The housing support study is due January 15, 2013.
- A study of ways to provide coordinated and cost-effective health care and coverage for individuals who meet eligibility standards for emergency medical assistance and who are ineligible for other state public programs. This is due January 15, 2013.
- A study of the treatment capacity of existing radiation therapy facilities in the state as well as the need for radiation therapy services. The study also will project future needs over the next decade. The report is due March 15, 2013.

The MMA will continue to track the progress of these studies and will report on them in future issues of the *Physician Advocate*.

EDITOR'S NOTE: *Keep track of legislative events through MMA News Now, delivered to your email box free each Thursday. To subscribe, go to www.mnmed.org and look for "MMA News Now" under the "Publications" tab.*



Governing Council as a lead delegate, and in April she was appointed to a one-year position as the RFS member of the AMA Council on Legislation. In June, she launched a campaign to run for a seat on the AMA's 2013 RFS Board of Trustees.

Babu also serves as the RFS representative on the MMA Board of Trustees and is a member of the MMA's Health Care Access, Finance and Delivery, and Marketing and Membership committees.

When asked about all of this activity and all the work it requires, Babu shrugs. For her, it's just the way she has operated for years. In fact, her summers have been as busy as her academic years. She interned in the Substance Abuse and Mental Health Services Administration in Rockville, Maryland, in 2005, in Medtronic's business development department in 2006 and for Piper Jaffray's Medical Technology Investment Banking Practice in 2009.

Although she may downplay her ambition, it's obvious to others that Babu is one extremely driven individual. "From her first days as a medical student, you could tell that she was a thoughtful committed person who wanted to help implement change within organized medicine," says Dave Renner, the MMA's director of federal and state legislation, who first met Babu at an AMA meeting when the young physician was exploring residency opportunities in Minnesota.

Along with residency and advocacy work, Babu is involved in

a program that pairs at-risk students with mentors in an effort to get them into college. Having debated at Eagan High School, Babu works with teenagers from Minneapolis, encouraging them to take up debate. "It's a great way to redirect their energy," she says. "It's a proactive way to use words in an effective way, not in a violent way."

When Babu finishes her residency in five years, her plan is to stay in academics, perhaps in pediatric neurosurgery. And, of course, to continue juggling multiple projects including her advocacy work.

AT A **GLANCE**

MEDICAL SCHOOL

Harvard Medical School

RESIDENCY

Mayo Graduate School of Medicine

MMA INVOLVEMENT

Resident and Fellow Section representative on the MMA's Board of Trustees and a member of Health Care Access, Finance and Delivery, and Marketing and Membership committees

HOBBIES

Hiking, spending time outdoors, going to the gym in winter

MMA IN ACTION

Happenings around the state

In May, **Karolyn Stirewalt, J.D.**, MMA policy counsel, represented the MMA at the Minnesota Board of Medical Practice meeting and the Health Professional Services Advisory Committee meeting. She also staffed the MMA's Ethics and Medical-Legal Affairs committee meeting.

Janet Silversmith, MMA director of health policy, participated in the AMA's Practice Management Federation Staff Steering Committee meeting in early May in Chicago. The meeting included discussions about the integrity and use of physician profiling data, payment audits, prior authorization and administrative simplification efforts.

Becky Schierman, MMA manager of quality improvement, spoke to members of the Nicollet-Le Sueur Medical Society on health care homes in mid-April. She presented a talk on what it takes to be an electronic health record meaningful user to physicians and other providers at Essentia Health-St. Mary's Medical Center in Duluth in early May.

MMA member **Robert Jacobson, M.D.**, presented a talk on "Vaccinations and Immunizations: a Public Health Triumph and a Public Relations Disaster" to members of the Stearns Benton Medical Society in April. Participants also learned about local vaccination statistics and discussed the struggles they face regarding vaccine awareness.

MMA Resident and Fellow Section (RFS) leaders **Vikram Jadhav, M.D., Ph.D.**, and **Stephen Darrow, M.D.**, attended the University of Minnesota's Transition to Residency event for graduating medical students in early May. Jadhav and Darrow talked with students about the MMA-RFS and their own experiences in transitioning from student to resident.



Dave Renner

Brian Strub, MMA manager of physician outreach, visited students at the University of Minnesota-Duluth medical school in mid-April as the MMA co-hosted a session for first-year medical students about working effectively with interpreters. Strub, **Dave Renner**, director of state and federal legislation, and **Eric Dick**, MMA manager of state legislative affairs, also met with students from Mayo Medical School at the Minnesota State Capitol to discuss legislation and the important role of physician leadership in advocacy.

Renner presented a federal health care legislative update in May for the University of Minnesota Department of Physical Medicine and Rehabilitation Residency Program.



Eric Dick

In mid-May, Strub and **Dennis Kelly**, MMA Foundation CEO, attended the Wright County Medical Society meeting in Buffalo.



Mandy Rubenstein

In April, the MMA's physician outreach staff—**Mandy Rubenstein**, and Strub—attended the Minnesota Academy of Family Physicians' spring conference.

Strub and Rubenstein attended the University of Minnesota's resident orientations in late June and early July.

In May, **Carmen Peota**, managing editor of *Minnesota Medicine*, represented the MMA at a series of talks on women's health, which the MMA co-sponsored with the Hennepin Medical History Center and the Hennepin County Medical Center department of obstetrics and gynecology. The series featured MMA member **Virginia Lupo, M.D.**, discussing substance abuse during pregnancy; **Jennifer Gunn, Ph.D.**, on childbirth in rural Minnesota during the first half of the century; and **Tara Gustilo, M.D.**, on acupuncture. The Hennepin Medical History Center is planning several exhibits this year to coincide with *Minnesota Medicine* themes.

The MMA's RFS sent 14 delegates to the AMA's RFS Annual Assembly in June. They included **Stephen Darrow, M.D., Mallika Anand, M.D., Maya Babu, M.D., Jenni Bartlotti, M.D., Mary Burgess, M.D., Lisa Gill, M.D., Kim Indovina, M.D., Vikram Jadhav, M.D., Ming Yeong Lim, M.D., Zach Lopater, M.D., Kimara March, M.D., Jae Yoon Park, M.D., Jason Puckett, M.D., and Will Schmalsteig, M.D.**

VIEWPOINT

| by Lyle Swenson, M.D.

Our value

Earlier this year, we surveyed member and nonmember physicians regarding the value of the MMA. We asked how satisfied they are with the MMA's performance and which initiatives are most important to them. Although the number of respondents was lower than we would have liked (299 or 4 percent of members and 155 or 2.6 percent of nonmembers), their feedback provided us with some very relevant information that we will use to guide our efforts in the future.

Members and nonmembers have differing opinions about which MMA activities are most important.

We learned that members and nonmembers have differing opinions about which MMA activities are most important. MMA members said that supporting the medical profession and our influence on medical issues were the MMA's most important activities. Regulatory advocacy and lobbying were close behind. Nonmembers thought regulatory advocacy and lobbying were most important, followed by physician education and maintaining our reputation as a leading health care organization.

Of the nonmembers surveyed, two-thirds previously have been MMA members. But when asked about joining or rejoining, only 7 percent said they were likely or highly likely to do so in the future. Nearly two-thirds said there is a low or very low likelihood of them joining.

Why don't these physicians want to be members? They gave a number of reasons, but the most common ones were cost, disagreement with MMA policies, lack of time, lack of knowledge about the MMA, and the fact that their professional needs are met by their specialty societies. Some primary care physicians perceive that the MMA gives more support to specialists; some specialists perceive that the MMA gives more support to primary care. Some perceive that the MMA is too liberal, while others think it is too conservative, politically. Some disagreed with the political action committee's endorsement of particular candidates for public office and with the MMA's position on particular pieces of legislation. Some were concerned that the MMA is closely aligned with the AMA and its policies. And some said the MMA does not provide good value for the money.

So what can we do to build MMA membership and become stronger? We must continue to be forceful advocates for our profession and for Minnesota physicians. We must continue to speak out and be actively involved in issues that affect the physicians of our state, especially those that could impose burdensome administrative and regulatory requirements, and reform health care financing and delivery.

To continue our advocacy efforts on behalf of our current members and to attract new members, the MMA needs to be sensitive to policy positions that



Lyle Swenson, M.D.
MMA President

Photo by Steve Weverka

have political ramifications. In addition, the support of specific candidates or controversial legislation that have the potential to alienate large segments of the physician community may have unintended consequences and may not serve the MMA well. At the same time, we must work to remind physicians that the MMA cannot be an effective advocate for the diverse group of physicians we represent if unanimity is expected on all issues. Finally, we must also encourage physicians-in-training and young physicians to become involved in order to build our organization and develop a stronger voice that will continue to speak for physicians in the future.

The MMA offers tremendous value to member and nonmember physicians alike. But we must do a better job of communicating about the work we do and continue to carefully weigh the pros and cons of emerging issues as we make decisions. If we do a good job in these areas, we will demonstrate the value that the MMA provides to Minnesota physicians and develop the stronger voice that comes from having a high proportion of Minnesota physicians as supportive and engaged members.

VITAL SIGNS: MMA NEWS IN REVIEW

DHS, Mayo team up to provide psychiatric counsel for primary care providers

The Minnesota Department of Human Services (DHS) has entered into a two-year contract with Mayo Clinic to develop and provide a statewide, collaborative psychiatric consultation service for primary care physicians who prescribe psychotropic medications for children.

As part of this effort, DHS Commissioner Lucinda Jesson has asked for the MMA's assistance in promoting the service and further improving care to children in need. "We look forward to partnering with the Minnesota Medical Association in developing the best mental health treatment for all of the children we serve, and especially for children in foster care who have often endured multiple forms of trauma," she wrote in a letter to MMA President Lyle Swenson, M.D.

A two-year state and federal investment of \$1.7 million in the program is expected to be fully offset by reduced costs for inpatient hospitalizations and medications in the state's Medical Assistance program. Although all Minnesota physicians will be encouraged to use the service, doing so will be voluntary. However, use will be required in order to receive payment for certain psychotropic medications for Medical Assistance fee-for-service patients.

"We are pleased to join with Mayo Clinic to provide better mental health care to all Minnesota children, especially children served by the Medical Assistance program," Jesson says. "This new psychiatric consultation service holds the promise of improved access and quality of care as well as greater efficiency so resources can be focused on appropriate treatment."

For more information on this service, visit the DHS website at www.dhs.state.mn.us/psychconsult. An article about the law that led to its establishment was published in the October issue of Minnesota Medicine at www.minnesotamedicine.com.

Foundation and MHA help two MDs get started in rural Minnesota

Andrea Westby, M.D. and **Robert Jeske, M.D.**, will soon be starting family medicine practices with a little less student loan debt. And the residents of Perham and Wabasha have the Minnesota Medical Association Foundation (MMAF) and the Minnesota Department of Health's Office of Rural Health and Primary Care to thank for the fact that they have physicians.

That's because the two organizations will provide both Westby and Jeske with up to \$100,000 over four years to help pay down their educational debt.

In exchange, Westby and Jeske must practice in rural Minnesota for at least three years. Westby will practice at Perham



Robert Jeske, M.D.



Andrea Westby, M.D.

Health/Sanford in Perham, and Jeske will practice in Wabasha, Minnesota, at the Wabasha Clinic, which is part of the Mayo Clinic Health System.

Westby, a 2009 graduate of the University of Minnesota Medical School, completed her residency at Allina/United Family Medicine in June. Jeske, a 2009 graduate of the University of Miami's Miller School of Medicine, recently finished his training at the Mayo Family Medicine residency program in LaCrosse, Wisconsin.

"This is a great opportunity to grow the primary care workforce and increase access to care in rural areas of the state," says Dennis Kelly, MMAF CEO.

The Office of Rural Health and Primary Care grants these awards through a competitive process, which includes a review by a panel of health care professionals that ranks all applicants. The panel seeks to identify those most likely to succeed in rural practice by assessing their interests, life experience and training in rural medicine.

This year, the panel identified several qualified applicants, but funding was available for just one. The MMAF, which works to improve health and health care in underserved communities, committed to match the state's \$100,000, allowing for a second award.

To contribute to the MMAF, visit the Foundation's website at www.mmafoundation.org/DonateNow.aspx.

Minnesota supports younger physicians with AMA Resolutions

Minnesota delegates were thinking of the future of medicine and the needs of young physicians when they submitted two resolutions at last month's AMA House of Delegates meeting in Chicago.

Resolution 328, "The Changing Environment: Access to Procedural Training for Residents and Fellows," addresses a growing problem—some residents and fellows are having difficulty gain-

ing enough experience with certain procedures. This is partially because of federal funding cutbacks for residency training and the increased use of nonphysician providers in hospital emergency rooms. The resolution asked the AMA to study the issues related to the funding of training sites and the financial pressures that prompt sites to use more mid-level providers. The resolution was referred for further study.

Resolution 713, “Transparency in Recruiting and Marketing Techniques for Young Physicians,” which was adopted, addresses a concern that hospitals and large health systems may be providing physicians, who are just completing their training, with unrealistic employment offers and not disclosing all of the information they need to make an informed decision. The resolution asked the AMA to explore strategies to increase transparency in marketing techniques used to recruit physicians who are finishing their residency or fellowship. Supporters of this resolution want to ensure that hospitals, clinics or health plans are not using deceptive or anticompetitive recruiting techniques and are fully disclosing to recruits all components of the contract. It also asked the AMA to provide physicians with information concerning various practice models so they can make more informed decisions regarding their careers.

MEDPAC looking to add board members

With all 210 legislative seats up for grabs this November, MEDPAC, the MMA’s political action committee, has an opportunity to influence the debate at the Capitol next session. MEDPAC works with MMA staff to provide targeted support and resources to pro-medicine candidates for state office.

If you are interested in playing an active role in MEDPAC, consider serving on its board of directors. There are seven openings in addition to the three to which the following individuals were appointed: **Eric Crabtree, M.D.**, **George Schoephoerster, M.D.**, and **Dan Carroll**, a fourth-year medical student at the University of Minnesota. Crabtree is an anesthesiologist practicing at St. Joseph’s Hospital in Brainerd. Schoephoerster practices geriatrics with Geriatric Services of Minnesota in St. Cloud.

Interested MMA members should contact Eric Dick (edick@mnmed.org), manager of state legislative affairs, for more information.

MMA looking for committee members

MMA members have an opportunity to influence the direction of the association by serving on one of its eight committees.

Openings for 2013 are expected for each MMA committee: Administration and Finance, Ethics and Medical-Legal Affairs, Health Care Access, Financing and Delivery, Membership and

Communications, Minority and Cross-Cultural Affairs, Public Health, and Quality.

“Serving on a committee is a great way to influence the direction of the MMA, acquire additional leadership skills and network with physicians who care about the same issues you do,” says George Lohmer, MMA CFO.

Appointments will be made in September for terms beginning in January.

For more information and to submit your name for consideration go to the MMA website (www.mnmed.org/AbouttheMMA/MMA-CommitteesTaskForces.aspx) and click on the committee application form.

Members making a difference

Terry Pladson, M.D., and **Steven Mulder, M.D.**, recently received awards from the Minnesota Hospital Association recognizing their commitment to patient safety, volunteerism, innovations in patient care and hospital excellence.

Ronald Petersen, M.D., of Mayo Clinic, helped develop a national plan on Alzheimer’s disease at the Alzheimer’s Research Summit 2012: Path to Treatment and Prevention in mid-May at the National Institutes of Health in Bethesda, Maryland.

Pediatrician **Richard Hart, M.D.**, received the Caduceus Award in late May from the Caduceus Society, a philanthropic guild of CentraCare Health Foundation. The Caduceus Society honored Hart, who works with the St. Cloud Medical Group, for his work improving health care in central Minnesota.

Jon Thomas, M.D., became the new chair-elect of the Federation of State Medical Boards in April. **Gregory Snyder, M.D.**, was elected to a three-year term as a director. Both Thomas and Snyder are members of the Minnesota Board of Medical Practice.

Review of 2012 BCBS Provider Service Agreement

The MMA, Twin Cities Medical Society and Minnesota Medical Group Management Association again teamed up to review the 2012 Blue Cross Blue Shield Provider Service Agreement. This year, the review highlights the top 10 changes affecting providers. The agreement went into effect on July 1. MMA members can see the review at: www.mnmed.org/Advocacy/KeyIssues/LegalAdvocacy.aspx. Scroll down to the section titled, “Contract Reviews.”

Editor’s Note: Keep track of news through MMA News Now, which is delivered to your email box free each Thursday. To subscribe, go to www.mnmed.org and look for “MMA News Now” under the “Publications” tab.



Joseph Bujak, M.D.

ANNUAL MEETING

National speaker to discuss common ground

In an effort to help Minnesota physicians—be they independent or employed, primary care or specialist—realize their commonalities, the MMA is hosting Joseph Bujak, M.D., a national speaker on health care organization and physician relationships, at its annual meeting September 14-15 in Minneapolis. Bujak will present a talk, “Bringing Physicians Together: A Journey from ‘I’ to ‘WE’ to ‘US.’”

In addition to hearing Bujak’s keynote, members will form a House of Delegates and vote on resolutions that determine the association’s policies and elect its Board of Trustees.

The meeting will also feature:

- An update on the Minnesota Department of Health from Commissioner Edward Ehlinger, M.D.;
- Breakout sessions on financial planning and how to engage patients in decision making;
- A presentation of awards to members;
- A performance by HC/MC, a band featuring MMA Board member Don Jacobs, M.D., and colleagues from Hennepin County Medical Center including Steve Sterner, M.D., Dean Tsukayama, M.D., and Mark Linzer, M.D.

For the latest information on the meeting, visit the MMA website at www.mnmed.org/About-theMMA/AnnualMeeting.aspx. For more background on Bujak, visit www.joebujak.com.

| employment opportunities

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Urgent Care

Mankato Clinic is looking for BC/BE physicians for our Urgent Care Department. Urgent Care is rotations of 3-12-hour shifts in a week, and one rotation of 2-12 hour weekday shifts plus a Saturday and Sunday Shift. Urgent Care hours are Monday – Friday 8 a.m. – 8 p.m.; Saturday 8 a.m. – 5 p.m.; and Sunday 11a.m. – 5 p.m.. There are no Call or hospital privileges required for Urgent Care.

Service lines that support our group include our own lab, sleep center, nuclear medicine, Medicare Certified endoscopic center and radiology department with a 128 slice CT and co-ownership in an ambulatory surgery center.

Opportunity highlights:

- Market competitive compensation guarantee to start, followed by RVU based production income thereafter;
- Fully integrated Allscripts electronic medical record
- 35 PTO / CME Days + generous CME allowance
- Practice connects to a regional, 270 bed, not-for-profit Mayo-affiliated hospital, Level 3 Trauma Center
- Highly trained and efficient staff;
- State university with 14k students; 150 undergraduate / 100 graduate / 4 PhD programs; 1800 Faculty / Staff
- High school students are eligible to take college courses for credit while in 11th and 12th grades;
- Named one of America’s Promise “100 of the Best Places for Youth”;
- Essential retail in the community; Target, Best Buy, Lowe’s, Sears, Old Navy
- Major shopping mall easy one-hour+ drive: Macy’s, Nordstrom, Bloomingdales
- Affordable housing: 4-bed, 4.5 bath, 3,572 Sq/Ft. home - \$264,900;
- 50 miles of local, paved trails / hundreds of acres of community parks;
- Four season outdoor activity; private country club / numerous public golf courses;
- International Airport an hour+ away;

Contact Dennis Davito, Provider Services, Mankato Clinic, 1230 East Main Street, P.O. Box 8674, Mankato, MN, 56002-8674; phone: 507-389-8654; email: ddavito@mankato-clinic.com.

MANKATO CLINIC

www.mankato-clinic.com

No J-1



Painted fingernails

HONORABLE MENTION Kimberly Schoonover, M.D.

AUTHOR'S STATEMENT

I love to write poetry; it is something I have done throughout my life. I was inspired to write this particular poem while rotating in the ICU as a resident. I have always been intrigued by the physician-patient relationship, especially how patients such as those who are intubated or who have severe dementia and cannot directly communicate with medical providers are perceived.

Kimberly Schoonover is finishing a fellowship in hospital medicine at Mayo Graduate School of Medicine.

Do you see my painted fingernails
Light orange-pink?
A bit chipped on my right ring finger
And have you seen my wedding ring
My husband in the hall
My daughter sleeping
Or would she be sleeping?

So still I was
Before they came
Not breathing, not beating
Until they came
And placed a tube down my trachea
Inflating my lungs
Bringing me here

And there you are
Staring at me
Seeing my painted fingernails
Wondering as I now jerk my legs,
My eyes
Will I be me again?
And if not
How sad
For the minute you thought of me
And my painted fingernails