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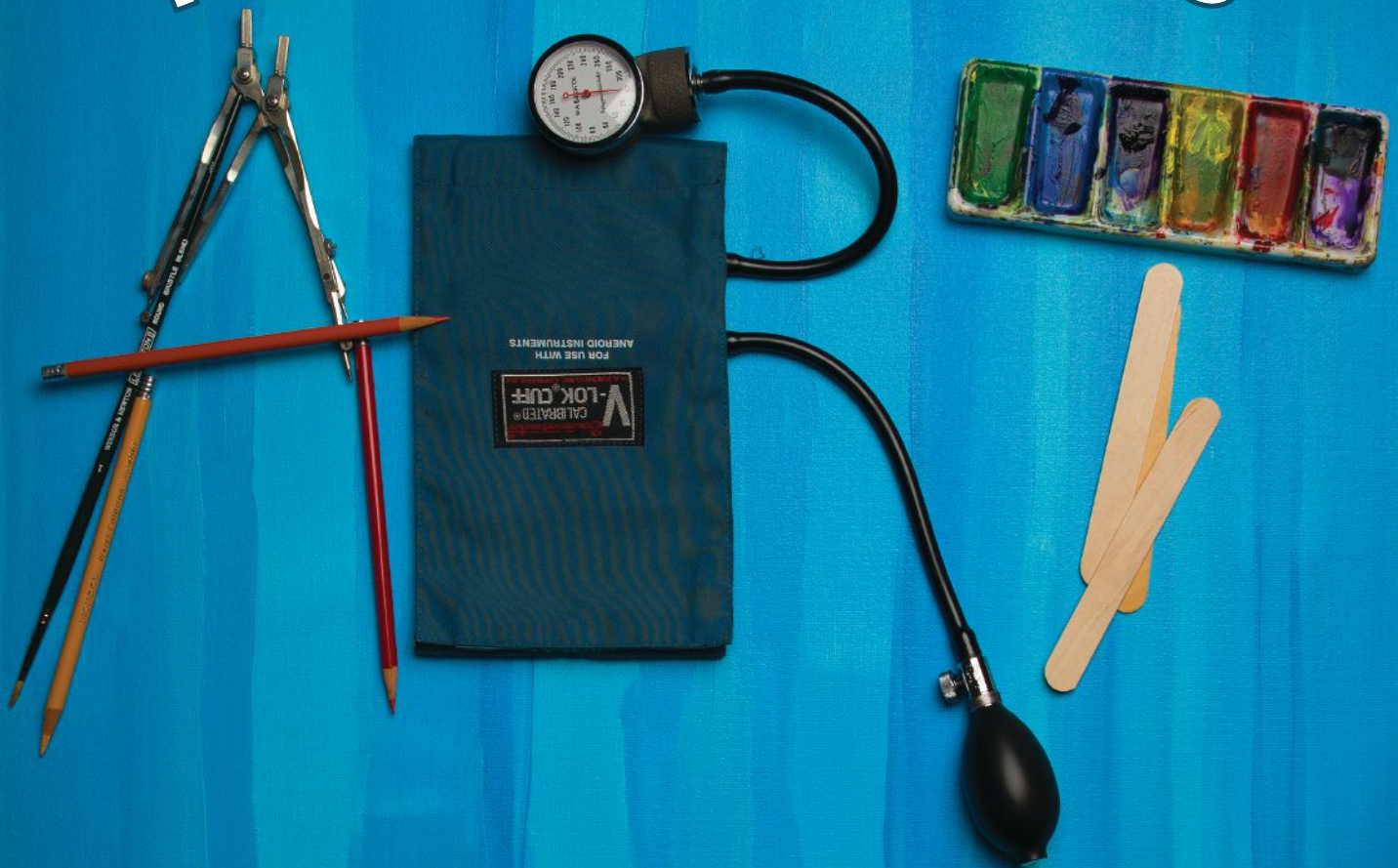
MEDICINE MEETS ART



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MINNESOTA MEDICAL ASSOCIATION

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*Victoza® 1.2 mg and 1.8 mg when used alone or in combination with OADs.
†**Victoza® is not indicated for the management of obesity, and weight change was a secondary end point in clinical trials.**

VICTOZA®
liraglutide (rDNA origin) injection

Indications and Usage

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

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

Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza®. Victoza® has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for pancreatitis while using Victoza®. Other antidiabetic therapies should be considered in patients with a history of pancreatitis.

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

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

Important Safety Information

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

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

Postmarketing reports, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis. Discontinue promptly if pancreatitis is suspected. Do not restart if pancreatitis is confirmed. Consider other antidiabetic therapies in patients with a history of pancreatitis.

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

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

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

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

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

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

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

Please see brief summary of Prescribing Information on adjacent page.

0513-00015590-1 June 2013

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

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

INDICATIONS AND USAGE: Victoza® is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. **Important Limitations of Use:** Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza® only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza® is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise. Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza®. Victoza® has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for pancreatitis while using Victoza®. Other antidiabetic therapies should be considered in patients with a history of pancreatitis. Victoza® is not a substitute for insulin. Victoza® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings. The concurrent use of Victoza® and prandial insulin has not been studied.

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

WARNINGS AND PRECAUTIONS: Risk of Thyroid C-cell Tumors: Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors (adenomas and/or carcinomas) at clinically relevant exposures in both genders of rats and mice. Malignant thyroid C-cell carcinomas were detected in rats and mice. A statistically significant increase in cancer was observed in rats receiving liraglutide at 8-times clinical exposure compared to controls. It is unknown whether Victoza® will cause thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors could not be determined by clinical or nonclinical studies. In the clinical trials, there have been 6 reported cases of thyroid C-cell hyperplasia among Victoza®-treated patients and 2 cases in comparator-treated patients (1.3 vs. 1.0 cases per 1000 patient-years). One comparator-treated patient with MTC had pre-treatment serum calcitonin concentrations >1000 ng/L suggesting pre-existing disease. All of these cases were diagnosed after thyroidectomy, which was prompted by abnormal results on routine, protocol-specified measurements of serum calcitonin. Five of the six Victoza®-treated patients had elevated calcitonin concentrations at baseline and throughout the trial. One Victoza® and one non-Victoza®-treated patient developed elevated calcitonin concentrations while on treatment. Calcitonin, a biological marker of MTC, was measured throughout the clinical development program. The serum calcitonin assay used in the Victoza® clinical trials had a lower limit of quantification (LLOQ) of 0.7 ng/L and the upper limit of the reference range was 5.0 ng/L for women and 8.4 ng/L for men. At Weeks 26 and 52 in the clinical trials, adjusted mean serum calcitonin concentrations were higher in Victoza®-treated patients compared to placebo-treated patients but not compared to patients receiving active comparator. At these timepoints, the adjusted mean serum calcitonin values (~1.0 ng/L) were just above the LLOQ with between-group differences in adjusted mean serum calcitonin values of approximately 0.1 ng/L or less. Among patients with pre-treatment serum calcitonin below the upper limit of the reference range, shifts to above the upper limit of the reference range which persisted in subsequent measurements occurred most frequently among patients treated with Victoza® 1.8 mg/day. In trials with on-treatment serum calcitonin measurements out to 5-6 months, 1.9% of patients treated with Victoza® 1.8 mg/day developed new and persistent calcitonin elevations above the upper limit of the reference range compared to 0.8-1.1% of patients treated with control medication or the 0.6 and 1.2 mg doses of Victoza®. In trials with on-treatment serum calcitonin measurements out to 12 months, 1.3% of patients treated with Victoza® 1.8 mg/day had new and persistent elevations of calcitonin from below or within the reference range to above the upper limit of the reference range, compared to 0.6%, 0% and 1.0% of patients treated with Victoza® 1.2 mg, placebo and active control, respectively. Otherwise, Victoza® did not produce consistent dose-dependent or time-dependent increases in serum calcitonin. Patients with MTC usually have calcitonin values >50 ng/L. In Victoza® clinical trials, among patients with pre-treatment serum calcitonin <50 ng/L, one Victoza®-treated patient and no comparator-treated patients developed serum calcitonin >50 ng/L. The Victoza®-treated patient who developed serum calcitonin >50 ng/L had an elevated pre-treatment serum calcitonin of 10.7 ng/L that increased to 30.7 ng/L at Week 12 and 53.5 ng/L at the end of the 6-month trial. Follow-up serum calcitonin was 22.3 ng/L more than 2.5 years after the last dose of Victoza®. The largest increase in serum calcitonin in a comparator-treated patient was seen with glimepiride in a patient whose serum calcitonin increased from 19.3 ng/L at baseline to 44.8 ng/L at Week 65 and 38.1 ng/L at Week 104. Among patients who began with serum calcitonin <20 ng/L, calcitonin elevations to >20 ng/L occurred in 0.7% of Victoza®-treated patients, 0.3% of placebo-treated patients, and 0.5% of active-comparator-treated patients, with an incidence of 1.1% among patients treated with 1.8 mg/day of Victoza®. The clinical significance of these findings is unknown. Counsel patients regarding the risk for MTC and the symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea or persistent hoarseness). It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate the potential risk of MTC, and such monitoring may increase the risk of unnecessary procedures, due to low test specificity for serum calcitonin and a high background incidence of thyroid disease. Patients with thyroid nodules noted on physical examination or neck imaging obtained for other reasons should be referred to an endocrinologist for further evaluation. Although routine monitoring of serum calcitonin is of uncertain value in patients treated with Victoza®, if serum calcitonin is measured and found to be elevated, the patient should be referred to an endocrinologist for further evaluation. **Pancreatitis: Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, has been observed in patients treated with Victoza®. After initiation of Victoza®, observe patients carefully for signs and symptoms of pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back and which may or may not be accompanied by vomiting). If pancreatitis is suspected, Victoza® should promptly be discontinued and appropriate management should be initiated. If pancreatitis is confirmed, Victoza® should not be restarted. Consider antidiabetic therapies other than Victoza® in patients with a history of pancreatitis.** In clinical trials of Victoza®, there have been 13 cases of pancreatitis among Victoza®-treated patients and 1 case in a comparator (glimepiride) treated patient (2.7 vs. 0.5 cases per 1000 patient-years). Nine of the 13 cases with Victoza® were reported as acute pancreatitis and four were reported as chronic pancreatitis. In one case in a Victoza®-treated patient, pancreatitis, with necrosis, was observed and led to death; however clinical causality could not be established. Some patients had other risk factors for pancreatitis, such as a history of cholelithiasis or alcohol abuse. **Use with Medications Known to Cause Hypoglycemia:** Patients receiving Victoza® in combination with an insulin secretagogue (e.g., sulfonylurea) or insulin may have an increased risk of hypoglycemia. The risk of hypoglycemia may be lowered by a reduction in the dose of sulfonylurea (or other concomitantly administered insulin secretagogues) or insulin **Renal Impairment:** Victoza® has not been found to be directly nephrotoxic in animal studies or clinical trials. There have been postmarketing reports of acute renal failure and worsening of chronic renal failure, which may sometimes require hemodialysis in Victoza®-treated patients. Some of these events were reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Some of the reported events occurred in patients receiving one or more medications known to affect renal function or hydration status. Altered renal function has been reversed in many of the reported cases with supportive treatment and discontinuation of potentially causative agents, including Victoza®. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment. **Hypersensitivity Reactions:** There have been postmarketing reports of serious hypersensitivity reactions (e.g., anaphylactic reactions and angioedema) in patients treated with Victoza®. If a hypersensitivity reaction occurs, the patient should discontinue Victoza® and other suspect medications and promptly seek medical advice. Angioedema has also been reported with other GLP-1 receptor agonists. Use caution in a patient with a history of angioedema with another GLP-1 receptor agonist because it is unknown whether such patients will be predisposed to angioedema with Victoza®. **Macrovascular Outcomes:** There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with Victoza® or any other antidiabetic drug.

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

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

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

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

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

Constipation	5.3	0.9	1.7
Dyspepsia	5.2	0.9	2.6
Add-on to Metformin + Glimepiride			
	Victoza® 1.8 + Metformin + Glimepiride N = 230	Placebo + Metformin + Glimepiride N = 114	Glargine + Metformin + Glimepiride N = 232
Adverse Reaction	(%)	(%)	(%)
Nausea	13.9	3.5	1.3
Diarrhea	10.0	5.3	1.3
Headache	9.6	7.9	5.6
Dyspepsia	6.5	0.9	1.7
Vomiting	6.5	3.5	0.4
Add-on to Metformin + Rosiglitazone			
	All Victoza® + Metformin + Rosiglitazone N = 355	Placebo + Metformin + Rosiglitazone N = 175	
Adverse Reaction	(%)	(%)	
Nausea	34.6	8.6	
Diarrhea	14.1	6.3	
Vomiting	12.4	2.9	
Headache	8.2	4.6	
Constipation	5.1	1.1	

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

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

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

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

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

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

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

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

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

OVERDOSAGE: Overdoses have been reported in clinical trials and post-marketing use of Victoza®. Effects have included severe nausea and severe vomiting. In the event of overdosage, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms.

More detailed information is available upon request.

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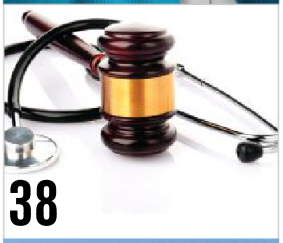

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PHOTO BY SCOTT WALKER

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

Firing the soul

Finding inspiration around you is what it takes to keep creativity in your life.

The articles in this month's issue—about medical students writing musicals and learning piano, cancer survivors finding their voice in reflective writing and an occupational medicine doctor writing screenplays—should have provided more than enough creative spark for me to generate this editor's note. Yet my fingers hovered impotently above the keyboard waiting for the muse to strike. I needed something to stoke the dying embers, to help me reclaim my writing roots. So I went to Asheville, North Carolina.

I had never been there but knew it was the birthplace of Thomas Wolfe, who was formative in my writing youth. During college as I discovered a love of language and the printed word, I found *Look Homeward, Angel,* Wolfe's classic coming-of-age novel set in the fictional town of Altamount, which was a thinly disguised model of Asheville, and featuring hero Eugene Gant, Wolfe's doppelganger. Wolfe's lush, poetic prose drew me in from the first page: "The seed of our destruction will blossom in the desert, the alexin of our cure grows by a mountain rock, and our lives are haunted by a Georgia slattern, because a London cutpurse went unhung. Each moment is the fruit of forty thousand years." Ever since reading that, I've tried to find the poetry in my prose.

So I tucked my copy of *Look Homeward, Angel* under my arm and headed for Asheville, a mecca not just for Thomas Wolfe fans but for artisans of all types. The first stop had to be Wolfe's home, a picturesque yellow frame house where Eugene Gant (aka Thomas Wolfe) endured the drunken tirades of his tombstone-carving father.

Today Asheville claims Wolfe as its native son; but it didn't always. So thinly did Wolfe cloak Altamount and its inhabitants and so brazenly did he paint their peculiarities and peccadillos that he was rejected by his fellow Ashevillians for years after the publication of *LHA,* prompting him to title his next novel, *You Can't Go Home Again.*

The raw energy of Wolfe's life and his writing seem to have fueled the creative explosion that Asheville has enjoyed during the 70 years since his death. In downtown shops and old warehouses along the river, artisans display colorful pottery crafted from local clays and hand-carved bowls hewn out of the panoply of woods available from the North Carolina forests. Bluegrass tunes waft from quaint eateries and raucous bars. Each block finds another Art Deco or arts and craft architectural gem. Like a potter's kiln, Asheville fires the souls of its artists and its very air inspires.

Finding inspiration around you is what it takes to keep creativity in your life and what's featured in this month's *Minnesota Medicine.* Whether you're pouring lattes at Starbucks or removing gallbladders in the OR, seeing the beauty and hearing the song around you will keep your fires stoked. It's a force that you can find on travels, but you don't really need to bring it back in your suitcase. It never really leaves you.

Now I can go home again. **MM**

Charles Meyer can be reached at meyer073@umn.edu.

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Over the past six years, the Center for Innovation has hosted the Transform Symposium, creating a community of thought leaders, innovators and disruptors. Transform is the premier, multidisciplinary conference focused on transforming the experience and delivery of healthcare as only as Mayo Clinic can. It's about pushing the health care system forward, inspiring creativity and innovation, and sharing new solutions and lessons learned. Transform connects design thinking, innovation, policy and world-class medical expertise to shape health care delivery of the future. Transform is always held in September, in Rochester, Minn., beginning the weekend after Labor Day.

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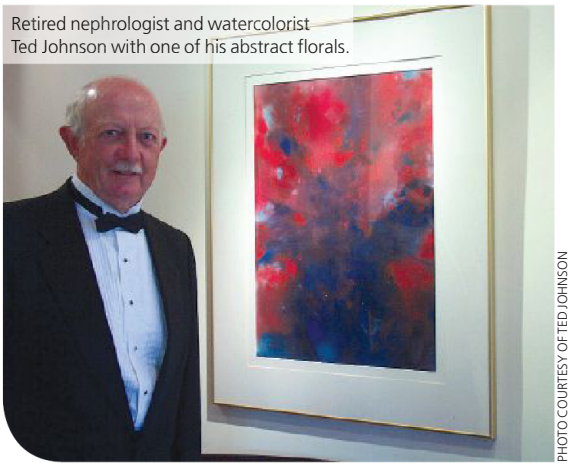


Retired nephrologist and watercolorist Ted Johnson with one of his abstract florals.

PHOTO COURTESY OF TED JOHNSON

Second-career artists

BY KIM KISER

Step into the Emeritus Room at Essentia Health's Duluth Clinic, and you'll likely see what some of the organization's retired physicians have been up to. That's because artwork by those very physicians is often on display.

One of the artists is Ted Johnson, M.D., a nephrologist who retired in 1998 and specializes in watercolors. A number of his works are in the Essentia Foundation's permanent collection and are on display in the organization's buildings in Duluth. He has also been selling his work through the mnartists.org website and at Lizzard's and Just for the Season galleries in Duluth and out of his studio. "I'm fortunate to have a retirement plan that does not depend on my painting for a living," he says with a laugh.

For Johnson, displaying in the Emeritus Room isn't about making money. It's about sharing his love of art with his colleagues and spreading the message that having interests outside of medicine is important.

Others are now doing the same. Retired cardiothoracic surgeon Per Wickstrom, M.D., has displayed his oil and watercolor paintings; retired surgeon Richard Adams, M.D., his wood turnings; retired dermatologist Tom Myers, M.D., his pottery; and practicing radiologist David Alexander, M.D., his photography. "The clinic is passively encouraging people to continue to produce art," Johnson says.

Johnson is the veteran artist of the group. Growing up in an artistic family (his father did oil paintings and his sister watercolors), he began painting as a boy, then put his skills on hold during college. About 20 years ago, he again picked up his brush and began going to workshops.

Johnson found that painting complemented the trips he and his wife liked to take; his subjects have included cathedrals in Germany, Sweden and Norway; Prague's canals; Norway's fjords; and scenes from Lake Superior and the Boundary Waters. "It adds a new dimension to traveling," he says. "You're always looking for sites that would lend themselves to paintings."

Johnson finds painting a way to remain productive. "We all have a need to feel like we're doing something creative and fruitful, like we are continually learning something," he says.

Music for a cause

BY CARMEN PEOTA

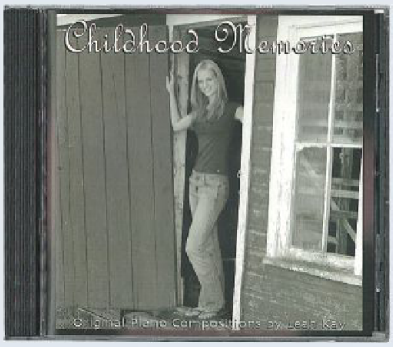
University of Minnesota medical student Leah Kay is one of those people who could as easily have gone into music as medicine. She plays a number of instruments including piano, bassoon and violin, and she composes music. And since she was a teenager, Kay has been selling recordings of her piano compositions to fund her education and support causes she cares about.

Kay says that when she was young, she used to listen to her mother give piano lessons, then go play what she'd heard. By the time she was 10, she wasn't just playing what she heard others play; she was playing what she heard in her head. By eighth grade, she had composed a number of pieces.

That prompted her parents to suggest she record a CD for family and friends. "What we didn't expect was that we had requests for the CDs," Kay says, noting that you'll hear her music playing in offices in her hometown of Dassel, Minnesota. That got her thinking people would be willing to pay for them. They did, and Kay made a second CD just before starting her undergraduate study at Concordia College in Moorhead.

With her father acting as agent, producer and distributor, Kay has sold or given away about 3,000 CDs over the years. About $3 from each sale goes to one of two organizations: the Make a Wish Foundation, in honor of her cousin, Christina Nordlie, and Jump Rope for Heart, in honor of a niece, Emerson Barbaro.

Kay says her composing has "slowed down significantly" since starting medical school last fall. Still, she hopes to record a third CD and would like to get her music on Pandora.



Leah Kay's recordings feature her original compositions for piano. She says she rarely writes out the notes but plays from memory.

To purchase a CD

Contact:
Craig Kay
24506 700th Ave
Dassel, MN 55325

The cast of 17 students from the University of Minnesota Medical School performing scenes from "A Medical School Musical: The Book of Netter."

PHOTOS COURTESY OF NATHAN WANDERMAN

A medical school musical

BY KIM KISER

Nathan Wanderman has always liked doing his own thing when it comes to music. Although he studied piano in grade school, once he became proficient enough to put chords together, he started writing songs. He also dreamed of one day writing a musical. "I don't really know why or where that came from. Maybe someone was whispering in my ear at an impressionable age," he says.

He didn't dream that his first attempts would be about life as a medical student. But such is the theme of "A Medical School Musical: The Book of Netter," which Wanderman, who recently started his third year of medical school at the University of Minnesota, wrote over six months starting last summer. "I wrote the first song while in Kenya with a couple of other people from my class. We were stuck in a rather boring meeting, so I wrote the song more to amuse them than anything else," he says, adding that he was inspired by a conversation with a classmate who had received a sizeable scholarship. "It seemed like good fodder for a song."

"The Scholarship Song" is one of 10 that make up the humorous hour-long musical. Last fall, Wanderman, who wrote all the original music and lyrics, put together a cast of 17 (one of whom was Nels Leafblad, who competed on "American Idol"), two stage managers, two choreographers, a light and sound director, and a four-member pit band—all of whom are members of the classes of 2015 and 2016—and staged the production for the medical school's annual talent show.

All the songs in the show deal with various aspects of medical school—studying, going to class (or not), mentors, wanting to be a doctor, the rivalry between medical students and law students, and having free time (for what may be the last time in a long time). The takeaway message: Make the most of your time in medical school.

The "Book of Netter" actually wasn't Wanderman's first attempt at combining medical school and song. He and some of the same students staged "Medical School: Turn Off the Dark," a 20-minute one-act that he billed as a "musical journey through the first semester of medical school." The show was performed at the 2012 talent show and later numbers from it were used in a Hippocrates Café program.

Wanderman says he doesn't have plans for another show at this point, and he hopes other students will "pick up the baton and put on something musical-wise." As he humbly says, "There are so many people here who are unbelievably talented."

You can watch
"A Medical School Musical: The Book of Netter" at
http://www.youtube.com/watch?v=zKULbJ9zTdg ***and***

"Medical School: Turn off the Dark" at
http://www.youtube.com/watch?v=S6ZnNEmLCas

2012 HealingScapes overall judge's choice: "Perfect Reflection" by Linda Weinmann

PHOTO COURTESY WINONA HEALTH.

Photo finishes

Hospital capitalizes on its scenic surrounds.

BY SUZY FRISCH

Imagine lying in a hospital bed recovering from surgery or an illness and gazing at peaceful images of the Mississippi River or southwestern Minnesota's stunning bluffs. Patients at Winona Health's 99-bed hospital can do that, as 29 photographs of local scenery are on display there.

The photographs were taken by area residents who entered Winona Health's HealingScapes contest. Launched last year as a way to celebrate the 50th anniversary of Winona Health's hospital building, the photo contest also helped the organization forge deeper connections with the community, says Betsy Midthun, vice president of community engagement.

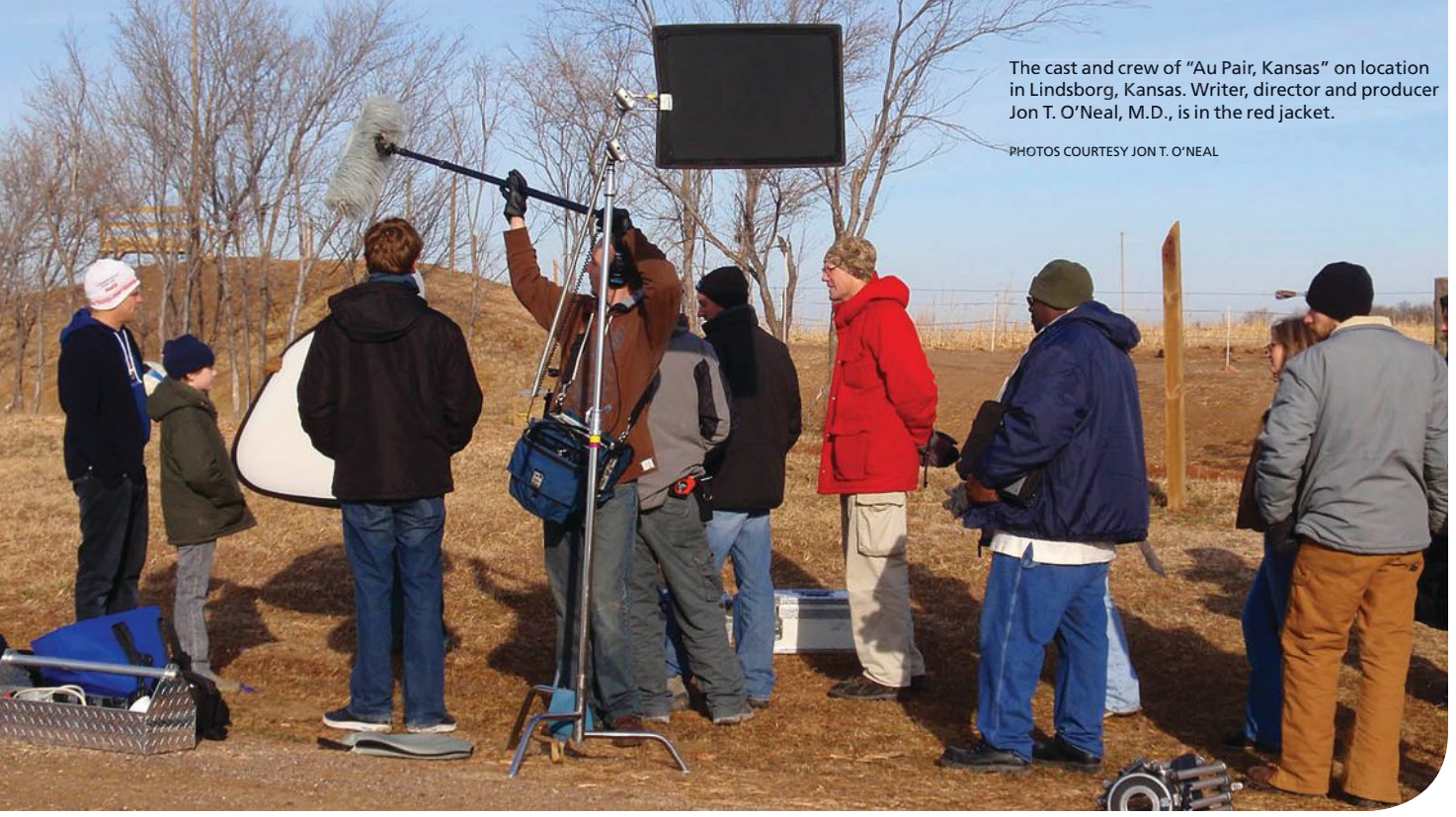
Inspiration for the contest came as the hospital finished converting patient rooms from doubles to singles, and staff discovered they needed art for the walls. Midthun, who moved to the area from South Dakota about four years ago and was taken with the scenic beauty surrounding Winona and the community's pride in its landscape, came up with the idea for having the contest and focusing on the area's healing landscapes.

"These photographs can be soothing for the viewer, and it gives us an opportunity to stop and think about the things around us in a different way, whether you're a patient or a doctor or a nurse," Midthun says. "The staff is under a lot of pressure to make sure everything is done well and that we provide excellent care. Having the art work on the walls makes people reflect in a different way and slow down a bit."

The hospital received 400 submissions from 150 photographers. All were initially displayed throughout the hospital and clinic. Employees, community members and professional photographers voted on their favorites; the final selections were made by the nurses on the floors where the pictures would be hung. The hospital auxiliary also held a gala, where guests could purchase a HealingScapes print for themselves and a framed print for the hospital.

Winona Health is currently holding its second HealingScapes contest, and it plans to continue the tradition. Its goal is to fill the hospital and clinics with work by local photographers.

Midthun counts HealingScapes a success. "When people are waiting for a loved one or a prescription, we see them wandering down the halls looking at the photos. It's a peaceful thing and it evokes memory," she says. It's also "is one more connection to our community."



The cast and crew of "Au Pair, Kansas" on location in Lindsborg, Kansas. Writer, director and producer Jon T. O'Neal, M.D., is in the red jacket.

PHOTOS COURTESY JON T. O'NEAL

Through a lens brightly

How a St. Paul physician mixes movie-making and medicine.

BY SARAH T. WILLIAMS

By his junior year at the University of Kansas, Jon T. O'Neal had already zoomed through his pre-med requirements and was pondering what to do with his remaining time in college when his older brother gave him a bit of advice that would crack open his universe: "Take art or music history classes," he said. "There will be questions on the MCAT."

"That was back in the day when people thought physicians should be 'well-rounded,'" says O'Neal, flashing one of many good-natured grins during a recent interview.

O'Neal heeded his brother's advice and enrolled in an art history class. The visuals went straight to the pleasure center of his brain: "I just loved it," he says. "It wasn't even like studying."

From that moment on, O'Neal pursued parallel and sometimes interweaving tracks: one in medicine and the other in photography, screenwriting and filmmaking. He now is director of the HealthPartners Occupational Medicine Residency Program and author of about a dozen screenplays, one of which became a full-fledged movie that won recognition at the 2011 Cannes Independent Film Festival.

Jon T. O'Neal, M.D.

Discovering the muse

If we were to rewind the tape of O'Neal's life to find the moment of his artistic awakening, we'd be in the basement of the Spencer Museum of Art at the University of Kansas, circa 1977, where O'Neal and his undergraduate classmates were granted a look at the hidden treasures. The museum's director pulled out a stunning oil landscape that grabbed O'Neal's attention. "I want to do my honors thesis on that painting," he announced.

The work was by Birger Sandzén, a Swedish artist who immigrated to the United States in the 1890s to become an art professor at Bethany College in Lindsborg, Kansas. His bold interpretation of the rolling plains, rocky outcrops, gnarled oaks and the Smoky River and Valley earned him the nickname "The Van Gogh of Kansas." O'Neal felt an instant affinity for Sandzén, who had discovered beauty in what others might regard as forbidding, frozen or lonely. In his own work, most notably in his 2011 film "Au Pair, Kansas," O'Neal would strive to replicate that love of place.

First forays in film

O'Neal's aptitude for the visual arts was in part a gift from his mother, who had been an art student at the University of Kansas. But because he could not paint ("no hand-eye coordination," he insists), O'Neal chose a camera as the outlet for his creativity. During his junior year in college, he took classes at the University of Southern California School of Cinematic Arts, learning the basics. He took a year off before starting medical school, primarily to spend more time with his father, who had been diagnosed with malignant melanoma, and explore using his camera.

During this break, he joined the mobile office staff of U.S. Sen. Bob Dole. As he traveled for Dole, and as he drove back and forth

from Kansas to Colorado Springs, where his parents had moved after retirement, O'Neal shot photos in all 105 of the state's counties. In retrospect, he regards the collection as "a rank imitation of the work of Walker Evans." Nevertheless, it is now in two Kansas museums and at the Library of Congress in Washington, D.C.

O'Neal's next project behind the lens was inspired by his work as an intern at the U.S. Air Force hospital in San Antonio during the mid-1980s. Doctors had just begun to test for HIV antibodies; anyone in the service who tested positive was sent to San Antonio. Besides checking for enlarged lymph nodes and Kaposi's lesions, there was little O'Neal could do medically for his patients. However, there *was* something he could do about the thick wall of silence that surrounded them. To create a safe place for his patients to meet and talk, O'Neal helped establish the San Antonio AIDS Foundation in the Bonham Exchange, a local bar.

In the empty upstairs ballroom, semi-consciously aware that he was witnessing an important chapter in medical and cultural history, he began photographing the torsos of his patients and their friends. When combined as a mosaic, the images had a simple symmetry that reminded him of the ancient Cycladic idols that he had studied in art history. In creating the piece, "The Bonham Exchange," he felt he had transformed the purely clinical into a work that was both aesthetic and of historic value.

"It's not just a picture, it's about what's behind the picture," he says. Curators at the Museum of Modern Art in New York agreed and accepted O'Neal's photographs into the museum's permanent collection.

Late nights at Harvard

Just as O'Neal was about to complete his military service, the Air Force made him an offer he couldn't refuse: full ride for a master's in public health and a residency in occupational medicine at Harvard.

There he learned about environmental toxins, management of blood-borne pathogens, prevention of workplace injuries, exposure investigations and industrial hygiene. And he began to explore yet another form of artistic expression: screenwriting.

Working late at night, O'Neal began writing a screenplay loosely based on real-life events: His older brother's roommate in medical school had died of AIDS, and Magic Johnson had just announced his HIV-positive status. O'Neal wrote a fictional story about a female physician who falls in love with a baseball player who happens to be HIV-positive.

To his surprise, he found himself channeling his characters' feelings. In medicine and in the military, "we train and drain the emotions out of our lives," he says. "And this was obviously very cathartic for me. I could open up and tell myself, 'It's OK to feel emotion. It's OK to cry.'"

Although the screenplay didn't get produced, the process of writing it helped him to become a more empathic listener, which O'Neal says is the biggest impact art has had on his life.

O'Neal with actress Traci Lords.

The making of "Au Pair, Kansas"

It sounds like the beginning of a joke: A soccer-playing Norwegian *au pair* comes to a Swedish town in the middle of Kansas to work on a bison farm. But this is the premise for "Au Pair, Kansas," a charming, poignant and sometimes funny full-length feature film by Jon T. O'Neal, M.D.

At the center is the impossibly ebullient and lovable Oddmund Lindeflaten (Håvard Lilleheie), who has been hired by the emotionally tight and vulnerable Helen Hazelton (Traci Lords) to act as a "role model" for her two sons and to help her run the farm. The family has many spoken and unspoken rules: No balls in the house. No forthright conversation about sexuality. No talk of death. No crying in the kitchen. Oddmund merrily breaks them all.

O'Neal seized on the idea for the film when he met Lilleheie at a film festival. "Yeah, sure," Lilleheie said after O'Neal proposed flying him from Norway to Lindsborg. As it turned out, the legal costs and fees for getting a work visa for the Norwegian actor were more than twice what he was paid for the work.

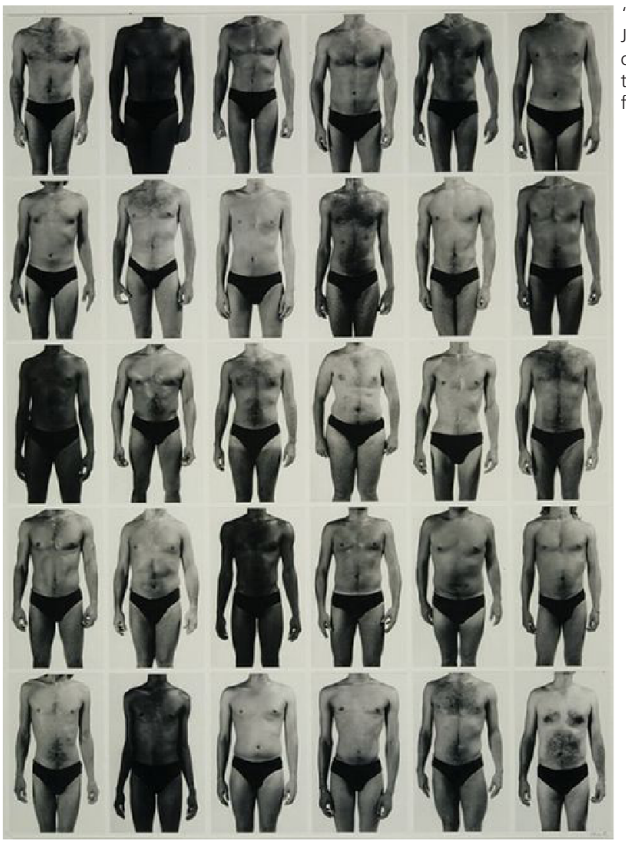
The film was shot with a Red One Camera in 18 days on location in Lindsborg, Kansas, and was named Best Low-Budget Feature Film at Cannes.

To read more about the film, go to www.aupairkansas.com. To order a copy of the DVD, e-mail aupairkansas@aol.com.—S.T.W.

Hollywood bound

After completing his Harvard education and spending several more years in the Air Force, O'Neal headed to Los Angeles, where he had been accepted in UCLA's competitive Master of Fine Arts in Screenwriting program.

While at UCLA, he won the school's prestigious Screenwriters Showcase award for "Black Diamond," a drama set in 1945 about a gospel/jazz singer who falls in love with a player for the Kansas City Monarchs Negro League baseball team; the Alfred P. Sloan Award for "Panther Lake," an environmental thriller set in Florida; and the Carl David Memorial Fellowship Award for "Diva and the Dudes," a musical comedy about an all-male *a cappella* quintet.



"The Bonham Project," a photo mosaic by Jon O'Neal, is now housed at the Museum of Modern Art in New York City. O'Neal shot these images of HIV-positive patients and their friends during the 1980s.

Meanwhile, he kept one foot in the world of medicine, serving as a medical consultant for Boeing's Rocketdyne division, where Space Shuttle engines were being made.

O'Neal didn't like much about Hollywood, but his schooling at UCLA helped him to define more clearly what he did and did not want to do as a filmmaker. "I really love small, independent feature films," he says. "I have no interest, for example, in having a screenwriter credit on 'Lara Croft Tomb Raider (V)'."

In his final semester, he told his classmates he wanted to write a script about a recently widowed woman living on bison farm in Kansas who brings over a Norwegian soccer player to be a nanny to her two sons. They looked at him as if he were from another planet.

O'Neal finished the script in 2004 and shot the film on location in Lindsborg, Kansas, in 2008. He was the first person in his screenwriting class to have a produced a feature film. "I willed it into being," he says. "I raised the money. I wrote, directed and produced the movie."

A foot in both worlds

O'Neal is still happily and passionately dividing his time between medicine and filmmaking.

In his role as residency director, he tries to instill in his students the same spirit of inquiry he inherited from his father, a career Air Force education counselor who made sure that not only his sons but also thousands of airmen completed their educations. O'Neal says, "I tell my residents that there's no way we can teach them about the tens of thousands of chemicals that people may be exposed to. I teach them to say, 'I don't know, but I *will* find out.'"

He's also getting ready to option a script that he co-wrote with producing partner and friend Tom Carmody. "Johnny Pigskin" tells the true story of the Haskell Indian Boarding School in Lawrence, Kansas, whose doughty football team played Notre Dame in 1914.

And he stays firmly grounded in the Midwest, grateful to his late parents for their unconditional encouragement of all his endeavors, to his brother, and to artist Birger Sandzén. "Au Pair, Kansas," he says, "is my love letter to Lindsborg, Kansas." **MM**

Sarah T. Williams is a longtime Twin Cities journalist.

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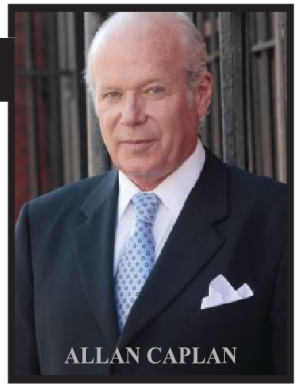

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Tapping THE

Mayo Clinic turns its arts focus toward those who care for patients.

BY SUZY FRISCH

Mayo Clinic pulmonologist Paul Scanlon rarely has time to come up for air, between caring for patients in the intensive care unit, seeing others who are critically ill, and directing research at Mayo's Pulmonary Function Laboratory and Pulmonary Clinical Research Center. But he tries to make time regularly to take in a concert, attend a writing workshop, or listen to a humanities lecture at Mayo.

He uses these small moments in his busy workday to tap into another side of himself—the side that majored in humanities at the University of Minnesota and that enjoys art and architecture.

"It keeps me sane. It's fun and enjoyable and stimulating in a totally different way than my practice of medicine," says Scanlon, who has chaired Mayo's Humanities in Medicine committee since 2003. "It keeps me connected and involved in the community. And to the extent that stimulating other parts of the brain improves your quality of life and productivity and ability to focus on your work, it has helped in that regard, too."

The notion of using art to promote healing is one the medical community has embraced for the past two decades, responding to growing body of research showing that it can reduce patients' anxiety, help them control their pain and increase their satisfaction. In recent years, though, many health care organizations, including Mayo Clinic, have started incorporating the humanities into the workplace as well as into patient care.

They, along with medical schools, are trying to bring art back into the science of medicine. "Since the late 19th century, the scientific basis of medical practice has been strengthened and some feel that perhaps we have lost, or are at risk of losing, a bit of the 'art and soul' of medicine in the process," says Johanna Rian, coordinator of Mayo's Center for Humanities in Medicine.

Mayo is now reaching out to future and practicing physicians through the arts, building on its long history of doing the same for patients and the community through concerts, displays of its extensive collections of paintings and sculptures, and therapeutic use of dance, music, art and writing.

Unlocking one's creative side helps doctors and medical students work through some of the emotions—positive and negative—that come from being deeply involved in patients' lives. That unburdening can have a therapeutic effect on their own well-being and help them be better physicians.

"Many studies have shown that physicians who are involved with the arts can be perceived by patients as more empathetic. They are better listeners and communicators," Rian says. "It also can help them achieve work/life balance and avoid burnout and stress."

Read on to learn about a few of the ways Mayo is encouraging physicians to tap their creative side.

Literature in medicine groups for staff

Once a month, a dozen Mayo Clinic physicians, residents, medical students and administrators come together for an interpretive reading and writing workshop called Literature in Medicine. Led by a facilitator from the Center for Humanities in Medicine, the participants read an excerpt from a work of fiction, a poem, a part of a play or an essay that often relates to health, illness or medicine. The facilitator then asks a thought-provoking question about what they just read and gives them about 10 minutes to respond.

Next the group comes together to discuss both the reading and the writing it inspired. It's a way for participants to gain exposure to different authors while also using their creativity to release some of their pent-up emotions or feelings about work, notes Rian, who is one of the facilitators.

"It helps them connect with a part of themselves that is too often silent and buried in the course of the average work day," she says. "There is so much pressure to see so many patients and move through all the red tape and paperwork that there seldom is time to be reflective. Those of us who write know how healing the act of writing is. This offers them some breathing space within themselves."

Dissection Day 8

In their hands
a human heart
fixed with formalin:
a thing they will learn
but never know.

Scars

Fifteen,
silver eyeshadow,
summer peach cheeks

I was in a bad place

Mismatched socks,
light jeans splotched
at the right knee

But I'm all fixed now

A black hoodie, torn
and faded from overuse,
oversized, probably
borrowed from the boy
who left his mark
in her left forearm:
a set of scarred slashes,
glossy pink tally marks

I'm ready to go home

Trang Ngoc Diem Vu wrote these and other poems while taking a narrative medicine selective at Mayo Medical School. "Dissection Day 8" was entered in the 2013 *Pharos* Poetry Competition.

creative side

Rian learned narrative medicine, an approach that ascribes honoring the stories of illness, from Rita Charon, M.D., director of the Humanities and Medicine program at Columbia University in New York. Charon spoke at Mayo last year about how the narrative medicine approach can help physicians and medical students develop their ability to reflect and increase their capacity for empathy.

It's something medical student Rachel Hammer takes to heart. A Literature in Medicine facilitator, Hammer is re-entering Mayo Medical School as a third-year after taking time off to earn an MFA in creative nonfiction from Seattle Pacific University. She finds it cathartic to express herself through writing and process some of the experiences from her training.

"The emotional collateral damage sustained by those working in the health professions is great," she says. "Literature in Medicine sessions provide a safe space for reflection on how patients' stories of loss and trauma brush up against our own."

In one of Hammer's recent sessions, she shared an excerpt from Mark Doty's lyrical book-length essay "Still Life with Oysters and Lemon." In it, Doty explores the interplay between the big picture and the small details of a painting and a life. Hammer juxtaposed the ideas in Doty's essay with taking a patient history, which requires weaving together a comprehensive personal narrative from snippets of information. She prompted participants to describe a clinical encounter where they could have taken a longer gaze at a patient's life instead of just noting their symptoms that day. "It's a time for them to capture situations they wouldn't necessarily take time to capture otherwise," she explains.

Humanities courses for medical students

In recent years, medical schools have used the arts to teach students about providing patient-centered care, harnessing their compassion and improving their communication skills.

Mayo medical students have a menu of electives to consider as part of the curricu-

lum. Called selectives, these are week-long classes and experiences that go beyond clinical education. Among the offerings are Humanities for the Physician in Training, Telling the Patient's Story and Narrative Medicine. Students also can do a visual arts independent study as a selective.

Scanlon believes it's important to teach humanities to medical students because it helps them obtain full-circle knowledge of human culture. He likes to quote 16th century French surgeon Ambroise Paré, who noted that "the art of medicine is to cure sometimes, to relieve often, and to comfort always." Adds Scanlon, "The part about comfort is where the arts come in."

For Diem Vu, who just completed her first year of medical school at Mayo, the humanities selectives she took allowed her to probe her experiences while unleashing her creativity.

For Vu, who minored in creative writing while she majored in molecular cell biology at Johns Hopkins University, the experience of taking the narrative medicine selective was like no other, as she got more individual attention from writing instructors than she ever did during her undergraduate studies. As part of the selective, Vu wrote poetry (see "Dissection Day 8" and "Scars," p. 17)

Humanities for the Physician in Training introduced Vu to experiences that pushed her outside her comfort zone. During one of the sessions, the executive director of the Commonweal Theater in Lanesboro used improvisation and movement to teach participants how to interact with patients and other physicians.

Vu found the acting instruction directly applicable to practicing medicine, explaining that improv skills come in handy when working with a patient whose condition is rapidly changing. The movement exercises have also helped her make a strong first impression with patients. "We had exercises where we practiced being centered and conveying confidence and competence when walking into a room," she says. "That's especially important for physicians because the physician-patient relationship starts when you enter an exam room."

CME events for physicians

For many physicians, continuing medical education can be less than engaging. In order to change that, Mayo recently teamed with the Guthrie Theater to teach physicians and other providers about addiction and mental illness. The first CME event, held at the Guthrie in May 2012, came about because Mark Frye, M.D., who chairs Mayo's Psychiatry and Psychology Department, wanted to delve into mood disorders through the work of Mary Pat Gleason, a movie and television actress who wrote a play about her struggle with bipolar disorder called "Stopping Traffic."

Participants listened to speakers, including Kay Redfield Jamison, a clinical psychologist who wrote *The Unquiet Mind: A Memoir of Moods and Madness* about her experience of having bipolar disorder, and then saw a performance/presentation about depression by Mayo psychologist Kristin Vickers Douglas. Using material she created for the CME event, Douglas presented three first-person monologues detailing a husband, a wife and a daughter's experiences with having a loved one with a mood disorder. Later in the day, participants watched Gleason perform her one-woman show, which was followed by a discussion.

Mayo's goal was to make physicians more aware of the symptoms of mental illness and the deep impact it has on patients' lives, explains Tim Lineberry, M.D., a psychiatrist and associate professor of psychiatry at Mayo.

"These illnesses are often missed or not treated adequately," he says. "Having a deeper understanding of the emotional impact of depression, mania, substance abuse or other mental illnesses can help physicians form an empathetic understanding of what the patient is going through… and focus on the importance of treatment."

Lineberry notes that hearing about individuals' experiences with mood disorders brought to life on stage hit home with many of the CME participants. "A number of physicians said it was the most powerful learning experience they've ever had for continuing education," he says. "It was so different from the way they usually do it."

PHOTO BY MICHAEL BROSILOW

A scene from "Long Day's Journey into Night." The Guthrie performance was followed by a discussion among physicians about addiction.

The event was so successful that Mayo hosted a second CME event at the Guthrie in January. That one used Eugene O'Neill's masterpiece "Long Day's Journey Into Night," about a family's struggle with alcoholism and substance abuse, as a vehicle to talk about addiction. Kathleen Brady, M.D., a psychiatry professor from the University of South Carolina, and other speakers discussed the biological basis of addiction, differences between addiction in men and women, and cutting-edge treatments. The event also featured actress Melissa Gilbert, who spoke about her and her family's experience with addiction.

Lineberry says Mayo plans to offer more theater-based CME programs in the future. "It works well with psychiatric illness and syndromes in particular because they are depicted often in drama and people can connect with them," he says. "When things are emotionally powerful, they stick with you. It's just good learning if you can make them real."

Rian says Mayo will expand its arts-focused CMEs to other departments while continuing to add workshops and classes for physicians and students. "It's about finding a balance between left and right brain, and arts and science," she says. **MM**

Suzy Frisch is a Twin Cities freelance writer.

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Kalob Johnson paints wooden boats with Heather Zinger, artist in residence at Sanford Health's Roger Maris Cancer Center in Fargo.

Artists in residence

Hospitals in Minneapolis and Fargo have hired artists to help cancer patients deal with the stress of treatment.

BY COLIN SOKOLOWSKI

Twice a week, artist Holly Nelson visits Hennepin County Medical Center's (HCMC) Comprehensive Cancer Center equipped with a colorful collection of art materials. As adult patients settle into chairs to receive outpatient chemotherapy, Nelson thoughtfully approaches them and asks, "Would you like to make something today?"

For Nelson, it's a delicate yet intense moment. Many of HCMC's patients do not speak English as their first language. Most do not participate in arts activities because of the expense. And many are exhausted from treatment, anxious about their outcome and sometimes less than hopeful.

"The ask is huge," she says. "I try to be calm, deferential and gauge their reaction. Simply saying 'no' can be empowering for them." More often than not, patients welcome the opportunity for a creative distraction. And when they do, Nelson pulls up a rolling cart that serves as an art table, and they get to work.

In October 2012, Nelson joined HCMC as an artist in residence assigned to work with cancer patients. Hennepin County Medical Center in Minneapolis and Sanford Medical Center in Fargo were among 90 organizations nationwide to win a $15,000 award from the Livestrong Foundation in the spring of 2012 to establish artist-in-residence programs for cancer patients.

Typically, artists in residence are professional artists brought into organizations to work with staff, clients or students who lack experience with a particular art form. In health care settings, artists in residence work with patients. (Note: They are not art therapists, who are specially trained to respond to patients' psychosocial needs and more closely integrate their work with that of other members of a health care team.)

The Livestrong grant recipients were required to create a program modeled after the Creative Center at University Settlement's artists-in-residence program in New York, which was designated a best practice model by the National Endowment for the Arts. Recipients were to hire artists to work at the bedside or in small-group settings to help patients learn about art and become absorbed in their own creativity as they deal with their diagnosis, treatment and survivorship. The grant also provided training for the artists.

HCMC used the funds to bring in an artist to work with patients in its Comprehensive Cancer Center eight hours a week for 11 months, plus purchase supplies. Sanford Health's Roger Maris Cancer Center used the money, and supplemented it with matching funds from the Sanford Health Foundation, to provide 16 contact hours a week for a year.

A creative distraction

Like many artists in residence, Nelson is a teaching artist. She is the adult program director at the Minnetonka Center for the Arts, and she owns Holly Nelson Studio, which sells drawings and paintings. This isn't her first stint as an artist in residence at a hospital; she has worked in the hematology/oncology unit at Methodist Hospital in Rochester.

Drawing from her extensive background, Nelson helps patients at HCMC paint with watercolors, draw or do crafts. For example, they might make a portrait or create a gift or card for a family member. A favorite project is making colorful clay flower blossoms using a pill cup as a vase.

ABOVE: "Art takes patients away from thinking about their illness and helps them focus on the present moment," says HCMC artist in residence Holly Nelson, pictured at left painting with a patient.

RIGHT: Introducing himself as a "leprechaun chip magnet" (he meant to say "chick magnet"), Gavin Maus had Sanford Medical Center nurses in hysterics with his artful disguise.

PHOTOS COURTESY SANFORD HEALTH AND HENNEPIN COUNTY MEDICAL CENTER

Sometimes if patients are too exhausted to participate or unable to use their hands, Nelson will take the lead. Listening intently to the patient, she'll paint a landscape or a childhood home or illustrate an important memory so patients can later admire the painting and meditate. She's also made farewell cards for terminal patients to give to loved ones. Nelson calls all of these projects "art collaborations" because, she says, she is merely "bringing out the art that is already within them."

Nelson notices her patients change when they get involved in a project: Jittery knees stop bouncing and anxious eyes soften. They often tell her time passes quickly while they are doing an art activity. And while working together, her patients frequently share stories about their lives, their families and their achievements. "We can enjoy a very important conversation on a different level than their conversations with physicians or nurses," she says. "I think patients feel better physically and emotionally after spending time with me. It makes their whole experience more positive."

HCMC has been integrating the arts into hospital care for more than a decade through its Inspire Arts program—a part of its Patient Experience Services Department. Funded by charitable donations, Inspire Arts offers patients and their families opportunities to make art at the bedside or in waiting rooms, an art cart stocked with art supplies, community and employee art exhibits, artist receptions and talks,

concerts and other events. The new artist-in-residence program is an extension of the initiative.

"We've always wanted a program like this, but we couldn't fund it," says Wenda Ballinger, arts program coordinator of HCMC's Inspire Arts. "An illness takes so much away from a person, but these art experiences give our patients the opportunity for self-expression and the chance to learn a new skill. It really contributes to a more positive healing environment."

Leasa Welter, Anne Stram and Stephanie Beyer admired a colleague's personalized lanyard on Nurse Appreciation Day at Sanford Medical Center.

Nelson is grateful to know her work is appreciated. "The staff have been incredibly supportive and encouraging from the beginning of my residency, and we have a shared enthusiasm for the work created by patients," she says. And she knows she's lucky to have landed her two artist-in-residency positions. "I know there are many teaching artists and professional artists who would love to do this work, but there simply are no positions available," she says.

Conversations and collaborations

At Sanford Health's Roger Maris Cancer Center in Fargo, artist in residence Heather Zinger is using art to connect with cancer patients and others in the community. Like Nelson, she gets patients involved in projects such as making domino magnets or transforming a photo of themselves into a humorous image of a leprechaun, the Easter bunny or Uncle Sam.

"It's a great way to pass the time," Zinger says, explaining that her patients are often receiving chemotherapy while working on art. "I want to bring humor to them."

She also involves others in projects. For example, she recruited elementary school students from Fargo Public Schools to make cards for patients depicting the children's favorite animals or something else that makes them happy. The idea was to get patients to visualize playful, cheerful images through the eyes of a child. Zinger also enlisted art students from North Dakota State University to create personalized lanyards to hold the I.D. badges for 16 medical oncology nurses.

"The lanyard project showed how nurses can be touched by the creative process," she says. "These customized, artful lanyards became a symbol of appreciation for their work and a testament to creativity put into a hospital setting."

The creative projects also get people talking. "Art is all about conversation, and these projects really gave our patients and staff something to talk about other than illness," Zinger says. She adds that the projects are appreciated by more than just patients. "The students felt like they mattered. With art, the focus isn't just on the patient. Everyone around it benefits as well."

Zinger firmly believes the arts can provide psychosocial benefits to people suffering from anxiety, loneliness or boredom. And she believes she's witnessing the healing power of the arts when her patients wear silly disguises they've created or when staff members join in the laughter. She believes providing an enriched environment and social interaction can have a measurable impact on how patients heal.

Research supports Zinger's belief. According to the 2009 State of the Field Report: Arts in Healthcare, some of the benefits of participating in visual arts activities include:

- Decreased symptoms of distress and improved quality of life for women with cancer
- Lessened depression symptoms and reduced fatigue in cancer patients receiving chemotherapy
- Fewer symptoms of acute stress in pediatric trauma patients
- Greater psychological strength in cancer patients
- More positive feelings and less distress in adult bone marrow transplant patients in isolation.

Shelby Terstriep, M.D., medical director of Sanford Health's Embrace Cancer Survivorship Program, has seen firsthand how the artist-in-residence program is helping patients. For example, her staff were able to cut the dose of a patient's pain medication in half because the woman was doing art while her wound dressing was changed. When the procedure was finished, the patient thanked the staff, telling them the art project was instrumental in reducing her pain.

"Healing comes in multiple ways," Terstriep says. "Patients have a lot of down time, and if we can engage and distract them with art, that helps. We need to treat their emotional side as well as their physical well-being."

Uncertain futures

Funding for these artist-in-residence programs will run out this fall. Both HCMC and Sanford Medical Center are looking for ways to continue and expand them to patients in other departments because of the benefits they've seen.

"Our whole industry should recognize the importance of art," Terstriep says. "In a perfect world, artist-in-residence programs would have as much consideration as any other medical center initiative. Showing that we care about the whole person matters." **MM**

Colin Sokolowski is a Twin Cities writer.

PHOTOS BY ADAM HIRSCH

MEDICAL STUDENTS *at play*

A look at some of this year's ***Fisch Art of Medicine award winners.***

BY CARMEN PEOTA

Each year at a celebration honoring University of Minnesota medical students who have received Fisch Art of Medicine awards (small grants allowing them to pursue an art form), retired pediatrician Robert Fisch, M.D., reminds the audience that he has only one expectation of the students: that they have fun. His deeply held belief is that physicians (and medical students) need to have an outlet, something that he says, "will give them joy to the end of their life."

For Fisch, one of those somethings is painting. But as this year's award winners demonstrate, what constitutes fun, let alone art, is very personal. The awards, which ranged in size from about $200 to $2,000, went to students pursuing pastimes ranging from playing the slide guitar to doing aerial arts.

Event emcee Jon Hallberg, M.D., noted at the celebration held at the Mill City Clinic in April that the mix of activities reflected the growing popularity of the seven-year-old program named for Fisch, a former University of Minnesota professor. About 40 students applied; 10 grants were given out. Hallberg said because of the strong interest, applicants are having to be more creative about what they intend to pursue in order to get a grant. For example, fourth-year student John Dunbar finally got one when he proposed using it to learn how to frame art. He had applied earlier to study photography. So had many others.

As they described their reasons for wanting to sing, swing from a trapeze or write prose instead of papers at the celebration, it was clear this year's crop of winners was an especially fun-loving bunch. Here's a look at how three of them used their awards.

Jonathan Avila

Two years ago, Jonathan Avila rented a house in St. Paul that came with a piano—not an out-of-tune clunker, but a newish Kawai in perfect condition. To Avila, who grew up in Brazil, this was an opportunity not to be missed. "I was always intrigued by the piano since I was a child. I just thought it was beautiful that people could make music, with their fingers dancing on the piano. So I had asked my parents to enroll me in piano classes. But we don't learn English in Brazil in school. We have to take private lessons," he explains. "We had to choose between English and piano, and they thought English would be more practical."

So knowing nothing about the keyboard or reading music, Avila applied for a Fisch award so he could take lessons. He didn't get an award his first time, but did so during his fourth and final year at the university. He found a piano teacher who could give him lessons on Saturdays and set what he thought was the reasonable goal of practicing 20 minutes a day. Instead of struggling to meet that, he discovered he loved playing so much, he'd often practice much longer.

"I finished the entire adult learner book," Avila says, proudly sharing that he even gave a little recital for his family when they came for his graduation. He says they were surprised that he chose medical school as the time to learn to play an instrument. But Avila told them it was a great way to relax. "If I came home from the ED, and there had been lots of trauma, I would just sit at the piano and play songs and things would seem all right," he says.

Avila says he expected learning to play the piano to be sort of like learning a language. "I was very surprised at how much fun I had and how much it's opened to me a whole new world that's out there." He plans to continue studying, even as he moves on to residency in pediatrics in Columbus, Ohio.

Fortunately, he will not have to bid farewell to the Kawai. His landlord was so pleased someone was using the piano that she gave it to him. Along with the piano, he's taking with him Book 2 in the adult learner series.

Laura McCarthy

Before she was a medical student, Laura McCarthy studied Spanish in Guatemala. During that time, she'd occasionally go salsa dancing. "I only took a handful of lessons when I was down there, but it sparked my interest," she says, explaining that it seemed to fill a gap created when she stopped doing gymnastics after a dozen years.

Fisch Art of Medicine Award Recipients 2012-13

Jonathan Avila, piano
Zack Beatty, slide guitar
Jennifer Beck-Esmay, voice
Aaron Crosby, writing
John Dunbar, photo framing
Michelle Hamline, piano
Laura McCarthy, dance
Erin Morcomb, flute
Alexander Ringeisen, voice
Xin Zhang, aerial arts

McCarthy, who just completed her third year of medical school, noticed that dancing was a big part of community life in Central America. As she and her husband, Patrick McCarthy, also a medical student, talked about going back there to practice medicine one day—they're both interested in global health—they realized knowing how to dance would be useful. "Being able to dance is a way to participate," she says.

So McCarthy applied for a Fisch award in order to take salsa lessons with her husband. She says dancing was an outlet for her during what turned out to be a stressful year. Not only was she contending with medical school, she helped care for her father who had adrenocortical carcinoma and passed away. The couple plans to keep dancing. Salsa, she says, was a springboard. "Once you get your feet wet with salsa, you realize there's so much more to learn."

In addition to being fun and a way to relieve stress, she says taking group lessons taught her a surprising lesson about herself. "I have a tendency to lead," she admits. "When you're confronted with someone you've never met before and they're about to lead you and they do it differently than the previous person, you have to learn to just go with the steps." When asked if that observation might apply to other aspects of her life, she replied: "Yeah, salsa has taught me adaptability."

Alexander Ringeisen

When Alexander Ringeisen was in the 10th grade in Lakeville, Minnesota, his high school choir teacher introduced him to barbershop singing, the style characterized by four-part, close harmony. He and three friends formed a quartet, and for the next eight years, they sang together and took part in local and national competitions. (The Barbershop Harmony Society and other organizations sponsor competitions for youths and adults across the country and around the world.) But the quartet disbanded about the time Ringeisen went to medical school.

When Ringeisen learned about the Fisch award program, he saw a chance to get back to singing. "It was such a great opportunity to get back into something that I used to be passionate about," says Ringeisen, who graduated and is starting a residency in ophthalmology at the University of Wisconsin. He used his award money to take voice lessons to get his voice back into shape and regain his confidence (he sings lead). He bought music and formed the new quartet OnChord. Because one member lives in San Francisco and the others are in the Twin Cities, they practiced "together" some of the time by emailing recordings to each other. Their distance approach paid off, and the quartet qualified to compete next fall in a competition in La Crosse, Wisconsin.

Ringeisen says singing in a barbershop quartet requires commitment. "You really have to practice a lot. With only four voices, one person making a mistake or not doing something at the right time can really throw off a performance." Mostly, though, he says it's just fun. "There's definitely a nerve-wracking component, but as soon as you start singing, it goes back to all the practice you've been doing and it really becomes fun."

And like Fisch, Ringeisen doesn't think fun is frivolous. "I'm a pretty firm believer that everybody should have not just one but multiple interests outside of medicine. It can help you stay grounded." **MM**

Carmen Peota is managing editor of *Minnesota Medicine*.

Medical student-artists Laura McCarthy, Alexander Ringeisen, Jennifer Beck-Esmay, John Dunbar, Aaron Crosby, Xin Zhang, Erin Morcomb and Michelle Hamline at the award celebration April 19 with Jon Hallberg, M.D., (far left) and Robert Fisch, M.D. (far right).

A DECADE OF MUSINGS

Ten years ago, we launched our Medical Musings writing contest not knowing what sort of response we would get.

We suspected that many physicians and medical students had stories to tell, but we didn't know whether they would actually put pen to paper. We were surprised by the number of heartfelt essays, poems and stories we received that year and have been each year since.

We've learned that for some, the contest is the nudge they need to get going on their writing. For others, it's permission to take a break from their busy days and process what's going on around them. And for all, it's the opportunity to share a piece of themselves with their colleagues.

In celebration of the contest's 10-year anniversary, we are holding a Hippocrates Café event on September 19 at the Mill City Clinic. Actors from the Guthrie Theater in Minneapolis will read some of the winning entries from the past decade. You'll find details in upcoming issues of *Minnesota Medicine*.

We would like to thank all who entered our contest this year. As always, choosing winners is never easy.

In the following pages, you'll find the top physician and medical student entries, "Blind" by Michael Shreve, M.D., a St. Paul pediatric pulmonologist, and "Walking Alone" by Lillian Johnson, who is starting her third year of medical school at the University of Minnesota. Over the coming months, we will publish the poems and essays that received honorable mention (see box on page 30). Be sure to watch for them.

PROFILES BY KIM KISER • PHOTOGRAPHY BY KATHRYN FORSS

PHYSICIAN WINNER
Michael Shreve, M.D.

For Michael Shreve and his siblings, writing poetry is a family affair. His brother, Paul, had published several books of poetry before he died of liver cancer in 2009. His sister, also a poet, has had some of her poems published online.

Shreve, a pediatric pulmonologist with Children's Respiratory and Critical Care Specialists in St. Paul, came later to the game of poetry writing, having just started last year. "Because of my brother and sister, I think I got the courage," he says.

Shreve had plenty of material to work with. For years, he has carried in his briefcase a journal into which he records observations and thoughts. "I write things when I think of them or see them," he says. Shreve thought the notes might one day come together in a novel. "But I started looking at the things I had been writing, and it didn't look like they would be pieces of a bigger story."

They have, however, provided the scaffolding for his poetry. The inspiration for his winning poem, "Blind," came from his notes about two individuals. One was a boy he met during residency who didn't want to be sedated for an outpatient procedure. Even though everyone assured him he would be all right and that it would keep him from feeling pain, it didn't make a difference. "We all thought he was crying about the pain," Shreve says. "But it was really about the fact that he would have to stop playing videogames, which the hospital had but he didn't have at home."

The other was a woman who had cancer. When the woman's friends asked what they could do to help her, she told them to make curtains for one of the rooms in her house. The reason for such an unusual request: so she could open and close them whenever she wanted. "It was something she had control over when she didn't have control over anything else in her life," he says.

Both stories were about the loss of something—the boy's ability to play video games and the woman's feeling of being in control.

And they made him think about what it would be like if something important to him, but seemingly unimportant to others, was taken away—in this case, being able to watch the trees change with the season. "I love the look of the trees and I thought if my sight was taken away, I'd still have the sound of my family's voices and the feel of their faces and people would come up with replacements for everything else, but that would be something I would never again have. And it would be hard to describe to other people why it was important."

Although Shreve doesn't often share his writing with others, he sent a copy of one poem that was published in a recent *Minnesota Medicine* to the parents of the child whose story inspired him. "Rose" described physicians keeping a baby girl alive until her parents could get to the ICU to be with her when she died. "I got the nicest letter back. It turned out the very day they got the magazine, their other child went to the ER with seizures. He turned out to be fine. But the mother looked at the fact that it happened on the same day as a sign, and that was very cool."

Blind

BY MICHAEL SHREVE, M.D.

For months
Wondered what he would miss most
Now he knows

Leafless branches on the trees
Black elm tributaries draining sky to trunk
Maple sticks not fiery leaves
Halloween oaks of Irving and Poe
Black, curving, tapering to air
Gossamer endings
Uninterested in wind, rooted to sky
Against the flaming sunset, sunrise
Twice daily, if he was lucky
God's shadow puppets, but still
Too intricate for art, science
That is what he would miss most

Macular degeneration, his doctor said
He had read about it, understood
Preoccupied with what he would miss most
Mind cataloged lists
When it is all gone
Now he knew

It should be her face
But it would endure, imperishable
Smiling more. No frown lines, ever
Or the little ones
They would grow by words, changing voices
Awkward squeaking, stories
Blind is love

The black, leafless branches
Pasted on red sky
That is what he would miss most
Wondered how long he could stand
Not seeing that

MEDICAL STUDENT WINNER
Lil Johnson

Lil Johnson has a love-hate relationship with writing. "I enjoy it," she says. "But at the same time it can be really tedious, and I feel like when I write something, it's never complete."

That was in part why she ignored English teachers in Alaska, where she grew up, who encouraged her to think about becoming a writer. "I couldn't see myself as a writer," she says. "I figured I would be one of those people who would be holed up at home and wouldn't finish anything for years. I didn't want to do that."

What she wanted to do, as she mentions at the beginning of her winning essay "Walking Alone," was become a doctor. "I don't have a good reason as to why—I didn't for my [medical school] interview, either. They say you're not supposed to say you want to help people—that it's too cliché. But that's really what it's all about. Ever since I was really little, I knew it's what I wanted to do," she says.

More specifically, Johnson wants to one day return to Alaska to work in a facility that serves Native Americans. She says that desire was what brought her to the University of Minnesota's Duluth Medical School, where she recently finished her second year. "Alaska doesn't have a medical school, so I applied to the campus in Duluth because I liked the small class sizes and because they have an emphasis on Native American care," she says.

Although as a medical student she has had to do writing assignments—to reflect on things that happened during training—her winning story didn't grow out of one of those exercises. Rather, it was the product of a sleepless night. "I decided to write what I was feeling to get it all out and clear my head," she says. "I'm the type who represses things. I don't think about it, and that's why every now and then something will bother me, and writing helps me get it out."

In this case, writing helped her process what she was feeling about her life and her role in medicine. Although the essay was initially done for her own benefit, she decided to enter it in *Minnesota Medicine's* writing contest when she got an email about the contest from a mentor, who had read some of her reflections and encouraged her to flesh them out and submit them for publication. "That's when the wheels started turning," she says. "I decided it was worth a shot."

Walking Alone

BY LIL JOHNSON

Little girl is asked, "What do you want to be when you grow up?"

"Doctor," she replies, beaming. Then little girl with a Brady Bunch life, the whole world in front of her, grows up.

Jaded by a life turned sour, teenaged girl is asked what her future plans are. "I'm not going to college," is her bitter response. College happens regardless, probably because she doesn't know what else to do. Then graduation, magna cum laude, head held high, a happy moment. She looks for her family afterward, only to be told her father didn't come, didn't watch her walk. A stunning slap in the face, even after years of disappointment that should have prepared her for this. She wanders away, tears streaming down her face, the girl who doesn't cry. She stays down for some years, defeated, ambition creeping away. She is lying still, staring at the same place on the wall, finding shapes in the plaster like children do with clouds—lying on the grass, the sun in their face … distant, happy memories. She tries to block out the screams from behind the door, the berating voice telling her she is nothing, will be nothing.

The years go on, the screams continue, her skin grows thick, determined. "What will you do now," she asks herself. "I'm going to be a doctor," is her hardened, driven response.

Brown girl in a sea of white, skin and garments both. Sticks out like a sore thumb at this momentous ceremony, the pitiful kid with no family. Her name is read, she walks across the stage, shrugs into the white coat placed over her shoulders and thinks about how no one is watching. No one cares. Right then she says a prayer, asking that her mom live long enough to watch her walk that final walk, where they call her "doctor." She says that prayer every day thereafter. She looks about and hates everyone around her. She hates them for their perfect lives. For their parents who are still married. For their parents who are still alive, who get to witness this important event. For their laughter and their easy smiles, and their pictures, and their happy tears. "I hate them, I hate them, I hate them," she thinks, at least for today. She feels robbed of all the milestones. A graduation ruined, a white coat ceremony made miserable. A father who will never, ever walk her down the aisle. A mother who may never see her get married, or know her children, or watch her become a doctor.

She sits in class and learns about the disease that killed her father. She pinches herself to keep from crying—she can't let down her guard. She studies about the severity her mother's health problems. You can't really stay in comfortable denial when you're going to be tested on this stuff, she thinks. More pinching. She hears that with Crohn's Disease, surgery should be avoided at all costs, should only be done in the most severe cases. She tries to count the number of operations her brother has gone through. How can they be so nonchalant, she thinks? That's her brother they're talking about!

A surgeon comes in to lecture. He jokes about patients who died under his care. He laughs. He actually laughs! Some of her classmates find him brilliant, they laugh along with him. Her heart pounds in her chest, enraged—what if he were her father's doctor? What if that were her father he was laughing about? She sits stoically in her seat, acting like the professional she's expected to be.

Notice comes that another brother, who has HIV, is not doing well. She is supposed to hear that and then go right back to studying, unaffected? She thinks about all the other places she should be, not here in medical school, so far from home—away from the people who matter to her. "What am I doing? Why does this feel so selfish?"

"At some point in your life, you have to be selfish," he tells her. They are sitting in her car. It's dark out and rain blankets the windshield, replacing the tears she cannot shed. Years of training her eyes to stay dry, her lip to not quiver. She wishes she had practiced harder on steadying the cracks in her voice. She is dropping her Minnesota friend off for the last time and confessing to him that she might not come back to start second year—she is going home to Alaska for the summer. She is afraid she will find that death is near her family and then she won't be able to leave them. One parent is gone, the other is not well. She's terrified. She can't walk across that stage again knowing no one is watching.

She leaves for the summer, the situation at home is not ideal, but something makes her return to Minnesota. Selfishness perhaps? She lives for the patient contact. She works at a clinic full of patients with challenges: alcohol and drug abuse, homelessness and poverty, depression and mental health disorders.

She is told there is a man in room 7, history and physical should be quick and easy. She walks in alone and doesn't come out for over an hour. The patient tells her about his rough life. She is always amazed at what people are willing to confide to her. She sits and listens for as long as he wants to talk. The beauty of being a medical student, she thinks, is that sometimes she has nowhere else to be, she can give patients all the time

(continued on next page)

they need. At some point he stops and apologizes, considers aloud how she probably has no idea what he's talking about. She pauses, cautious. How much of her own background is appropriate to share with a patient? She doesn't want to overstep her boundaries. She takes a leap and confides details about her life. They share many of the same hardships. His eyes grow wide, then his tears come. He cries for her, how beautiful. She keeps composed, as she is so accustomed to doing, and tells him how she has made it through the darkness. They talk forever, and as she leaves he expresses gratitude, praises her as a future doctor, tells her preceptor that this girl made his day.

She realizes, in a way, she has a gift. She wears a white coat, a symbol of prestige, still she is one of them—a brown girl with a broken life, pieces glued together. As much as she hates the suffering she has endured, she realizes it has given her the ability to relate to her patients, earning their respect, touching their lives.

She walks away, head held high, a happy moment. Perhaps she is walking by herself, yet never alone, and it is a very, very full life.

Honorable Mention

Honorary MD
Marianne Bernadino
medical student

Check Meds
Benjamin Marsh
medical student

Adeline
Margaret Nolan, M.D.

Diastole
Diane Pittman, M.D.

My First Delivery in Africa
Pete Olsen, M.D.

THESE PIECES WILL BE PUBLISHED IN FUTURE ISSUES OF *MINNESOTA MEDICINE*.

THEIR BEST SHOT

THE WINNERS OF OUR THIRD ANNUAL PHOTO CONTEST

Many amateur photographers take pictures when they see something—often a landscape or a building—that strikes them as beautiful. To the judges of our photo contest, great photos aren't necessarily the ones of beautiful places or things. They're images that tell a story. They're the ones that get us into the moment with the photographer, that cause us to pause, to take a second look, to wonder.

Professional photographer Steve Wewerka, who with *Minnesota Medicine*'s art director, Kathryn Forss, helped judge this year's contest, says the winners in the student category clearly show the photographers' intent to tell a story. "All three compelled me to stop and look closely at the creative way they captured a moment," he says.

Of course, good photographs also display the photographer's technical prowess—they're well-composed and well-lit. Wewerka says technique was especially evident in the submissions in the physician category. "Where the images by the students captured the in-the-moment feel, the photographs in the physician category display a thoughtful understanding of the photographic process," he says. "Each winner has a solid understanding of composition, balance and the use of light to convey a story." Here are the winning entries.

STUDENT CATEGORY

First place

The Cow in the Tower

PHOTOGRAPHER: Kristi Hultman

WHAT INSPIRED THIS PHOTO? "After hiking up to the top of Glastonbury Tor in England, I was surprised to see a herd of cows grazing around St. Michael's Tower. The Tor has been occupied by various groups for thousands of years. The image captures its current resident, framed within the stone tower's arches."

WEWERKA: "Great composition and a bit of humor. The lines lead me in to the main subject."

STUDENT CATEGORY
Second place

Maripositas

PHOTOGRAPHER: Erica Bohan

WHAT INSPIRED THIS PHOTO? "I wanted to capture the bliss of second graders eager to share what they had learned from a lesson about animal names."

WEWERKA: "Great balance. What makes this image compelling is the suggestion of a child in the middle. … I don't feel I am looking into this image but being looked at by the kids."

STUDENT CATEGORY
Third place

North Shore Storm Front

PHOTOGRAPHER: Dan Larson

WHAT INSPIRED THIS PHOTO? "We were relaxing on the rocky shores of Lake Superior near Hovland, Minnesota, when this incredible storm front crept up on us. I ran inside to grab the camera and got this shot before we were pummeled with a violent hail storm."

WEWERKA: "We are drawn to this photo's atmospheric oddities. This photo has both intriguing subject matter and solid composition."

PHYSICIAN CATEGORY

First place

Alleyway near Ponte Vecchio, Florence, Italy

PHOTOGRAPHER: Marilyn Peitso, M.D.

WHAT INSPIRED THIS PHOTO? "Strolling down a back alley in Florence, I was attracted by the juxtaposition of shapes, flash of color and symmetry in an otherwise drab and dingy back street."

WEWERKA: "Great balance and intriguing use of lines and mix of old and new subject matter. Shows awareness of lighting, which was used to make an image that demands attention."

PHYSICIAN CATEGORY
Second place

Humming Courtship

PHOTOGRAPHER: Paul Dondlinger, D.O.

WHAT INSPIRED THIS PHOTO? "The technical challenge of capturing the detail of humming birds in flight. I was also inspired to capture one the most fascinating backyard displays nature affords us. We are surrounded by art, even in the least expected situations."

WEWERKA: "Great use of color and natural space. Sometime it is the spaces not used that are the most telling aspect of an image. Top that with a great moment."

PHYSICIAN CATEGORY
Third place

On the Trail to Mt. Cook

PHOTOGRAPHER: Alex Sneiders, M.D.

WHAT INSPIRED THIS PHOTO? "I was imagining someone hiking to Mt. Cook under the southern stars."

WEWERKA: "When used properly, the most basic photographic elements create an eye-catching image. This image uses complementary colors and vanishing point of view to capture the viewer's eye."

Getting the word out on MNsure

The many facets of promoting the new health insurance exchange

BY MELISSA MRACHEK

While most Minnesotans are enjoying summer, a team of health care, IT, marketing, outreach and education experts are hard at work gearing up for an unprecedented event—the fall launch of Minnesota's health insurance exchange, MNsure. Over the past three years, every aspect of MNsure has been scrutinized and debated. Now it's time to roll it out to the community.

It's becoming crunch time for MNsure. The summer months will be devoted to heavily marketing the online tool to its future users.

That will be done in multiple ways, according to April Todd-Malmlov, executive director of MNsure. "You will start to see a whole host of marketing efforts including TV, billboards, radio, newspapers and social media such as Facebook, Twitter and LinkedIn," she says. MNsure staff are also working with corporate partners to get the message out and sending speakers to community forums to create awareness. "We are really trying to hit people in every possible venue that we can," she says.

Reaching the right people

In addition to the broad-based marketing efforts, MNsure is launching outreach campaigns targeting specific communities and audiences. "For Hispanic populations, we are working with organizations that already have an established presence and trust in those communities," Todd-Malmlov says.

To reach small businesses, MNsure is connecting with insurance brokers and local chambers of commerce. Staff members currently are collecting letters of intent from brokers who wish to work with the exchange. "I have heard from some that they see this as a business opportunity," Todd-Malmlov says. Brokers who wish to work with MNsure are required to complete training and pass a competency test.

For those who use the exchange, Todd-Malmlov says MNsure will provide assistance in the form of staff members and counselors who might work for hospitals, clinics or social service agencies but who have been trained and certified to access the system and help people review options and enroll in a plan that is right for them. "We need to ensure that anyone acting as an advisor on behalf of MNsure understands the new rules for the Affordable Care Act, the programs and systems available through MNSure, how the system works, how you access it, and privacy and security rules," she says. The exchange also will have a robust customer service center and website.

The physician's role

Todd-Malmlov hopes physicians and other health care providers will help create awareness of MNsure. "The doctor's office is a place people trust for health care information," she says. "We want to make sure physicians are aware of MNsure and provide formal mechanisms for them to access information for their patients." Todd-Malmlov says they are also working to make sure physicians have information in multiple languages to offer patients.

Even though many of the pieces are in place, MNsure's implementation won't be without its challenges. "Doing something of this magnitude in this amount of time is unprecedented," Todd-Malmlov says. "We know things won't be perfect and we will have a few bugs to fix along the way. As time goes on, the measures of success will be that consumers are getting enrolled, the number of uninsured is decreasing, and we have high satisfaction levels from all customers."

Physicians who've shaped MNsure

MMA members have played integral roles in MNsure's development. Roger Kathol, M.D., served on the 15-member exchange task force. He also served as co-chair of the Adverse Selection Work Group. Kurt Hoppe, M.D., served on the Measurement and Reporting Work Group. Marilyn Peitso, M.D., was a member of the Plan Certification Work Group and also served on an earlier group that provided feedback on the informational needs and process flows for the exchange's infrastructure. Kathryn Duevel, M.D., is a member of the MNsure governance board. (See story on next page.)

A FEW MINUTES WITH…

Kathryn Duevel, M.D., MNsure board member

BY DAN HAUSER

Kathryn Duevel, M.D., freely admits that MNsure, Minnesota's health insurance exchange, is a "gamble." But in the next breath, she is quick to add: "Without it, the gamble would have been even bigger."

When it launches October 1, MNsure will be the online marketplace for individuals and business with 50 or fewer employees to shop for and secure health insurance. It will have an impact on more than 1 million Minnesotans, or about 20 percent of the people in the state.

Duevel and five other Minnesotans were named to the MNsure board by Gov. Mark Dayton at the end of April. They joined Lucinda Jesson, the commissioner of human services, who was appointed to the group earlier this year.

Duevel, who retired from ob-gyn practice in 2012, knows the MNsure board will be closely scrutinized. And she realizes that as the lone board member with medical training, she'll be in the spotlight. "We have our hands full, but I'm pretty confident it will go well," she says.

This isn't the first time Duevel has joined a board; she has served on hospital and local community boards. But the work of this one is far and away the most complex. Duevel, an MMA member since 1991, recently discussed her new role.

Kathryn Duevel, M.D.

What made you want to be part of the MNsure board?

I think the basic idea of a health insurance exchange was very attractive to me because it is so difficult for people to negotiate the complicated system of finding health insurance. I've been following the legislation and when I saw that it had passed and was signed, I started to inquire as to how to be involved. I felt that it was really important that someone with a medical background have a seat at the table.

Did your background as an ob-gyn factor into your wanting to be part of this board? Have you dealt with many patients who have had trouble obtaining insurance?

I think I have kind of a unique perspective. Indeed, I've had patients who were struggling with how they were going to pay for something. I remember one patient who was going through a divorce and had to get her house sold before she could afford to buy insurance when we were diagnosing her with early cervical cancer. What a position to be in! That's just one story among many. I also think being an ob-gyn makes me particularly well-positioned because in some ways, we ob-gyns belong to all parts of medicine. We do a lot of primary care. We care for pretty much the whole spectrum of patients—from the newborns we deliver to the adolescents and young women of reproductive age to aging women. But we are also surgeons and do procedures, so we have perspective on that kind of care. I think that puts me in a unique position for looking at providing good coverage.

What do you hope to accomplish on the board?

My personal goal, which may be very different from that of the other members of the board, is to think about patients. We need to provide a system that's usable from the patient's perspective; it's going to need to be understandable for people from all parts of our state. And by that I don't just mean geographic differences. I also mean economic, educational and language differences. We have to remember who this is about—it's about the people of Minnesota. I think that I can bring the perspective of the patients who have struggled. And I think I have an advantage in that I recently completed a master's program in health care delivery science out of Dartmouth.

What have you heard from your peers?

I have heard from a lot of providers, colleagues, physicians, nurse practitioners—a variety of people—who have expressed almost relief that there is somebody with a medical background on the board. They're concerned about how this is going to work. We all are—because it's such a new entity and way approach to things. Everybody I've met who is involved with the exchange is very thoughtful and purposeful. I don't see anything being done that makes me concerned about the viability of practice in our state or that this is going to be detrimental to small practices or large practices. I feel pretty positive about this and the goals. I'd like to leave a note of encouragement to physicians who have apprehension about the health insurance exchange: I hope to be part of making sure this has a positive impact on our patients, so that they have more of opportunities to get the health care they need.

News briefs

State Supreme Court recognizes "loss of chance" claim for medical malpractice

In an opinion that departs sharply from established precedent, the Minnesota Supreme Court held for the first time that a claim for medical malpractice exists if a physician's negligence causes a patient's chance of survival to be reduced.

The 3-2 decision on May 31 in Dickhoff v. Green reversed law that had previously held that a physician may only be liable for harm a patient actually incurs. Under the old law, in order to prevail on a claim for medical malpractice, a patient had to establish that the physician's negligence more likely than not caused the patient's claimed harm. Now, a medical malpractice claim may prevail if a patient merely establishes that the physician's negligence made survival or recovery less likely—even if survival is unlikely in the natural course of the disease.

With this ruling, Minnesota joins approximately 40 other states that recognize a "loss of chance" claim for medical malpractice. This ruling has the potential to generate a significant increase in medical malpractice claims, most of which will likely be missed cancer diagnoses.

Both the MMA and the Minnesota Hospital Association (MHA) filed an amicus ("friend of the court") brief in the case last year.

The MMA and the MHA retained attorneys Charles Lundberg and Mark Whitmore of the Minneapolis-based firm Bassford Remele to write and file the amicus brief on behalf of their members.

"Defendants, hospitals and physicians in general are now subject to liability, even if they haven't caused the death," Whitmore told the Associated Press after the ruling.

"Forever, the law has been, you can receive compensation or you can receive an award if somebody causes you harm, and they do that negligently," he said. "The problem with this case is, if somebody is negligent, but it doesn't cause harm that is more likely than not to occur, under the majority it is still possible they would receive compensation, and that's neither right nor fair."

Save the date: Legal event planned for August

The MMA will host a special forum on the Dickhoff v. Green case on August 28 in Minneapolis. Watch your email or go to mnmed.org/events/policyforum to learn more.

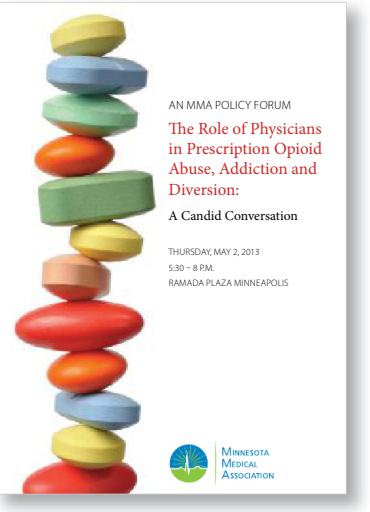
Series gets to the heart of prescription opioid abuse

Prescription opioids are overused. At least that's the opinion of the physicians who attended the three policy forums on the topic this past May.

More than 75 physicians, clinic administrators, residents and medical students gathered in Minneapolis, Duluth and Rochester to hear drug expert Carol Falkowski describe the current landscape of prescription opioid abuse, addiction and diversion.

As part of the forum, the MMA polled attendees about their opinions on the topic. The forum revealed that:

- More than 70 percent said that prescription opioids are generally overused in Minnesota.
- More than 60 percent said that patient pressure is the leading cause of inappropriate opioid prescribing.
- More than 50 percent said their clinic/hospital has an opioid prescribing policy/guideline.
- Nearly 35 percent said they never use the state's Prescription Monitoring Program.



Attendees told the MMA that they would benefit from an evidence-based protocol for opioid prescribing, access to patients' controlled substance prescription history and tips for communicating with patients about nonopioid treatment options.

The MMA plans to share the findings with its Prescription Opioid Management Advisory Task Force, which formed last December. Some possible outcomes the task force will consider include developing a specific policy on opioid prescribing that hospitals can use; urging better health insurance coverage for addiction treatment; creating informational videos that physicians could use when explaining the risk of addiction to patients; and supporting legislation to develop community-based opioid overdose prevention programs.

The prescription opioid forums were the second in a series of MMA policy forums scheduled for 2013. Future forums will address prior authorization of prescription drugs; primary care

physician workforce capacity, professionalism and Minnesota's quality measurement agenda.

The policy forums aim to bring physicians together to learn about and discuss important issues affecting the practice of medicine in Minnesota. They also provide physicians with an opportunity to debate and influence MMA policy.

Physicians' point of view provided in two Court of Appeal cases

A pair of Twin Cities-based legal teams made their cases before Minnesota Court of Appeals panels this May on two cases that directly affect Minnesota physicians.

On May 15, a three-judge panel heard oral arguments in the case of *In re the Guardianship of Jeffers A. Tschumy*. A week later, a separate panel heard oral arguments in the case of Avera Marshall Medical Center Staff vs. Avera Marshall Regional Medical Center. Both panels will issue opinions within 90 days of the hearing.

The Tschumy arguments centered on the scope of a legal guardian's powers regarding a ward's medical care and whether those powers extend to termination of life support. The court devoted significant time to the issue of what constitutes "life

support" and appeared receptive to the argument that "end-of-life" decisions are not clearly definable. The court also appeared to agree that clinical teams and ethics committees are better equipped than judges to counsel guardians and families on end-of-life decisions.

Earlier this year, the MMA submitted an amicus brief supporting the argument that legal guardians have the inherent power to make medical decisions on behalf of their wards, including the decision to decline medical care and terminate life support.

The guardian is represented by Bob McCloud, a guardianship law specialist and partner at Lindquist and Vennum. Also present at the hearing were amicus counsel Diane Bratvold, Jennifer Lammers and Amie Penny Saylor from Briggs and Morgan, and Teresa Knoedler, MMA policy counsel.

The Avera arguments focused on whether a medical staff is a legal entity that may bring suit on behalf of its member physicians, and whether the bylaws agreed to by a hospital and its medical staff constitute a contract to which both parties must adhere.

The Avera medical staff legal team includes attorneys from Oppenheimer, Wolff & Donnelly; Briggs & Morgan; and the MMA's Knoedler.

Physicians invited to celebrate the arts in September

Minnesota Medicine will celebrate the 10th anniversary of its Medical Musings writing contest with a special Hippocrates Cafe program at Mill City Clinic in Minneapolis. The event will take place September 19, the night before the Annual Meeting.

Hippocrates Cafe is a live, made-for-radio "show" that explores themes related to health and medicine through story and song. MPR's Jon Hallberg, M.D., the creator and host of the show, will be accompanied by some of the Twin Cities' finest actors as they interpret contest-winning essays and poems written by Minnesota physicians and medical students. Musicians will perform before and after each piece.

Physicians and medical students and their guests are invited to this free event.

Help influence the MMA's direction, join a committee

The MMA is looking for members wishing to serve on one of its direction-setting committees for 2014. Nominations are due July 26.

"When you take part in a committee, you help influence the direction of the MMA, learn additional leadership skills and get the opportunity to interact with physicians who care about the same issues you do," says George Lohmer, MMA's CFO.

Serving on a committee takes about 16 hours a year, most of which is spent attending meetings, either in person or by telephone. The MMA has the following committees:

- Administration and Finance
- Ethics and Medical-Legal Affairs
- Health Care Access, Financing and Delivery
- Membership, Marketing and Communications
- Minority and Cross-Cultural Affairs
- Public Health
- Quality

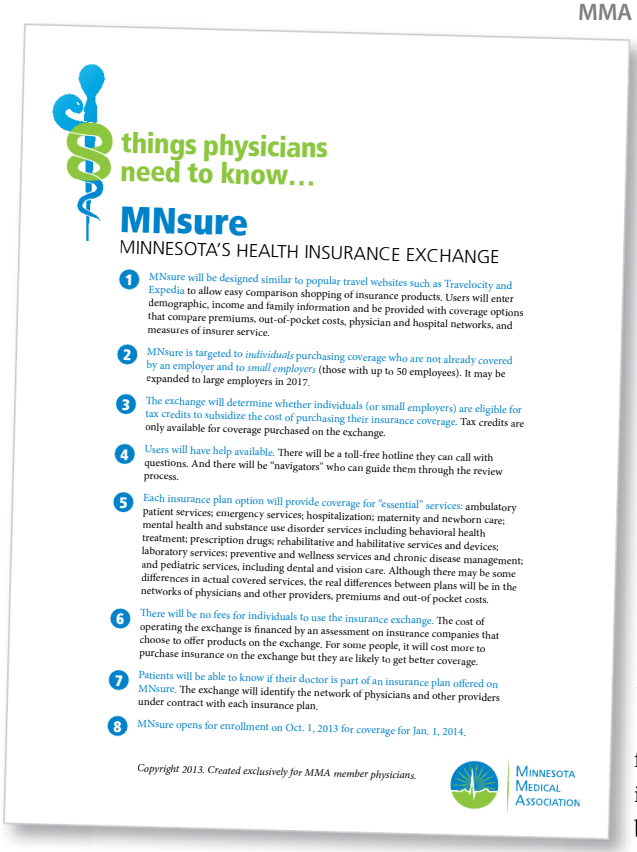
Appointments will be made in mid-October for terms beginning in January 2014. For more information on the individual committees and to submit your name for consideration, go to www.mnmed.org/AbouttheMMA/MMACommitteesTaskForces.aspx and click on the committee application form.

Reminder: Resolutions for House of Delegates due July 12

All resolutions for this year's Annual Meeting must be submitted by July 12. Late resolutions will be considered only if of a truly urgent nature. Information can be found on the Annual Meeting page at mnmed.org/annualmeeting. This year's meeting takes place September 20-21 at the Minneapolis Marriott Northwest (formerly the Northland Inn) in Brooklyn Park.

MMA debuts new information tool for physicians

The MMA has created a new tool that provides physicians with quick tips about topics of interest. Called "8 things physicians need to know about …" the fact sheets are available on the MMA website (mnmed.org/8things) and through the MMA membership team.



8 things physicians need to know…

MNsure

MINNESOTA'S HEALTH INSURANCE EXCHANGE

1. MNsure will be designed similar to popular travel websites such as Travelocity and Expedia to allow easy comparison shopping of insurance products. Users will enter demographic, income and family information and be provided with coverage options that compare premiums, out-of-pocket costs, physician and hospital networks, and measures of insurer service.
2. MNsure is targeted to *individuals* purchasing coverage who are not already covered by an employer and to *small employers* (those with up to 50 employees). It may be expanded to large employers in 2017.
3. The exchange will determine whether individuals (or small employers) are eligible for tax credits to subsidize the cost of purchasing their insurance coverage. Tax credits are only available for coverage purchased on the exchange.
4. Users will have help available. There will be a toll-free hotline they can call with questions. And there will be "navigators" who can guide them through the review process.
5. Each insurance plan option will provide coverage for "essential" services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including dental and vision care. Although there may be some differences in actual covered services, the real differences between plans will be in the networks of physicians and other providers, premiums and out-of pocket costs.
6. There will be no fees for individuals to use the insurance exchange. The cost of operating the exchange is financed by an assessment on insurance companies that choose to offer products on the exchange. For some people, it will cost more to purchase insurance on the exchange but they are likely to get better coverage.
7. Patients will be able to know if their doctor is part of an insurance plan offered on MNsure. The exchange will identify the network of physicians and other providers under contract with each insurance plan.
8. MNsure opens for enrollment on Oct. 1, 2013 for coverage for Jan. 1, 2014.

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Minnesota Medical Association

Lawmakers request series of studies and reports before next session

Legislators called for a series of health care-related studies and reports to be completed before the next legislative session, which begins February 25, 2014.

- The commissioners of Revenue and Management and Budget are to conduct an analysis of health care taxes, including the provider tax, to determine whether MinnesotaCare, the state's subsidized health insurance program, is adequately funded. The commissioners also will study the long-term solvency of the Health Care Access Fund, which is funded in part by the provider tax and helps pay for MinnesotaCare. The results of this study will be used as part of the state's budget forecast due in November 2013. The study and report will help lawmakers understand how these state funding sources will complement the federal funds made available under the Affordable Care Act.
- The Minnesota Department of Health (MDH) is to create a plan for advancing health equity in Minnesota. The MDH will work with local public health, health care and community agencies to assess health disparities within the state; the report is due February 1, 2014.
- The MDH, Department of Human Service and Commerce Department will study methodologies for determining the appropriate levels for capital reserves maintained by the state's HMOs. Provisions in the House HHS budget proposal called for caps on HMO reserves; caps on reserves were not included in the final bill. Key HHS committee leaders are slated to receive the report by February 1, 2014.
- The MDH will outline a plan for long-term storage and use of newborn screening test results. A provision in the data practice omnibus bill requires the MDH to consult with pediatricians, specialists in metabolic care, immunologists, epidemiologists, medical geneticists, and representatives from patient advocacy and data privacy groups to develop such a plan. The report is due to the Legislature February 1, 2014. A Minnesota Supreme Court ruling in 2011 changed how MDH must handle newborn screening test results and data.
- The MDH will take the lead in studying the correlation between nurse staffing levels and patient outcomes. This study, which is due to the Legislature by January 15, 2014, was called for in a controversial bill that drew significant attention before being scaled back. Under the original proposal, hospitals would have been required to implement specific nurse-to-patient staffing ratios. The bill signed into law requires hospitals to report information about their staff levels on the Minnesota Hospital Association website.

Maya Babu, M.D.

Babu wins RFS seat on AMA board

MMA member Maya Babu, M.D., was elected to a two-year term as the Resident and Fellow Section member of the AMA Board of Trustees in June.

"She ran a great campaign and wowed most everyone with whom she met," says Dave Renner, MMA's director of state and federal legislation, who attended the AMA meeting in Chicago.

MMA members Blanton Bessinger, M.D., and Paul Matson, M.D., served as Babu's campaign chairs.

Cirque De-Stress

BY GARY CHRISTENSON, M.D.

This article describes how the circus arts used in a public health campaign targeting University of Minnesota students increased awareness of mental health and stress-reduction resources on campus.

Ladies and gentlemen, students, faculty and staff, prepare to be entertained, amazed and informed!

These are not words you would expect to hear from a psychiatrist, nor would you associate them with a public health campaign. Yet these were my opening remarks at an event, Cirque De-Stress, which was held April 3, 2013, on the University of Minnesota's Twin Cities campus to increase awareness among students of the stress management and mental health resources available to them.

The Metaphor of Balance

Cirque De-Stress was conceptualized during the two years I served as president of the board of the Global Alliance for Arts and Health (formerly the Society for the Arts in Healthcare). During my tenure, I had the good fortune to meet Paul Miller, founder of Circus Mojo, a troupe based in Ludlow, Kentucky, that had already demonstrated how an arts organization could foster health and social change through its performances in hospitals and jails. He showed me one of the activities the troupe does with its audiences: teaching them to balance a peacock feather on a fingertip. I suggested that this could serve as a metaphor for achieving balance in life.

We decided to test the concept during Respect U, an event for all first-year University of Minnesota students held during Welcome Week 2012. The idea was for the students to learn about campus programs that promote respectful relationships. The Provost's Committee on Student Mental Health was to have a table at the event with information on mental health resources on campus. As we planned the event, we acknowledged that students were likely to be dealing with information overload, given that they would have already attended multiple presentations during their orientation week. We needed a unique activity to get their attention.

A Day of Feathers

When they arrived at Respect U, one of the first things students encountered was staff and faculty balancing peacock feathers on their fingers. The students were invited to try this themselves. Most took up the challenge. But as expected, many became mildly frustrated when they discovered it was more difficult than it looked. They were advised not to look at the juncture of feather and finger but to focus on the colorful feather instead. Almost immediately, they were able to perform the task. The exercise served as a segue to a more important discussion on balancing the demands of college life. Most admitted they were apprehensive about handling all of the new challenges they were about to face. This offered us the opportunity to provide them with information about mental health and stress-reduction programs.

We felt the approach was successful, as 3,500 students left the event with a peacock feather and information about the university's mental health website. As the students walked around campus with feathers in hand, others stopped to ask about them. This provided an opportunity for the students who attended Respect U to tell others about the university's mental health and stress-reduction services. Many students still have their feathers, and they know where they can find help if they need it.

The Circus

Following the Respect U campaign, we thought the next step seemed obvious: plan a circus!

I contacted Paul Miller and, after some enthusiastic brainstorming, we came up with an idea for an event that would focus on the importance of managing stress. We would call it Cirque De-Stress. We crafted a list of acts that could serve as vehicles for delivering messages about caring for your mental health: high-wire walks, trapeze acts, plate-spinning, stilt-walking, unicycle riding, circus-ball balancing, gym-wheel performances and juggling.

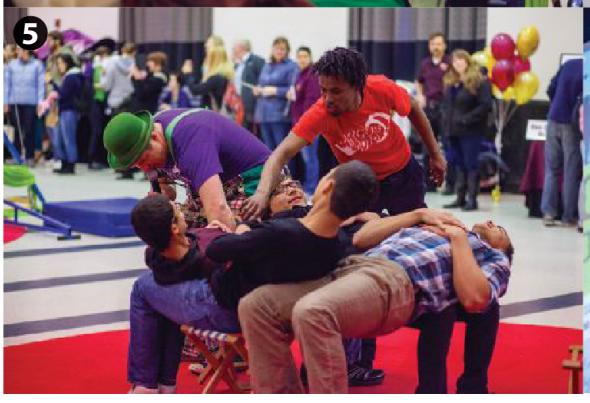
We planned a small three-ring circus in the high-ceilinged Great Hall of Coffman Memorial Union. Seven 30-minute acts would be held on the hour throughout the day. In between performances, attendees would be encouraged to visit stations promoting stress reduction and mental health resources. Unlike Respect U, which was designed for incoming first-year students, this event was for all students on campus.

The idea of a circus proved an easy sell, and in short order, we had backing from programs throughout campus. We invited several student groups to participate as well. Two of them, the unicycle club ONE and the Modern Yo-yoing club, committed. Posters and postcards were created to promote Cirque De-Stress. We designed give-aways that included information about mental health resources for distribution at the event. We also developed ways to evaluate the event's impact on attendees.

Under the Big Top

On April 3, 2013, I joined the circus. That wasn't the original plan, but when Paul Miller suggested that I serve as ring master, it was hard to resist. Staff and students also pitched in, unloading a trailer packed with thousands of pounds of circus gear, constructing a high wire and trapeze frame, and searching for a door big enough to allow the passage of a large circus ball.

As the performers changed into costume and warmed up, representatives from the organizations promoting their services set up their stations along the periphery. Each had been encouraged to have attendees do an arts (a circus art, if possible) activity as well as offer information about mental health or resources. At the Boynton table, students could learn to juggle red, green, blue and yellow stress balls stamped with the URL of the mental health resource website. In addition, Boynton's massage therapist provided chair massages. At the Provost's Committee on Student Mental Health's table, attendees were encouraged to balance feathers. Stationed nearby were teams from an animal-assisted interactive program featuring therapy dogs and Woodstock, a registered therapy chicken. The Center for Spirituality and Healing offered opportunities to try scarf juggling, as well as hand massages, Reiki and laughter yoga. Students could color with crayons at the Rothenberger Institute table. Staff at the University Counseling and Consulting Services table made balloon animals. Belly dancers from the Aurora Center promoted the importance of a healthy weight (rather than being obsessed with



1. Performers spin hub caps. **2**. Boynton Health Services chief medical officer Gary Christenson, M.D., (right) served as the Cirque De-Stress ringmaster. **3**. University of Minnesota student Carolina Gwinn on the aerial silks. **4**. Members of the audience with peacock feathers and stress balls advertising the mental health resources website. **5**. Students do a balancing exercise in which chairs are pulled out from under them and they support each other. **6**. Circus Mojo's Paul Miller.

PHOTOS BY JOEL MOREHOUSE AND LADONA TORNABENE

being thin). At the Active Minds table, students taught yo-yo tricks and gave out popcorn. Circus Mojo set up a photo booth where students could dress in circus costumes, write a phrase on a white board about how they would balance or juggle their busy lives, and have their picture taken. The ONE unicycle club offered an opportunity to learn to ride a unicycle. All tables were stocked with handouts and brochures about specific offerings—tai chi and yoga classes and affordable massages at Boynton Health Service; mindfulness stress reduction classes at the Center for Spirituality and Healing; online courses from the Rothenberger Institute about how to reduce stress, alcohol use, financial health and healthy sexual behavior; and individual and group therapy, medication management and disability services related to mental health. All stations were staffed by individuals who were knowledgeable about their group's specific offerings and who had been coached to talk about "balance" and "juggling" with attendees.

The Performances

The circus performances were, of course, both the central attraction and the glue that held the day-long event together. We had an array of feats executed by performers from Mexico, Argentina, Ethiopia and the United States. Two local performers also participated: Neal Skoy, a clown from St. Paul, and Jonah Finkelstein, a senior at the University of Minnesota who is a talented high-wire walker and juggler.

All performances were based on aspects of student life: The Circus Mojo performers spun hubcaps and a pizza box. The high-wire walker laid down on the wire as if to take a nap. A performer illustrated the experience of a student studying into the night, waking up late, grabbing a cup of coffee and throwing on a backpack all while rolling across the floor on a gym wheel. The audience was also encouraged to participate. For example, four students had to support each other after their chairs were pulled out from under them.

Throughout the day, more performers appeared, including four University of Minnesota students who amazed the audience with juggling feats, a hoops act, and a performance on the aerial silks

Outcomes

Cirque De-Stress proved to be a hit. Altogether, 2,333 people, mostly students, attended. Attendance at the shows increasing throughout the day. The effectiveness of the event was measured through a survey completed by 174 attendees. Of those who responded, 85% indicated that the event had increased the likelihood that they would use a University of Minnesota mental health and/or stress-reduction resource, if needed. Eighty-seven percent felt the event helped reduce the stigma associated with mental health issues. Awareness of various services increased ranging from an increase of 13% for the Mental Health Clinic (not surprising as it was already heavily marketed) to an increased of 50% for the relatively new animal-assisted interaction program.

The survey results support our premise that the arts are an effective alternative to brochures and lectures for delivering messages about mental health. Attendees indicated that their primary reasons for attending Cirque De-Stress were curiosity, an opportunity to have fun and the fact that they enjoyed circuses. Only 19% said they came because they wanted to learn more about mental health; 25% said they attended to learn more about managing stress. This was somewhat surprising since these themes were clearly advertised in the marketing of Cirque De-Stress. Following the show, 83% reported that they had learned a stress-reduction skill and 81% indicated that they were more likely to proactively manage their stress. Sixty-one percent of respondents reported decreased stress from attending the event itself.

We are in the process of doing an additional evaluation using a qualitative assessment developed at the University of Minnesota Duluth.[1] Students took photos at the event and then commented on why their picture was meaningful to them Their responses are being analyzed to derive themes on how the event affected them.

Concluding Comments

The circus arts are one of many art forms that are being integrated into health care. In clinical settings, medical clowns are being used to distract patients undergoing medical procedures, helping decrease their anxiety. The data are beginning to demonstrate effects that go beyond distraction and stress reduction.[2] For example, in a recent study, pregnancy rates improved when medical clowning was used in conjunction with in vitro fertilization and embryo transfer.[3] Juggling has also been shown to have the potential for decreasing anxiety[4] and has even been shown to result in white matter changes in the brain on functional magnetic resonance imaging.[5] There have been a few other cases in which the circus arts have been successfully used to deliver public health messages and get people to change their behavior. For example, Vegetable Circus, with bases in Boston; Oakland, California; Asheville, North Carolina; and Raleigh, North Carolina, teaches circus skills to children while educating them about food choices.

Cirque De-Stress appears to be a unique application of the circus arts. Based on our experience at the University of Minnesota, we think that it was an effective method for reaching out to college students on the crucial topics of stress reduction and mental health. **MM**

Gary Christenson is chief medical officer at Boynton Health Services at the University of Minnesota.

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Healing through Reflective Writing

Breast Cancer Survivors' Experience

BY COLLEEN BAGGS, B.S.N., LISA MCKHANN, M.A., CHARLES E. GESSERT, M.D., M.P.H., AND BRIAN P. JOHNSON, M.P.H.

This article describes an intervention for breast cancer survivors called Journal of My Medical Experiences in which participants engaged in reflective writing over six weeks. The 107 participants were encouraged to explore concerns and issues in a safe online environment. About half of the women posted writings to a website once a week or more; others logged on solely to read what others had written. A number of themes emerged as the women explored their feelings. We share some of those.

"How does one make plans for the future? Whenever I think I'm done, something seems to come up. What is the balance between getting on with one's future and the continued care/counseling?" ~ Nels

"Will I ever get my strength back? Will I ever stop thinking about this? Will I ever not be afraid?" ~ Kylie

For women like Nels and Kylie, who have survived breast cancer, survivorship is about more than dealing with delayed toxicities, having unresolved symptoms or having a heightened risk for recurrence. Survivorship is the all-encompassing experience of having lived beyond those initial words "you have cancer." It is about moving beyond diagnosis and treatment and toward a new life in which one can embrace both its gifts and burdens. But grappling with remission, the possibility of recurrence and other issues of surviving is a significant and ongoing struggle for many who have faced breast cancer. Hence, health care and cancer organizations have recognized the need to address the concerns of these individuals.

Research from a variety of fields including social work and psychology has shown that participating in patient support groups, including Internet-based groups,[1-6] and expressive writing and journaling[7-13] can help cancer survivors process their feelings. The relatively new field of narrative medicine has expanded our understanding of the cathartic power of storytelling for "meaning making," that is, making sense of experiences and feelings.[14,15]

Thus, when a local writer, artist and ovarian cancer survivor approached the manager of Essentia Health's Caring Ways Cancer Resource Center about studying the effect of web-based journaling and selective reading on the psychosocial well-being of cancer survivors, she was willing to explore the idea. The result was an intervention for breast cancer survivors called Journal of My Medical Experiences (JOMMA). The team designing the intervention used the term "reflective writing" rather than "expressive writing," which has been used by James Pennebaker and others,[16] to better describe the fact that participants would do their writing over an extended period of time (six weeks) rather than during a few intensive sessions. The team used the writing and reading groups described in Rita Charon's *Narrative Medicine: Honoring Stories of Illness* as a model. [15]

The Experience

The intervention was designed to encourage survivors to explore their concerns and issues in a safe environment. Subjects gave themselves online nicknames so they could journal anonymously. Altogether, 107 women participated in the project. The women were divided into nine groups.

Participants could save their writing as private (to be viewed only by the study team) or share it in their group's Reading Room (to be viewed by other members of the group and the study team). There

were no direct responses or threaded comments. A moderator provided weekly encouragement and "Quick Start" writing prompts. For example, at the start of Week 2, participants received an email with this message:

The main thing about journaling is…just do it! Every day, every other day. The more the better.

Explore and describe something you have seldom expressed—a feeling, thought or experience. Skimming the surface is less effective. Dig a little. Stay with it. Focus on your deepest feelings.

Let the words flow. Don't worry about spelling or grammar. Who really cares?

The journaling page also included a list of subjects the women could explore such as "sexuality/libido," "at peace/calm/okay," and "dark humor/laughs."

The study team monitored the writings daily to determine if any entry indicated a woman needed psychological or social help. About half of the participants posted writings at least once a week; others posted less frequently or logged on solely to read others' writings.

At the end of six weeks, participants were asked to comment on the JOMMA experience. Their writings and comments are being subjected to qualitative analysis, and we are assessing the impact of the project on participants.

In general, for all the women who participated in the writing project, plain talk was the rule. Among the stories, anecdotes, and expressions of worry and humor, everything from D cups to God and paddling through lily pads was discussed. Here we share some of the postings.

Sexuality and Body Image

Sexuality and body image troubled many of the women. Some explored the feelings of facing one's changed body in the mirror and presenting it in public.

"Now that the treatment is over, I have started to wonder if I am still a woman without any of the parts that make me one. I am beginning to feel insecure when I am around others. I find myself crossing my arms to cover up my flat chest." ~ Irish

"When I first had my surgeries I avoided the mirror. No hair, no breasts. I literally looked like a man." ~ Queenie

Some indicated an intimate relationship between a cancer survivor and partner can remain broken well after the body is healed. We learn that a spouse's own feelings of loss and fear may interfere with re-establishing intimacy with a partner.

"I do miss my breasts sometimes, especially during intimate moments. They were sexy." ~ Dragonfly

"My husband cannot look at me the same, doesn't look at me the same. He never says anything. Just doesn't look, cannot look. He never sees me completely naked anymore. It is too hard for him to look and too hard for me to see him look away." ~ Joseym

"I have never wanted to be defined by '36D' . . . but like it or not, the lack thereof could have ended a relationship that started when I was 15." ~ Elle

"I had my double mastectomy a year ago and yesterday was the first time I really talked with my husband about what I felt and am feeling now. I was also able to ask him to look at my chest and to touch the scars. Before this journaling I was not able to open up so much to anyone." ~ Irish

Changed Relationships

From the new and unwanted vantage of illness, many wrote of changes in their relationships. Some set new boundaries and discovered how well-meaning people offered unhelpful messages.

"After she left, I reflected on our relationship over the years. She was a 'taker,' one of those people that when she needed something she was your friend. I literally just do not have the energy for carrying the load of that type of friendship." ~ Queenie

"More often than I like, I run into someone who seems to look down their nose at me because I've had cancer. As if cancer was a result of something 'bad' I did. Bad diet. Bad attitude. Bad lifestyle. Bad belief system. Bad person. Bad habits. Bad, bad, bad." ~ Faith

"When I was diagnosed with inflammatory breast cancer, so many people gave me little gifts and most of them were pink. Pink pens, socks, scarves, books, writing paper, shirts, hats and PJs. I quickly got to the point that every time I saw something pink I felt like throwing up." ~ Irish

Many women also expressed deep appreciation for the support of friends, coworkers and family members.

"I was blessed to have the support of all my men. One son quit his job in California. He was my chauffeur to chemo from May until September." ~ Dragonfly

"I have been blessed with many good doctors, nurses, friends, church family and close family. It is amazing what God will bring to your life when you need it the most." ~ Joseym

Making Meaning of Illness

Much of the reflective writing experience was designed to allow participants to be in a space where they could make meaning of illness. In their musings, many writers stepped back to pause and declare themselves "Here Now."

"Well, it is another day in my life. I have a life and for that I am ever grateful. It has changed dramatically since my cancer diagnosis." ~ Queenie

"In the days and weeks ahead I will be faced with many new and frightening things. But I have to remember that when God aims us in a new direction, we have to let go of what we've known. We have to be willing to embrace the unfamiliar and trust that He will sustain us on the new journey." ~ Joseym

"The journey goes on. My cancer is part of the past and could have been someone else's story. I don't dwell on my experience with cancer and cannot change what it has done to my body but I can keep it from eating away my mind." ~ Faith

"In the summer I take my kayak out every day. There's a special place that I go to, which is a little secluded bay on the other side of the lake. I think that as a former cancer patient, I have a lot of conflicted emotions and sometimes I need a little space for myself." ~ Joel

A number of participants also indicated that the writing groups provided them a sense of community, people with whom they could express truths they could not easily share with others.

"I have journaled before, but not like this. I have found this rather freeing." ~ Elle

"I'm not a person that writes things down, especially my thoughts and feelings. I did enjoy writing things I never really share with my family/friends." ~ Feather

"It has been helpful for me to have someplace to share some of my thoughts and feelings with other women who have, in one way or another, shared the same journey as I. This has been a safe place for me and I will miss it." ~ Joseym

"It was very affirming. I looked forward to journaling. I felt like I could tell my story in a way that I couldn't with people when I was going through my two surgeries and radiation. At times I was surprised at what I wrote." ~ Neffie

Sharing the Findings

A number of the writings were included in a script entitled "Good to Get It Out," which was performed at the University of Iowa's Examined Life conference in April 2013 by actors from Iowa City's Riverside Theatre. Afterward, audience members said they were struck by the concreteness of the language and the fact that the personality of each woman came through in her words. They said there was a palpable sense that some of these women really were expressing feelings for the first time. Many were impressed by how intimate and how raw the writings were. They said the readings should be shared in other settings such as caregiver group meetings and grand rounds.

The women's writings can help health care providers better understand the concerns of cancer survivors. And the online writing groups appear to have provided participants with an avenue that they otherwise would not have had for dealing with their feelings. **MM**

Colleen Baggs is the program manager at Caring Ways Cancer Resource Center. Lisa McKhann is director of Project Lulu. Charles Gessert is a senior research scientist and Brian Johnson is a biostatistician at Essentia Institute of Rural Health in Duluth.

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For more information

A number of resources are available on the role of writing within the context of healing. Here are some of them:

Journal Writing: A Journey of Self Discovery www.cedu.niu.edu/~shumow/iit/doc/journalwriting.pdf

PsychCentral http://psychcentral.com/blog/archives/2012/05/02/4-journaling-exercises-to-help-you-manage-your-emotions

Women on Writing www.wow-womenonwriting.com/44-FE7-JournalingForHealing.html

Penmia http://www.penmia.com

Penzu http://penzu.com

Write Yourself Well: Writing for Better Physical, Mental, and Spiritual Health www.psychologytoday.com/blog/write-yourself-well/201208/expressive-writing

Inkwings www.inkwings.com

Writing Through Cancer http://writingthroughcancer.com

Writing to Heal Writing to Grow www.writingtoheal.com

Project Lulu www.projectlulu.org

Skin-Lightening Practices and Mercury Exposure in the Somali Community

BY AMIRA ADAWE AND CHARLES OBERG, M.D., M.P.H.

Somali women often use creams and soaps to lighten skin tone, fade freckles or get rid of age spots. Use of these products raises a health concern, as some have been found to contain mercury. This article describes an investigation that involved interviewing Somali women about skin-lightening practices and the products they use and then testing those products for mercury. Twenty-seven samples of products purchased at markets in Minneapolis and St. Paul were analyzed by the Minnesota Department of Health for specific mercury levels. Eleven of the 27 (47%) were found to contain mercury. Some exceeded the current FDA threshold of 1 part per million. This has prompted both state and federal health officials to issue warnings about the use of these products.

An estimated 87,500 Somalis have settled in the United States since the start of civil war in Somalia in 1991.[1] To escape the fighting, many fled to refugee camps in neighboring countries such as Kenya before migrating to Europe and North America. Minnesota now has one of the largest Somali communities in the United States, with some 32,000 people;[1] many Somalis have migrated here to reunite with family members.

Although Somalis living in Minnesota are adapting to the ways of their new homeland, many retain traditional values. One of those is about beauty. Most Somali women believe lighter skin is more beautiful than darker skin. They see having light skin as more socially acceptable and believe it will increase their chances of finding a husband.[2] Consequently, many Somali women living in the United States use skin-lightening products. These products, which were widely used in Africa, are thought to eliminate imperfections and even out skin tone.[3] Some of these creams and soaps have been found to contain inorganic mercury.[4]

Skin Lighteners and Mercury

In 2011, a Somali health educator with St. Paul-Ramsey County Public Health raised concern that Somali women were using skin-lightning products that may contain mercury. This was based on her historical knowledge of the practice in Somalia as well as recent reports about skin-lightning products containing mercury being discovered in Chicago, California and New York. As a health educator, she conducted interviews with Somali women in the community, which confirmed her concerns. She then brought her findings to leaders of the St. Paul-Ramsey County Public Health Department.

Cosmetic products containing mercury are banned in Minnesota. In addition, a number of skin-lightening products that contain hydroquinone have been banned in Europe and Canada. These chemicals are proven neurotoxins and have been linked to birth defects if used by women during the prenatal period.

Most of the skin-lightening products used by Somali women are manufactured in Asia or the Middle East. According to the U.S. Food and Drug Administration, they are brought into the United States and illegally sold online and in stores owned by immigrants from Latin America, Asia, the Middle East and Africa.[5]

To understand more about use of these products in Minnesota, we conducted interviews with seven Somali women in April of 2011. Our intent was to learn which facial creams were being used, why, how often, and if women use them when they are pregnant or breastfeeding.

The women indicated they use skin-lightening products to get rid of dark spots from pregnancy and be more attractive to men. Most of the surveyed women mixed together four creams: Lemon Herbal Whiting Cream, Lulanjina, Diana and Dermovate. The first three were later found to contain mercury, and the fourth is a steroid-based preparation. The mixture is poured into a container and placed in the refrigerator, as it is believe it is more effective when cool. All the women said they apply the creams to their entire body twice during the day and once in the evening, even when they are pregnant or breastfeeding. One of the interviewees indicated that she has used the creams since the second week after she gave birth in the hope of getting rid of the dark spots from pregnancy faster. Women said they use the creams more than usual before attending special events such as a wedding. They also indicated that they fear skin discoloration if they stop using the creams.

We presented our findings to the leadership of the St. Paul-Ramsey County Public Health Department. Afterward, the Minnesota Department of Health sought to ascertain the level of mercury in several fre-

quently used products. The products were purchased from the Somali Mall (Karmel Mall) in Minneapolis and the Hmong Market in St. Paul. Twenty-seven samples of creams and soaps were obtained. A laboratory at the Minnesota Pollution Control Agency analyzed the products using mercury vapor testing. Eleven of the 27 products contained inorganic mercury (Table). The Food and Drug Administration (FDA) allows only trace levels of mercury in creams (less than 1 part per million).[6] The levels in the products tested ranged from 4.08 ppm to 33,000 ppm. The samples were then taken to the Minnesota Department of Health, where they were re-analyzed.

The Minnesota Pollution Control Agency and the FDA then looked at how the products were getting into the state. They determined that one store supplied the other stores in the Twin Cities. A similar pattern had been seen in cities in Illinois, New York, California and Texas. In June 2011, the Minnesota Department of Health issued a warning urging people to stop using the contaminated products.[7] In March 2012, the FDA issued a consumer alert about skin-lightening products.[5] The alert warned that infants and small children might be exposed to mercury if they touched parents who have used these products, got the cream on their hands and then put their hands and fingers into their mouth.

Inorganic mercury exposure is associated with rashes, skin discoloration, scaring, secondary bacterial and fungal infections, and even renal impairment and damage to the nervous system. Exposure also may be associated with anxiety, depression, psychosis and peripheral neuropathy.[8] It should also be noted that mercury acts as a teratogen during pregnancy and can be transferred from mother to infant through breast milk.

No cases of mercury poisoning associated with these products have been identified in Minnesota. However, in California health officials identified a 39-year-old Mexican-American woman in Alameda County who was found to have mercury poisoning after presenting with headaches, numbness, depression and forgetfulness. The likely source of the mercury was a skin-lightening cream smuggled in from Mexico.[9]

TABLE

Inorganic Mercury Levels in Skin Lightening Creams

PRODUCT	MERCURY LEVEL-PARTS PER MILLION (PPM)
Lemon Herbal Whitening Cream	33,000 ppm
Lulanjina – yellow cream Lulanjina – white cream	16,700 ppm 12,800 ppm
Crème Diana C.T.R.	6,370 ppm
Qian Mei – white cream	4,650 ppm
Fasco	4,600 ppm
Milk Cream	4,600 ppm
Crème Diana C.T.R. (a second sample from a different country of origin)	4,180 PPM
Qian Mei – yellow cream	3,540 ppm
Jiao Li – container 2 Jiao Li – container 1	1,700 ppm 1,070 ppm
Cream Aghader	135 ppm
Savon pour L'acné Diana soap Savon pour L'acné Diana soap	31 ppm 4.08 ppm

Source: Minnesota Department of Health

Ongoing Work

Public health messages about the risk of mercury exposure from skin-lightening products are being disseminated in the Somali community through television and radio, in meetings with community leaders and at educational forums. In addition, efforts are underway to stop the sale of these products. Physicians and others who provide care to Somali women and other immigrants can help educate their patients about the potential dangers of these products as well. **MM**

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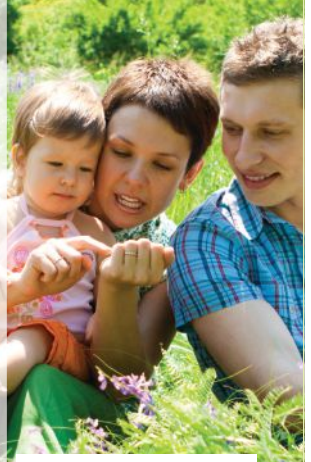

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On art

For writer and painter Robert Fisch, art is essential.

At age 88, Robert Fisch, M.D., is brimming with ideas, and in conversation they overflow. A pediatrician who started life in Hungary, nearly died in a Nazi concentration camp and then resisted the communists in Hungary before immigrating to Minnesota, Fisch knows he has a unique vantage from which to observe the human condition. In recent years, he's felt compelled to share his observations through both painting and writing. Here is an illustration and excerpt from the section on art in his forthcoming book *The Sky Is Not the Limit.*

"The first time I saw a painting of olive trees by Vincent van Gogh, I sat and shivered—overcome by the artist's genius. When I finished my training in pediatrics, I studied drawing and painting at night school for 10 years, painting for fun. My daughter, at about the age of five, sat in my lap and together we painted huge flowers.

Art always has been a way for me to express feelings, to connect with my inner world and to escape reality. Initially, I covered canvases with bright colors. More recently, I've realized my thoughts are better conveyed in black and white, with the simplest lines and forms. In this book and others I've written, I found myself author and illustrator. Art is communication; and for me, it is heartfelt, necessary and joyful."

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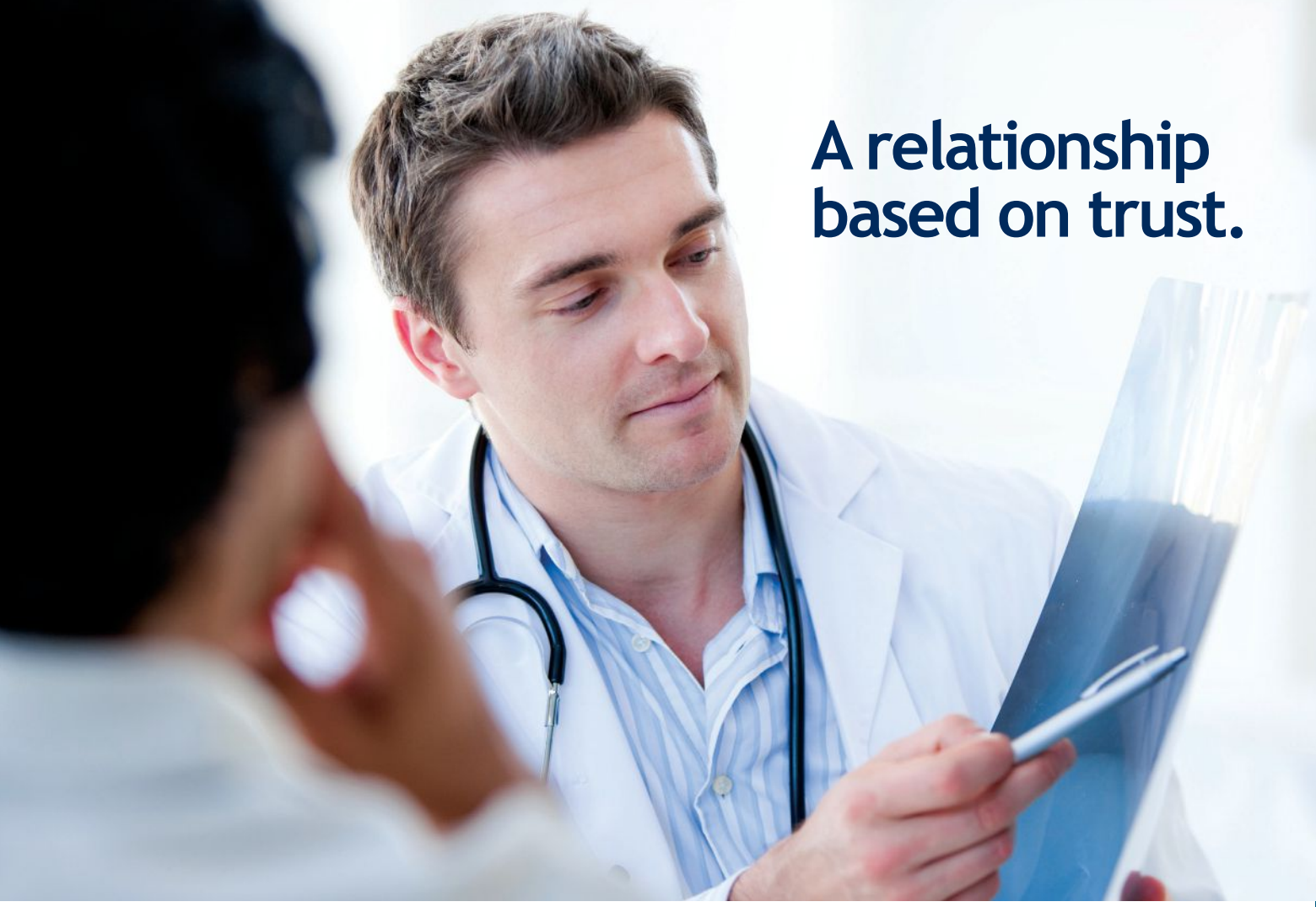

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