THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

NOV/DEC 2023 • $9.99

Diagnosing diagnosis errors

Medical students and trainees are learning the skill of diagnostic reasoning in new ways and new places.

PAGE 12

ALSO

The puzzle of **TICK DISEASES** PAGE 20

Q&A: Whose hospital? PAGE 24

FINDING JOY in medicine PAGE 8

MAYO CLINIC

Build on 150+ years of **life-changing care.**

Discover a life-changing Internal Medicine career at Mayo Clinic – the #1 US hospital and #3 employer in Minnesota. Our patient-centric approach, led by physicians, has defined us for over 150 years – and now it can define you too. After all, as part of the Mayo team, you won't just be building a stable career in a supportive environment. You'll also be building on our legacy for award-winning patient care.

Learn more about the impact you can make at Mayo Clinic:
jobs.mayoclinic.org/internalmedicine

Mobility matters.
Rehab therapy can help.

Completing the tasks of everyday life can be overwhelming after an illness or injury. Our rehabilitation therapy team at the Good Samaritan Society provides individualized support during every phase of your patient's recovery.

When your patient is facing physical challenges or needs help with speech, language or swallowing, we'll help them heal faster so they can get back to living.

Call (855)-GOOD SAM to refer your patient.

Sponsored by

The Evangelical Lutheran Good Samaritan Society (the Society) and Owner comply with applicable Federal civil rights laws and does not discriminate against any person on the grounds of race, color, national origin, disability, familial status, religion, sex, age, sexual orientation, gender identity, gender expression, veteran status or other protected statuses except as permitted by applicable law, in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, and in staff and employee assignments to individuals, whether carried out by the Society directly or through a contractor or any other entity with which the Society arranges to carry out its programs and activities. All faiths or beliefs are welcome. © 2023 The Evangelical Lutheran Good Samaritan Society. All rights reserved.

CONTENTS

Nov/Dec 2023 | VOLUME 106 | ISSUE 6

IN THIS ISSUE

Diagnosing illness is one of the most important things physicians do. Yet they get it wrong a small but significant part of the time. Building on discoveries about the cognitive science behind clinical reasoning, medical schools are changing the way medical students and trainees learn and practice the skill of diagnosis.

ON THE COVER

12 Diagnosing diagnosis errors
Medical students and trainees are learning the skill of diagnostic reasoning in new ways and new places.
BY SUZY FRISCH

FEATURES

20 Ticking all the boxes
Habitat expansion means physicians should keep their eyes peeled for tick-borne disease when evaluating puzzling symptoms.
BY ANDY STEINER

24 Q&A: University and Fairview: Whose hospital?
Who or what should own the University teaching hospital, and what are key players looking for from the governor's healthcare task force?

DEPARTMENTS

4 **EDITOR'S NOTE**

6 **GOOD PRACTICE**
The Legislature recently funded the Minnesota Drug Overdose and Substance Use Surveillance Activity (MNDOSA) program to expand statewide. The program is seeking partnerships with emergency departments throughout Minnesota.
BY GREG BREINING

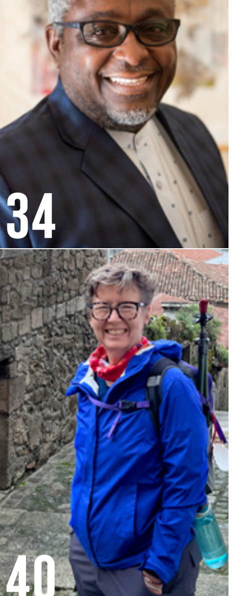
8 **COMMENTARY**
Physicians and their practices should aim higher than simply avoiding burnout. The practice of medicine is an occupation that should be highly conducive to finding joy.
BY KERRY D. OLSEN, MD

30 **RESEARCH**
Morphea is an inflammatory disorder of the skin and underlying tissues. As this case study illustrates, it may be difficult to assess as it can mimic many other dermatologic conditions.
BY TENZIN SERPOLAMATSANG, BS; SAMANTHA GARDEEN, MD; ANNA KOZLOWSKI, MD; MS; LAURA FURDA-RAINE, MD

32 **THE PHYSICIAN ADVOCATE**
More than 150 physicians and physicians-in-training gather for education and networking. August elections determine new MMA leadership. MMA honors physicians, physicians-in-training, advocates. MMA offering new benefit for well-being. New law encourages transparent talk after adverse incidents. MMA launches new video series on racism in medicine. Report: Healthcare quality improving, slowly. MMA wins awards for excellence in communications, advocacy and health equity. MMA code of conduct ensures all are welcome.

40 **ON CALL**
Siri Fiebiger, MD, MPH, FACOG

Minnesota Medicine is intended to serve as a credible forum for presenting information and ideas affecting Minnesota physicians and their practices. The content of articles and the opinions expressed in *Minnesota Medicine* do not represent the official policy of the Minnesota Medical Association unless this is specified. The publication of an advertisement does not imply MMA endorsement or sponsorship.



MINNESOTA MEDICINE

CONTACT US
Minnesota Medicine
3433 Broadway Street NE, Suite 187
Minneapolis, Minnesota 55413-2199
PHONE: 612-378-1875 or 800-DIAL-MMA
EMAIL: mm@mnmed.org
WEB AND DIGITAL EDITION: mnmed.org

OWNER AND PUBLISHER
Minnesota Medical Association

EDITOR
Greg Breining

DIRECTOR OF COMMUNICATIONS
Dan Hauser

ART DIRECTOR
Kathryn Forss

CIRCULATION/WEB CONTENT
Mary Canada

MEDICAL EDITORS
Rahel Nardos, MD
Christopher Wenner, MD
Colin West, MD, PhD

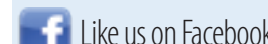
ADVISORY COMMITTEE
Veda Bellamkonda, MD
Grant Botker, MD
Devon Callahan, MD
Derrick Lewis
Charles Meyer, MD

COPYRIGHT AND POST OFFICE ENTRY
Minnesota Medicine (ISSN 0026-556X) is published bi-monthly by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 187; Minneapolis, Minnesota 55413-2199. Copyright 2023. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Periodicals postage paid at St. Paul, Minnesota, and additional mailing offices. POSTMASTER: send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 187; Minneapolis, Minnesota 55413-2199.

SUBSCRIPTIONS
Annual subscription: $45 (U.S.) and $80 (all international)

MISSING ISSUES AND BACK ISSUES
Missing issues will be replaced for paid subscribers at no additional charge if notification is received within six months of the publication date. Replacement of any issues more than six months old will be charged the appropriate single back issue price. Single back issues of *Minnesota Medicine* can be purchased for $25 (U.S.) and $30 (Canada, Mexico, and other international). Send a copy of your mailing label and orders to Mary Canada, 3433 Broadway Street NE, Suite 187; Minneapolis, Minnesota 55413-2199 or fax it to 612-378-3875.

To submit an article
Contact the editor at mm@mnmed.org.
The editors reserve the right to reject editorial, scientific or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors or any of its constituents.


Like us on Facebook

Follow us on Twitter @MNMedMag

TO ADVERTISE
Contact Dom Weyker
PHONE: 651-288-3435 | **EMAIL:** domw@ewald.com

MINNESOTA MEDICAL ASSOCIATION

PRESIDENT
Laurel Ries, MD

PRESIDENT-ELECT
Edwin Bogonko, MD, MBA

CHAIR, BOARD OF TRUSTEES
Kimberly Tjaden, MD

SECRETARY/TREASURER
Amrit Singh, MBBS

PAST PRESIDENT
Will Nicholson, MD

CHIEF EXECUTIVE OFFICER
Janet Silversmith

Colin West, MD, PhD

Supporting the pursuit of excellence in patient care

As we consider healthcare quality metrics, monitoring systems for key public health issues, and programs to reduce medical errors, we must insist that these tools are designed to integrate into healthcare workflows so they enhance each physician's ability to care for their patients and communities.

As physicians, we want the best for our patients. Being open to improvements in our practices is essential; yet all too often structural efforts to promote better outcomes can come across as unwelcome additions to overwhelming workloads, or intrusive to the physician-patient relationship.

The solution to these tensions is to put the needs of patients at the center of every process in healthcare. By recognizing this common goal for every participant in each patient's care, we can remain mindful of the shared responsibility we have in meeting these needs.

Management consultant W. Edwards Deming said, "Eighty-five percent of the reasons for failure are deficiencies in the systems and process rather than the employee." Therefore, most desired outcomes can be more effectively ensured by fixing the workplace rather than the worker. In medicine, this perspective can be aligned with the objective of meeting patients' needs by ensuring that clinical working environments and the system processes in place to promote quality are held to the highest standard in supporting dedicated healthcare professionals as they serve patients. Quality measures should be tools to support outstanding care rather than presenting clerical and administrative barriers to meaningful experiences in delivering that care.

As we consider healthcare quality metrics, monitoring systems for public health issues, and programs to reduce medical errors, we must insist that these tools are designed to integrate into workflows so they enhance each physician's ability to care for patients and communities. Processes that allow physicians to deliver better care actually connect physicians with the most meaningful aspects of our work. I believe physicians are not averse to these measures and processes when they improve outcomes, because then our central objectives in patient care are satisfied. But physicians object when these measures seem to present additional tasks and workload without clear benefits.

Deming's assertion also carries a message for physicians individually in taking responsibility for our own 15% of the problem. When we encounter recommendations oriented to reducing harms and promoting good outcomes, reminding ourselves of our primary goals in meeting the needs of our patients can reframe such recommendations positively as a service to our patients, rather than negatively as yet another bureaucratic mandate.

As physicians, we can assess how these healthcare quality measures represent better health experiences for patients and strive to achieve targets that reflect those experiences. In essence, aggregate quality measures are surrogate outcomes supporting the true objective, the desired outcomes experienced by each patient. By focusing on the patient rather than the metric, we can remain mindful of what is most meaningful in our work. At the level of the system, it is also critical that healthcare quality measures and structures enabling physicians to meet them are designed in concert with workflows so that the effort to achieve them does not require additional and separate attention from the many other patient care tasks that already stretch physicians beyond limits. This approach to process design requires active and intentional partnership with physicians, who best understand what the work of patient care requires.

Physicians feel immense responsibility for improving patient outcomes. When processes intended to further this goal are developed and implemented with both the patient and the physician in mind, healthcare systems and physicians can work in partnership to most effectively honor this responsibility. MM

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

1,000 TO 28,000 SQUARE FEET

MEDICAL SPACE FOR LEASE

West Health Campus - Plymouth

RARE OPPORTUNITY TO BE ON CAMPUS

Southdale Medical Campus - Edina

BE PART OF A MEDICAL NEIGHBORHOOD

- Turnkey suites available
- Custom design/build your new space
- Space to accommodate large users
- Competitive rental rates
- Generous tenant improvement allowance

Midtown Medical Buildings - Minneapolis

ON ABBOTT NORTHWESTERN HOSPITAL CAMPUS

Discover opportunities to relocate or expand your practice.

MIKE FLEETHAM
(952) 767-2842
MFleetham@MedCraft.com

JOLENE LUDVIGSEN
(952) 838-7126
JLudvigsen@MedCraft.com

medcraft.com/leasing

Overdose surveillance program funded to expand statewide

BY GREG BREINING

Led by deaths from fentanyl, the number of fatal drug overdoses in Minnesota has skyrocketed in the last five years. In 2021 the 978 overdose deaths overtook falls as the leading cause of injury mortality, according to the state Department of Health (MDH).

Concern about overdoses and the appearance of new drugs led to the creation of the MDH program known as Minnesota Drug Overdose and Substance Use Surveillance Activity (MNDOSA). Five cooperating Essentia Health emergency rooms in northeastern Minnesota and Hennepin Healthcare in Minneapolis now send clinical specimens from fatal and nonfatal overdose patients to the MDH public health laboratory to be screened against a library of more than 1,000 different legal and illicit drugs from around the world.

The Legislature recently funded MNDOSA to expand statewide. The program is seeking partnerships with emergency departments throughout Minnesota.

MNDOSA helps identify:

- Clusters of overdoses and what substances they involve.
- Substances causing severe or unusual illness, including new drugs with unexpected symptoms.
- Who is most at risk for substance use, information that can be used to focus prevention efforts.

"MNDOSA is able to provide situational awareness on the drug environment, and really show how that environment changes over time," says MDH epidemiologist Deepa McGriff. As a result, emergency department physicians will have "a greater awareness of what is in the drug environment, what patients might be exposed to, and what substances may contribute to certain clinical presentations, which translates to more specialized, more evidence-informed care."

Elisabeth Bilden, MD, a medical toxicologist and emergency medicine physician with Essentia Health St. Mary's Medical Center in Duluth, says knowledge gleaned from hard data on drug use in the community is valuable to practicing emergency physicians. "When we see trends, we can say, yep, that fits. No, this doesn't fit. That I think is one of the biggest things." It can also alert them to new developments, such as the recent appearance of the powerful sedative xylazine mixed with fentanyl, which can change the clinical presentation and treatment.

The program also helps measure the impact of overdoses and visits to emergency departments and the need for additional support for treatment of patients with substance use disorder. "This is really solid data," says Bilden. "It's not guesswork."

MNDOSA data can also inform broader public policy questions. A recent study of the drug information from the five hospitals in northeastern Minnesota found that nearly one-third of drug misuse and overdose patients were homeless (compared with a rate of homelessness among area residents generally of less than 1%). According to the MDH, "The findings highlight the need for a comprehensive

"MNDOSA is able to provide situational awareness on the drug environment, and really show how that environment changes over time. As a result, emergency department physicians will have a greater awareness of what is in the drug environment, what patients might be exposed to, and what substances may contribute to certain clinical presentations, which translates to more specialized, more evidence-informed care."

— Deepa McGriff, epidemiologist
Minnesota Department of Health

approach to break the harmful relationship between chemical dependency and homelessness."

The study also showed that the homeless patients "were more likely than others to be referred to further treatment, but also more likely to decline further treatment, suggesting that available treatment options may not address the needs of unhoused individuals."

MNDOSA began in 2017 as a partnership with the MDH, northeastern Minnesota emergency departments, and the Minnesota Poison Control System in response to the abuse of "bath salts"—synthetic cathinones—in area communities.

The identity of these unfamiliar substances was a puzzle, "but the public health lab, with its high-resolution toxicology testing, was able to identify the new substances," says McGriff.

Since then, the trends of drug use documented by participating emergency departments appears on the MNDOSA website. Among the quarterly data are the detection rates of five groups of substances—opioids, amphetamines, cocaine, marijuana, and synthetic cannabinoids/cathinones; combinations of substances detected; and suspected versus detected substances.

Hennepin Healthcare joined the program in 2022, giving greater clarity to regional trends in the state.

Data collected through the MNDOSA program has provided the following insights, among others:

Substance detection trends suggested that drug use varied by region. In 2022, amphetamines were more prevalent in northeastern Minnesota compared with the Metro, while cocaine was more common in the Metro.

Because of expanded toxicology testing of clinical specimens, polysubstance detection increased from 31% in 2017 to 72% in 2022. Says McGriff, "We are referring to detection, as opposed to use, of more than one substance; toxicology shows us a snapshot of exposures, but cannot tell us whether substances were used together or separately."

Linking MNDOSA data to hospital billing information showed that nonfatal overdose data does not capture the full impact of substance misuse on Minnesota emergency departments. Stimulants caused many cases of psychiatric symptoms; they were not overdoses but nonetheless required acute care and taxed the capacity of emergency departments.

"Timely and accurate data on the substances impacting Minnesota communities is critically important to inform responses to the overdose crisis," says McGriff. "Expanding MNDOSA throughout the state will allow for better surveillance of new trends and substances seen in various regions of the state. The goal is to empower local communities to leverage this data into targeted responses to outbreaks or spikes in overdoses." **MM**

Greg Breining is editor of *Minnesota Medicine.*

"When we see trends, we can say, yep, that fits, no, this doesn't fit. This is really solid data. It's not guesswork."

— Elisabeth Bilden, MD
Medical toxicologist and emergency medicine physician
Essentia Health St. Mary's Medical Center in Duluth

Finding joy in the practice of medicine

Physicians and their practices should aim higher than simply avoiding burnout.

BY KERRY D. OLSEN, MD

Gianrico Farrugia, president and CEO of Mayo Clinic, has championed joy in healthcare as a major strategic initiative. This may be one of the most challenging and important activities for a healthcare leader to acknowledge and undertake. A joyful practice of medicine does not allow burnout, dissatisfaction, poor quality of care, or unwillingness to do extra to help patients and colleagues. Indeed, a joyful practice is inspirational, innovative, engaging, purposeful, and has an inner vitality where patients and staff thrive.

The practice of medicine is an occupation that should be highly conducive to finding joy. It has been the author's experience over a 40-year medical career that establishing trusted relationships with patients and working with outstanding partners in discovery, growth, and treatment form a bedrock for joy.

Joy, however, is rarely used to describe the practice of medicine. Indeed, it is far

more common to focus on its antithesis: burnout. With over 50% of physicians experiencing burnout and 20% reporting depression, it is no wonder joy seems so elusive in medical care. Attempts to assess and reduce physician exhaustion and disillusionment have been a major focus for most medical groups. Micromanagement of physicians' time, loss of autonomy, a focus that often seems solely on productivity and RVU generation, and especially increasing clerical duties and documentation requirements all combine to make up the ingredients of burnout and emotional illness.

Corrective steps are being taken in most medical centers to try to address and reduce burnout. The end result may be a reduction in burnout, but the current practice is still rarely described as joyful. If physicians fail to address this in their careers, they risk feeling less "burned out," but with a feeling of lassitude, without joy. Too many practitioners feel that they are merely an unappreciated, overused productivity unit. Absence of joyful engagement could result in a refusal to undertake discretionary effort. Unwillingness to take on new patients, lack of timely response to patient needs or colleagues' requests for help, and less interest in taking on other duties in the areas of education, administration, and leadership can lead to an overall ineffective clinical practice. Once this occurs it is very hard to reverse.

But first, there's an elephant in the room that must be addressed. To succeed, any medical group or organization must have as elements of their strategic plan and managerial operations the following three components. First, a financially viable practice. As Sister Generose Gervais, long-time administrator of Saint Marys Hospital, is so often quoted, "No money, no mission. But no mission, no need for money." Second, there must be a focus on meeting the needs of the patient in terms of satisfaction, efficiency , quality, and outcomes. Finally , the staff must be treated and viewed as the most valuable asset. Most physicians believe their leaders prioritize these three in the order of finances, patients, and staff last. I believe there will never be sustainable joy in a medical practice unless the prioritization is patient, staff, and then finances. Without this alignment, the best intended plans to nurture joy can fall short.

Based on prior studies of intervention for burnout, priorities for addressing joy and satisfaction should be greater physician productivity, satisfaction, purpose, wellness, improved quality of care, timely care, and increased patient satisfaction. Rather than accept their current practice, every physician should be an advocate for continuous improvement. Consider the following suggestions to add joy to your practice. I'm sure you will find many more.

Management

Physicians must be strong advocates for each other and support leaders who feel that staff are the most important asset of an organization. Encourage leadership to be accessible and not work in isolation. Make management aware of staff concerns and seek transparency in all decision-making. Staff input must be valued. Communicate effectively. Although one voice can be very effective, look for ways to bring a choir. A toxic work environment must not be allowed. There should be no fear of retribution if a contrarian opinion is expressed, and there should never be bullying, abusive, or disrespectful behavior by anyone. The worst behavior? For leaders to communicate, explicitly or implicitly, "If you don't like it, you can leave."

Work group leadership

The capability and performance of your work group leader is probably the most important factor in reducing burnout and achieving practice satisfaction. Leaders must be carefully selected, trained, supported, and resourced for success. They must be regularly evaluated, and changed when necessary. Joy can come only when physicians feel that their leader listens to them, values and seeks their input, openly shares and communicates a vision, and models the behavior they want to see in their members. For physician staff to find joy, leaders must look for ways to remove the hassles from practice. Meaningful practice change always comes from those engaged in the day-to-day practice of medicine. Effective leaders also understand the human dynamics of the people on their team, recognize good work, and correct or stop bad behavior. There must always be equity and fairness in decisions such as assigned work duties.

Teamwork

Medicine is a team sport. It is a joy to work with talented colleagues and especially to work together. Every physician leads a team of assistants. Find activities, opportunities, and ongoing efforts to learn about each person on your team. Encourage in your practice setting the establishment of workrooms, joint coffee breaks, common space, or disease management groups to discuss patient care issues. Sur-

geons should find any opportunity to operate with colleagues. This practice allows ready exchange of techniques, instrumentation, and enhanced patient care. Whenever possible, contact your colleagues in different specialties and try to meet in person or by phone to jointly plan the care of your patients.

Recognition and gratitude

Take the time to thank, in person, by phone, through written note, or email those who provided great work for patients or colleagues. Supporting and demonstrating gratitude serves to improve all aspects of one's overall well-being. Physicians should be ever mindful that nothing can be accomplished in a medical practice without the assistance of a team. The regular practice of thankfulness leads to a personal practice of gratitude and is essential for finding joy in one's work.

Patient-physician relationship

Strive always to preserve and hold sacrosanct the patient-physician relationship. Scheduling systems must allow flexible and adequate time to provide an unhurried patient evaluation. Adequate patient time does not have to mean just more minutes. A skilled clinician knows how to navigate the patient experience to provide efficiency and satisfaction in just the right amount of time. Scheduling must be flexibile, however, as the practice of medicine is rarely predictable. Often the most successful outcome occurs from human touch and listening as opposed to the use of drugs, tests, or the scalpel.

Mentorship values and culture

Most medical organizations have a rich history with important values and a model of care. For example, the defined Mayo Clinic model of care has served that institution successfully for over 150 years. It's necessary to identify and preserve the best elements of an institution's model of care as the practice continues to change.

Mentorship brings awareness of this institutional culture. Be a mentor to one of your colleagues. Every new staff member should be assigned a personal mentor. Culture and organizational values must be regularly discussed, displayed, and lived. Having a known mission and working for a cause larger than oneself is a key aspect of joy and helps to sustain staff during inevitable difficult times.

Fun and laughter

Identify and make known episodes of joy in the workplace. These efforts can include anecdotes, videos, or posters depicting joy found at work, from patient stories, and with colleagues. Encourage socialization and fun events at and outside of work. Humor and fun must be shared and valued. The presence of many social events with colleagues is a clear indicator of a healthy work environment. Laughter can help reduce the emotionally challenging aspects of patient care. An additional benefit to knowing the interests and talents of your colleagues is the opportunity to share and participate in new activities together. You will benefit by trying new

"The sense of high expectation coupled with a supportive environment is so key for my child. He's surrounded by other high-potential students who inspire him and take inspiration from him as well." –Dr. Sirid Kellerman '88, MPA Parent

MPA FAMILIES HAIL FROM **82** DIFFERENT ZIP CODES

7:1 STUDENT TEACHER RATIO

100% COLLEGE PREPARATORY

RIGOR WITH MEANING AND PURPOSE

COLLABORATION OVER COMPETITION

PREK-12 MPA PREVIEW

JOIN US! SUNDAY, NOVEMBER 5 | RSVP today at moundsparkacademy.org/rsvp

things and spending time in activities outside of medicine.

Wellness promotion

Physicians should model a life of preventative care and recognize problems of well-being at an early stage. There is nothing more beneficial for eliminating burnout and promoting joy in the workplace than having you regularly commit to physical activity, resilience, adequate sleep, optimal nutrition, and abstinence from substance abuse. Exercise remains the best treatment to prevent or mitigate almost all medical conditions.

Autonomy

A joyful medical practice cannot exist if you are given no latitude to make changes in your work schedule. Work life events and attention to self care demand flexibility in your patient calendar. There must be a level of respect and trust. Insist on this privilege, but don't abuse it.

Alternative paths

The practice of medicine is constantly changing with regular innovations in patient care. Change must be celebrated and embraced to keep adapting and improving patient care and insure lifelong learning and avoidance of boredom. However, all practices over time have areas of routine and frustration. To help counter this, develop alternative areas of interest to provide variety to your normal work. This can be focused time in subspecialization or work in education, research, teaching, or administrative and committee duties. Time must be set aside for these activities. Support for practice improvement and innovation must be championed by all physicians. Your organization will be stronger, physicians happier, and patient care improved.

These are just a few suggestions to bring joy back into the practice of medicine. Adoption will not be easy. When physicians describe joy in their practice, this should correlate strongly with high patient and physician satisfaction, increased productivity, improved quality of care, enhanced efficiency, and innovation and financial success. Discretionary effort will not be lost. Physicians can focus again on helping patients and colleagues. Joy will be found when we find ways to seek it for others and ourselves. **MM**

Kerry D. Olsen, MD, is an emeritus Mayo Clinic head and neck surgeon, having practiced for 40 years and retired in 2020. He was on the Mayo Clinic Board of Governors and Board of Trustees. He was past chair of the Division of Head and Neck Surgery, president of the Mayo Clinic staff, and medical director of the Dan Abraham Healthy Living Center. Currently he is an executive leadership coach at Mayo Clinic and promotes healthy living as president of 12 for Health LLC.

REFERENCES

AMA Joy in Medicine Health System Recognition Program

Friedberg MW, Chen PG, et al . Factors affecting physician satisfaction and their implications for patient care, health systems, and health Policy. Rand Health Q. 2014 Winter; 3(4) 1

Lohrenz C. How to fight for joy even if suffering burnout. ForbesBooks Nov 23 2021

Medscape physician burnout and depression. Report 2022 shows pandemic continued impact. Web MD New York, NY Jan 21,2020

Muthuri RNDK, Senkubuge F, Hongoro C. Determinants of happiness among healthcare professionals between 2009 and 2019: a systematic review. (2020)7:98.https://doi.org/10.1057/s41599-020-00592

Olsen KD, Brown ME. Preserving the core of quality care as the practice evolves:the Mayo Clinic model of care. Group Practice. J. 2001: 50(4):11–19

Olsen KD, Dacy MD. Mayo Clinic—150 years of seeing humanity through hope and healing. Mayo Clin Proc 2014, 89(1)8–15

Shanafelt TD, Noteworthy JH. Executive leadership and physician well-being: nine organizational strategies to promote engagement and reduce burnout. Mayo Clin Proc 2017;92(1):129-146

Sull D, Sull C, Cipolli W, Brighenti C. Why every leader needs to worry about toxic culture. MIT Sloan management review March 16 2022.

West CD, Dyrbye LN, Shanafelt TD. Physician burnout: contributions, consequences, and solutions. Journal Int Med 2018,283;516-529

Most Insurances Accepted

Medication Management
Ketamine/Spravato®
TMS/VNS
Laboratory Analysis

Diagnosing diagnosis errors

Medical students and trainees are learning the skill of **diagnostic reasoning** in new ways and new places.

BY SUZY FRISCH

While teaching clinical reasoning at Mayo Clinic, John Bundrick, MD, MACP, is always looking for opportunities to improve skills of students and residents in the critical domain of making accurate diagnoses. An older woman presents with nausea, mild confusion, and an abnormal urinalysis, and is given a working diagnosis of urinary tract infection. But the UTI turned out not to be the source of her symptoms (which were caused instead by a recently added medication). It would have been easy to jump to an erroneous conclusion based on misinterpretation of a nonspecific test result as well as "premature closure"—failing to consider other options after noting the abnormal urinalysis.

Even veteran physicians miss out on opportunities to improve their diagnostic skills unless they follow up on their own cases to see the outcome, Bundrick notes. Otherwise, they may assume they were correct in every case—an example of confirmation bias. "None of us is infallible. It's a difficult business we're in, and it's way more challenging than people realize," says Bundrick, a Mayo Clinic hospitalist who has reflected deeply on his own cases and taught clinical reasoning for years.

Diagnostic errors are a stubborn aspect of medicine that often seems intractable. It's a deeply rooted problem with complex causes, leading to nearly 800,000 deaths or serious injuries in the United States each year. And while there are many systemic reasons that 5% to 15% of hospitalized patients are misdiagnosed—and 5% of clinic patients—a growing body of research has zeroed in on a key culprit: the traditional ways that medical education has approached teaching diagnostic reasoning.

To address the persistent problem of diagnostic errors, healthcare previously focused most of its efforts on safety and quality improvement initiatives. Discoveries about the cognitive science behind clinical reasoning led researchers to build a case five years ago advocating to get ahead of the problem. They proposed changing the way medical students and trainees learn the skill of correctly diagnosing patients.

The goal is the same: teaching medical students and trainees to take all of the components from a patient's medical history, physical exam, and symptoms, and use their knowledge of various conditions to home in on potential sources of illness. All the while, they must learn to avoid error in the form of delayed, wrong, and missed diagnoses.

"When we think about teaching diagnostic reasoning, we're teaching one of the key skills of being a doctor," says James Nixon, MD, MPHE, a professor of internal medicine and pediatrics and vice chair of education for the Department of Medicine at the University of Minnesota. "It's taking someone who comes in with a complaint and helping them figure out the cause of their symptoms and helping them figure out how to get better. We're a lot more deliberate in how we teach diagnosis now."

"None of us is infallible. It's a difficult business we're in, and it's way more challenging than people realize."

JOHN BUNDRICK, MD, MACP
HOSPITALIST
MAYO CLINIC

Not that long ago, medical schools did not specifically teach diagnostic reasoning. Students and trainees learned through apprenticeship. Today, teaching and training is changing to reflect understanding of how people digest vast amounts of information about human physiology and anatomy, synthesize it, put it in context with a real human's experience, and learn to apply it in the field much sooner.

Medical education used to emphasize memorization of various diseases and syndromes, with characteristic symptoms, in isolation, Bundrick says. More recently, instruction has evolved toward exposing students earlier to illness scripts—the way that clinicians store prototypical cases and diagnoses in their memories that they can easily recall.

Building these illness scripts is a more efficient way for medical students and new physicians to tap into all of the information they have learned about physiology, anatomy, and disease processes, and retrieve them in service of clinical reasoning, says Katherine "Betsy" Murray, MD, MPH, assistant dean for curriculum at the University of Minnesota and a developmental-behavioral pediatrician who does medical education research.

"Adult learning theory teaches that we haven't successfully integrated information that we read in a book into our long-term memory. It's not ever there, and if it is there, it probably isn't retrievable because you have no index to go and get it," Murray says. "Education has shifted so that we're helping students build that catalog and index it correctly so they can learn to access it."

Curricular changes

In recent years, the state's two medical schools, at the university and Mayo Clinic, have been shifting their curricula. They intend to better reflect understanding of how people learn to weigh patients' symptoms, data from tests and screenings, observation, and other contextual information to land on a diagnosis, and then course correct as circumstances evolve.

At the university, a new approach to learning flips the old model on its head, Murray says. Instead of having students listen to lectures focused on basic science disciplines—microbiology or anatomy, for example—the medical school now frames its instruction around biological systems.

Launched in fall 2023, the university's Serve Curriculum starts students off with learning about skin and many related topics. They include features of skin, its cel-

Where hunches go wrong

What are some of the cognitive dangers when it comes to pinpointing a diagnosis? Here are a few to watch out for.

ANCHORING EFFECT

A clinician takes their initial idea for a diagnosis and runs with it, even if new evidence emerges pointing to a contrary diagnosis. Then they avoid pursuing alternate explanations that also could explain what is happening with a patient, says James Nixon, MD, MPHE, vice chair of education for the Department of Medicine at the University of Minnesota.

CONFIRMATION BIAS

This often follows the anchoring effect. A physician quickly lands on one condition, then uses that lens to apply information from physical exams, lab tests, or other diagnostics to support this diagnosis. The person disregards other inputs that fail to support the initial diagnosis.

To avoid this pitfall, Nixon advises people to take a diagnostic time out before pronouncing what a patient has. "We need to ask ourselves, 'What else can this be? Is there anything that doesn't fit? What can't we explain about a patient's symptoms? What is the patient most worried about? Is it possible they have more than one problem?'" he says. "Going through this diagnostic time out is a forced cognitive strategy that allows us to use pattern recognition and then cross-check to make sure they aren't missing anything."

PREMATURE CLOSURE

This is when a clinician settles on a quick diagnosis, stops collecting data, and fails to consider other possibilities. A key reason physicians might go down this path is time pressure to land on a diagnosis and general discomfort with uncertainty, says John Bundrick, MD, a Mayo Clinic hospitalist. One way to prevent this is to refer to a diagnosis as a working diagnosis. Note that the preponderance of the evidence points in a direction, but that the physician is still collecting data and considering other options.

Unfortunately, simply recognizing common patterns of cognitive bias doesn't lead to significantly better diagnoses. "Strategies focused on decreasing bias are relatively ineffective at improving diagnosis," says Andrew Olson, MD, associate professor of medicine at the University of Minnesota.

"Certainly, bias does lead to diagnostic errors, but asking people, 'Are we anchored' or 'Are we using premature closure?' has never been shown to improve outcomes," says Olson. "Instead, focusing on case-specific strategies, getting lots of feedback, as well as the other general strategies, are more likely to be successful. From an individual point of view, focusing on things like structured reflection are likely to be met with more success."

lular structures, metabolism, genetics, skin infections, cancer, and discrimination related to skin. Future foundational lessons are broken down into cardiology, respiratory, gastrointestinal, and more.

This format creates much more context for exploring rich and varied medical concepts. "The theory here is that you are creating more retrievable stories that are the first layer of clinical reasoning," Murray says. "It all refers back to the general big idea called skin, and we're hoping to create links so that when a patient comes in with a concern, it's helping them organize their thinking about what the patient is telling them. Patients don't come in organized by discipline, they come in organized by complaint. The first landing place you can go with that complaint is what general part of the body does this seem to be affecting."

It's a markedly different way of teaching that uses backward design. Instead of downloading information to students to memorize, professors build their instruction based on what goal or competency

"When we think about teaching diagnostic reasoning, we're teaching one of the key skills of being a doctor. It's taking someone who comes in with a complaint and helping them figure out the cause of their symptoms and helping them figure out how to get better. We're a lot more deliberate in how we teach diagnosis now."

JAMES NIXON, MD, MPHE
PROFESSOR, INTERNAL MEDICINE AND PEDIATRICS AND VICE CHAIR, EDUCATION
DEPARTMENT OF MEDICINE
UNIVERSITY OF MINNESOTA

Making CANDOR possible

BY STEPH LINDGREN, JD

One of the most difficult situations a healthcare professional will face is when unexpected harm occurs to a patient. Most physicians are never taught how to communicate with a patient or their family in the aftermath of such an event. The process can leave a physician feeling isolated and unsupported and a patient feeling ignored and unable to get answers.

One program that attempts to remedy this situation is CANDOR. CANDOR stands for Communication and Optimal Resolution. It's a program designed to promote transparent and honest conversations between a healthcare professional, the facility, and the patient or their family after an adverse event. It is within this "safe space" that patients can have their questions answered and come to understand exactly what led to the unexpected harm. Along with providing answers and supporting the patient, CANDOR encourages conducting a thorough investigation into the circumstances surrounding the adverse event to ensure that it will not occur again, which improves patient safety.

During the 2023 legislative session, Minnesota joined several other states, including Colorado and Iowa, that have enacted CANDOR-type legislation. The MMA worked closely with the Minnesota Association for Justice to reach agreement on language that was agreeable to both medical professionals and patient attorneys. The legislation encourages use of the CANDOR program by physicians, other healthcare providers, and facilities by providing protection for information and documents that may be disclosed during a CANDOR conversation with a patient and their family. These protections ensure that everyone involved can engage in an open and honest conversation without fear that what they say could be used against them in a subsequent lawsuit.

It is important to note that the legislation is voluntary, and all involved must agree to participate. A patient can withdraw from the CANDOR conversation at any time and choose to pursue a lawsuit; however, what was disclosed during the CANDOR process remains protected. In the states that already have CANDOR legislation, there has been a substantial decrease in the time it takes to come to a resolution after an adverse event. This means that a patient and physician or other healthcare provider have fewer years of prolonged emotional and possibly financial hardship.

The MMA encourages all Minnesota facilities, physicians, and other healthcare providers to consider how the CANDOR process could be used in their practice.

Steph Lindgren, JD, is the MMA policy counsel.

they want students to master. The previous form typically involved lecturing and then testing students on human infections and their commonalities. Or teaching the anatomy of human lungs through lecture and dissection. Then when it was time to put the two topics together—say when seeing a potential patient with pneumonia—the necessary knowledge is not retrievable, Murray says.

Now, students will listen to a 10-minute talk on the fundamentals of insulin and its role in the human body instead of a long lecture about endocrinology. Then they break into small groups to review three cases of patients presenting with common symptoms of diabetes. They will work through a series of questions using provided resources and discussion that gently guides students to answers, helping them build connections between the science and the real world.

"Think about that exercise in contrast to someone showing you 10 slides about a disease. It creates an illusion that you learned something and can remember it, but it's not accessible to you," Murray says. "This is a more active way to learn—to pursue the learning yourself, to ask questions, to wonder about answers. That is really important to integrating knowledge successfully into long-term memory and making it retrievable."

In addition to new ways of teaching, the university also is getting students into the clinic earlier in medical school, Nixon says. Students still need to a build a foundation of broad general knowledge that they can draw on when they start seeing patients. But now classroom learning is designed to be more relevant, allowing students to more quickly deploy their basic science knowledge in the clinical arena, Nixon says.

A few months after starting medical school, students will begin going into clinics with preceptors. First, they will learn to take histories and do physical exams, practice with simulated patients, and work on presenting patient scenarios in small groups, and very quickly they will start seeing patients alongside their preceptor. "It's more problem-based learning and a framework for learning where students are presented with undifferentiated information, and they have to learn to find answers to problems," Nixon says. "That's what happens every time a patient comes to the clinic."

"Adult learning theory teaches that we haven't successfully integrated information that we read in a book into our long-term memory. It's not ever there, and if it is there, it probably isn't retrievable because you have no index to go and get it. Education has shifted so that we're helping students build that catalog and index it correctly so they can learn to access it."

KATHERINE "BETSY" MURRAY, MD, MPH
ASSISTANT DEAN FOR CURRICULUM AT THE UNIVERSITY OF MINNESOTA AND A DEVELOPMENTAL-BEHAVIORAL PEDIATRICIAN WHO DOES MEDICAL EDUCATION RESEARCH

Competency-based education

In training future physicians in the skill of diagnostic and management reasoning—two universal aspects of patient care—Mayo utilizes a blend of traditional apprenticeship and competency-based medical education, says Neel Shah, MB, ChB, a Mayo Clinic hospitalist and director of clinical education at the medical school. Competency-based education is rooted in skills-based learning and assessments that focus on entrustable professional activities (EPA).

Mayo has been progressively rolling out this approach since 2021, and it recently

Mayo utilizes a blend of traditional apprenticeship and competency-based medical education. "We're confident that this is giving us a perspective on students that we didn't have before." Taking the long view with students as they learn means "there are no blind spots when it comes to how they will be in the workplace."

NEEL SHAH, MB, CHB
HOSPITALIST AND DIRECTOR OF CLINICAL EDUCATION MAYO CLINIC MEDICAL SCHOOL

implemented it fully across its three campuses in Minnesota, Arizona, and Florida. Supervisors engage in serial assessments of medical students as they learn, practice, and master 14 entrustable skills. For example, completing a history and physical examination, prioritizing differential diagnoses, and interpreting screening tests results are all clinical reasoning skills that students develop over time. As they work to hone these abilities, assessors evaluate them about a dozen times during simulations and with live patients. They use a five-point scale that ranges from being trusted to watch another practitioner, trusted to do the skill while being supervised, or trusted to complete it independently.

The EPA assessment system gives medical students opportunities to be evaluated as they learn these new skills. Doing numerous assessments over a longer time makes the evaluation less high-stakes and gives students the opportunity to continue honing their abilities to the point of being trusted to handle the work independently, Shah says. “We’re confident that this is giving us a perspective on students that we didn’t have before,” he says. Taking the long view with students as they learn means “there are no blind spots when it comes to how they will be in the workplace.”

Another way Mayo approaches diagnostic reasoning is to teach medical students early on to engage in hypothesis-directed questioning during physical exams. Though they learn the traditional head-to-toe exam, they build on it by gathering information that relates to what the patient reports, Bundrick says.

Much of diagnostic reasoning occurs through pattern recognition: Clinicians interpret the constellation of symptoms, exam findings, and test results as matching up with the pattern of a specific illness that is stored in memory. “Such pattern recognition is extremely fast and—for experienced clinicians—highly accurate,” says David Cook, MD, MPHE, an internal medicine physician and medical education researcher at Mayo. “When clinicians are working with a spectrum of patients common to their practice, whatever that practice might be, pattern recognition is a good thing. It is efficient and accurate.”

However, pattern recognition doesn’t always work. “If the pattern doesn’t quite fit, or if I have less experience—weaker or fewer patterns to match—then I need to switch gears,” says Cook. When the symptoms don’t neatly match disease patterns, explicit, deliberate hypothesis testing is the next step. “Hypothesis testing shifts to a thoughtful and logical approach. We slow down and switch gears and become more contemplative,” Cook says. A related approach is structured reflection, in which clinicians pause to think about what they might be missing before closing in on a diagnosis. “Medical schools, doctors, and clinical educators are trying to figure out the best ways to help students develop both the fast approach of pattern recognition and the thoughtful, slow approach of hypothesis testing and structured reflection. We are also trying to understand and teach how to help clinicians recognize when they need to switch gears,” Cook says.

“Medical schools, doctors, and clinical educators are trying to figure out the best ways to help students develop both the fast approach of pattern recognition and the thoughtful, slow approach of hypothesis testing and structured reflection. We are also trying to understand and teach how to help clinicians recognize when they need to switch gears.”

DAVID COOK, MD, MPHE
INTERNAL MEDICINE PHYSICIAN AND MEDICAL EDUCATION RESEARCHER
MAYO CLINIC

Teaching structured reflection has shown modest success in a few studies. Yet the strongest evidence to date indicates that a time-honored tradition still holds true: Students and trainees benefit most from seeing numerous patients, which builds progressively robust knowledge structures in their brains. After each case, students and new physicians store the details into their memory, integrating this new pattern with other past cases, to build an elaborated model, Cook says. Here is where tools like simulation labs and computer-based virtual patients speed up the learning process—by presenting both a larger number of patients and a greater variety of diagnoses and patterns.

“If I see lots and lots of cases, the elaborated model in my brain becomes more robust, more encompassing, faster, and more accurate,” Cook says. “It helps me think through cases and think through them in more ways.”

Active learning in action

As early medical students more quickly build their diagnostic catalog, they can truly begin to put their diagnostic reasoning skills to the test. During rotations, third- and fourth-year students typically join teams with residents, attendings, and veteran physicians as they see patients and learn by watching and doing.

At this point, many medical students have started developing illness scripts and often can develop potential diagnoses

when given a rundown of a patient's symptoms. But they don't have the experience to know what conditions are most likely, says Samuel Ives, MD, an internal medicine physician at Hennepin Healthcare and site director of internal medicine rotations for medical students. Part of the teaching he does, in small groups, is to help students understand the frequency and rarity of some conditions.

Ives tells students that he will buy them a latte if they go one week without seeing at least one patient with pneumonia, a urinary tract infection, and a skin infection. "I tell them, 'I'm going to save my money because I've worked here 17 years and I never had a week when I didn't see all three,'" Ives says. "They learn all about illnesses but they don't necessarily know the base rate of different diagnoses and they don't necessarily have a 3D feel of what it's like. By teaching them what is frequent or infrequent, I'm helping them make a decision that they can do independently, with a little guidance."

Ives finds that when teaching medical students, "near-peer" learning is another way for them to continue honing their diagnostic skills. The theory is that people who just recently nailed a concept will have an easier—and more effective—time teaching others a topic because the information is fresh in their mind. They have most recently grappled with the complexity of the situation and often remember what was key to helping them understand. "The person who has to explain it is reinforcing what they know and is more likely to point out what's confusing than I might," Ives says.

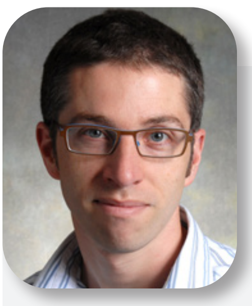
Other times, Ives has students work in small groups to look at an EKG and collaborate on a diagnostic assessment. This active learning is far more effective, and provides opportunities for applying new diagnostic knowledge, compared with listening to a sage on the stage lecture about EKGs.

During rounds, Bundrick teaches students and residents about uncertainty and probability by handing 10 poker chips to each small group participant. They might be weighing a potential diagnosis of a patient who presents with abdominal pain, perhaps caused by acute cholecystitis, a perforated ulcer, or ascending cholangitis. Bundrick asks them to place their chips on their chosen diagnosis (or a combination of the two) and explain why they think it's that condition. He participates as well, giving the group a chance to rib him when he's wrong.

"It's a fun way to teach about probability and differential diagnosis. And we're teaching not to stick a diagnostic label on something when there is not 50 or 60 percent certainty on it," he says. "And then, of course, we talk about next steps and how to rule out something serious that might be occurring."

Another important aspect of training students and residents in diagnostic skills is the work environment. There must be a culture of psychological safety for clinicians at all levels to say when they aren't sure of a diagnosis and model that uncertainty, says Benoit Blondeau, MD, division head of surgical services at Regions Hospital in St. Paul and chair of the surgery department.

"If you don't allow people to say, 'I don't know,' you will force them to say 'I know, it's A,' when it turns out to be B. And that has implications for the treatment of a patient with B when it was A," Blondeau says. "It's very common for [physicians] to



"Near-peer" learning is another way for students to hone their diagnostic skills. "The person who has to explain a skill is reinforcing what they know and is more likely to point out what's confusing than I might."

SAMUEL IVES, MD
INTERNAL MEDICINE PHYSICIAN AND SITE DIRECTOR OF INTERNAL MEDICINE ROTATIONS FOR MEDICAL STUDENTS
HENNEPIN HEALTHCARE

"If you don't allow people to say, 'I don't know,' you will force them to say 'I know, it's A,' when it turns out to be B. And that has implications for the treatment of a patient with B when it was A," Blondeau says. "It's very common for [physicians] to make a decision and act. We need to be able to pause, reflect, and act, considering other diagnostic options."

BENOIT BLONDEAU, MD
DIVISION HEAD, SURGICAL SERVICES AND CHAIR, SURGERY DEPARTMENT
REGIONS HOSPITAL

make a decision and act. We need to be able to pause, reflect, and act, considering other diagnostic options."

In fact, teaching uncertainty is an emerging area in clinical diagnosis instruction. It's not easy for many physicians to acknowledge that they do not know exactly what is happening with a patient, says Andrew Olson, MD, an associate professor of medicine at the university who has advocated for improving medical education related to diagnostic reasoning. But if veteran clinicians are not comfortable with the practice, then medical students, trainees, and other junior physicians won't be either.

Yet having that skill is integral to avoiding delayed or incorrect diagnoses. "Comfort with uncertainty correlates with experience," Olson says. "The more you do it, the more comfortable you are with it. The most important thing a supervising physician can do or say is, 'I don't know. Let's find out together.'"

Several things happen if clinicians don't acknowledge uncertainty. "Everyone might think a diagnosis has been made when it hasn't, and it's still in question. In that case, we stop early and say, 'Hey, we are done,'" Olson says. "Another possibility is we are so uncomfortable with uncertainty that we will grasp at certainty. Instead, we are teaching uncertainty and communication about it—that uncertainty isn't good or bad, it just is."

Another way to get better at clinical reasoning is to understand how clinicians arrived at a questionable diagnosis and learn from their outcomes. That's why trainees at Regions are encouraged to attend weekly morbidity and mortality sessions to dissect a troubling case. They can observe as others analyze what happened, discuss what could have been done differently, and prepare to make changes going forward, Blondeau says.

"They can see a seasoned surgeon say, 'This is what I was thinking when I treated a patient for a, b, c, d.' They remain humble and vulnerable in sharing their thinking with their peers. It helps people use best practices and protocols that will guide them and teach a systemic mode of evaluating patients," Blondeau says. "It creates a common language."

After many years of researching clinical reasoning, Olson has more hope than ever that improving diagnostic reasoning is on the horizon. "I firmly believe that we are much closer to improving diagnosis than we were when I started this work, but it's more complex than I ever could imagine," he says. "We know that this is a complex problem that requires complex solutions. Simple things like teaching slowing down—there might be value sometimes—but we really need to understand how healthcare systems work in certain environments and try to improve that."

"I firmly believe that we are much closer to improving diagnosis than we were when I started this work, but it's more complex than I ever could imagine. We know that this is a complex problem that requires complex solutions. Simple things like teaching slowing down—there might be value sometimes—but we really need to understand how healthcare systems work in certain environments and try to improve that."

ANDREW OLSON, MD
ASSOCIATE PROFESSOR OF MEDICINE
UNIVERSITY OF MINNESOTA

Current areas of Olson's exploration that he finds especially promising include studying how to foster high functioning diagnostic teams. Much of the early thinking on improving diagnostic reasoning focused on the individual and trying to prevent common cognitive pitfalls like premature closure. But physicians don't generally make diagnoses alone. More often than not they are working in a clinical team, whether that's in-person collaboration with nurses, pharmacists, other physicians, and the patient, or via electronic health record systems. It encompasses the notion of shared cognition and the context in which diagnoses are made.

For example, why is seeing patients in a hospital different at 3 a.m. versus 3 p.m.? And why is it different in an urban or rural hospital, or an academic medical center? "The facts might not change," Olson says. "But it's helpful to understand distributed cognition. We create a shared understanding of a situation among people, and we each have a part. A complete understanding of a situation requires putting all the pieces—that come from different people—together." **MM**

Suzy Frisch is a Twin Cities freelance writer.

TICKING ALL THE BOXES

Habitat expansion means physicians should keep their eyes peeled for tick-borne disease when evaluating puzzling symptoms.

BY ANDY STEINER

These days, ticks exist in just about every part the United States. But that wasn't always true. Ask Bobbi Pritt, MD, chair of Mayo Clinic's Division of Clinical Microbiology. When she was growing up in northern Vermont, she says she and her family never saw ticks—neither wood ticks nor black-legged (deer) ticks.

"We didn't have ticks there at all," Pritt recalls. But now, she says, there are plenty of ticks in her home state—and nearly all 50 states: "Throughout much of the United States, the tick populations are expanding, and they are moving into areas where they hadn't been for many, many years."

The spread of ticks—and tick-borne disease—is due to a combination of climate change and human behavior, Pritt says. A nationally recognized expert in clinical parasitology and vector-borne diseases, she explains that warmer global temperatures ("Milder winters allow for the ticks to survive and come out earlier") combined with a growing population of deer and small rodents for ticks to feed on have created "the perfect environment for ticks to thrive."

Add to this "perfect environment" humans' increased exposure to tick-carrying wildlife from abundant deer and rodent populations that live near our homes, and rates of tick-borne disease naturally increase, Pritt says. "We have created these little micro habitats of wooded forest areas around our houses which are a perfect environment for the deer and the rodents to survive."

All this means that ticks—and tick-borne disease—exist just about everywhere. This should be an important reminder for regular people—and the physicians who treat them, Pritt says: Tick-borne disease is "definitely something almost everyone in the United States now needs to worry about."

The land of 10,000 ticks

Some Minnesotans brag every time their state lands at the top of a "best of" list, but there's one first-place spot that few care to boast about. The state's abundant lakes, woodlands, and wildlife make it a top breeding ground for ticks and the diseases they carry.

"There's certainly a lot of tick-borne diseases in Minnesota," Pritt says. "We're definitely a hot spot, right near the top of the list."

By far the most common tick-borne disease in the state is Lyme disease. Lyme can cause a constellation of symptoms, including fever, headache, fatigue, and skin rashes that sometimes confuse or stump physicians and delay treatment.

Jonathan Oliver, PhD, is a public health entomologist and assistant professor at the University of Minnesota School of Public Health, Division of Environmental Health Sciences. He explains that Lyme disease is spread by the black-legged tick, also known as deer tick, the state's "main tick of concern."

"Deer ticks can transmit seven diseases," Oliver says. "In Minnesota, the most common of those is Lyme disease by far. There are around an estimated 476,000 cases of Lyme disease a year in the U.S.—mostly in the Northeast and the upper Midwest."

The second-most common tick-borne disease is human granulocytic anaplasmosis, Oliver said, explaining that there are about 500 cases of the bacterial illness diagnosed in Minnesota each year. "About a third of all cases diagnosed nationwide are here," he says.

The symptoms of human granulocytic anaplasmosis are, like those of many tick-borne diseases, "very vague," Oliver says. "They include fever, malaise, feeling unwell. It is an interesting tick-borne disease because the bacteria that cause it invade the white blood cells in your body." While the disease resolves itself in most people without treatment, Oliver cautions that it can be potentially fatal if "it gets out of control," causing, in severe clinical presentations, difficulty breathing, hemorrhage, renal failure, or neurological problems. Fatality in humans is extremely rare, at 0.6%, according to the National Institutes of Health. Timely antibiotic treatment of 10–14 days is the best way to avoid extreme reaction to anaplasmosis.

Other tick-borne diseases of note include babesiosis, Rocky Mountain spotted fever, ehrlichiosis, and *Borrelia miyamotoi* disease. Most bacterial diseases transmitted by ticks can be treated with antibiotics, particularly doxycycline. "That's the good news," Pritt says. "You can use one drug and even if you didn't diagnose everything, the doxycycline will take care of it."

The bad news is that some tick-borne illnesses, including Powassan virus, can-

"Throughout much of the United States, the tick populations are expanding, and they are moving into areas where they hadn't been for many, many years.... We have created these little micro habitats of wooded forest areas around our houses which are a perfect environment for the deer and the rodents to survive."

BOBBI PRITT, MD, CHAIR
DIVISION OF CLINICAL MICROBIOLOGY
MAYO CLINIC

"If they have a fever or rash in the summer, tick-borne illness should be at the top of the list. If it walks like a duck and it quacks like a duck, it is a duck. It is Lyme disease until proved otherwise if it is Minnesota in the summer."

LAURIE RADOVSKY, MD
FAMILY MEDICINE PHYSICIAN WITH A SPECIAL FOCUS ON TREATING LYME DISEASE
ST. PAUL

not be treated with antibiotics. "That's one where we don't have any good treatment," Pritt says. "Most of the time people who get it probably don't have very many symptoms, but some people get really severe symptoms where it invades the brain and the spinal cord and they can even die—or if they do survive they have long-term deficits."

Thankfully, Powassan virus is still relatively rare, Pritt says: "In Minnesota, it looks like there are about 10 cases reported each year. The cases that get reported are the ones where people get really, really sick. There are probably 100 times more cases where people don't have that bad of an illness and they don't get tested."

Another tick-borne illness that does not respond to antibiotic therapy is alpha-gal syndrome. Commonly spread by the lone star tick, this disease, Oliver says, is "really interesting. It is not a disease that is caused by a pathogen. It is caused by an allergic-type immune response. Basically, people who are bitten by this tick are developing a severe red meat allergy due to exposure to glycosylated proteins."

The lone star tick is, Pritt explained, "a very aggressive biter of humans." Lone star ticks are "spreading throughout the United States and into Minnesota, although they don't look like they are officially established here yet. Still, there are people who are exposed each year."

Oliver backs up Pritt's concern. "Even though we don't have the tick here yet, we do have cases of alpha-gal that are being diagnosed in the state," he says. "A physician in Duluth who is an expert at recognizing cases of alpha-gal said there is a cluster of cases around Duluth that he has identified."

"If it walks like a duck…"

Because the symptoms of many tick-borne diseases are hard to pinpoint, physicians have struggled to diagnose and treat patients who come to them complaining of a range of concerns that could mimic other illnesses.

Laurie Radovsky, MD, a St. Paul-based family medicine physician with a special focus on treating Lyme disease, says that because too many doctors lack clear education on Lyme, some cases go untreated, forcing patients to have to advocate for themselves. Some of those patients eventually end up in her office.

"I once saw a woman who had a headache, fever, chills, sweating," Radovsky says. "She developed a full-body rash. When she went to the ER, they focused on her high heart rate. They did an EKG." When the woman eventually developed the classic bull's-eye rash that is known as a Lyme symptom, she went to another ER. "She had to say, 'You have to test me for Lyme disease,'" Radovsky recalls. "She hadn't had an attached tick, but she went camping in Wisconsin over the Fourth of July."

While there is an antibody test for Lyme disease, it is not foolproof, Pritt says: "It can take a good week or two for your body to produce antibodies. That's why if you have the bull's-eye rash in an area like Minnesota where Lyme disease is pretty common, the CDC guidelines say that is diagnostic of Lyme disease. Just go ahead and treat it as if it were a case of Lyme disease."

Erring on the side of caution, Radovsky would go a step further. She wants to encourage her fellow physicians to think beyond the bull's-eye.

"With someone who has an acute illness after having been outdoors or after a tick bite, tick-borne illness should be at the top of the list," Radovsky says. Aching joints and fever are typical symptoms of tick-borne illness, she adds: "There is no such thing as a summer flu. If they have a fever or rash in the summer, tick-borne illness should be at the top of the list. If it walks like a duck and it quacks like a duck, it is a duck. It is Lyme disease until proved otherwise if it is Minnesota in the summer."

Diagnosing tick-borne disease isn't always simple, Pritt says. It requires a physician to be thinking about the possibility of tick-borne illness when a patient comes in complaining of a range of symptoms. Some physicians do not have tick-borne disease in the front of their minds, and patients may need to ask specifically to be tested or treated for these diseases. "Patients can really act as their own advocate

and say, 'Hey, I've been outside a lot. I've been exposed to ticks,'" Pritt says. "Most healthcare providers only think about tick-borne disease in the summertime." Ticks can be active throughout the fall as well.

There are readily available tests for some tick-borne diseases, but not for others. "The big ones—anaplasmosis, babesiosis—we have good tests for them," Pritt says. But some of the newer tick-borne diseases that she and her colleagues at Mayo have recently discovered "don't have widely available tests yet—or maybe the tests are only available at a larger laboratory like mine."

Radovsky hopes that the increased focus on tick-borne disease at places like Mayo Clinic will help to create a greater awareness among her colleagues of the potential dangers of tick diseases—and the available therapeutic treatments.

"The first thing that is frustrating to me is that clinicians often don't have a high index of suspicion of Lyme disease," Radovsky says. "It is not on their radar. I've had patients have to say to their clinician, 'Don't you think this could be Lyme disease? I was camping in the Boundary Waters. I had a tick attached. I feel sick.' I'm hoping more doctors will start thinking of tick-borne disease before a patient has to twist their arm." **MM**

Andy Steiner is a Twin Cities freelance writer and editor.

"Deer ticks can transmit seven diseases. In Minnesota, the most common of those is Lyme disease by far. There are around an estimated 476,000 cases of Lyme disease a year in the U.S. – mostly in the Northeast and the upper Midwest."

JONATHAN OLIVER, PHD
PUBLIC HEALTH ENTOMOLOGIST AND ASSISTANT PROFESSOR
UNIVERSITY OF MINNESOTA SCHOOL OF PUBLIC HEALTH, DIVISION OF ENVIRONMENTAL HEALTH SCIENCES

WOOD TICK DEER TICK LONE STAR TICK

TICK-PREVENTION STRATEGIES

Though experts like Bobbi Pritt of Mayo Clinic and Jonathan Oliver of the University of Minnesota are acutely aware of the potential dangers of tick-borne illness, they still encourage people to go outside and enjoy the natural world—with caution.

Tick-borne disease is, Oliver says, "more easily prevented than treated." If you're going to be outdoors, learn what tick habitat looks like and when ticks are going to be around. "If you need to be out in tick habitat, it is a great idea to wear repellants that contain DEET," he says.

He also recommends daily tick checks, especially when you've been outside. "It takes more than 24 hours for bacteria to move from the tick's body to your body, so you have an opportunity to find and dispose of a tick before it spreads disease."

Tick-busting precautions—repellant with DEET, long pants tucked into socks and long-sleeved shirts—should become part of your outdoor routine, like putting on sunscreen, Pritt says. "A major message for anyone living in Minnesota is, 'Make this part of your life.' It's very manageable. You should still go and have a wonderful day outside—but first, take these precautions."

— Andy Steiner

University and Fairview: Whose hospital?

Who or what should own the **University teaching hospital**, and what are you looking for from the governor's healthcare task force?

Recent merger talks between Sanford Health and Fairview Health Services triggered lots of alarms among Minnesotans versed in healthcare.

Fairview owns the University of Minnesota teaching hospital, and suddenly one of the primary tools of the university medical school seemed destined for control by a company from another state—a state that differs from Minnesota in politics over COVID-19, abortion, and Medicaid expansion.

Moreover, Sanford and Fairview are major players in the Minnesota health market, and many believed a merger would exacerbate ill effects of healthcare consolidation.

In the midst of these negotiations, the University announced it wants to buy back its teaching hospital (sold to Fairview in 1997) and build a new medical center—a proposal the *Star Tribune* called "a bold vision with few financial details but one requiring taxpayer money."

This spring, the Legislature passed—and Gov. Tim Walz signed—a bill that would require review of major healthcare transactions by the state attorney general and health commissioner to make sure deals are in the public interest and would not "substantially lessen competition" or "tend to create a monopoly or monopsony."

Then, this summer, Sanford quit merger negotiations, giving all parties a chance to take a deep breath and ask who or what should own the university hospital. The governor took the opportunity to create a task force to make recommendations by Jan. 15 "to support world-class academic health professions education, research, and care delivery … that advance equity, center primary care, and ensure that Minnesotans can continue to receive the highest-quality care in a financially sustainable way."

Whew! Lots to consider.

As Minnesotans await the task force recommendations, *Minnesota Medicine* asked some key players and observers to comment on the possible future of the University-Fairview relationship and the M Health Fairview University of Minnesota Medical Center. Interviews have been edited for brevity and clarity.

During talks about a Sanford-Fairview merger, did you have concerns about a South Dakota company taking over the U of M teaching hospital, now owned by Fairview?

MORRISON: You probably followed when former governors Pawlenty and Dayton both testified in front of the Health and Human Services Committee on which I sit, both in opposition to the concept of a merger with a company that is based out of state regarding our academic medical center. I think there's pretty broad consensus in the Legislature that that makes a lot of us uncomfortable.

Fairview is based in Minnesota. So, you know, at a minimum we're talking about the same kinds of values around healthcare and the same law. I agree with you that there is a similar question around merging public-private relationships. But at a minimum with Fairview we're working with the same rules. Sanford is based in a state that has laws that restrict access to healthcare. And that just doesn't jibe with our values here in Minnesota.

The University of Minnesota is a land grant university. It trains about 70% of our physicians who practice in the state. And when we talk about aligning ourselves or being owned by an entity that is headquartered in a state that has restrictive laws around healthcare, you know, problems start to arise. I think it's a dangerous precedent to be set. And I think it really puts the health of our state at risk, quite frankly.

BAUMGARTEN: I thought that the entire deal of Sanford Health capturing the Fairview system, including the U of M hospital, was bad for a series of reasons, one of which falls under the heading of anti-competitive transactions. Combining Fairview and Sanford would give the combined system significant market power and result in anti-competitive markets for healthcare, especially for employers. That would have consequences for employers in the state of Minnesota, and for the state of Minnesota as an employer statewide.

TJADEN: Having that system owned and managed by an out-of-state entity raised several red flags for me and other physicians in the state. South Dakota and Minnesota are right next door and you talk about Midwest values. But clearly when you look at our health systems and our healthcare, we have different values. A great example of my perceived difference in values is the way we managed the COVID pandemic versus South Dakota and North Dakota.

Minnesota cares deeply about health equity and reproductive health. And we have definitely seen that healthcare, especially for

Sen. Kelly L. Morrison, MD, DFL-Deephaven, is assistant majority leader and member of the Senate Health and Human Services Committee. She is also an OB/GYN with Women's Health Consultants, Minneapolis, and affiliated with Allina Health Abbott Northwestern Hospital.

Rep. Robert Bierman, DFL-Apple Valley, is the vice chair of the House Health Committee and primary author of legislation to require review of any proposed out-of-state ownership of the University medical system.

Allan Baumgarten is an independent analyst of healthcare markets and organizations. He is author of *Minnesota Health Market Review*, an annual analysis of providers and payers in the market and their strategies. He publishes reports in five other states and consults for several organizations, including the Robert Wood Johnson Foundation.

Kim Tjaden, MD, MPH, FAAFP, is the chair of the MMA Board of Trustees and family physician in St. Cloud.

women and children, has worsened in those states that have not done Medicaid expansion for sure. [South Dakota was a Medicaid expansion holdout; voters approved expansion to adults 19 through 64 years, effective earlier this year.] I think we have to make sure we can educate our future Minnesota physicians, PAs, nurses, pharmacists—all of those folks—with our values.

Is it necessary for a university teaching hospital to be owned by a Minnesota-based entity? Is it best if the owner is the university?

BIERMAN: That hospital was created for the mission of improving the health of Minnesotans. So to me, it's imperative that it stays at the center of Minnesota's healthcare and is controlled by Minnesota entities and interests. The number of physicians that are trained there—it's over 70% from Minnesota are trained at the university. It attracts talent, it's world renowned. It's an education destination and a research destination. And I think that's something we have to not only maintain, but build upon.

All of us, you and I and everybody else, we've supported not only the University of Minnesota, but the University of Minnesota Medical School over the years, so there is substantial public interest in what happens with that facility and the university. And so we had to write something about who could control the school and medical school. There was a lot of debate about whether the Legislature should make that decision, but we ultimately decided it would be better in the hands of the university regents themselves, the Minnesota Department of Health, and the attorney general, with the caveat, of course, that it needs to be in the public interest.

BAUMGARTEN: There are certainly examples of academic medical centers whose primary teaching hospital is owned by a company based in a different state. The Loyola hospital, I believe, is owned by the Trinity Health system. That's in Chicago, but the Trinity health system is based in Michigan. Tenet [Healthcare] I believe still owns academic medical centers in St. Louis, and that's a for-profit company, which people have other concerns about.

> "Having that system owned and managed by an out-of-state entity raised several red flags for me and other physicians in the state. South Dakota and Minnesota are right next door and you talk about Midwest values. But clearly when you look at our health systems and our healthcare, we have different values. A great example of my perceived difference in values is the way we managed the COVID pandemic versus South Dakota and North Dakota."
>
> **Kim Tjaden, MD, MPH, FAAFP**
> CHAIR, MMA BOARD OF TRUSTEES
> AND FAMILY PHYSICIAN, ST. CLOUD

The University of Minnesota has said it should take back its Minneapolis teaching hospital and then build a new medical center on its campus — a bold proposal with few details except that it would require taxpayer money. What are its chances in the Legislature?

MORRISON: Now, the reason we find ourselves in this situation is because of the problems that the U-Fairview union has been having. It's a complicated question. But we've also allocated a lot of money to the university. And so [reacquiring the hospital] would require new money if we were going to talk about a rebuild of the university's medical school. Obviously, we'd need to flesh out many more details. And I hope that the task force looks at some of those questions as well. I hope they consider the Sanford question, and I hope they consider the Fairview question. And I hope they consider different paths and what they might look like, because we're all going to have to put our thinking caps on and come up with the best possible solution so that the University of Minnesota Medical School is healthy and thriving.

BIERMAN: The chances [that the Legislature would approve buying back the hospital] would have to be evaluated based on what they put forward in the future. And I think there are many legislators who may concur. At some point, they are going to have to improve their facility and upgrade. But you know, the devil's in the details. The Legislature—anytime they're going to be ponying up resources, they're going to want to have some oversight about how that money is utilized, and that will not change. I think there are a lot of steps ahead that have to be taken before that can really be something that legislators are going to jump on board with.

BAUMGARTEN: I agree in principle with the notion that the state's primary academic medical center should have a first-class hospital. The existing University medical center is somewhere between 30 and 40 years old and definitely showing signs of age. I think that the university owes it to the State Legislature and others to have a more fully fleshed out plan for what kind of facilities

they would build, what needs it serves, how to best finance it, how they will operate it over time, and whether it will require ongoing significant state subsidies to make it feasible to operate going forward.

Squabbles over finances between the U and Fairview suggest all is not right with the relationship, which runs through the end of 2026. If Fairview and the U want to terminate the relationship, either side must give notice by Dec. 31. Thoughts about what might happen? Or what *should* happen?

BIERMAN: I'm going to remain hopeful that Fairview and the university can reach an amicable understanding, to renew and reset their arrangement to both of their advantage. And I think there are a lot of benefits to each entity in keeping that arrangement together. Fairview benefits in a lot of different ways, and so does the U, and to just walk away from that would be complicated. I think they need to focus on the positives of what is working for them.

Clearly with Fairview, to have elite physicians of the U in their ranks is a big deal. If we do this task force and can come forward with some great recommendations and changes to benefit Fairview and all health systems in the state, with renewed emphasis on workforce development, that's going to help them.

There's an enhanced income generation of specialists that Fairview benefits from. They have this continuum of care beyond just delivering healthcare, as normal healthcare systems do, but they benefit more from training and the teaching hospital, and they benefit from the research and trials of product development. Fairview gets the U of M brand, and I would say, even shares in some of their fundraising efforts, which help boost Fairview. So it's in Fairview's interest, and I hope that their board sees all of the advantages that are built in.

And the U gets what they need with Fairview. They have patient referrals—they need that. If it's not Fairview, it's got to be some other entity or a combination of entities. They offer the U the whole business side of healthcare. The U is able, with their arrangement with Fairview, to reach out to all 87 counties in the state at some level.

So I remain hopeful that they can work this out.

BAUMGARTEN: The university and the Fairview system have this codependency—they each need the other.

The university needs a feeder system of community hospitals and community doctors that will send it patients so that it has the patients to fulfill its teaching mission, to fulfill its research mission, to give its training doctors sufficient patients to be practicing on or practicing with. So the university needs partners like that to bring it patients.

Fairview needs the university because it has a group of highly skilled specialists that a major community hospital system needs access to in order to hold on to its patients who want to go to a hospital system where they can have their primary care needs met, as well as their secondary and tertiary care needs met. They don't want to have to go from hospital system to hospital system or from one network of providers to a different network in order to have care, because they want their care to be coordinated and have doctors that are practicing in a collaborative way.

"The university and the Fairview system have this codependency—they each need the other. The university needs a feeder system of community hospitals and community doctors that will send it patients so that it has the patients to fulfill its teaching mission, to fulfill its research mission, to give its training doctors sufficient patients to be practicing on or practicing with. So the university needs partners like that to bring it patients."

Allan Baumgarten
INDEPENDENT ANALYST OF HEALTHCARE MARKETS AND ORGANIZATIONS

And I think Fairview also needs the university for other reasons. There is a program called 340B [Drug Pricing Program], where hospitals serving a high percentage of either Medicaid recipients or low-income recipients get subsidies for the cost of their medications that are used, and that brings a lot of money into the Fairview system through the doorway of the University hospital. So being a system with University hospital gives the Fairview system access to certain streams of revenue, gives it access to certain kinds of technology or research that it might not have access to otherwise.

So I come back to the notion that the two of them need each other or need equivalent partners to supply what they're giving each other today. I don't think it's an easy thing to substitute other partners for what they have today. So, for example, I'm not sure that Allina wants to become a feeder system to the University of Minnesota hospital, because the Allina system would say, well, we

have in many specialties specialists who are on par with the University specialists. So we want to keep those patients within our system and seeing our specialists. We don't want to be referring them out to the University of Minnesota except in the case where we don't have equivalent specialists to serve that population. So it would not be a simple thing to find new partners for either the university or for Fairview that fill the gap that would be created if the two of them divorced.

I think that's a strong possibility [that the U and Fairview will patch over their relationship]. It may take longer than between now and the end of 2023 to work that out. So even if one of them did give notice that they intended to leave the partnership, I hope that they would still hold the door open for the possibility of renegotiating the arrangements they have before the expiration date of the partnership.

When the university put the hospital up for sale and Fairview bought it, it was portrayed then and even today as sort of a rescue, and it makes it sound a little bit one-sided—that the University was struggling and Fairview came along and said we will relieve you of struggles that you're going through by taking over financial responsibility for your hospital.

But I think it's important to recognize that Fairview also got some significant benefit from that because—do you remember the Fairview hospital on the West Bank? That was an aging collection of buildings, because it was the old St. Mary's, the old Fairview Riverside—a collection of aging buildings that really had reached its expiration date. Whereas the University Hospital was at that time a bright and shiny new hospital. So Fairview, in the next few years from that transaction, would have had to make significant investments so that it would have the kind of hospital they needed in that decade. And instead, they chose to put money into taking over the University hospital and gaining at that time very valuable assets. So it was in some respects a rescue of University hospital, but it was also something with significant benefits to the Fairview system.

Does another state provide a good model for how the hospital-university relationship might work?

MORRISON: I would hope that [what other states have done] would be part of what the task force examines—to see if there are other examples that we can learn from.

BIERMAN: How do other states do it? I think that that is something that we are looking at, too. Having a medical school in the state is really important; not all states do. So the states that don't have a medical school, they have to teach their workforce through hospitals, and most of those states have to have a stream of funding for entities to do some teaching so that they have the people they need. Fairview, to have the University of Minnesota Medical School affiliated with it, there are certainly some costs to that. And how could the state alleviate some of that and make it work better for them?

BAUMGARTEN: Here in the Midwest, very successful university medical centers are owned by public universities like the Univer-

"How do other states do it? I think that that is something that we are looking at, too. Having a medical school in the state is really important; not all states do. So the states that don't have a medical school, they have to teach their workforce through hospitals, and most of those states have to have a stream of funding for entities to do some teaching so that they have the people they need. Fairview, to have the University of Minnesota Medical School affiliated with it, there are certainly some costs to that. And how could the state alleviate some of that and make it work better for them?"

Rep. Robert Bierman
DFL-APPLE VALLEY

sity of Wisconsin and the University of Michigan in Ann Arbor. I would say they are very successful for all of their missions, whether it's teaching or research or patient care, and are also successful financially.

What are you looking for or hoping for from the governor's task force?

MORRISON: I hope that no questions are off the table. I hope that they take a really fulsome look at several different possibilities. And I really hope that they get great minds around that table with deep expertise, particularly in academic healthcare and medicine, which is different from private and even community-based medicine. So I really hope that we have people with deep expertise around that table, and that they come up with some great solutions. And then we can proceed with enacting whatever it is that's going to be best for the university and best for our state.

You know, next year is an election year, and that always could bring in complications, of course—to make things political, even when they don't have to be. I'm going to be hopeful that we all have the best interests of the U and our state in mind.

I'm really excited that the governor is forming this task force because they are complicated questions. And they require a thoughtful deep dive so that we're proceeding in the smartest way for our state, for the health of the university, for the health of the university medical school, and ultimately, for the health of Minnesotans themselves. I'm really pleased that this is going to happen. I'm excited about the future and excited about the ideas the task force will bring to us.

BIERMAN: The University of Minnesota Medical School—I've said it in committee numerous times—they are at the center of healthcare in this state and we need to keep it that way. I liked the way the governor set the tone for this task force to be focused on equity, primary care quality, and financial sustainability. I think he covered all the bases on what this task force should be doing. This is an opportunity to redesign our whole healthcare future in this state, and I'm very, very excited about it.

TJADEN: Should the hospital be owned by anybody else? Should the university not just have ownership of it? I would hope that the governor's task force would help us answer those questions: Is it sustainable for a university to own a teaching hospital and medical center? What other states have modeled this and how? How could we do it? Or do we need to partner with somebody?

I think there's a role for the Minnesota Medical Association in an advisory capacity. I think that our goal is to have the healthiest state in the nation. That the university is teaching most of our future healthcare providers is a good reason for us to be involved in an advisory role.

The University of Minnesota is a treasure. They do a wonderful job of training the healthcare workforce for our state. They are able to understand and incorporate education about rural and urban healthcare, health equity, reproductive health. These are very important pieces of healthcare education. I worry that if another entity came into our state and started running our medical school, important parts may be discarded due to the bottom line or differences in values. We must safeguard our treasure so we can continue to work to be the healthiest state in the union. **MM**

"Now, the reason we find ourselves in this situation is because of the problems that the U-Fairview union has been having. It's a complicated question. But we've also allocated a lot of money to the university. And so [reacquiring the hospital] would require new money if we were going to talk about a rebuild of the university's medical school."

Sen. Kelly L. Morrison, MD
DFL-DEEPHAVEN

Interviews by Greg Breining, editor of ***Minnesota Medicine***.

CASE REPORT

The many faces of morphea

BY TENZIN SERPOLAMATSANG, BS; SAMANTHA GARDEEN, MD; ANNA KOZLOWSKI, MD; MS; LAURA FURDA-RAINE, MD

Morphea is an inflammatory disorder of the skin and underlying tissues. It may be difficult to assess as it can mimic many other dermatologic conditions. Typically, morphea presents as erythematous and circumscribed plaques. It affects female patients more often than male patients. In this case, morphea eluded diagnosis due to changing clinical and histologic morphology. The etiology of this rare, fibrosing disease is not completely understood and treatment options are limited.

Case

A 74-year-old woman presented to clinic with a rash that had waxed and waned for several months, affecting the lower torso, upper medial thighs, inguinal folds, and bilateral hips. Biopsy was consistent with interstitial granulomatous dermatitis (IGD) with eosinophils, suggestive of interstitial granuloma annulare versus an interstitial medication reaction.

Her anti-DNA antibodies, ANA screen, and ENA panel were normal, and she was treated intermittently with triamcinolone 0.01% cream.

Seven years later, a new atypical-appearing lesion developed on the left hip, which revealed an evolving hypertrophic scar on histology. Four months later, the patient returned to clinic with scattered 5- to 20-mm red-purple plaques across the bilateral upper medial thighs, with histology consistent with superficial dermal scar with keloidal features, and lack of granulomatous dermatitis. These plaques were treated as eruptive keloids with intralesional triamcinolone and local excision, but continued to recur.

Two years later she presented with yet a third morphology of white scarlike, atrophic plaques on the breasts, abdomen, and hips. The final biopsy of the left lower abdomen was notable for superficial dermal sclerosis, most consistent with a lichen sclerosus–morphea overlap and a uniting diagnosis of longstanding evolving morphea. She was presented with options for therapy including phototherapy, methotrexate, or high potency topical steroids and is currently on narrowband UVB therapy with clobetasol 0.05% ointment.

Discussion

This case highlights the evolving nature of clinical morphea as demonstrated through its various clinical and histologic representations of interstitial granulomatous dermatitis, hypertrophic scars, and keloids. It also emphasizes the importance of clinical suspicion of various morphea variants. In our case, the initial biopsies thought to be IGD were more likely representative of the inflammatory stage of morphea, based on the patient's clinical progression and lack of classic IGD-associated disease, such as rheumatoid arthritis, seronegative arthritis, autoimmune thyroiditis, systemic lupus erythematosus, and arthralgia.

Keloidal or nodular morphea is a rare variant of cutaneous sclerosis that typically presents on the trunk, extremities, and neck. Due to the rarity of this condition, there's little consensus regarding treatment. The most well-supported treatment option is methotrexate in combination with systemic steroids, but for patients preferring to avoid systemic medications, narrowband UVB, potent topical steroids, or calcipotriol are alternatives. **MM**

Tenzin Serpolamatsang, BS, is a dermatology scribe at HealthPartners Institute. Samantha Gardeen, MD, and Anna Kozlowski, MD, are PGY4 residents at HealthPartners Institute. Laura Furda-Raine, MD, is a board-certified dermatologist at Park Nicollet in St. Louis Park.

REFERENCES

Cunningham BB, Landells ID, Langman C, Sailer DE, Paller AS. Topical calcipotriene for morphea/linear scleroderma. J Am Acad Dermatol. 1998;39(2 Pt 1):211-215. doi:10.1016/s0190-9622(98)70077–5

Fett N, Werth VP. Update on morphea: part II. Outcome measures and treatment. J Am Acad Dermatol. 2011;64(2):231–244. doi:10.1016/j.jaad.2010.05.046

Dancey AL, Waters RA. Morphea of the breast. Two case reports and discussion of the literature. J Plast Reconstr Aesthet Surg. 2006;59(10):1114–1117. doi:10.1016/j.bjps.2006.01.018

Peterson LS, Nelson AM, Su WP. Classification of morphea (localized scleroderma). Mayo Clin Proc. 1995;70(11):1068–1076. doi:10.4065/70.11.1068

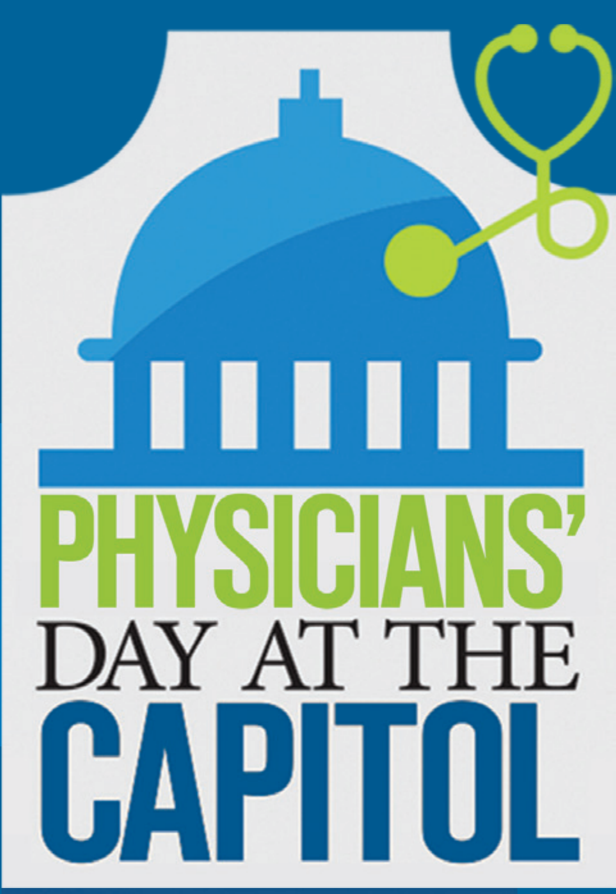
Ahmed ZS, Joad S, Singh M, Bandagi SS. Interstitial granulomatous dermatitis successfully treated with etanercept. Am J Case Rep. 2014;15:94–96. Published 2014 Mar 1. doi:10.12659/AJCR.890074

Błażewicz I, Szczerkowska-Dobosz A, Pęksa R, Stawczyk-Macieja M, Barańska-Rybak W, Nowicki R. Interstitial granulomatous dermatitis: a characteristic histological pattern with variable clinical manifestations. Postepy Dermatol Alergol. 2015;32(6):475–477. doi:10.5114/pdia.2015.48060

Veronez IS, Dantas FL, Valente NY, Kakizaki P, Yasuda TH, Cunha TA. Interstitial granulomatous dermatitis: rare cutaneous manifestation of rheumatoid arthritis. An Bras Dermatol. 2015;90(3):391-393. doi:10.1590/abd1806-4841.20153263

Nodular-keloidal morphea in a 14-year-old female and a review of the literature. Journal of the American Academy of Dermatology. 2012;66(4):AB165. doi:https://doi.org/10.1016/j.jaad.2011.11.696

Kassira S, Jaleel T, Pavlidakey P, Sami N. Keloidal Scleroderma: case report and review. Case Rep Dermatol Med. 2015;2015:635481. doi:10.1155/2015/63548



Wednesday,
February 28, 2024

ADVOCATE
FOR YOUR
PROFESSION

www.mnmed.org/
education-and-events/
Day-Capitol

EMPOWERING PHYSICIANS CONFERENCE 2023

More than 150 physicians and physicians-in-training gather for education and networking

PHOTOGRAPHY BY KATHRYN FORSS

For the first time in four years, the MMA held its annual conference in person and filled the day-long event with a panel discussion on the changing dynamics of physician practices, a workshop on conflict resolution, and talks by Minnesota Health Commissioner Brooke Cunningham, MD, PhD, and bestselling author Abraham Verghese, MD, MACP.

Held on the 50th floor of the IDS Center, the conference provided great views of downtown Minneapolis.

The event, held September 21 on the 50th floor of the IDS Center in downtown Minneapolis, attracted more than 150 physicians and physicians-in-training.

Cunningham kicked off the conference, urging Minnesota physicians to get involved, noting the number of state committees that deal with healthcare issues. She also suggested that physicians reach out to her staff to share their ideas for how they can work together. “Physicians are hugely powerful,” she said. “Show up and speak out. Physicians are highly respected still in 2023.”

The panel discussion on practice issues included Michael Cumming, MD, MBA, ABWM, who runs a vascular and interventional radiology center in Edina; Rebecca Givan, PhD, an associate professor of labor studies and employment relations at Rutgers University; and Julia Reiland, JD, a partner in Lathrop GPM’s Minneapolis office who advises healthcare organizations on complex business transactions and strategic partnerships. Former MMA President Cindy Firkins Smith, MD, MHCI, FAAD, CentraCare’s vice president for medical education, served as moderator.

The panel discussed several topics, but often came back to the current issue of physicians unionizing, which the group agreed is born out of “new stresses and strains on physicians,” as Givan put it. “Unionization is more than money,” she said, adding that it’s usually about patient care and physician wellness. She cited nurses’ strikes and how they are often about staffing, not income.

1 The conference attracted more than 150 physicians and physicians-in-training.

2 Bestselling author Abraham Verghese, MD, MACP, capped off the day with a talk and a Q&A session with Laurel Ries, MD, the MMA's new president.

3 Minnesota Health Commissioner Brooke Cunningham, MD, PhD, kicked off the conference.

4 Martin Stillman, MD, JD, led a hands-on session on conflict resolution.

Local physician, attorney and mediator, Martin Stillman, MD, JD, led a hands-on workshop, leading attendees in a role-playing exercise to go through real-life scenarios of resolving conflict in a medical clinic. Stillman is a practicing general internist at Hennepin Healthcare System in Minneapolis, where he also serves as the mediation and conflict resolution officer.

Participants learned how to prepare for meetings in which conflict resolution is addressed. They learned how to identify common interests behind competing positions to generate solutions that work for everyone, and how to put specific follow-up plans in place that give the best chance for post-resolution success.

Before Verghese closed out the conference, Will Nicholson, MD, MMA's outgoing president, welcomed Laurel Ries, MD, as the new president, during a reception. Ries began her one-year term October 1. A video of the official hand-off of the presidential medallion can be found here: www.mnmed.org/ac23.

After signing copies of his books at the reception, Verghese discussed "Humanism, Meaning, and Medicine in the era of AI and COVID," touching upon a variety of topics from the beginning of diagnosis (following years of going to the barber surgeon, whose every cure involved cutting and bleeding) to the 1891 painting by Luke Fildes called *The Doctor*.

He talked about *Jaws*, the movie he saw when he first came to America, and how it embodied the key to all good stories—conflict. He compared the great white in the Spielberg movie to the "monster" that all the physicians in the room recently faced—the COVID-19 pandemic. He called healthcare workers the heroes of that story. He also encouraged physicians to advocate for the profession and be part of the solution.

Following his address, Verghese took a half-hour of questions and then signed more books for attendees.

Next year's conference is scheduled for Friday, September 27. **MM**

Local bookstore, Moon Palace Books, sold copies of the latest work by Abraham Verghese, MD, MACP.

Attendees met with a variety of vendors at the event.

News Briefs

Edwin Bogonko, MD, MBA

August elections determine new MMA leadership

Edwin Bogonko, MD, MBA, a hospitalist in Shakopee and past MMA board chair, has been elected as the MMA's president-elect in this year's leadership election, which was held electronically during August.

Caleb Schultz, MD, MPH, was elected as a trustee and five incumbent trustees were re-elected: Lynn Cornell, MD; Saam Dilmaghani, MD, MPH; Elizabeth Elfstrand, MD; Dania Kamp, MD, FAAFP; and David L. Smith, MD.

Three incumbent members of the Minnesota delegation to the AMA were also re-elected: Cindy Firkins Smith, MD, MHCI, FAAD delegate; Andrea Hillerud, MD, delegate; Lisa Mattson, MD, FACOG, alternate delegate.

Board member terms began October 1, and AMA delegation terms begin January 1.

MMA honors physicians, physicians-in-training, advocates

Five physicians, three physicians-in-training, the former head of the Minnesota Board of Medical Practice, and Hennepin Healthcare were all honored with MMA awards as part of this year's Empowering Physicians Conference. Each year, the MMA honors those in medicine for going above and beyond.

George Schoephoerster, MD

George Schoephoerster, MD, of St. Cloud, received the MMA's highest honor, the Distinguished Service Award, for his years of service to the association and to medicine. Schoephoerster, a retired geriatrician, has been a member of the MMA since 1986. He is a former president of the association and has served on the board of MEDPAC, its political action committee. He is currently the president of the MMA Foundation. He has sat on numerous committees that dealt with a variety of subjects: public health, membership and communications, nominating, awards, finance and audit, and ethics. He was chair of the former Medical Practice and Planning Committee and the Prescription Drug Prior Authorization Committee.

Patrick Bigaouette, MD, Larry Hook, MD, and the estate of Charles Crutchfield III, MD, received the MMA's President's Award, which recognizes those who have given much of their free time to help improve the association.

Bigaouette, a practicing psychiatrist in Mankato, has been described as having a unique ability to connect with people from all backgrounds, which enables him to provide culturally sensitive and personalized care. He is a champion of physician well-being and has raised awareness of mental health issues and championed inclusion efforts in the Mankato community. He is highly regarded by his peers, patients, and the wider healthcare community for his leadership skills. He has served as a mentor to numerous residents, trainees, PA, pharmacy, and NP students. His commitment to education and research is evident in his publications, presentations at national conferences, and participation in clinical trials with a Rochester group aimed at advancing psychiatric treatments and interventions.

Hook is the medical director of hospital-based psychiatric services at St. Cloud Hospital. In 2021, his advocacy and passion led to the opening of CentraCare's EmPATH psychiatric stabilization unit. Its opening has been a significant benefit to the people of central Minnesota and exists as a testament to Hook's vision and determination to see it to completion. He has supported his colleagues in expanding programs within the hospital to address the crises of addiction and psychiatric disorders. Because of his work, CentraCare has been able to start additional consultation services for women's mental health and for addressing substance use disorders in a more comprehensive fashion for its patients. He is described as doing his work with grace, wisdom, and humor.

Crutchfield, who passed away this June after a lengthy battle with non-Hodgkin lymphoma, has been called a pioneer in his field. Throughout his career, he was a leader in the field of dermatology. He was one of the first medical professionals to tailor skin treatments for people of color. He was a respected researcher and educator, always at the forefront of new developments. He served as the team dermatologist for the Minnesota Twins, Minnesota Timberwolves, Minnesota Wild, and Minnesota Vikings. Plus, he was active with the Minnesota Association of Black Physicians.

Sally Jeon and Nick Hable received the Medical Student Leadership Award, which recognizes physicians-in-training who demonstrate exemplary leadership in service to medical students, the profession of medicine, and the broader community. Both attend the University of Minnesota Medical School.

Rebecca Yao, MD, received the Resident and Fellow Leadership Award, which recognizes physicians-in-training who demonstrate exemplary leadership in service to residents and fellows, the profession of medicine, and the broader community. Yao works in Rochester.

Janet Chestnut, MD, of Lake City, received the COPIC/MMA Foundation Humanitarian Award, which recognizes MMA members who go above and beyond to address the healthcare needs

of underserved populations in Minnesota. Chestnut is a retired family physician who volunteers much of her time to the C.A.R.E. Clinic in Red Wing.

Former head of the Minnesota Board of Medical Practice Ruth Martinez, of St. Paul, received the James H. Sova Memorial Award for Advocacy. Sova was the chief lobbyist for the MMA from 1968 until his death in December 1981. This award is given to a person who has made a significant contribution to the advancement of public policy, medical sciences, medical education, medical care, or the socioeconomics of medical practice. During Martinez's tenure, the state board collaborated with the MMA and others on several important initiatives, including implementing the Health Professionals Services Program, establishing telemedicine registration, modifying application questions related to mental health, and becoming a member of the Interstate Medical Licensure Compact.

Hennepin Healthcare is this year's recipient of the Eric C. Dick Memorial Health Policy Partner Award, given to an individual, group of individuals, a project or an organization that demonstrates their commitment to pursuing sound public policy, building coalitions, and creating or strengthening partnerships with the goal of improving the health of Minnesotans or the practice of medicine in Minnesota. Dick was the MMA's manager of state legislative affairs from 2010 until his death in January 2021. Hennepin Healthcare partnered with the MMA to ensure that Minnesotans experiencing homelessness receive needed short-term care in their recovery following hospitalization.

MMA offering new benefit for well-being

In its ongoing efforts to promote well-being for its members and their families, the MMA is offering discounted pricing for a comprehensive suite of resources created to address career fatigue and promote work-life balance.

The new MMA SafeHaven Program, which has been developed in partnership with VITAL WorkLife, includes a subscription to a package of resources such as clinician peer coaching, elite concierge services, in-the-moment telephone support, in-person and virtual counseling, and a SafeHaven app.

Introductory pricing of $99 for a 13-month subscription is available to the first 75 actively practicing MMA members who enroll. This is 75% less than the subscription-model price of $395 available to non-members.

For more information and to enroll, visit safehavenhealth.org/enroll/mma/. MMA members should use the code MMAMEMBER. MMA SafeHaven services began November 1, 2023, and end December 31, 2024. This resource is also available to non-members for $395.

MMA Immediate Past President Will Nicholson, MD, (right) discusses CANDOR with Cathy Wurzer and Eric Eskola on "Almanac" September 8.

New law encourages freer talk after adverse incidents

A new law that took effect on August 1 is designed to encourage open and transparent communications between physicians, other healthcare providers, facilities, and patients after an adverse healthcare incident.

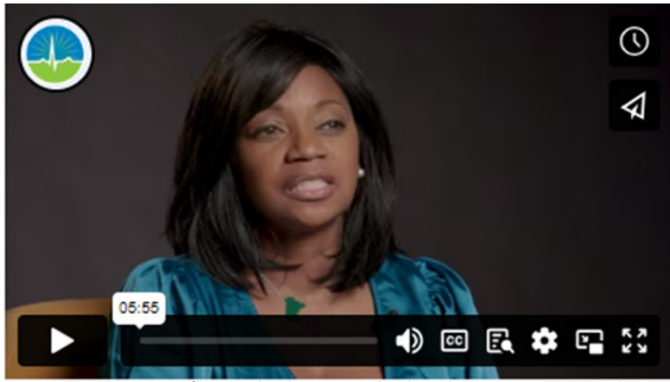
The Communication and Resolution after a Health Care Adverse Incident legislation was supported by the MMA, which worked closely with the Minnesota Association for Justice during the 2023 legislative session. The new law provides protection to healthcare providers and facilities from civil liability for information that may be disclosed during such an open conversation.

At the heart of the legislation is a process known as CANDOR (Communication and Optimal Resolution). It is used by healthcare facilities and healthcare professionals to respond to and resolve adverse events. It involves immediate disclosure of an adverse event to a patient or their family and includes communication with the patient throughout the entire investigation and resolution. In other states where it is used, the CANDOR process has been shown to improve patient safety, better support the healthcare team members involved in the event, and decrease malpractice claims.

For many patients who experience an adverse event, the inability to get answers is frustrating and compounds the harm they experience. Many healthcare facilities and providers are hesitant to enter into frank conversations with the patient or their family due to fear of liability.

Even in situations that may not rise to the level of a lawsuit, patients still deserve answers and could enter into CANDOR conversations with the care team. The CANDOR process can provide closure for a patient who otherwise may not have received it.

For additional information and resources concerning CANDOR, visit www.mnmed.org/advocacy/key-initiatives/candor.



Dionne Hart, MD, is one of 10 people who appeared in the video series *Racism in Medicine: Truths from Minnesota Physicians.*

MMA launches new video series on racism in medicine

The MMA launched a new video series, "Racism in Medicine: Truths from Minnesota Physicians," with an online event in late July.

About 50 physicians from across the state took part in the event, which featured a panel discussion with seven of the featured physicians in the videos, as well as a breakout session on how the MMA could better address racism in medicine in the state.

The group discussed a variety of topics, from the microaggressions they've experienced, to how to become an anti-racist and allyship vs. "doing it alone."

A recording of the forum is available at www.mnmed.org/RacismTruths.

The video series "Racism in Medicine: Truths from Minnesota Physicians" includes a range of Minnesota physicians discussing the effects of racism and implicit bias.

Participants in the project include Maria Camila Arciniegas Calle, MD; Nathan Chomilo, MD, FAAP, FACP; Aakash Desai, MD, MPH; David Hamlar, MD, DDS; Dionne Hart, MD; Adrina Kocharian (MD/PhD student); Derrick Lewis, MD; Cybill Oragwu, MD; Mary Owen, MD; and Yeng Yang, MD, MBA, FAAP.

The project is part of the MMA's broader work to promote an anti-racist culture of medicine in Minnesota. Efforts toward making medicine more inclusive require more inclusive narratives. With this work, the MMA aims to inspire understanding, compassion, and action.

This work is made possible by support from UCare.

Report: Healthcare quality improving, slowly

Healthcare quality is improving in Minnesota, but not at the levels seen before the COVID-19 pandemic, according to a report released in August by MN Community Measurement (MNCM).

The Minnesota Health Care Quality Report Part 1: Clinical Quality Measures Reported by Medical Groups includes information about trends for measures of healthcare quality, including asthma, depression, diabetes, heart disease, and colorectal cancer screening. The report includes data on statewide averages and trends, along with variation across medical groups and regions.

The new results come from data reported to MNCM in 2023, covering services received by patients in 2022. The report includes a total of 20 measures (11 for adults, and nine for children and adolescents). Report highlights include the following:

- Statewide rates for six quality measures improved in 2022, including diabetes care, mental health screening for adolescents, follow-up for depression care, and the use of specific tools for assessing symptoms in people who have depression.
- Statewide rates for 12 quality measures worsened in 2022, including for colorectal cancer screening, adult depression remission and response one year after diagnosis, optimal vascular care, and optimal asthma control for children.
- Statewide performance for many measures remains below pre-pandemic levels. For example, the rate of optimal vascular care for adults in 2022 was 5.0 percentage points below the rate for 2019 (55.3% versus 60.3%). For children, there was a 5.0 percentage point gap between the rate of optimal asthma care in 2022 versus 2019 (53.5% compared with 58.3%).

- Statewide rates of colorectal cancer screening declined substantially in 2022 (from 72.2% to 67.8%). In part, this decrease occurred because the age group for whom screening is recommended expanded to include people aged 45 to 49. Even without the expansion of the population included in this measure, however, the rate would still have decreased by a statistically significant amount in 2022.

The report includes performance data for approximately 117 medical groups that operate more than 750 clinics in Minnesota and border communities in neighboring states.

MMA wins three Profiles of Excellence awards in communications, advocacy, and health equity

The MMA received three 2023 Profiles of Excellence (POE) Awards from the American Association of Medical Society Executives (AAMSE) in July for its work in a variety of areas.

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

The MMA's special publication—*Health, Equity, Racism and the Minnesota Medical Association*—was selected as the winner in the Membership category in the large organization division.

The MMA's Advocacy Champions program was selected as the winner in the Advocacy category in the large organization division.

And the MMA's implicit bias training was selected as the runner-up in the DEI category in the large organization division.

Dan Hauser, APR, MMA's director of communications, education and events, receives the first of three awards from Aileen Wetzel, FAAMSE, AAMSE immediate past president, and CEO and executive director of the Sierra Sacramento Valley Medical Society.

"It's an honor to have our work recognized by our peers," said MMA CEO Janet Silversmith. "MMA leaders and staff are working hard to advance our strategic plan and create meaningful impact. Our colleagues in other medical societies are also doing great work, and to be singled out by this group is gratifying."

AAMSE is the professional association of more than 1,300 medical society executives and staff specialists. Through its more than 300 member organizations, AAMSE advances the profession of medicine through education, communication of knowledge, leadership development, and collaboration. Member organizations include county, regional, state, state specialty, national, national specialty, and international medical societies, as well as affiliated healthcare organizations and industry partners.

MMA code of conduct ensures all are welcome

In order to create a welcome and inclusive environment for all physicians, trainees, staff, and guests, the MMA established a code of conduct. Each year, we remind members of the policy and encourage you to review it and help us create a space of belonging for all.

View it at: www.mnmed.org/application/files/3516/9203/5162/IPPM_Code_of_Conduct.pdf. MM

PS Form 3526 — **Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)**

1. Publication Title	2. Publication Number	ISSN	3. Filing Date
MINNESOTA MEDICAL ASSOCIATION/ MINNESOTA MEDICINE	351900	265560	09/22/2023

4. Issue Frequency	5. Number of Issues Published Annually	6. Annual Subscription Price
BI-MONTHLY	6	$ 45.00

7. Complete Mailing Address of Known Office of Publication
1300 GODWARD ST NE STE 2500
MINNEAPOLIS, HENNEPIN, MN 55413-1878

Contact Person LINDA PICONE
Telephone (612) 362-3758

8. Complete Mailing Address of Headquarters or General Business Office of Publisher
3433 BROADWAY ST NE STE 187
MINNEAPOLIS, MN 55413-2199

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor

Publisher *(Name and complete mailing address)*
MINNESOTA MEDICAL ASSOCIATION
3433 BROADWAY STREET NE STE 187
MINNEAPOLIS, MN 55413-2199

Editor *(Name and complete mailing address)*
GREG BREINING
3433 BROADWAY STREET NE STE 187
MINNEAPOLIS, MN 55413-2199

Managing Editor *(Name and complete mailing address)*
GREG BREINING
3433 BROADWAY STREET NE STE 187
MINNEAPOLIS, MN 55413-2199

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
MINNESOTA MEDICAL ASSOCIATION	3433 BROADWAY STREET NE STE 187, MINNEAPOLIS, MN 55413-2199

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Hoding 1 Percent or More of Total Amount of Bonds. Mortgages, or Other Securities. If none, check box [X] None

Full Name	Complete Mailing Address

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

PS Form **3526**, September 2007 *(Page 1)* **PRIVACY NOTICE:** See our privacy policy on *www.usps.com*

13. Publication Title MINNESOTA MEDICAL ASSOCIATION/MINNESOTA MEDICINE
14. Issue Date for Circulation Data Below 09/01/2023

15. Extend and Nature of Circulation			Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Numbers of Copies *(Net press run)*			4354	4274
b. Paid Circulation *(By Mail and Outside the Mail)*	(1)	Mailed Outside County Paid Subscriptions Stated on PS Form 3541 *(include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)*	4082	4008
	(2)	Mailed In-County Paid Subscriptions Stated on PS Form 3541 *(include paid distribution above nominal rate, advertiser's proof copies, and exchange copies)*	0	0
	(3)	Paid Distribution Outside the Mails Including Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Paid Distribution Outside USPS	0	0
	(4)	Paid Distribution by Other Classes of Mail Through the USPS *(e.g. First-Class Mail)*	0	0
c. Total Paid Distribution *(Sum of 15b (1), (2), (3), (4))*			4082	4008
d. Free or Nominal Rate Distribution *(By Mail and Outside the Mail)*	(1)	Free or Nominal Rate Outside County Copies included on PS Form 3541	49	45
	(2)	Free or Nominal Rate In-County Copies included on PS Form 3541	0	0
	(3)	Free or Nominal Rate Copies Mailed at Other Classes Through the USPS *(e.g. First-Class Mail)*	0	0
	(4)	Free or Nominal Rate Distribution Outside the Mail *(Carriers or other means)*	75	75
e. Total Free or Nominal Rate Distribution *(Sum of 15d (1), (2), (3), (4))*			124	120
f. Total Distribution *(Sum of 15c and 15e)*			4206	4128
g. Copies not Distributed			148	146
h. Total *(Sum of 15f and 15g)*			4354	4274
i. Percent Paid *((15c / 15f) times 100)*			97.05 %	97.09 %

16. If total circulation includes electronic copies, report that circulation on lines below.

a. Paid Electronic Copies	0	0
b. Total Paid Print Copies *(Line 15C)* + Paid Electronic Copies	4082	4008
c. Total Print Distribution *(Line 15F)* + Paid Electronic Copies	4206	4128
d. Percent Paid *(Both Print and Electronic Copies)*	97.00 %	97.00 %

[ ] **I Certify that 50% of all my distributed copies (Electronic and Print) are paid above a nominal price.**

17. Publication of Statement of Ownership
[X] If the publication is a general publication, publication of this statement is required. Will be printed in the 11/01/2023 issue of this publication. [ ] Publication not required.

18. Signature and Title of Editor, Publisher, Business Manager, or Owner	Title	Date
Dan Hauser	Business Manager	09/22/2023 09:23:47 AM

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including civil penalties).

PS Form **3526**, September 2007 *(Page 2)* **PRIVACY NOTICE:** See our privacy policy on *www.usps.com*

FROM THE CEO

Medicine in Minnesota needs a "both-and" approach

"Physicians are the highest paid clerical workers in the United States." Those are words that Abraham Verghese, MD, MACP, shared at the MMA's Empowering Physicians Conference in September.

Verghese, the bestselling author, Linda R. Meier and Joan F. Lane provostial professor, and vice chair for the theory and practice of medicine at the School of Medicine at Stanford University, is known for his passion for healing, his belief in the importance of the physical exam, his commitment to the patient-physician relationship, and his gift of storytelling. In his conference address, he lamented the state of medicine, particularly with respect to electronic health record functionality (or lack thereof) and the corporatization of healthcare. His message, not surprisingly, resonated deeply with the audience. He urged optimism and challenged physicians to work together—collectively, as a profession—to "get angry" and reassert the interests of patients and medical professionalism.

That, in fact, is the essence of the MMA's work. We bring physicians of all specialties, practice types, and geographies together to work to make Minnesota the healthiest state and the best place to practice medicine. We've been committed to that goal—to be the voice of medicine in Minnesota—for 170 years. And yet, there are physicians who are unfamiliar with the MMA, who don't understand the work that we do, and who, at the same time, wonder how they can have a voice in the healthcare issues facing Minnesota. I take responsibility for that lack of awareness. The MMA must do better to communicate our work, our impact, and our value to all Minnesota physicians. Preserving and protecting the medical profession cannot and should not be the responsibility of only a few.

For those physicians who know about our work and mission but choose to remain on the sidelines as nonmembers, the time to get involved and engaged is now. I respect, appreciate, and value the role that specialty societies and issue-specific interest groups play in advocacy and in supporting physicians, but it is a "both-and" time. Physicians need to invest both in their specialty societies and in the collective of medicine in Minnesota—the MMA.

The MMA has been and will continue to be called upon by legislators and other public officials to help inform policy. Consider a few of the issues from the 2023 legislative session alone that will be informed by physician input—the future of telehealth and audio-only services, the design of a "public option" or expanded MinnesotaCare program, healthcare affordability, the use of psychedelics in medicine, adult-use cannabis regulations, and more. The MMA's ability to influence the direction of these critical topics is a function of our membership levels and the engagement of our members.

So, we need your help. If you are reading this column, it is most likely because you are a member of the MMA. I would ask you to share this issue of *Minnesota Medicine* with a colleague; invite us to a meeting of your clinic, department, or medical staff to hear about our work and impact; share the reason you are an MMA member with your partners; tell us why the MMA's work matters to you; be sure to renew your membership for 2024; ask your colleagues, who may not be members today, to support membership now.

Help the MMA help you focus on what matters.

Janet Silversmith
JSilversmith@mnmed.org

Laurel Ries, MD
MMA President

VIEWPOINT

Playing the long game

As I begin my term as MMA president, I have been thinking about the adage: "Blessed are those who plant trees under whose shade they will never sit." As physician leaders, we should leave things better off than when we found them. We should strive to create a healthy present and future, where both physicians and our patients thrive.

It's why we focus on advocacy at the MMA. I joined 18 years ago to make a difference, to help make that possible. Advocacy is about playing the long game. Often, significant changes take time. You must lay out the groundwork and then be persistent.

When thinking of the long game in terms of healthcare, three contemporary challenges come to mind, issues that the MMA has been advocating for at length and will continue to fight for: prior authorization, firearm safety and health equity.

We need to continue seeking legislation that ensures health plans and insurers don't stand in the way of caring for our patients. We acknowledge that controlling costs is critical in healthcare and acknowledge the role of formularies and preferred drug lists in reducing costs. But it is critical to limit unnecessary barriers to care so that we can efficiently and sustainably ensure that our patients receive the care they need.

Fighting the bureaucracy of prior authorization wears too many of us down and often leads to physician burnout. The opposition is well-funded and will resist our efforts the entire way. That's why as long as I hold a leadership position, this will continue to be a top priority for the MMA.

Gun violence and firearm-related injuries kill more than 30,000 Americans each year, making firearm death and injury a public health crisis. We lost 513 Minnesotans due to firearm-related injuries in 2020; 69% were suicides and 27% were homicides.

To prevent and address this crisis, we need to continue to advocate for firearm death and injury research funding, and commonsense gun safety laws at the state and federal level. We also need to equip physicians with the necessary tools to discuss firearm death and injury prevention in the exam room.

We made progress this past session in passing firearm safety laws, but we need to keep advocating for legislation that works. Sadly, firearm injury has become the No. 1 killer of children in the U.S. Too many Minnesotans, including our youngest residents, are dying. Minnesota can and should do better.

Health equity may be our greatest challenge—and one we cannot ignore. Minnesota, on average, ranks among the healthiest in the nation. But those averages do not tell the whole story. Minnesota has some of the greatest health disparities in the nation. To achieve our goal of being the healthiest in the nation, we need to address this complex issue.

The MMA is advancing efforts to diversify Minnesota's physician workforce, addressing impacts of social drivers of health, and providing tools to address implicit bias and structural racism in the culture of medicine.

As with prior authorization and firearm safety, much work is needed. It's not easy work but is important. And physicians have the skills and tenacity to do it. Together, let's make Minnesota the healthiest in the nation and the best place to practice. We can make a difference now, and for future generations. Let's plant trees for those who will follow. Are you with me? MM

Advocacy is about playing the long game. Often, significant changes take time. You must lay out the groundwork and then be persistent.

SIRI FIEBIGER, MD, MPH, FACOG

- Obstetrician/gynecologist currently winding down an eight-year stint as an OB hospitalist working for Allina Health's perinatology group. Prior, worked as a generalist for nearly 25 years in Fargo for Essentia Health.
- MMA member since 2015.
- Grew up in Fargo, N.D., minus a short stint as an AFS exchange student in Tokyo.
- Majored in biology and Norwegian at St. Olaf College.
- Went to med school at the University of North Dakota.
- Residency at Georgetown University during the AIDS epidemic.
- Returned to Fargo in 1990 because of my mother's ill health, joining a multi-specialty physician-owned clinic.
- Began co-leading a mission team that made 20-plus trips to rural Haiti and prompted my master of public health studies at Johns Hopkins, completed in 2008.
- Joined clinic leadership as we partnered briefly with Blue Cross and Blue Shield of Minnesota and built a new clinic-hospital complex.
- Testified and organized to defeat reproductive healthcare restrictions in North Dakota. Joined the board of directors of Planned Parenthood Minnesota, North Dakota, South Dakota.
- Share home with my partner, Tom, an employment law and human rights lawyer and recovering politician, who's happily working part time for our son Rolf. Other son Erik is a creative in New York City.
- Spend as much time as possible at our little house on Otter Tail Lake year-round where we kayak, sail, hike, and cross-country ski. Otherwise, we stay in an apartment near Lake of the Isles.
- Traveled to Bangladesh and soon to Tanzania for global health work for an American College of Obstetricians and Gynecologists (ACOG) steering committee.

Became a physician because…

Of my sense that we are here to care for each other. I learned from my chaplain father that virtually everyone has a story and that the invitation to share in it is holy. My nursing assistant role during high school and college taught me that generous listening while giving back rubs was part of the healing we had to offer.

The greatest challenge facing medicine today…

Our growing despair as we struggle to provide patient-focused, empowering care and are buffeted daily by the demands and restrictions inflicted by the market-industrial infrastructure that is our healthcare system. Burn out and moral injury result when despite our best efforts, we learn our patients can't get in, our outcomes are worsening, our severe morbidity and mortality rates are rising—and have long been much worse than any other developed country, despite spending more than twice per capita per year on healthcare. An immoral amount of the healthcare dollar is spent by systems arguing with payers to get payment, and by payers trying not to pay us—and then passing this cost on.

How I keep life balanced…

Assuming I have done so! My partner and my sons have long provided honest reflection and request for choices grounded in balance within our life together. Early in my career, my annual trips to Haiti kept me connected to why I became a physician, as I learned much from my Haitian colleagues and community.

Amplifying the voices and needs of my patients as a legislative advocate also feeds me. As a result, I engaged in the Minnesota ACOG Legislative Committee and then leadership.

I've managed the practice demands by realistically limiting the time spent, initially convincing the clinic leadership that a four-day work week was full time, then cutting back my practice to three days a week, and finally switching to a very defined hospitalist position.

I also have taken two sabbaticals: one for five months when I began my MPH studies in 2005, and another for nine months before becoming a hospitalist. I have done periodic intentional retreats (including Bounce Back), have worked with physician and life coaches, a spiritual director, and have a meditation practice—and still aspire to "balance."

If I weren't a physician…

I'm not sure what I would pursue. I have been so blessed by colleagues who encouraged and challenged me, and patients who have entrusted me with their care in their most vulnerable times. At times this work has demanded everything I have and more, but the benediction of accompanying someone on their journey to parenthood, or to better health, or through their life is like no other. **MM**

Rediscover meaning, joy and purpose in medicine.

MMA now offers a member benefit with MMA SafeHaven, a subscription to a suite of resources created to address career fatigue and promote work/life balance.

MMA will cover 75% of the cost of the service to the first 75 actively practicing members who enroll, offering it for **only $99 for an annual subscription.**

Scan the QR code to sign up today!

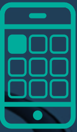
safehavenhealth.org/enroll/mma

Clinician Peer Coaching
Talk with someone like you who can help you grow both personally and professionally

Counseling
Virtual counseling sessions are available for you and your family

Support When You Need It
In-the-moment telephonic support is available 24/7

WorkLife Concierge
A virtual assistant to help with every day and special occasion tasks



VITAL WorkLife App
Mobile access to resources, well being assessments, insights, videos and more

CONFIDENCE

BEYOND

COVERAGE

As your premier medical liability insurance carrier, you can trust us to put our strength, expertise, and agility to work on your behalf. Our claims support includes access to alternative resolution programs designed to help you confidently manage unexpected outcomes and preserve patient relationships. If a claim progresses, we protect and guide you, help you understand your options, and are with you each step of the way. **That's Value Beyond Coverage.**

COPIC is proud to be the endorsed carrier of the Minnesota Medical Association. MMA members may be eligible for a 10% premium discount.

CALLCOPIC.COM | 800.421.1834