A NEW DIRECTION
HAS THE MMA FOUND THE RIGHT FORMULA TO ENGAGE PHYSICIANS? BY GAYLE GOLDEN

Change is tough, especially for an organization with 160 years of tradition.

That was evident two years ago, when the annual meeting of the Minnesota Medical Association’s House of Delegates ran overtime during a floor debate about proposed reforms to the organization’s governance, one of which was abolishing the delegate body itself.

As the meeting went on, guests for a wedding reception, the next ballroom event at the Marriott City Center in Minneapolis, began gathering outside the doors. Hotel staff needed to set up tables. The delegates were finally forced to adjourn and exit through the kitchen.

“We had to be evacuated immediately because we couldn’t solve the problem and make progress,” says Will Nicholson, M.D., then one of the youngest MMA members, who recalls that his frustration mixed with fatigue from an overnight shift at St. John’s Hospital in Maplewood. “It’s just really hard to keep people engaged if we’re not respectful of their time.”

Two years since that meeting, change has certainly entered the room for the MMA.

After a lengthy debate in 2013, the House of Delegates did indeed agree to suspend itself for three years as the association moves forward with new strategies aimed at keeping younger, time-pressed physicians engaged and making the organization more nimble and relevant.

Since then, MMA staff members have reached out to doctors around the state through listening sessions, advocacy discussions and educational forums on issues such as health care disparities, opioids, medical marijuana and a single-payer system. The association is also in the process of trimming its Board of Trustees by half, has opened officer elections to the entire membership and has created a Policy Council of physicians from around the state to prioritize issues for board action.

This month, the MMA will for the first time host an annual conference, not an annual meeting as it was called when it served chiefly as the House of Delegates’ session. The conference, called “Thriving in Change: Meeting the Challenges of Modern Medicine,” will be open to all physicians, not just MMA members who are delegates. It will feature policy forums on telemedicine and the health care workforce along with one open-issue forum. Educational sessions will discuss leadership, well-being, burnout and digital innovation.
“The main reason we wanted to change was to create something that would light a fire under the physicians in this state, to find a way to get more people involved,” says Cindy Firkins Smith, M.D., the current MMA president who has spent the past year traveling around to introduce these changes to the state’s doctors. “The system we had before wasn’t conducive to easy participation.”

But the changes haven’t come easily. Nor is it certain whether they will succeed in increasing membership in the state’s only association serving all physicians regardless of specialty.

Although most applaud the MMA’s new outreach efforts, some fear the loss of the House of Delegates will result in an organization driven solely by staff, not physician members, and that important individual voices may be lost amid the clamor of clickers, social media posts and triaged forums.

THE WINDS OF CHANGE

The MMA isn’t the only state medical association trying to change with the times. In recent years, approximately 15 others have opted for or are considering new decision-making models. Here’s a look at some of them:

**Kansas Medical Society.** In 2013, it approved plans to restructure its 37-member Council into a smaller Board of Trustees with 18 voting members. Board members for the most part will be elected by the membership at large.

**Medical Society of Delaware.** In 2011, it voted to replace its House of Delegates, Board of Trustees and Executive Committee with a 17-member Executive Board and 66-seat Council. It also eliminated its county medical societies and instead created geographic “affinity groups.”

**Iowa Medical Society.** Earlier this year, it replaced its House of Delegates with a Policy Forum that will meet twice a year to create and amend policy. Any member can submit issues or concerns and participate in online debates. The Policy Forum, which will be made up of 19 elected members of the Board of Trustees, will consider those virtual discussions when making decisions about policy.

**Pennsylvania Medical Society.** In 2013, a work group recommended changes to the governance structure including replacing its 325-member House of Delegates with an eight-member Board of Trustees, a 19-member Executive Policy Council and a 122-member Representative Assembly. It also recommended streamlining the process for nominating and electing officers and new mechanisms for engaging members, including a revamped annual meeting.

**Medical Society of Virginia.** In 2013, it put forth recommendations to open up the election of leaders to all members, rather than just those participating in the House of Delegates. It also proposed reducing the size of its Board of Directors from 36 to no more than 15 members and making it the primary governing body of the society, with responsibility for setting policy. The society also wants to test new ways of gathering member ideas and feedback, including regional meetings, town hall discussions and an online forum.

**Maine Medical Association.** In 2003, it replaced its House of Delegates with a general membership meeting held annually. Members can still submit resolutions, but decisions about them will be made by a 25-member Board of Directors.

**Oregon Medical Association.** It established a Board of Trustees as its policy-making body and transformed its House of Delegates assembly into a meeting of all members.
Yet proponents say the changes are designed to include more, not fewer, voices and that the old way of doing business simply does not work for today's doctors.

“It's actually been a very good first year of transition,” says MMA CEO Robert Meiches, M.D., who shepherded the reforms from conception to fruition over the last four years. “We now see people more satisfied, perceiving more value, and they think we are looking at the right issues, that our strategic plan is moving in the right direction.”

Changing realities, declining membership
Four decades ago, when Paul Sanders, M.D., began practicing as a family physician, nearly every doctor in the state belonged to the MMA. For years, there had been a tacit agreement among doctors that they needed an organization to exchange information and promote the medical profession in the state.

“Everybody joined the medical association because that's what you did,” says Sanders, who in 1990 became the first practicing physician to serve as the association's chief executive officer, a position he held for 12 years.

The organization served practical purposes when it was formed in 1853, upholding standards to guard against quacks, providing a forum for sharing medical developments and giving doctors a voice for urging action on public health issues such as vaccinations. For more than 100 years, most of the state's physicians looked to the MMA for education and professional connections. Then as medicine became more specialized and specialty associations assumed more continuing education, the MMA shifted its focus to advocacy, pushing for laws, regulations and policies to protect physicians and their patients.

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Like all member associations, the MMA relied heavily—as it still does today—on dues for revenue (currently 55 percent of the association's income comes from member dues) and on the volunteer efforts of physicians. Members served on committees.
They also sat on the 30-plus member MMA Board of Trustees. Once a year, local and specialty medical societies from around the state would elect doctors for a 270-seat House of Delegates, which also voted on resolutions and elected the board and officers.

But by the 1990s, when Sanders took over as CEO, membership was becoming harder to sell to doctors, who increasingly were leaving solo practices and small groups for large health care systems. Because those systems managed more decisions about workplace issues, physicians had fewer reasons to pay the MMA dues or devote time and energy to its causes.

One large employer, Sanders recalls, gave its doctors a choice of benefits that pitted membership in a medical association against dental insurance. “So when you have a young physician raising three or four kids, and they have to choose dental insurance over Minnesota Medical Association membership, that’s not much of a choice,” he says. “We tended to take the back seat.”

Although the MMA took steps to regain membership in 2004 by discounting dues for certain groups or individuals, the number of members paying full dues began to decline. In the past five years, the percentage of members paying discounted rates has risen significantly, now accounting for about three-quarters of the membership. As a result, revenue from dues has dropped as a percentage of its $4 million operating budget.

Other state medical associations, and even the American Medical Association, have experienced the same downward trends in membership to varying degrees, says Peter Kernahan, M.D., a University of Minnesota medical historian. He cites a number of reasons including the growing diversity of practice models, the end of the connection between local society membership and hospital privileges, and increasing specialization. For the past two decades, he says, many physicians have been simply too busy at work and at home to join both a specialty group and a multispecialty association—particularly if they didn’t see how it served their needs. “All of that has helped undermine an overarching identity for the medical profession,” Kernahan says. “It’s partly demographic, partly generational, partly just increasing demands on physicians’ time.”

Pediatrician Fatima Jiwa, M.B., Ch.B, joined the MMA as a new doctor in 2001 not out of great passion for organized medicine, she says, but because her physician group paid for it. At first, she wasn’t quite sure of the organization’s value, but her interest in culturally sensitive health care led her to the MMA’s Committee on Minority and Cross-cultural Affairs, which she chaired for three years, and then to the Board of Trustees as an at-large member.

Yet she sometimes questioned the value of an association that operated with lots of formality and did not appear to reflect the full complexion of the state’s doctors or passions. “When you went to the board meetings, you noticed you were in a group of middle-aged male physicians, a majority of whom are white,” she says. “I don’t want to discount physicians who are near retirement and who happen to be white. They’ve got a lot of wisdom. But it can be daunting.”

Meanwhile, she says, her young physician peers were focused on patient care and didn’t want to spend time serving as an MMA delegate or a committee member. “Many of the issues discussed in those meetings would not relate directly to a young physician’s own clinical interests, or they couldn’t see the value of a broad association that operated more like a big black box than a participatory forum.”

Jiwa became a part of a task force, created in 2011, to evaluate how the MMA made decisions. Two years earlier at a board retreat, a consultant had suggested the organization’s governance wasn’t in step with the changing realities of medicine. As it turned out, many state medical associations were also struggling to stay relevant. Their struggles reflected a broader decline of all types of membership organizations whose lifeblood of volunteer staffing, face-to-face meetings and slow, risk-averse governance was often at odds with 21st century realities, says Harrison Coerver, a management consultant in Florida and co-author with Mary Byers of the 2011 book *Race for Relevance*. That book, which was used by the MMA governance task force, recommends empowering staff to represent members, building technology to reach members more quickly and, most of all, trimming old governance structures.

“You ask those doctors why do we have annual regional delegate meetings? Because in 1890, when the physician finished with his meeting, he—and it was a he—got on his horse and rode back to his home,” Coerver says. “We are in a health care environment that is changing so rapidly that you can hardly keep track of it,
and yet you are going to get the group together once a year to set policy and make decisions? That’s ludicrous.”

**A House divided**

When the initial task force introduced its recommendations at the 2012 annual meeting—with the House of Delegates in the cross-hairs—some longtime members were stunned. Nearly everyone recognized the delegate body’s inefficiencies, and various resolutions through the years had been aimed at fixing those problems.

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But axing it was strong medicine. “It was a controversial meeting,” Meiches acknowledges. “Think about it. It’s sort of like the U.S. Senate saying we’re not needed any more and we’re going to step aside.”

Defenders of the House of Delegates argued the yearly delegate discussions and votes were part of a critical democratic right of members. They pointed out the AMA had a similar process that was highly successful.

The House of Delegates was especially important to rural physicians who were not connected to medical communities in metropolitan areas. “As somewhat inefficient as it used to be, the House of Delegates at least gave me a reason to show up once a year, get together, hear the reports,” says Jim Dehen, M.D., a surgeon in Brainerd and a former MMA president. “It gave me a chance to meet the leadership.”

That year, the delegates opted for a partial decision. Before adjourning through the kitchen, they agreed to shrink the size of the board from 33 to 14 members over three years and reshape it to reflect not only geography but also diversity, gender, type of practice or other expertise. The delegates also approved outreach efforts such as policy forums. But they stopped short of abolishing the House of Delegates, saying the idea needed more study.

When a second task force was formed and proposed the same recommendations a year later, a vigorous debate had already begun among MMA members. Some expressed concern the association’s staff was steamrolling the recommendations to gain more
Dehen, who kept his and now sits on the new Policy Council, says he’s worried that the suspension will be for good. Indeed, no other state medical association has reinstated its legislative body after disbanding it. No physicians in the state are mobilizing to resurrect it.

“Worst case scenario is that these changes are a failure. How do you reconstruct the House of Delegates when delegates have been out of the loop for three years?” he asks. “It’s a lot easier to keep a customer than to get them back. ”

Creating a new order
MMA staff say most members don’t think about governance. They think about what the MMA is doing for them. And for now, they say, they are working hard to connect with members in new and improved ways.

Since March of last year, staff and officers have organized seven policy forums and have held more than 46 listening sessions with doctors in practices small and large all through the state. Those activities alone have engaged more than 300 physicians, MMA staff say. In late July, the association’s more than 9,000 members received email ballots for officers and delegates, a job formerly reserved for the House of Delegates. By mid-August, more than 300 ballots had been cast, more than three times the number cast by delegates who attended the annual meetings in recent years.

Younger doctors are clearly a target of staff efforts. In the past year, for example, the organization has sponsored sessions on contracts and financial planning, social events and a discussion about grassroots political action for residents.

“We are very interested in advocacy issues, but there’s a lot of uncertainly about how to get involved,” says Matthew Kruse, M.D., a third-year psychiatry resident at the University of Minnesota who was recently at the MMA offices to learn about political activism with two colleagues. Leading the discussion was the MMA’s energetic newly hired manager of grassroots political engagement, Evelyn Clark. Joining her was Nicholson, the same young physician who had expressed such frustration at the late-running 2012 House of Delegates meeting. He now serves as secretary of the MMA’s political action committee, MEDPAC.

“I certainly have lots of passionate colleagues who are interested in being involved in organized medicine,” Nicholson says, “but there were a lot of ways we did things that weren’t that appealing to folks. The governance changes are going to offer inroads to more people.”

Indeed, MMA staff say the new methods are already proving useful. Earlier this year, when the Legislature began considering a bill to legalize medical marijuana, the association held a policy forum on the issue. The discussion, as well as an online survey sent to all members, quickly shaped the MMA’s opposition to the bill’s early versions, says Dave Renner, director of the association’s department of state and federal legislation.

“It was very helpful,” Renner says of the forum, where participants discussed the issue and then used clickers to register their opinion. “It engaged our members in the issue more. We had a really good substance-based discussion on the pros and cons.”

Dionne Hart, M.D., a psychiatrist from Rochester who has been active in the MMA since her residency seven years ago, says a June policy forum on health disparities energized minority physicians in a way she had never seen before. For years, Hart served with what she called “the same soldiers” as chair of the MMA’s Minority and Cross-cultural Affairs Committee. When that committee was disbanded in May, Hart and others organized the disparities forum, hoping for at least 20 participants. More than 70 showed up.

“It was packed,” she says. “And it wasn’t just physicians in the room. It was social workers, community activists, hospital administrators, members of the LGBT community. It was a group of people we could not have captured with the committee model we had.”

The MMA also has begun using technology to make it easier for members to participate in events virtually. It tested live streaming capabilities in August during a forum on single-payer health care that drew groups from as far as Detroit Lakes and Duluth.

Yet Hart and others remain concerned about what seems like the inevitable loss of the House of Delegates. Her experience as a delegate to the AMA, she says, has shown her how individual vot-
ing power inspires physicians to engage with issues more deeply. The new Policy Council, with its nonbinding recommendations, doesn’t offer the same stakes.

V. Stuart Cox, M.D., a current MMA board member, says he worries the loss of member voting power may have driven out a cadre of committed older physicians without necessarily inspiring new ones. “Basically you’re disenfranchising the members. If they don’t feel they have any say, they’re less likely to be involved,” he says. “These public policy forums are nice and informative, but if physicians don’t have any way of exercising power, why are they paying their dues?”

MMA CEO Meiches, for one, says he understands those concerns. But he contends the new structure will still permit individual proposals to prevail if they are compelling. Resolutions can be submitted to the Policy Council. Recommendations adopted by the council with a two-thirds majority cannot be rejected unless two-thirds of the board votes to do so. “We will still have an opportunity for people to bring forward other issues and throw those into the pot,” he says. “Some of those, my guess is, will move up to the top, and some won’t go anywhere because they won’t be viewed as key. But it will be a much more robust and nimble process.”

Meanwhile, the MMA is just beginning to figure out how to measure success. Membership numbers are a big metric.

“The success of membership is the key thing that tells us we’re moving in the right direction,” says Terry Ruane, the MMA’s director of membership, marketing and communications. “If we continue to get members because of the things we do, then we’re succeeding. If you do all these things and nobody comes, then have you truly succeeded?”

Although it’s too early to tell, Ruane says he’s already seen encouraging signs. This year, membership has inched 3 percent above what was forecasted. New groups, including the 82-member Mankato Clinic, have joined. At forums or in small-group discussions, people just seem more interested in the MMA’s work, he says.

MMA president Cindy Firkins Smith says she’s confident the changes, as controversial as some were, will ultimately inspire more doctors to engage with and join the MMA.

“Any time you make major changes in an organization, it’s a struggle,” she says.

She sees the MMA’s niche as advocating for patient care in a way that transcends the siloes of specialty and practice size. “Physicians are not a homogenous group. Clinically we are extremely diverse. But no matter what our work or our political view or our practice specialty, at the end of the day, we want to do what’s best for our patients.” MM

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