THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

NOV/DEC 2024 • $9.99

Held hostage by rounds

Michael Pitt, MD, asked a question: Why isn't attending rounds as easy as getting a haircut? PAGE 14

ALSO

MINNESOTA MEDICAL ASSOCIATION

Trustworthy. Dedicated. Caring.

Sanford Hospice is a trusted partner for quality, compassionate end-of-life care. Our team provides comfort through the next steps of life's journey.

We can ease the journey for your patients and their families with:

- 24-hour room service
- Bereavement counseling
- Pain management
- Spiritual and social support

Learn more about Sanford Hospice at sanfordhealth.org.

SANFORD HEALTH

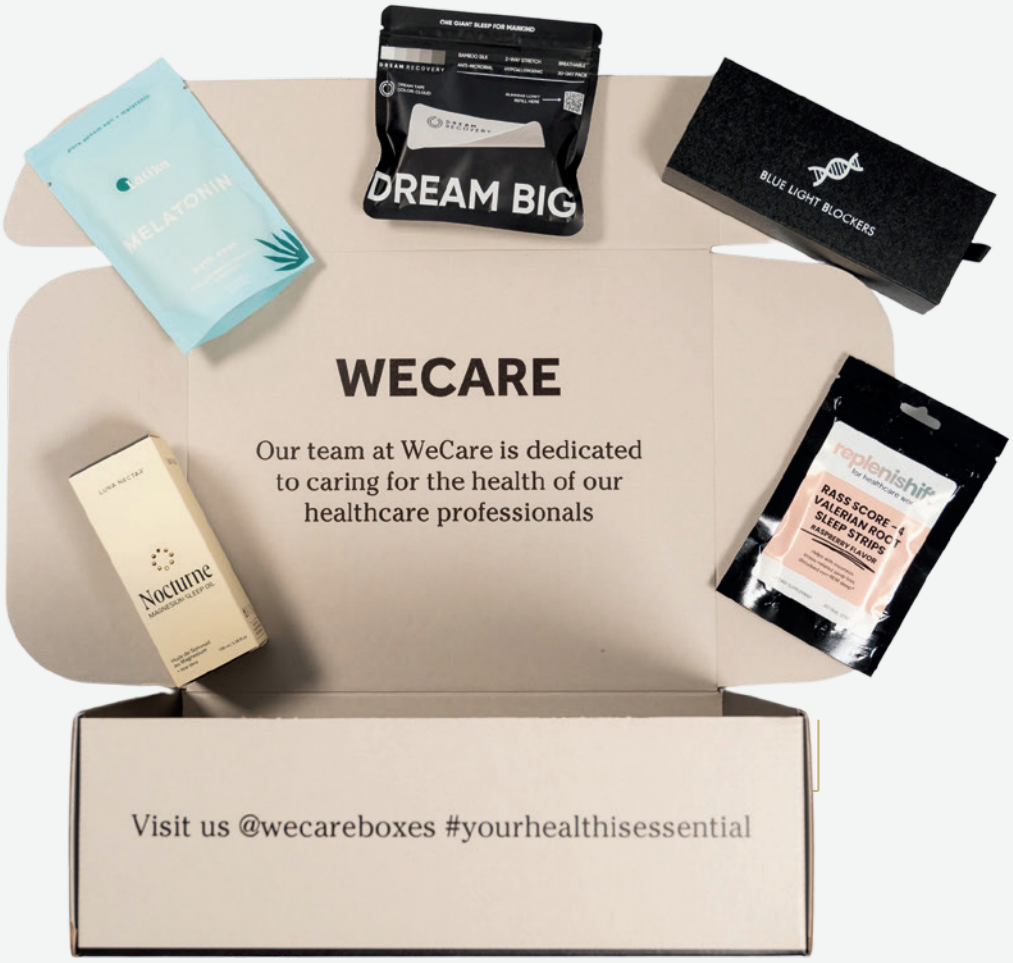
195-963-862 1/24

BUY ONCE OR SUBSCRIBE FOR MONTHLY BOXES ONLINE:

WECARENONPROFITFOUNDATION.ORG

WeCare Boxes Now Available Online!

Virtual CME courses + clean and impactful wellness products selected by expert clinicians. Brought to you by WeCare, a Nonprofit.



WHERE YOUR DOLLARS HELP:

CARING FOR OUR HEALTHCARE PROFESSIONALS WHO CARE FOR US.

PRODUCTS CONFERENCES RETREATS SERVICES PROFESSIONAL MEMBERSHIP PROVIDER DIRECTORY

CONTENTS

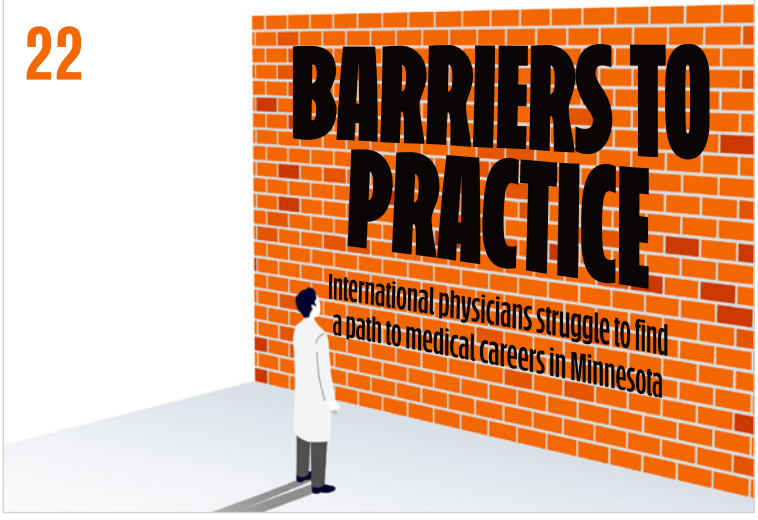
Nov/Dec 2024 | VOLUME 107 | ISSUE 6

IN THIS ISSUE

If you can get notified when it's your turn in the stylist's chair, why can't you find out when you can speak with the physician at the hospital? Michael Pitt, MD, has a solution to the scheduling problem.

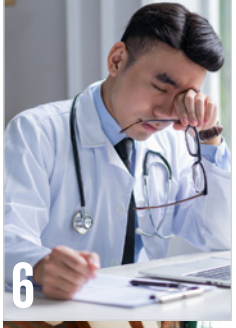
ON THE COVER

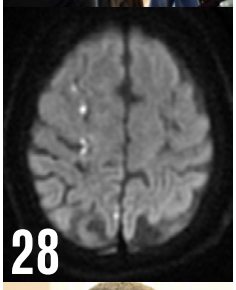
FEATURES

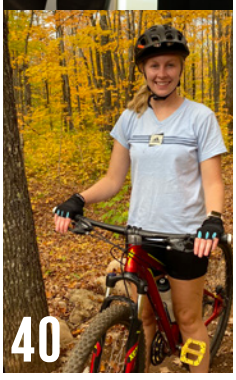


DEPARTMENTS

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

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.

Colin West, MD, PhD

A 30,000-foot view on oxygen masks and physician self-care

I fly quite a bit, perhaps too much if my Delta Medallion Status is any indication. It may seem cliché, but I think about physician self-care every time the preflight safety announcements reach the section directing passengers to "secure your own mask before assisting others." I've yet to hear anyone argue this is selfish, but we often struggle to apply the same principle to our own well-being. How can we more successfully embrace this approach? I have a few thoughts.

First, we must acknowledge that we are human and need care. We all too easily fall into the hero trap, but always placing ourselves second actually diminishes our ability to sustain the best possible care for our patients. Self-care is a necessary part of our service to our patients, so it is not selfish. This attitude needs to be modeled in training and practice to shift cultural norms in medicine away from the common historical standard of the invulnerable physician who is somehow separated from the human experiences of their patients. This standard is illogical and unachievable, and the harms it has caused have only recently become more widely understood and discussed in medicine.

Second, it is important that we nurture all aspects of health and well-being. The same preventive measures we routinely recommend for our patients apply to us, including appropriate screening tests, immunizations, and attention to healthy diet and exercise. Support for mental health is also critical. The Minnesota Medical Association has worked hard to advance efforts to destigmatize help-seeking and protect physicians who need healthcare of any kind. These efforts include important changes to licensing and credentialing language, on the vanguard of similar changes nationally. It is in society's interest to know if we have an impairment that adversely affects our ability to safely and effectively care for patients. But requiring disclosure of medical histories that are well managed and have no such effects is intrusive and inappropriate. Even worse, it discourages physicians from seeking care for fear of having to deal with these disclosures and possible negative career repercussions. I'm proud of Minnesota for taking steps to move beyond these policies.

Third, as individuals we can both support and lean on our colleagues, who understand our challenges because they share them. We do need to allow ourselves to be cared for, though. Perhaps understanding that this allows us to better care for our patients offers a rationale for even the most self-sacrificing physician. So-called "pathological altruism" is another trap we readily ignore, but inattention to self-care can diminish the intended benefits of altruistic behaviors to patients. Surprisingly, physicians display lower self-valuation than other members of the working population. Valuing ourselves with kindness neither is arrogant nor demonstrates lack of humility, but rather honors our shared humanity and may even promote deeper empathetic understanding of those we hope to help in our professional roles.

Valuing ourselves with kindness neither is arrogant nor demonstrates lack of humility, but rather honors our shared humanity and may even promote deeper empathetic understanding of those we hope to help in our professional roles.

My physician colleagues are remarkable people, and my hope is that we can all see ourselves as deserving of the same care we wish for our patients. At some point nearly all of us will be patients ourselves, after all, and surely we would want this for our own physicians when that time comes. **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*.

Private equity in medicine—helping hand or…?

Let's apply simple logic here. Where does the money for healthcare go? Our healthcare dollars go for: patient care, prescriptions, medical equipment, doctors' compensation, staff compensation, and facility expense. Now if a business is owned by a private equity company one needs to add their desire and intent to make a profit. How can that happen? Where does the private equity profit come from? Less patient care? Lower physician compensation? Lower staff pay? Less staff? Higher prices? None of these are desirable outcomes for the overall community.

Private equity owns businesses to make money, not to provide better healthcare. To believe the private equity people can step in and squeeze additional cash from a business without undesirable consequences is delusional.

I am disappointed *Minnesota Medicine* took the space to address this issue as if private equity owning more of healthcare may be a good idea. It is not a good idea. We should all support the perspective of Toby Pearson. An essential part of the way forward to making healthcare in Minnesota better is "transparency."

There is no credible argument that businesses involved in healthcare should be allowed to have secrets in their financial arrangements. The Minnesota community needs full insight into the financing of hospitals, clinics, nursing homes, and health insurance companies. These businesses have only one reason to hide their finances and that is to hide how they are misusing dollars which should be used to keep our community as healthy as possible.

– Mark Brakke, MD

Editor's note: The MMA Board of Trustees last December adopted the following policy on private equity investment in healthcare:

The MMA recognizes that private equity investments in healthcare pose potential benefits and harms, not only to the autonomy and well-being of clinicians, but also to the health of the populations they serve.

To better understand the reach and impact of private equity investments in healthcare in Minnesota, the MMA advocates for the following:

1 That the state of Minnesota collect and publicly report annual, site-level data describing whether healthcare sites are private equity affiliated. For the purposes of this policy, a "private equity affiliated healthcare site" means a healthcare site whose owners enter into contract with a private equity firm or a private equity firm-owned management services organization.

2 That the State of Minnesota study the effects of private equity investment in healthcare on: healthcare utilization and spending, healthcare costs to patients, healthcare access, healthcare quality, clinician physician turnover, staffing composition ratios of physicians to nonphysician clinicians, and clinical decision-making autonomy.

Furthermore, the MMA will educate its members on private equity, its approach and application to physician practices, and considerations for physicians entertaining private equity investments. **MM**

Write to us

Something on your mind? Email us at mm@mnmed.org. We'll edit for style and length.

State recommends broad use of telehealth

Telehealth, including phone consultation, should continue to receive support and be made widely available, according to a Minnesota Department of Health (MDH) report released this fall.

The recommendation is part of MDH's final report to the Minnesota Legislature on the impact of the 2021 Minnesota Telehealth Act on private sector health insurance. The report builds on a preliminary study of telehealth expansion and payment parity issued in June 2023. (The MMA has been a strong advocate for expanded telehealth services to increase Minnesotans' access to care.)

"Minnesotans are accessing a variety of services in the digital space, including, increasingly, healthcare," said Minnesota Commissioner of Health Brooke Cunningham, MD, PhD. "This study shows that telehealth offers a real choice that can be comparable to in-person care, especially for behavioral healthcare and chronic disease management. However, telehealth cannot replace in-person care in all situations. For telehealth to reach its full potential, further digital infrastructure investments are needed to address existing inequities. Lack of sufficient broadband in greater Minnesota and the cost of high-speed internet, both for rural and urban communities, create barriers to accessing healthcare via telehealth."

The report makes nine recommendations to support the availability and use of telehealth. These recommendations include support for reimbursing the same amount (known as payment parity) for audio-visual and audio-only telehealth services and the continued inclusion of audio-only care in the definition of telehealth. According to the study, audio-only telehealth fills an important gap in healthcare availability and access, particularly for people seeking behavioral healthcare, older Minnesotans, those with complex chronic conditions, and those residing in areas with poor broadband access.

The report summarizes findings from two years of research and stakeholder engagement led by MDH to address questions from the Legislature about the im-

Drug overdose deaths in Minnesota are decreasing, data shows

Drug overdose deaths among Minnesota residents dropped 8% from 2022 to 2023, according to data from the Minnesota Department of Health. If the preliminary count of 1,274 deaths holds up, 2023 would mark the first time since 2018 that Minnesota has seen a drop in total overdose deaths among its residents.

Minnesota overdose deaths in the synthetic opioid category that includes fentanyl are down 6%, (949 to 892 deaths), but nonfatal overdoses in that category increased by 11% (4,328 to 4,819 overdoses). Most fatal overdoses (about 70%) nonetheless involved synthetic opioids like fentanyl. All other opioid-related categories including prescription opioids, heroin, and methadone continued to show a decrease in deaths.

"We have seen a decline in opioid deaths, alongside an increase in nonfatal overdoses, in part due to greater naloxone availability," says Minnesota Commissioner of Health Brooke Cunningham, MD, PhD.

Greater Minnesota experienced a 21% decrease in overdose deaths (482 to 381 deaths). The seven-county metro area saw a 1% decrease as well (902 to 893 deaths).

Minnesota's preliminary 2023 overdose data is reflective of national trends. The U.S. Centers for Disease Control and Prevention (CDC) reports a nationwide 3% decrease in all overdose deaths from 2022 to 2023.

While opioid-involved deaths went down in 2023, deaths from the psychostimulant category, which includes methamphetamine, continued a 10-year upward trend with methamphetamine deaths

pact of telehealth expansion and payment parity on healthcare access, quality and outcomes, satisfaction, costs, and equity.

Since the start of the COVID-19 pandemic forced the widespread adoption of telehealth, patients and healthcare providers have increasingly found value in the convenience and flexibility of the technology. MDH's study of telehealth identified wide agreement among Minnesota providers, patients, health plans, and public health professionals that telehealth expands access to care, makes getting care faster and easier, and reduces barriers for patients.

The final report also concluded that telehealth expanded access to healthcare without appearing to compromise quality of care or patient satisfaction. Importantly, the report also concluded that the increased use of telehealth did not lead to an increase in healthcare spending.

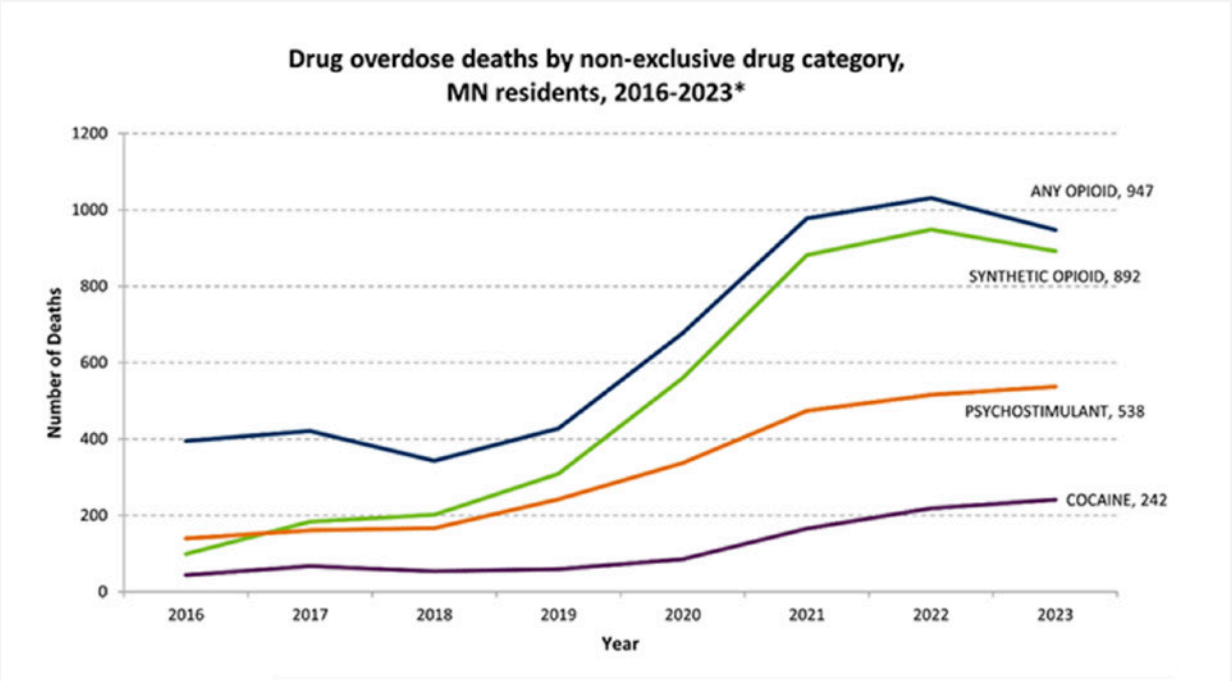
"Though telehealth use by Minnesotans has come down from the highs witnessed during the peak of the pandemic, our research shows that it has stabilized at a much higher level than before 2020," says Pam Mink, the study lead and MDH health economics program director of health services research. "In short, telehealth has cemented its place as a healthcare option, particularly in the treatment of mental and behavioral health. But it is just one tool in the care-delivery toolbox. In-person care must continue to be offered as an easily obtainable option for Minnesotans, and too many still find it challenging to find care that is geographically and financially accessible to them."

Most Minnesotans who used telehealth were satisfied with their experience, and both patients and providers appreciate the option of telehealth. However, preferences for telehealth versus in-person care varied, and the availability of in-person care is needed to ensure telehealth is one choice, but not the only choice.

The increased access to healthcare offered by telehealth also has the potential to strengthen health equity by reducing some of the inequities in healthcare access that exacerbate health disparities, according to the study's findings.

However, the study found that the gateways to telehealth itself are not equitable. This is especially true for people with limited digital access or digital literacy. Further investments in telecommunications technology, including broadband, and actions to help people build their knowledge, skills, and comfort to use telehealth effectively are needed to improve and ensure equitable access to healthcare via telehealth.

MDH's final report on telehealth is available on the MDH Health Economics Program website.



increasing 4% (516 to 538 deaths) and cocaine 11% (219 to 242 deaths).

As drug overdose remains a crisis in Minnesota, MDH, tribal nations, and health organizations have increased their investments in overdose prevention activities. The state's 2023 One Minnesota Budget included more than $200 million to address substance use and overdoses—with $50 million of that coming to MDH over the next four years. The investment addresses prevention, harm reduction, treatment, and recovery. Additionally, the governor and Legislature passed a policy to reduce drug overdose deaths by requiring all schools, law enforcement officials, emergency responders, and residential treatment programs to have naloxone on hand. MDH and the Minnesota Department of Education have posted a toolkit to help schools obtain cost-free naloxone and implement the new requirement.

New report shows physician well-being still an issue

The Physicians Foundation issued data in September showing that the state of well-being remains critically low for physicians, with healthcare consolidation exacerbating the issue.

Data from the 2024 "Survey of America's Current and Future Physicians" points to the urgent need to improve physician well-being and focus physicians' perspectives in today's rapidly evolving healthcare landscape.

Key findings from the report include:

- Six in 10 physicians and residents, and seven in 10 medical students, reported often experiencing burnout.
- More than half of physicians know of a physician who has ever considered, attempted, or died by suicide.
- Medical students (49%) are significantly more likely than residents (33%) and physicians (18%) to have sought medical attention for a mental health problem.
- Seven in 10 physicians and medical students, and at least six in 10 residents agree that consolidation is having a negative impact on patient access to high-quality, cost-efficient care.

According to physicians, negative impacts of mergers and acquisitions include job satisfaction (50%), quality of patient care (36%), independent medical judgment (35%), and patient healthcare costs (30%).

Safeguards for consolidation identified by physicians, residents, and medical students include preserving physician autonomy (90%), maintaining patient standards (87%), increasing transparency and disclosure (86%), and assessing long-term impact (84%).

The Physicians Foundation, the Dr. Lorna Breen Heroes Foundation, the National Academy of Medicine, the U.S. Surgeon General, and others have all called for systemic change and investments to decrease health worker burnout and improve well-being.

New study details reasons for delays in mental health boarding

A new study released in July shows that 17% of people being treated for mental health or substance use disorders in Minnesota experienced a discharge delay from inpatient care and that the delays averaged eight days per patient.

The Minnesota Study of Behavioral Health Discharge Delays included a study sample of 182 inpatients and 537 emergency department patients experiencing delays at Minnesota hospitals during a 14-day period between September 5 and October 20, 2023.

The most common reason for discharge delays was a lack of available beds in a safe setting like inpatient psychiatric units and intensive residential treatment service facilities for adult and pediatric patients.

The study was conducted by Wilder Research and the Minnesota Department of Health's Health Economics Program to examine reasons for the prolonged transfer and discharge delays experienced by mental health and substance use disorder patients who seek hospital care in Minnesota.

Whether a patient had state public insurance program coverage was the leading predictor for experiencing delays. According to the study, 75% of patients who experienced a discharge delay from inpatient care were covered by Medicaid or MinnesotaCare, despite accounting for just 46% of patients admitted with behavioral health diagnoses. The study also found a disproportionate percentage of inpatient delays impacting Minnesotans of color and specifically those who identify as African American or African-born.

The emotional cost to patients and families of boarding is significant, as is the

economic cost to hospitals when accommodating patients who are ready to be transferred to an inpatient bed or discharged to community-based services.

The study indicates that creating additional post-hospital infrastructure is a key element of reversing Minnesota's stubborn boarding issue. At the same time, the data show that streamlining the transfer and discharge processes could have significant benefits and should be an important policy goal.

This May, the MMA Board unanimously approved a set of recommendations from the Physician Well-being Advisory Committee to help physicians and physicians-in-training foster well-being, avoid burnout, and achieve an improved quality of life.

In addition, in 2023, the MMA launched its SafeHaven program after recognizing a greater need to help physicians struggling with stress, burnout, and the effects of COVID-19. SafeHaven, a confidential and independent resource, is designed to help physicians get the help they need to reduce stress and burnout, promote work-life integration, and support their own well-being.

An approach aimed at helping youth has been the Mental Health Collaboration Hub, funded by MDH. The hub is a statewide virtual networking center aimed at helping children and youth who are boarding in hospitals and emergency departments get connected to mental health treatment settings. To date, this program has helped hundreds of children. Preliminary data collected from October 2023 to January 2024 through the hub showed a 55% reduction in days children or youth were boarded, or 24 fewer days. Approximately 80% of youth entered in the hub's virtual community were able to discharge in less than 45 days.

During the 2024 legislative session, the Minnesota Legislature passed additional budget and policies designed to assist in expediting hospital discharges and increasing access to behavioral health services. The Legislature added additional mental health beds to the state's direct care and treatment system, funded rate increases for some outpatient mental health services and residential substance use disorder services paid for through Medicaid, and made policy changes to improve access to supports in the community.

The MMA welcomes the study as it continues its advocacy related to mental health boarding. In May 2023, the MMA and the Minnesota Chapter of the American College of Emergency Physicians (MNACEP) released a 44-page report on mental health boarding, complete with recommendations on how to address it.

Since then, the MMA has developed a "Mental Health Resource Guide for Physicians," (www.mnmed.org/resources/mental-health-resource-guide) with the goal of empowering physicians with tools to better connect patients with mental health services before patients' symptoms drive them to emergency rooms. The MMA is also pursuing a stronger, more regular data collection system to better monitor the mental health boarding situation in Minnesota and to evaluate the efficacy of proposed solutions.

Report: Nurse numbers increase, physician numbers of concern in Minnesota

A Minnesota Hospital Association (MHA) analysis of healthcare workforce data released in early September shows hospitals and health systems are replenishing their staff in the wake of the COVID-19 pandemic. However, physician numbers remain concerning.

The data comes from a months-long survey of human resources at most Minnesota hospitals, health systems, clinics, and other facility settings.

Data shows more than one in seven primary care physicians in Minnesota will reach retirement age in the next five years. For specialty physicians, the number is nearly one in five. A new national survey found that more than 60% of physicians are considering retirement, finding a new job, or changing careers, citing growing workloads.

It shows job vacancies among nurses declined notably in 2023 for the first time since the pandemic. Separations and vacancies among nursing staff had grown rapidly as the state grappled with COVID-19.

Overall, the number of working nurses also grew for the fifth straight year—although barely two in five registered nurses are choosing to work full time, and the proportion of nurses working full time (defined as over 32 hours a week) has hit an all-time low.

Greater Minnesota continues to experience workforce challenges. Physician employment grew in the Twin Cities but fell in greater Minnesota. Also, providers outside the Twin Cities saw a 22% increase in nurse departures last year, compared to 2023.

Other findings in the data, which includes both MHA and government statistics include:

- Average pay for registered nurses (RNs) in Minnesota hit nearly $95,000 in 2023, up by 6.7% from 2022, according to federal data. That was the biggest increase in more than a decade.
- From 2022 to 2023, RN licensees grew 9.3% and have increased by 17.6% over the past five years.
- Licensed Practical Nurses (LPNs) and Certified Nursing Assistants (CNAs) continue to upgrade within the healthcare field with an average of 3.8% of LPNs and 4.6% of CNAs getting their RN license annually over the last three years.
- Workforce issues are of critical importance to healthcare in Minnesota. Declining birth rates, an aging population, rising retirements, and falling net migration have had historic impacts on the state's healthcare workforce.

According to the Minnesota Business Partnership, labor participation fell by 7% between 2001 and 2022, a reduction of 325,000 workers in the state.

This year's MHA workforce report has some bright spots and shows that strategies like flexible schedules and pay increases can help declines in the workforce. MM

Taking serious illness communication seriously

A free class from the Center for Advancing Serious Illness Communication can help both patients and physicians

BY GREG BREINING

The Center for ADVANCING SERIOUS ILLNESS COMMUNICATION
A JOINT INITIATIVE OF THE MMA & MHA

Many physicians are uncomfortable talking to patients about serious illness and end-of-life considerations. Others aren't particularly good at it. Many scarcely received any training in it, and while that is changing—slowly—their discomfort means that many of these conversations, as vital as they are to patients and their families, are pushed off till the very end of life or occur only in truncated fashion.

To remedy that, the Center for Advancing Serious Illness Communication (CASIC), a joint initiative of MMA and the Minnesota Hospital Association, is offering free training, eligible for CME credit, with evidence-based, patient-tested script and protocol to physicians and other members of healthcare teams who work with patients with serious illness. Sponsored by Blue Cross and Blue Shield of Minnesota, the goal is to address known gaps in care delivery for patients with serious or terminal conditions with the aim of driving systemic change by enabling patients to make more well-informed decisions. Thus, the program is designed to train clinicians in how to have more timely, specific, and meaningful conversations with patients about their treatment and care preferences.

The payoff, according to actual studies of the program: Greater likelihood

"Let's say a patient has a terminal cancer diagnosis. They maybe have a year or six months to live, based upon the best information that everybody has at that time. The goal is to have this conversation when they're feeling better, so they can think more clearly, understand their options, and achieve greater concordance of care at end of life."

LORI BROSTROM, EXECUTIVE DIRECTOR, CASIC

"The physician really needs to have a facility with this and a comfort level with this for themselves, so that they can put the patient and family at ease and present this information to them. Most doctors, even those that are good communicators, haven't been trained in these types of conversations and are still uncomfortable."

VIC SANDLER, MD, HOSPICE PHYSICIAN, HEALTHPARTNERS AND MEMBER OF THE CASIC ADVISORY COUNCIL

physicians will discuss serious illness with patients, decreased depression and anxiety among patients with serious illness, and greater physician satisfaction. According to palliative care physician Erik Fromme, MD, MCR, "It sort of brings me back to why I wanted to be a doctor in the first place."

Serious illness conversations are discussions between a physician and a patient—as well as their family and caregivers in many cases—that address a patient's goals of care including their diagnosis and prognosis, values, fears, trade-offs they are willing to make as their illness progresses, and what is most important to them, says Lori Brostrom, executive director of CASIC.

Who should have them? Patients who are facing serious health conditions and quite possibly a life expectancy of less than a year. And generally, sooner is better than later, Brostrom says.

"Let's say a patient has a terminal cancer diagnosis," she says. "They maybe have a year or six months to live, based upon the best information that everybody has at that time. The goal is to have this conversation when they're feeling better, so they can think more clearly, understand their options, and achieve greater concordance of care at end of life."

"These conversations are so important for patients and families to be able to understand their illness and understand their options, and for them to be able to understand also their prognosis with their condition, and all that information is necessary for them to be able to process the options that they have for treatment or observation of their condition," says Vic Sandler, MD, an MMA member who sits on the CASIC Advisory Council to help guide development of the Minnesota program. Sandler is a hospice physician at HealthPartners.

"The physician really needs to have a facility with this and a comfort level with this for themselves, so that they can put the patient and family at ease and present this information to them," he says. "Most doctors, even those that are good communicators, haven't been trained in these types of conversations and are still uncomfortable."

The CASIC program consists of a prerequisite of three self-administered online modules that present the need, rationale, and research behind this protocol. Those are followed by a three-hour classroom training session by Zoom that makes use of the *Serious Illness Conversation Guide*, a script and protocol for conducting these conversations. Practicing with specially trained actors serving as patients (part of the University of Minnesota's M Simulation team), participants receive feedback to improve their skills.

The script in the *Serious Illness Conversation Guide* is useful not only in training, but also in real patient conversations. "That's very reassuring for physicians, even the ones who have these conversations all the time," says Brostrom. "It encourages them to use this patient-tested language. It also means that they don't have to remember, or be concerned that they've forgotten something."

Says Brostrom, "It allows clinicians conducting these conversations to help

"You've talked to doctors before. They tend to talk a lot, right? They're better at informing you than listening. The Ariadne protocol approach sort of tricks them a little bit into listening, because the script is all open-ended questions."

ERIK FROMME, MD, MCR, DIRECTOR OF THE SERIOUS ILLNESS CARE PROGRAM AT ARIADNE LABS

"I don't care if you've had the training before. You're going to repeat the training, because I can't vouch for the quality of the training that you had. It fits so well with what we're taught to do. We're just not taught to do this part exceptionally well."

JENNIFER WELSH, MD, CHIEF MEDICAL OFFICER, GENEVIEVE

their patients discuss end-of-life issues in a way that is focused on their needs, not the needs of the the hospital or the practice or the physician."

The study guide and class protocol were developed by Ariadne Labs, a joint center for health systems innovation at Brigham and Women's Hospital and the Harvard T.H. Chan School of Public Health. The center was founded by surgeon and Harvard professor Atul Gawande.

Gawande was researching his book, *Being Mortal: Medicine and What Matters in the End*, by "going around to palliative care physicians to try to understand what they were doing that was different from what he as a cancer surgeon was doing," says Fromme, director of the Serious Illness Care Program at Ariadne Labs. That's when Gawande spoke with Susan Block, MD, codirector of the Harvard Medical School Center for Palliative Care (and later cofounder of Ariadne Labs' Serious Illness Care Program).

As Fromme describes it, Block suggested Gawande delay talking to the patient about the risks and benefits and alternatives of surgical procedures and instead ask what they understand about their prognosis. How much do they want to know? What are their most important goals if their health worsens? And what tradeoffs would they be willing to make to buy more time?

"And what she said to him was, if you understand the answer to those four questions, then you can make a recommendation to the patient to say, based on what I understand is most important to you, I would recommend this," says Fromme. "Rather than all the procedures and the alternatives, and asking the patients what they want to do, this gives the clinician the opportunity to make a recommendation based on their understanding, not only of the illness and the prognosis and whatnot, but also of the patient's values and their goals."

From those initial interviews a script developed. "That got tested with every kind of clinician you can think of. And they went and took it, used it with their patients. And we went through about 100 different revisions," says Fromme. Ariadne continued to hone the language with patients and various caregivers.

Then the script was tested as part of a randomized trial at the Dana-Farber Cancer Institute. Patients whose clinicians were trained to use it were more likely to have a serious illness conversation with their patients, and the conversations were more patient-centered. For example, "91% of conversations using the script included an opportunity for the patient to talk about their prognosis or their understanding of their illness, versus 48% in the control group," says Fromme

The script, as opposed to contemporaneous conversation, "gives the patient a lot more opportunity to say what they want to say," says Fromme. "You've talked to doctors before. They tend to talk a lot, right? They're better at informing you than listening. This approach sort of tricks them a little bit into listening, because the script is all open-ended questions."

When CASIC was looking for a curriculum, they picked up the Ariadne protocol and ran with it. "They did just an outstanding job of putting this together, and road tested it," says Sandler. "They developed really an excellent model for this work." CASIC's trained instructors began offering small classes last summer.

Jennifer Welsh, MD, the chief medical officer of Genevieve, a medical practice that provides care for frail older people who live primarily in facilities such as for skilled nursing, memory care, and assisted living, has begun sending all her new hires to the CASIC classes. As a small company, she says, Genevieve can't afford to set up its own program offering CME credit.

"I don't care if you've had the training before. You're going to repeat the training, because I can't vouch for the quality of the training that you had," Welsh says. "It fits so well with what we're taught to do. We're just not taught to do this part exceptionally well."

Sandler says that in the future he imagines that the curriculum that CASIC is using will be taught in large healthcare settings, medical schools, and in smaller settings as CASIC is doing now.

"I would say all of the above," Sandler says. "It should be tried in medical school. It should be taught in residency. It should be a part of doctors' being evaluated in their ongoing practice. So I think it really needs to be a universal part of medical education, because it's foundational to good patient care." MM

The free CASIC training is available to all members of care teams who work with patients with serious illnesses. For more information, contact Lori Brostrom, CASIC executive director, at lbrostrom@advancingsic.org. Space is limited and must be reserved and confirmed in advance. For more information on upcoming classes and to register, visit https://www.advancingsic.org/training-and-events.

Greg Breining is editor of *Minnesota Medicine*.

NEW DEA CERTIFICATE RENEWAL REQUIREMENTS ARE YOU READY?

Special Discount Available for Minnesota Medical Association Members!

Use MNMED100 for $100 Off

HTTPS://CLINICALOPTIONS.COM/CONTENT/DEA-RESOURCE-CENTER

LEARN MORE

WHAT IS IT?

Effective June 27, 2023, the US Drug Enforcement Administration (DEA) requires all DEA license holders to take at least 8 hours of training on opioid or other substance use disorders, as well as the safe pharmacologic management of dental pain, to apply for or renew their DEA certification.

HOW CAN I FULFULL THIS REQUIREMENT?

In partnership with Clinical Care Options (CCO), MMA now offers a comprehensive, DEA-compliant CME course, Controlled Substance Prescribing and Substance Use Disorders. Learn at your own pace on-demand—with expert-led sessions that can be taken whenever, wherever.

Minnesota Medical Association

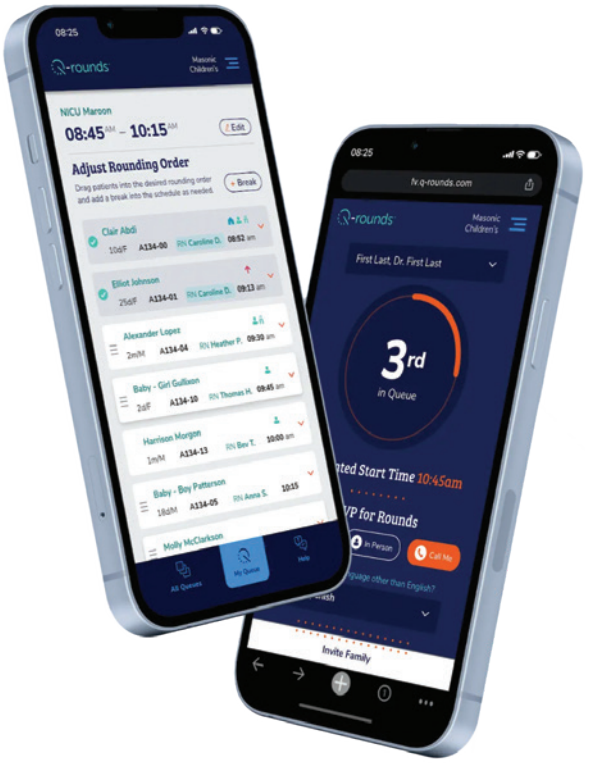
Held hostage by rounds

Michael Pitt asked a question: Why isn't attending rounds as easy as getting a haircut?

MICHAEL PITT, MD

PHOTOGRAPHY BY KATHRYN FORSS

Michael Pitt, MD, professor of pediatrics at University of Minnesota Masonic Children's Hospital, is well acquainted with the tyranny of hospital rounds. Not just physicians, but also nurses, support professionals, and most of all, patients' families—everyone connected to a hospitalized patient is forced to put their plans on hold as they wait for the physician to show up at a patient's bedside. As a result, it's often the case that physicians, nurses, and patients' families fail to make the connection. And that hurts healthcare.



Pitt had a plan and started the company Q-rounds to provide what so many other businesses have had—a method to notify people when their turn is coming. Pitt talked to *Minnesota Medicine* about his idea, his company, and the implications for hospital care. The interview has been edited for clarity and brevity.

> I'm a doctor so I know these pain points of what it's like to try to coordinate, getting everybody together for that most important discussion of rounds during the day. I kept thinking, if I can go to Great Clips, where they cut my hair, I can get a text message that says I'm three haircuts away from my turn. Why aren't we doing that when it actually is the highest stakes in people's lives, when they are waiting for the doctor?

Tell me how you got this idea of Q-rounds. When did all this start?

I'm a doctor so I know these pain points of what it's like to try to coordinate, getting everybody together for that most important discussion of rounds during the day. But it was really having been a loved one of a patient. When my father and father-in-law were hospitalized, I'd spend every day expecting a call or hoping for a call, and kind of feeling held hostage by this, trying to catch this 15 minutes with the doctor. I kept thinking, if I can go to Great Clips, where they cut my hair, I can get a text message that says I'm three haircuts away from my turn. Why aren't we

doing that when it actually is the highest stakes in people's lives, when they are waiting for the doctor?

We've come to expect this time transparency in every arena of our life. Where is my package? When is my DoorDash coming? When is my haircut turn? Yet we abandon that expectation when it matters the most.

So the idea simply came from, if we can do this in other arenas, why aren't we doing this in the inpatient setting in the hospital?

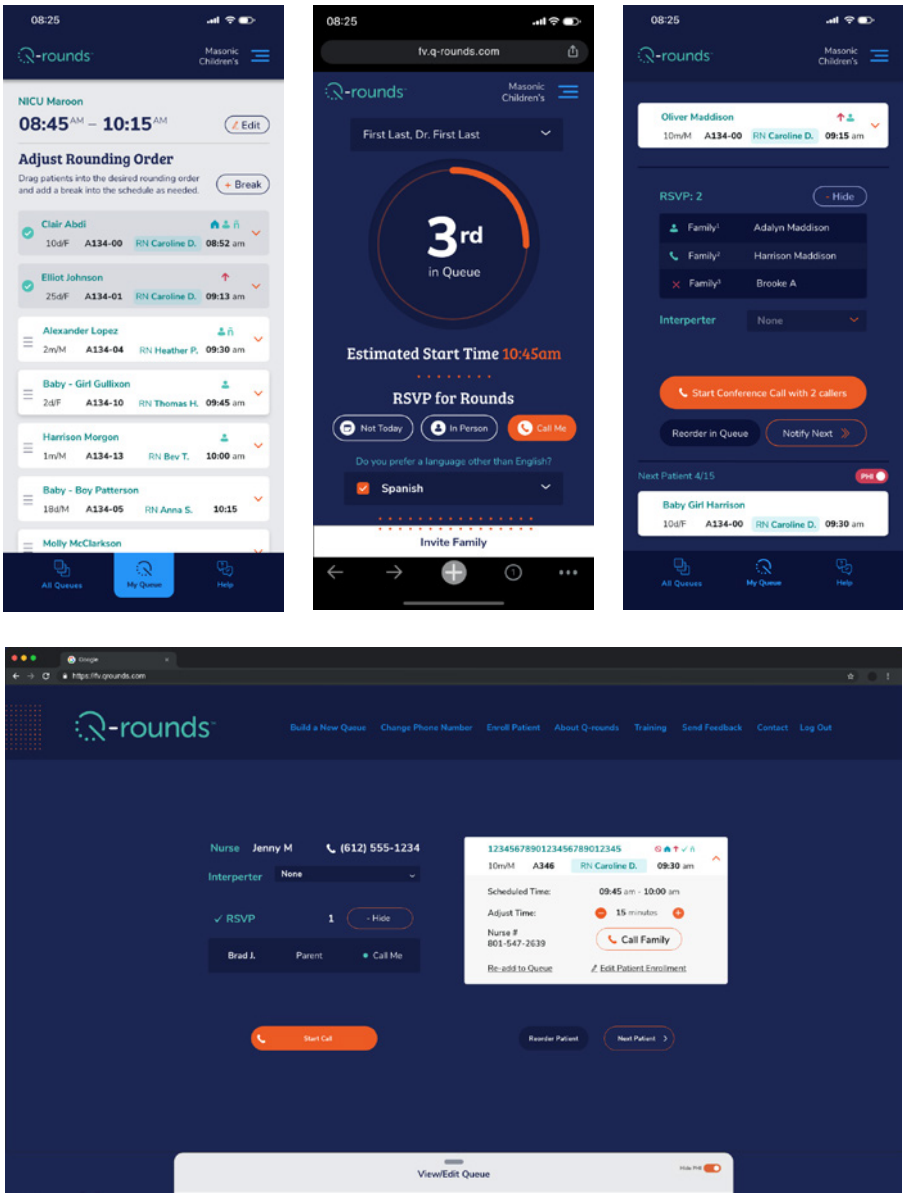
Just to help me establish the time frame—when was it that your father was ill?

So both my father and father-in-law died about two years ago but had been hospitalized quite a bit during this time. So I've had this idea for about seven years. We've been working on it for just a little over four.

How did you put this into motion? I mean, as a pediatrician, you work in a hospital. I don't imagine that tech is your strong suit.

I had done some research that involved app development and technology, but I contacted a colleague at the University of Minnesota, John Sartori [associate professor of electrical and computer engineering], who's one of the cofounders of Q-rounds, and met with him for Korean food. I said, look, this is what they do in Great Clips. Could you build that in healthcare? And his answer was, yes, we could build it. It's an easy sentence to say yes to, but it's a complicated solution. You know, there's a lot of nuance in the way things work. What happens when a patient is sick and the order needs to be adjusted and things like that.

So we got a grant from the university to do some focus-grouping and build a beta-type of this. We did that during COVID. We ran some testing of this in our neonatal intensive care unit. And then once we saw that that was successful, then it became a project where we really needed to get some more grant money, raise money to be able to actually do this as an integration with the electronic health record, make it fully seamless. And now we've been live at M Health Fairview Masonic Children's Hospital for over a year.



Example pages of the Q-rounds application. Mobile (above) and desktop (below).

Tell me how it works.

Okay, so the beauty of Q-rounds is the only person that is using it is the doctor. It's not an app that you have to have families download. It's not a password that nurses need to know. The doctors have the app downloaded either on their hospital device, their personal device, or desktop computer, so they can do this on a workstation on wheels.

When they choose to build a queue they pull in the patients from the electronic health record that they need to see that day. They select a start time for rounds. They pick a duration for how long they want per patient, and then they put a number in that they're going to receive a conference call on if the family can't be there in person. So when they hit next, this now pulls their patients in. They can flag a patient that they think is sick, that wants to be at the top of the list, or somebody that's ready for discharge that will prioritize putting them to the top of the list here.

And then they drag and drop into the order they plan to see patients. All of this takes about 40 seconds. Once they hit *share*, three things happen. One, every

The beauty of this has been that it's a solution that every stakeholder thinks was invented for them. So the families are getting text messages with when the doctor's going to be there. They can RSVP to join remotely. The nurses are getting automatically included in rounds by seeing those real-time updates. And so nurses are telling us they're eating lunch again for the first time in years because they know when the doctor is going to be there and they're not held hostage themselves.

nurse is going to get a call that tells them that the doctor shared the queue, and this is the estimated time for the patient. "Dr. Pitt has shared his rounding queue. You are have one patient on the queue. Your first patient is at 8:45."

The next thing is, it gets pushed into the electronic health record so everybody can see the patient order that the doctor is going to see the given patients in. This allows people like the pharmacist, the social worker, to know when the doctor is going to be to a given patient.

The family gets a text that shows them, "I'm fourth to be seen, I'm third to be seen, I'm next to be seen." So just like the deli counter. They also see their estimated time, and they can RSVP. "I'm going to be there in person today or call me." They can have their language needs put in. That queues up an interpreter, and they can invite additional family members.

Now, when I'm ready to start rounding, every time I get an orange button, the next people are notified. So this nurse is given a call to say to head to that room, so that they're waiting for me at the room, as opposed to the doctor showing up and not knowing where the nurse is.

The family gets a text that I'm on my way to the room. In this case, they're RSVP'd in person, so we just have a traditional rounding conversation. But when I go to the next room this family's RSVP'd for a call. So because of that, when I press this button, my phone will ring, the family's phone will ring, and the interpreter will be on the line if necessary.

So what we've seen is a tripling of the nurses being present for rounds, and a tripling of the family members being present for rounds, with as many as seven additional families joining rounds on a given day per team. And again, this is updating in real time, so that if something goes on with rounds and they need to change the order and see a patient that's sicker, and that gets moved to the top of the list, that's going to adjust everything downstream.

And you say that only the doctors need to actually have this app installed and be operating it. Everybody else can participate with their cell phones. No special equipment.

Yeah, if you've ever been to a hotel and you get a text that your room is ready, it's very analogous to that for the family. This all happens to their phone. The nurses, it communicates with whatever the devices they are already using in the hospital. And it really has just been a game changer.

The beauty of this has been that it's a solution that every stakeholder thinks was invented for them. So the families are getting text messages with when the doctor's going to be there. They can RSVP to join remotely. We've had over 10,000 families join rounds remotely, and these are families that wouldn't have been able to be there otherwise in the NICU. So the families think this was for them.

The nurses are getting automatically included in rounds by seeing those real-time updates. And so nurses are telling us they're eating lunch again for the first time in years because they know when the doctor is going to be there, and they're not held hostage themselves.

I was always skeptical that the doctors would do it. We've been live in our NICU for over a year and not had a single day that they didn't use it. They see the value right away in connecting with families. And we've actually had doctors tell us it's the first technology that they have had in a hospital that brought them closer to a patient. Usually, technology's driving you away from patients; yet this was bringing them back to the bedside in a way technology doesn't usually do. So that's been really exciting.

You had mentioned that there are actually some measurable improvements in healthcare that this would facilitate by getting a doctor and nurse in a room together with the patient.

Absolutely. Three things we know right off the bat: Number one, medical errors go down when the nurse is at the bedside with the doctor for rounds. There's a 38% reduction in medical errors when you have the nurse present. Yet it happens as rarely as 5% of the time that the doctor is rounding with the nurse. We've gotten that rate in our NICU to nearly 100%. Just having the nurse there decreases medical errors.

Having the family present also decreases medical errors and increases the speed to discharge, because you identify barriers that would have kept patients in the hospital longer. You have the whole story when you have the family there every day.

And then there's direct dollars that are tied to patient experience scores, and this is a game changer for patient experience. Families have not had a complaint about communication in our NICU since this started. When you get every family together, they're feeling part of the team every single day. You know, a lot of times people get discharged from the hospital without a clear understanding of the plan. When you have the whole family there for that discussion, you've magnified the chances of that being an accurate understanding.

In another interview, you had mentioned something very interesting—that as you became an entrepreneur, you became accustomed to thinking about a hospital's bottom line, that you're kind of forced to do that because, after all, somebody has to pay for this. And Q-rounds actually appealed to their bottom line, because it helped them turn over rooms more quickly, turn over beds more quickly, and facilitated some of their other work that made things more economical for them.

As noble as it is, it has to be at the very least revenue neutral for a hospital, to pay for itself. And the increases in patient satisfaction scores, the ability to turn beds over faster, and the decrease in errors that you see when you have that whole team are all things that cost hospitals money, and this is able to address those.

Well, you had mentioned at the beginning of our conversation here that you reached out to Mr. Sartori to help you with the technical aspects of developing an app. I would imagine that the business aspects were probably just as formidable to you as a doctor as the tech aspects. Tell me a little bit more about how you put your entrepreneur hat on.

So I've been an entrepreneur my whole life. You know, when I was 8 years old, I started doing magic professionally four nights a week, and I was doing taxes since the age of 12. I bought my sister a car when I was 12. I used to sell sodas out of a wagon at the store at Periwinkle Place on Sanibel Island. And then when they saw how much I was making as a 10-year-old and bought a soda machine, I put an out-of-order sign on the soda machine and started charging twice as much for the soda. So I never not had that as part of my life. That said, the learning curve to running a business, hiring, doing fundraising—that's why we brought in our third cofounder. Chelsea Klevesahl came in as our COO. So pulling a team together, knowing what I don't know was a huge part of that.

> Medical errors go down when the nurse is at the bedside with the doctor for rounds. There's a 38% reduction in medical errors when you have the nurse present. Yet it happens as rarely as 5% of the time that the doctor is rounding with the nurse. We've gotten that rate in our NICU to nearly 100%. Just having the nurse there decreases medical errors. Having the family present also decreases medical errors and increases the speed to discharge, because you identify barriers that would have kept patients in the hospital longer. You have the whole story when you have the family there every day.

For Q-rounds to be adopted by a hospital, what has to happen? It sounds like there isn't a lot of hardware that has to be installed.

Yeah, there's no hardware. It's purely a software solution. So we have to work with their informatics team, their hospital IT team to do the integration with their electronic health records. So Q-rounds talks to Epic, for example. There are the nuances of, how do your nurses get notified? Is it via pager? What do you use in your system? We need to communicate with that. So there's some partnership we do. And then there's the training to get the doctors on board. And then it runs itself, you know, which is beautiful.

You had mentioned that Masonic Children's Hospital is using this. Where else have you been talking about making use of this?

So we we've started with children's hospitals, because every single child that's hospitalized has a family member that needs to be updated. You don't get to say to a 7-month-old, tell your mom what we talked about. You have to talk to the family.

We are starting this in adult settings as well, because if your loved one is ever hospitalized, you too should have those opportunities to be present for that. The other extreme from pediatrics is elder care, memory care, places where doctors are showing up and families might be across the country, and you can't rely on the family member to give that update. So we're looking at that other extreme as well.

We're looking to expand within some of the other Fairview hospitals. We're going to be working on something with M Health Fairview Ridges Hospital. They were a development partner, allowed us to kind of build this in their environment. So we're giving Fairview that priority as a development partner. We're in discussions with two dozen hospitals across the country. So lots of programs.

What's next? It sounds like just approaching more and more institutions and trying to sell the idea to them.

We have the gift of the fact that everybody that uses this loves this. We just need to work on getting hospitals ready to be the next hospital to use it. I anticipate our tipping point will be once we start getting those second and third hospitals and it really starts to grow. You know, we built this as an internal solution. It's doing exactly what we wanted it to and more. **MM**

Interview by Greg Breining, editor of *Minnesota Medicine*

THE physician patient

Treating fellow physicians can be equal parts fulfilling, frightening, frustrating, flattering, and even fun

BY SUZY FRISCH

Erin Stevens, MD, knows that physicians have a sea of choices when it comes to picking an OB-GYN, so she takes it as a compliment when one chooses to see her. Even with those good feelings, though, she makes sure to approach her physician patients like any other, providing the same care to all.

Without that caution, Stevens realizes that it's easy to fall into common traps when treating fellow physicians. There might be a tendency to assume physicians know more than they actually do about her specialty, which could lead to undercommunicating about their care. Or there's the opposite concern of providing Cadillac care—overevaluating or overtreating people because they are physicians.

"There can be some sort of pressure, whether from ego or society, that this is another physician so I should do more of a workup. But overdoing it can lead to harms," says Stevens, who practices at Clinic Sofia in Edina. "If I'm caring for someone in a different way, I step back and think, 'Why am I doing that? If I'm doing that for this patient, I should be doing it for everyone else.'"

It's common for physicians to feel a range of emotions when treating physician peers. Certainly, many feel flattered, while others describe it as awkward, intimidating, or anxiety-inducing, according to research published in 2023 in the *BJGP Open*, a publication of the Royal College of General Practitioners. Newer physicians might get nervous around veteran physicians, recalling recent memories of facing scrutiny as trainees. Others might avoid asking tough questions about mental health or substance use, preventing them from getting to the root of a problem.

When physician patients are in the exam room or hospital bed, there certainly are challenges and rewards for the treating physician. The keys to providing excellent care start with not making assumptions about what a physician knows or doesn't know. Then that gets paired with communication to determine how detailed or technical the physician patient wants the conversation to be, says Colin West, MD, PhD, an internist and director of the Mayo Clinic Program on Physician Well-Being.

"I try to approach every patient the same way, at least to begin with. If we start

"There can be some sort of pressure, whether from ego or society, that this is another physician so I should do more of a workup. But overdoing it can lead to harms. If I'm caring for someone in a different way, I step back and think, 'Why am I doing that? If I'm doing that for this patient, I should be doing it for everyone else.'"

ERIN STEVENS, MD
OB-GYN
CLINIC SOFIA, EDINA

making assumptions and putting pieces together before we actually have information, that doesn't help us and it doesn't help the patient," West says. "For me, it's really important to have the same process whether it's a physician, an executive, or someone living on the street."

If West knows or comes to understand that a patient is a physician, he is sure to acknowledge that background and expertise. "Then I tell them, 'For the purposes of our discussion and trying to get at the root of your medical question, I'm going to use general language meant to be accessible for any patient. If that ends up being too high or too low a level for our communication, we can adjust together.'"

Another important step is determining how a physician patient wants to approach decision-making, West says, notably because shared decision-making means different things to everyone. Some physicians regard West as the expert and put their care in his hands, not questioning his diagnosis and recommendations.

Others might want to more actively direct their own care with West. Some physicians arrive in his office with a self-diagnosis and treatment plan that they want him to just sign off on. "That can be a problem. You're not objective when it's your own healthcare," he says. In these situations, West will do his own evaluation to either confirm the physician's diagnosis or discuss why he sees the situation differently, and then set about making a plan together.

Assessing knowledge

When treating fellow physicians, it's important to remember that their knowledge in a specific area of medicine might not be current—or fresh in their minds—if they completed medical school years ago, West says. Along the same lines, physician patients have plenty of general medical knowledge but not necessarily a deep understanding of the specialty where they are seeking care, observes Catherine Benziger, MD, MPH, FACC, FAHA, a noninvasive cardiologist at Essentia Health and director of Heart and Vascular Research.

That means taking the time to ensure that physician patients understand all of the pertinent information. "You have to be careful because you don't want to assume what they know," Benziger says. "I can speak to a physician using a bit more technical terms, and I don't have to sugarcoat things or dumb them down. I'll tell them what the labs are and speak more frankly to them."

Similarly, Ronda Farah, MD, a dermatologist at M Health Fairview Maple Grove Clinic and founder and director of the M Health Cosmetic Center, will sometimes use varying terms for different audiences. Instead of calling a potential side effect a lump or bump as she would for general patients, Farah would say a skin granuloma or infectious nodule to physician patients. "That would be confusing to a patient. But it's confusing to a physician to say lump or bump," Farah says. "I tend to lean toward using more medical terminology with them because it typically makes them more comfortable."

Rajini Katipamula-Malisetti, MD, an oncologist and executive vice president at Minnesota Oncology, finds it a delicate situation when physicians with cancer come to her for care. In a highly stressful time for the individual, she needs to assess what their knowledge base is and adjust accordingly. "The hardest part is knowing

"I tell them, 'For the purposes of our discussion and trying to get at the root of your medical question, I'm going to use general language meant to be accessible for any patient. If that ends up being too high or too low a level for our communication, we can adjust together.'"

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

and understanding what they know and understand versus what you think they should know," she says. "It's always that communication to meet the patient where they are."

Katipamula-Malisetti usually starts with the basics, detailing how the cancer is diagnosed and staged, as well as treatment options and possible side effects. She pauses to make sure patients understand, and that the details aren't too basic or too high level. "As a physician patient, depending on their specialty and their prior experiences and knowledge, there is an extreme level of anxiety. So I usually like to start with understanding what their biggest fears and concerns are. Having that initial discussion has really helped form a bond of trust and helps caring for them a little less challenging."

"There is often good mutual respect. I actually feel like I get less pushback from physicians than I do from the general population. If you are recommending a treatment, they know it's because you have a good reason, and they are pretty agreeable to doing that."

CATHERINE BENZIGER, MD, MPH, FACC, FAHA
NONINVASIVE CARDIOLOGIST AND DIRECTOR OF HEART AND VASCULAR RESEARCH
ESSENTIA HEALTH

Rewards and challenges

Farah finds it especially gratifying to take care of physicians, whether they are dealing with acne, hair loss, or want a refresh with cosmetic dermatology. She knows that many physician patients feel guilty for taking time away from their work and families to seek medical or cosmetic dermatology care. She understands—she often feels the same way.

"It's an emotionally and intellectually rewarding population to treat because we understand each other's lives. A lot of time I can sort of cut to the chase and use their time slot more efficiently. I know that it must have been weeks if not months in advance that they blocked their schedule for this appointment," Farah says. "I find joy and pride in trying my best to make sure they have a good experience and don't feel like they've done anything wrong by seeking care or taking time for themselves."

Benziger knows some coworkers don't particularly enjoy treating physicians because they find it stressful, but she enjoys it. She calls physicians her most agreeable patients. "There is often good mutual respect. I actually feel like I get less pushback from physicians than I do from the general population," she says. "If you are recommending a treatment, they know it's because you have a good reason, and they are pretty agreeable to doing that."

As a rule, Benziger finds that physician patients are less likely to engage in follow-up care because their own schedules are jam-packed, and she often will communicate with them about their care via MyChart. While some are less likely to embrace medication, they are often the most compliant with her other recommendations. "They might not need that relationship-building that you do with other patients because they just trust you," Benziger adds.

When treating colleagues, many physicians have gotten accustomed to their experiencing a range of emotions that differ from those they have when treating non-physician patients. Katipamula-Malisetti regularly sees physician patients who wonder how they missed the signs and symptoms of their cancer, often paired with guilt that they didn't detect their illness.

"As a physician patient, depending on their specialty and their prior experiences and knowledge, there is an extreme level of anxiety. So I usually like to start with understanding what their biggest fears and concerns are. Having that initial discussion has really helped form a bond of trust and helps caring for them a little less challenging."

RAJINI KATIPAMULA-MALISETTI, MD
ONCOLOGIST AND EXECUTIVE VICE PRESIDENT
MINNESOTA ONCOLOGY

Though it's very common for patients with cancer to be scared, physicians with cancer have a different level of fear because of their knowledge of the disease and potential outcomes. Many of Katipamula-Malisetti's physician patients are highly anxious because they have treated or seen patients going through end-of-life cancer care.

Katipamula-Malisetti is empathetic to everyone, of course, but with physicians she tries to provide data and other information to try to ease their anxiety. She shares her cell number and encourages fellow physicians to text or call directly with their questions and concerns. Katipamula-Malisetti also texts physician patients immediately when scans or test results come in. "This is a physician and my colleague, and I like to leave an open channel that I will always be available," she adds. "You have to go in with that compassion and understanding and remember that they are coming to you as a patient."

Stevens has gotten used to physicians being extra anxious both during their pregnancies and after their babies are born. That might mean being hypervigilant about the newborn's Apgar score or if the baby isn't crying much. "They can get wrapped up on specific data points. Sometimes it can be harder when you are a physician to take a step back and look at the bigger picture," she says. "When we've seen the worst outcomes, we can imagine those are going to happen to us and people are hyperaware of any change in symptoms or status. That's okay—I do the same things, too."

In these situations, Stevens tries to give that big picture perspective, providing assurance that everything is okay. She might share some of her own pregnancy and childbirth experiences to normalize physician patients' fears and put them at ease. And if she's seeing a fellow OB-GYN about a pregnancy, Stevens concedes that complications do tend to happen more often to physicians in their field.

"Classically, if you are an OB, most of us have something go wrong in pregnancy. We have stressful jobs and crazy hours, ultimately increasing risk of things like preterm labor and preeclampsia," Stevens says. "I acknowledge their fear and say, 'I know we're in the same line of work, but it's OK to still have questions. We can figure out a good plan together.'"

Armed with opinions

One common concern for physicians treating peers occurs—though not super often—when a physician patient questions their judgment. Some might push back on recommendations or opt to not follow advice. And then things can get awkward.

It's quite normal for physician patients to thoroughly investigate a topic and come into an appointment with strong opinions, Stevens says. However, they might interpret information in a different way than Stevens or lack broader context that comes from reading additional studies. "There is a danger in knowing too much and not quite enough," she adds.

When a patient has strong opinions about a specific concern, Stevens wants to explore where the worry is coming from and then address it. She might counsel patients by saying, "Here is what we know, and here is how we manage it. It might be different from what you remember from medical school or residency, but here is what we do to keep patients safe.'" And then they will work together on how to approach the individual's medical care.

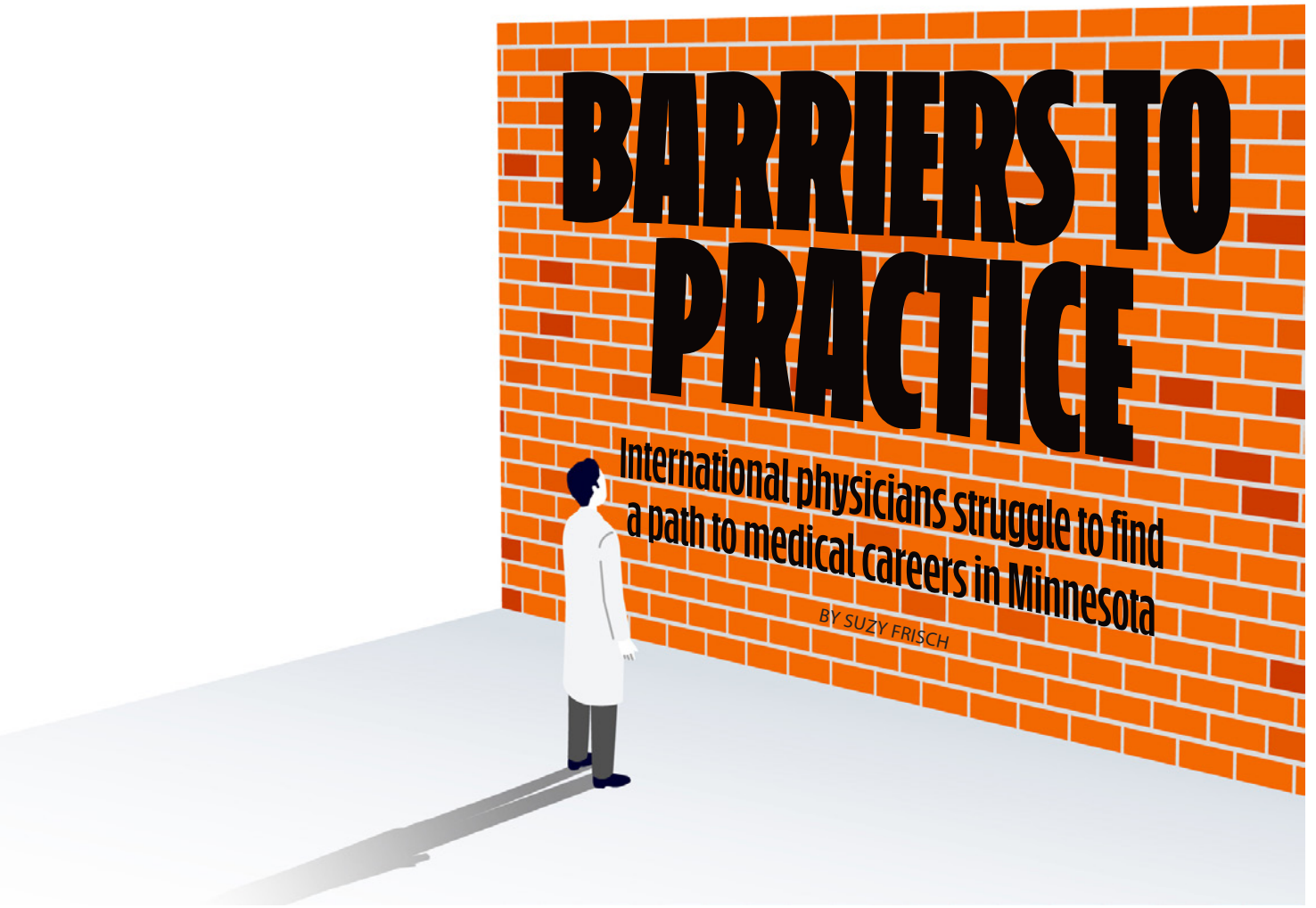
Though getting directly challenged has not happened to Farah, she knows that if a physician patient wanted to debate her suggested treatment plan, she would take it seriously, perhaps asking permission to discuss the case with a colleague. "I'd say, 'Thank you for the points. I will look into it and get back to you,'" Farah says. "These are my colleagues, and you do need to stay humble," she says.

It doesn't happen often, but West certainly has seen physician patients with strong opinions about their care. He then gently asks why the physician is seeking that specific test or medication. "When I'm feeling pushed in a direction, I might say, 'Tell me more about why you are concerned about this. Tell me a little more about why that test stands out to you'—in a nonchallenging way," he says. "There is context to this, and I need to understand it. Then the thing the person is suggesting may become more reasonable or perhaps more open to adjustment."

With that understanding, West and his physician patient can discuss options, based on evidence rather than gut feelings. When there is pushback, he also tries to remember the guidance of an advisor at Mayo. "Yes, the needs of the patient come first. But there's a reason it says the needs of the patient, not just the wants of the patient," West says. "We have to think about the bigger picture of balancing risks and benefits." MM

> "Physicians are an emotionally and intellectually rewarding population to treat because we understand each other's lives. A lot of time I can sort of cut to the chase and use their time slot more efficiently. I know that it must have been weeks if not months in advance that they blocked their schedule for this appointment. I find joy and pride in trying my best to make sure they have a good experience and don't feel like they've done anything wrong by seeking care or taking time for themselves."
>
> RONDA FARAH, MD
> DERMATOLOGIST
> M HEALTH FAIRVIEW
> MAPLE GROVE CLINIC
> FOUNDER AND DIRECTOR
> M HEALTH COSMETIC CENTER

Suzy Frisch is a Twin Cities freelance writer.



BARRIERS TO PRACTICE

International physicians struggle to find a path to medical careers in Minnesota

BY SUZY FRISCH

After years of trying to use her medical degree in the United States, Sehar Minhas, MBBS, was about to put her dream of being a physician to rest. It had been a long road since she graduated from medical school in Pakistan in 2013 and completed her year of internship training.

Minhas married her husband, a native Minnesotan, and came to the United States in 2014. She quickly passed the U.S. medical licensing exams but then had no luck matching with a residency program. She kept getting feedback that she didn't have enough hands-on clinical experience. But Minhas couldn't get that experience without being board-certified and covered by malpractice insurance, which is difficult to get unless you are a current medical student. A real catch-22.

In the meantime, Minhas participated in as many observerships as she could, worked as a research intern at the University of Minnesota, and earned her master's degree in hospital administration. Then she heard about a program at the university called the Bridge to Residency for Immigrant International Doctor Graduates through clinical Experience (BRIIDGE), applied, and got accepted in 2019

The nine-month program gave Minhas ample clinical experience, and she landed a pediatrics residency at the university. This summer, she started practicing as a pediatrician at Wayzata Children's Clinic in Chaska. "The time and effort and hard work it takes to get into medical school and get a medical degree, it's hard to give that up and do something else," Minhas says. "That's what kept me going."

"The time and effort and hard work it takes to get into medical school and get a medical degree, it's hard to give that up and do something else. That's what kept me going."

SEHAR MINHAS, MBBS, PEDIATRICIAN, WAYZATA CHILDREN'S CLINIC

Obstacles preventing practice

Finding a path to becoming a physician in the United States is no joke for people who are international medical graduates (IMG). The vast majority of physicians

from countries outside of the United States and Canada must complete at least one year of graduate clinical medical training at an Accreditation Council for Graduate Medical Education–accredited program before they can practice. Most end up doing a full residency, even if they already completed one in their home country and practiced for years.

These obstacles prompted State Sen. Alice Mann, MD, MPH, to propose an alternative path to practice. The legislation would allow IMG physicians to have a limited license, provided they are in good standing with at least five years of experience in the past decade. For two years, they would need to work in a rural or underserved urban area under the supervision of a practicing physician and hospital or clinic. After that, physicians would be eligible for full and nonrestricted licenses to practice in Minnesota.

Minnesota currently has about 250 to 300 physicians who can't work here because of residency requirements, Mann says. At the same time, the state is expected to be short 2,260 physicians by 2030, including 1,187 primary care doctors, according to the nonpartisan Cicero Institute. Rural areas are especially hard hit.

"I sponsored this bill because we have a national physician shortage, and we have qualified, seasoned physicians stocking shelves and driving buses in Minnesota. We are wasting human potential," Mann says. "By removing the residency requirements, we can get experienced physicians into the workforce and open up residency spots for new graduates who actually need the training. We also have a shortage of residency spots, so opening up those spots is very important."

"I sponsored this bill because we have a national physician shortage, and we have qualified, seasoned physicians stocking shelves and driving buses in Minnesota. We are wasting human potential."

ALICE MANN, MD, MPH
STATE SENATOR

The bill is similar to legislation recently passed by eight states, including Illinois, Iowa, and Wisconsin. The new laws provide IMG physicians who have been actively working for a set number of years a way to obtain a full medical license in that state, without needing to complete a residency in the United States. California and New York approved renewable limited licenses, while eight other states have considered similar bills, according to the Federation of State Medical Boards.

Mann introduced the bill in 2024; it passed out of a Senate committee but didn't make it to the House or Senate floor. She plans to try again in 2025. Mann believes that a selling point is the proposed structure, where IMG physicians work under a collaborative agreement with a supervising physician. During the two-year window, IMG physicians would have opportunities to get familiar with documentation, HIPAA laws, standards of care, medications, and more. "This will give them time to acclimate to the culture and laws of American medicine, while not repeating all of their medical training," Mann says.

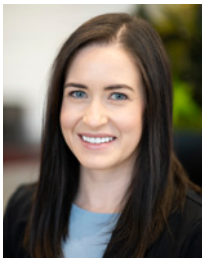
Several Minnesota Medical Association committees and the board have debated the bill and see its pros and cons. The MMA seeks a balance between utilizing this pool of available physicians while "ensuring that there is enough oversight and supervision so that we're protecting the public and holding up standards" during the two years of limited licensure, says Dave Renner, director of advocacy.

Some physicians, including those trained in other countries, expressed concern that medical education and training is not standardized around the world, Renner says. Two years of minimal supervision might not provide enough time or opportunity to meaningfully assess an individual's clinical skills. "Others have said, 'Wait a minute—you're putting people who have not had their clinical skills assessed to practice in rural areas. Does that somehow create a separate standard of care?' But then on the other side, is it better to have someone of unknown competency or nobody?" Renner says. "That's the push and pull of it."

"Others have said, 'Wait a minute—you're putting people who have not had their clinical skills assessed to practice in rural areas. Does that somehow create a separate standard of care?' But then on the other side, is it better to have someone of unknown competency or nobody? That's the push and pull of it."

DAVE RENNER, DIRECTOR OF ADVOCACY, MINNESOTA MEDICAL ASSOCIATION

"Quite a few of our members have voiced a real concern with allowing international medical graduates to practice in Minnesota without going through the required residency or fellowship process. This is because residency provides a standardized training and standardized assessment of clinical skills. Many of these same physician members have also voiced their support for finding ways to bring highly skilled and trained international medical graduates into the Minnesota workforce, but in a way that maintains Minnesota's high quality of care."



STEPH LINDGREN, JD, POLICY COUNSEL, MINNESOTA MEDICAL ASSOCIATION

"Quite a few of our members have voiced a real concern with allowing international medical graduates to practice in Minnesota without going through the required residency or fellowship process. This is because residency provides a standardized training and standardized assessment of clinical skills," says Steph Lindgren, JD, policy counsel for the Minnesota Medical Association. "Many of these same physician members have also voiced their support for finding ways to bring highly skilled and trained international medical graduates into the Minnesota workforce, but in a way that maintains Minnesota's high quality of care."

Pathways in action

The state has been working for some time to help IMG physicians find ways to practice in Minnesota. In 2015, the Legislature created the International Medical Graduate Program in the Minnesota Department of Health (MDH), designing a multi-pronged approach to mitigate the challenge.

The Legislature sought to address a growing need for healthcare workers, especially physicians. Then, there were about 200 internationally trained physicians living in Minnesota who couldn't practice in the state, says Zora Radosevich, director of the MDH Office of Rural Health. "The Legislature clearly saw that there was a workforce here and that we could probably find ways to encourage them to use their education in support of Minnesotans," she adds.

"The Legislature clearly saw that there was a workforce here and that we could probably find ways to encourage them to use their education in support of Minnesotans."

ZORA RADOSEVICH, DIRECTOR, OFFICE OF RURAL HEALTH, MINNESOTA DEPARTMENT OF HEALTH

The International Medical Graduate Program directs grants to nonprofits or colleges to provide career guidance and support to help IMG physicians enter the Minnesota workforce. It gives funds to the University and Minnesota healthcare systems to add residency slots for IMG physicians to train in rural and underserved areas. The program also funds clinical preparation programs like BRIIDGE, a nine-month program that aims to help international medical graduates develop the skills necessary to become successful residents. This year, BRIIDGE received additional funding from the Legislature because it's been effective at helping physicians secure the clinical experience they need to land residencies, says Ann Linde, MDH program administrator of healthcare and workforce development programs.

Currently, the International Institute of Minnesota is the state's nonprofit partner. It offers career support to help more IMG physicians practice in Minnesota, including career and academic advising, study and financial support for medical licensing exams, and peer support. Another key component provides networking opportunities to help IMG physicians develop the connections they need to get hands-on experience in the United States—essential to securing a residency. It also assists physicians who want to explore other healthcare jobs with shorter pathways to licensing, such as physician assistant or nursing.

So far, the International Institute has served 77 clients from 30 countries, with 10 people matching into residency programs, Linde says. The University and Hennepin Healthcare have been the main places IMG residents are training, in high-need areas like family medicine, internal medicine, pediatrics, OB-GYN, general surgery, and psychiatry, Linde says.

Programs like BRIIDGE are especially important when people are more than five years out of medical school. Then it's much more difficult to land a residency, even if they have work experience in another country, says Michael Westerhaus, MD,

assistant professor of medicine at the University and BRIIDGE codirector. During the program, participants get hands-on training in the University's hospitals and other community clinics, including direct patient care with supervision.

It's integral to have set time for physician preceptors to observe and guide the participating physicians, just as they do with medical students and residents. It's a key reason Westerhaus has some concerns about the proposed limited license legislation. "What we've learned in our program is that it's a talented group of people, but you cannot put all IMGs in the same bucket," he says. "Everyone has different levels of exposure to certain clinical situations. Some folks need lots and lots of hands-on work to get them to the level where we'd feel good about them practicing in Minnesota, and some are super ready to go."

Westerhaus and others recommend that Minnesota establish a mechanism for assessing the clinical readiness of physicians, based on milestones that medical students and residents must pass, before they can get the limited license. There also are concerns about the level of feedback and supervision that IMG physicians would receive. It takes time to provide such guidance—a big ask for busy working physicians, he says.

"So far, the International Institute has served 77 clients from 30 countries, with 10 people matching into residency programs. The University and Hennepin Healthcare have been the main places IMG residents are training, in high-need areas like family medicine, internal medicine, pediatrics, OB-GYN, general surgery, and psychiatry."

ANN LINDE, PROGRAM ADMINISTRATOR OF HEALTHCARE AND WORKFORCE DEVELOPMENT PROGRAMS, MINNESOTA DEPARTMENT OF HEALTH

Opening doors

Since BRIIDGE started in 2017, it has had 20 participants with 90% landing residencies. Six people who completed their residencies are now primary care providers in Minnesota. A current participant, Ericka Lara, MD, MPH, graduated from medical school in Costa Rica in 2013 and worked for two years as a primary care provider. Her work in rural Costa Rica fueled an interest in ear infections, prompting her to come to Minnesota to do research in otolaryngology. Lara earned a master's in public health from the University of Minnesota, then decided during the pandemic that she wanted to return to patient care. She explored being a medical assistant, nursing assistant, or nurse, which all had many steps to start working and none recognized her foreign medical degree. Lara decided to direct her efforts to being a physician, and that meant taking the medical licensing exams.

After passing in 2022, Lara quickly learned that her chances for residency were slim because of the time elapsed since medical school. She hopes the BRIIDGE program helps her achieve her goal to work as a physician in Minnesota. "Nothing is guaranteed—this is a leap of faith for all of us," Lara says. "It's a good stepping stone for getting back into practice and understanding the requirements and what is expected of you as a resident."

If she can match with a residency, she would like to continue working in primary care in a community with a large population of Latinos, as a native Spanish speaker and Latina herself. "I would want to be that doctor that can actually communicate with patients in their native language, where they feel valued and respected and can trust me because I understand their culture and their first language," says Lara, who speaks a total of six languages.

She knows there are more people like her—friends who are an anesthesiologist, OB-GYN, and cardiologist now working minimum wages jobs in Minnesota. "They

"What we've learned in our program is that it's a talented group of people, but you cannot put all IMGs in the same bucket. Everyone has different levels of exposure to certain clinical situations. Some folks need lots and lots of hands-on work to get them to the level where we'd feel good about them practicing in Minnesota, and some are super ready to go."

MICHAEL WESTERHAUS, MD, ASSISTANT PROFESSOR OF MEDICINE, UNIVERSITY OF MINNESOTA AND CODIRECTOR, BRIIDGE

"Immigrant physicians are all very experienced people in their late 30s and 40s who still have energy and passion for patient care and medicine, and they are very knowledgeable. I think we need to be paying more attention to this section of immigrants who are coming here and want to stay."

ERICKA LARA, MD, MPH, MEDICAL SCHOOL GRADUATE FROM COSTA RICA AND CURRENT BRIIDGE PARTICIPANT

are all very experienced people in their late 30s and 40s who still have energy and passion for patient care and medicine, and they are very knowledgeable," Lara says. "I think we need to be paying more attention to this section of immigrants who are coming here and want to stay."

Critics of the current situation complain about all the red tape needed to get licensed here. Physicians with credentials from other countries have to get board certified and get medical malpractice insurance, which they can't get their hands on without completing a residency in the U.S. And there just aren't enough slots for BRIIDGE or residencies to accommodate the demand. Demand far outstrips slots available for programs like BRIIDGE and other supports from the International Medical Graduate Program that improve odds for landing a residency. BRIIDGE has four spots annually, and there is no guarantee that its graduates will match into a residency program in the state.

In addition, Minnesota already has high demand for its residency programs, with 99% of available slots filled each year, making it tough for IMG physicians to compete. And then consider the international physicians with decades of experience in other countries who can't practice without a license from Minnesota. The notion of starting completely over, with the rigorous training demanded by a residency, is often insurmountable.

Given these shortcomings, Mann will continue championing the limited license legislation because the state needs another mechanism to help more IMG physicians get to work in Minnesota.

Says Mann, "The IMG program provides intensive nine months of clinical supervision for IMGs in Minnesota to prepare them for residencies. It does not remove the residency requirement. That's the difference and why the bill is necessary. We are talking about doctors who have practiced medicine for many years. Making them go backwards to do at least three years of training is unnecessary."

Rahel Nardos, MD, MCR, a urogynecologist and associate professor of obstetrics, gynecology, and women's health at the University, attended college and medical school in the United States as an immigrant from Ethiopia. When it came time to apply to residency programs, she was in luck as a green card holder married to an American citizen. Still, Nardos knows many immigrant physicians with years of experience in other countries who have struggled to land residencies, as well as people who were surgeons now working in primary care because that was the training they could get.

Nardos would like to see a path for immigrant physicians to have a trial period where they are observed and assessed before transitioning into practice. Then they can serve people from Minnesota's diverse communities. "We are losing that opportunity for diversity. And also, this is why we don't have a lot of doctors who look like the populations we serve," Nardos says. "There is a lot of evidence that patients do best when they are seeing doctors who look like them. There are very few people who look like me serving the East African community. The reasons we don't are because of all the layers and hardships they have to overcome to get to this point."

And if the path for international physicians to practice in the state wasn't so fraught and cumbersome, Minnesotans would have access to a host of physicians using all of their expertise and talent. Says Nardos, "I know amazing OB-GYN surgeons who are primary care doctors—this is the best-case scenario—and some who move here and become taxi drivers." **MM**

Suzy Frisch is a Twin Cities freelance writer.

"There is a lot of evidence that patients do best when they are seeing doctors who look like them. There are very few people who look like me serving the East African community. The reasons we don't are because of all the layers and hardships they have to overcome to get to this point."

RAHEL NARDOS, MD, MCR, UROGYNECOLOGIST AND ASSOCIATE PROFESSOR OF OBSTETRICS, GYNECOLOGY, AND WOMEN'S HEALTH, UNIVERSITY OF MINNESOTA

YOUR MEMBERSHIP EXPIRES 12/31

DON'T LET YOUR MINNESOTA MEDICINE SUBSCRIPTION LAPSE

MINNESOTA MEDICAL ASSOCIATION

Renew today!

mnmed.org/renew

612-362-3728

Case report: Multifocal stroke in the setting of nonbacterial thrombotic endocarditis with rare association to rheumatoid arthritis

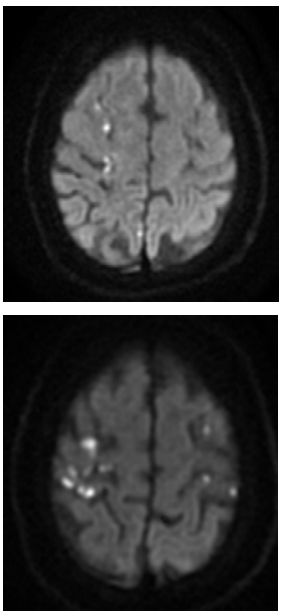
Much remains to be learned about the uncommon and complex relationship between nonbacterial thrombotic endocarditis, rheumatoid arthritis, and anticoagulation.

BY MEGAN KINDOM, MD; JOHN MCCABE, MD

This case report highlights the management of nonbacterial thrombotic endocarditis (NBTE) and the rare relationship between NBTE and rheumatoid arthritis. A 54-year-old female with a known history of rheumatoid arthritis and prior deep vein thrombosis on rivaroxaban presented to the emergency department with stroke symptoms. She was subsequently found to have multifocal embolic strokes with an echocardiogram showing NBTE. There is minimal literature on appropriate anticoagulation with NBTE. Heparin is considered first line since direct oral anticoagulants have not been thoroughly studied in NBTE. For this patient, enoxaparin with bridging to warfarin was recommended. Finally, this report discusses the unclear pathogenesis between rheumatoid arthritis and NBTE.

FIGURE 1

Magnetic resonance image of the brain showing multifocal bilateral acute infarcts



Introduction

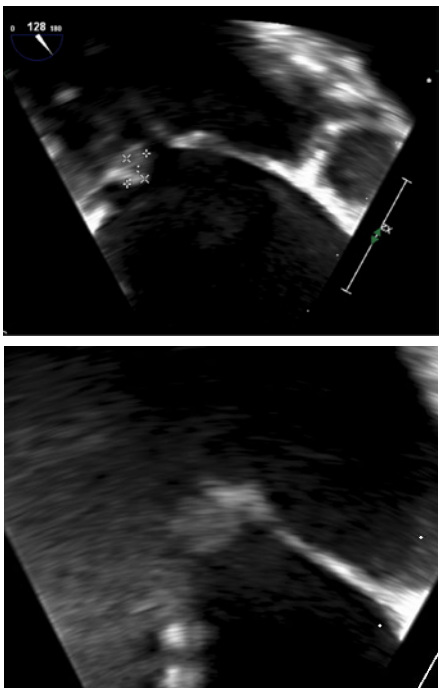
Nonbacterial thrombotic endocarditis, also known as Libman-Sacks endocarditis, is a condition where noninfectious vegetations attach to heart valves. This typically presents in malignancy or systemic lupus erythematosus; it is rarely associated with rheumatoid arthritis[2]. In this case NBTE occurred in a patient with rheumatoid arthritis who was anticoagulated for previous deep vein thrombosis and known genetic hypercoagulability. There are few case reports that discuss occurrences of NBTE while anticoagulated or of cases of NBTE secondary to rheumatoid arthritis.

Case report

The patient is a 54-year-old female on rivaroxaban for a history of deep vein thrombosis, heterozygous prothrombin gene mutation, and on chronic steroids for rheumatoid arthritis. She has a history of substance abuse but denied any history of IV drug use. She initially presented

FIGURE 2

Transesophageal echocardiogram pictures depicting multiple small vegetations/masses on atrial side of mitral valve. Appearance ("kissing" lesion) is suggestive of Libman-Sacks/nonbacterial thrombotic endocarditis.



with left-sided weakness and sensation changes. Vital signs were notable only for mildly elevated blood pressure. On physical exam she had a significant decrease in her left-hand grip strength and a left upper extremity pronator drift. Computed tomography (CT) of the head was negative in the emergency department for any acute pathology, but a subsequent magnetic resonance image (MRI) showed extensive multifocal bilateral acute infarcts (Figure 1). Because of length of time from symptom onset to presentation, the patient was not a candidate for thrombolytic intervention.

On admission to the hospital, a more detailed physical exam was completed, and a heart murmur heard most clearly at the midclavicular fifth intercostal space was noted. Multiple splinter hemorrhages were seen on her hands and feet. A transesophageal echocardiogram was done and showed two "kissing" echogenic masses on the mitral valve and a patent foramen ovale (Figure 2). Drake criteria (to determine the probability or likelihood of infective endocarditis) suggested nonbacterial thrombotic endocarditis rather than infective endocarditis based on echocardiogram findings, vascular manifestations, and immune manifestations (Table 1). Blood cultures were drawn (total of six during her admission) and antibiotics initiated. Blood cultures remained negative except for one that grew *Staphylococcus epidermidis*, considered to be a contaminant. In consultation with neurology, hematology, and vascular medicine, nonbacterial thrombotic endocarditis with emboli showers was thought to be the most likely etiology of her presentation. Because patient was on a direct oral anticoagulant therapy when her symptoms occurred, she was placed on Lovenox with plans to transition to warfarin after documented improvement in vegetations. She was discharged from the hospital on enoxaparin with plans to repeat a transesophageal echocardiogram in one month.

Outpatient follow up was challenging. Flight from domestic abuse and consequent housing insecurity, financial restraints, and transportation limitations significantly impeded coordinated follow up with subspecialty consultants. However, with help from a local women's shelter, county public health workers, and our clinic health equity coordinator, we were able to secure reliable transportation, safe housing, and coordinate her complicated medical course. A follow-up transesophageal echocardiogram one month later surprisingly showed no improvement in patient's vegetations. Vascular medicine was reconsulted and transition to warfarin with a goal INR of 2–3 was recommended. The echocardiogram two months later, three months from initial presentation, showed a significant decrease of the vegetations. Ongoing monitoring includes transesophageal echocardiogram every 6–12 months until vegetations have completely resolved and lifelong warfarin therapy.

TABLE 1

Modified Drake Criteria. Depicts the criteria and components to determine possibility of infective endocarditis[4]

DEFINITE INFECTIVE ENDOCARDITIS	POSSIBLE INFECTIVE ENDOCARDITIS	REJECTED
• Pathological criteria: either microbiologic or histopathologic. Both refer to samples from the actual vegetation, cardiac tissue, embolus, or valve. • Or clinical criteria of 2 major criteria, 1 major + 3 minor, or 5 minor (see below)	• 1 major and 1 minor • 3 minor	• Alternate diagnosis • Sustained resolution of symptoms after < 4 days of antibiotics • No evidence on autopsy after < 4 days of antibiotics

MAJOR CRITERIA	MINOR CRITERIA
Positive blood cultures isolated from 2 or more sets	Predisposition: previous history of IE, prosthetic valve, previous valve repair, congenital heart disease, previous valve disease (greater than mild), HOCM, IV drug use, endovascular CIED
Positive PCR for atypical organisms	Fever
Echocardiogram and/or cardiac CT demonstrating a vegetation, aneurysm, perforation, or abscess	Vascular manifestations: arterial emboli, septic pulmonary infarcts, cerebral or splenic abscess, intracranial hemorrhage, mycotic aneurysm, conjunctival hemorrhages, Janeway lesions
New partial dehiscence of prosthetic valve	Immunologic phenomena: positive rheumatoid factor, Osler nodes, Roth spots, immune complex mediated glomerulonephritis
Evidence of IE as seen during cardiac surgery	Positive blood cultures or PCR not meeting major criteria
[18F]-FDG PET/CT imaging showing abnormal metabolic activity in a prosthetic valve or material	New valvular regurgitation on physical exam

Discussion

While the true pathogenesis of NBTE is unclear, it is known that inflammation plays a role. NBTE vegetations are comprised of platelet aggregates and fibrin. These vegetations are sterile and mostly found in malignancy or systemic lupus erythematous, both accounting for over 80% of cases. NBTE lesions are more likely to become dislodged than vegetations in infectious endocarditis because of less inflammatory reaction at the valve attachment site. This results in higher rates of embolization and infarction. Presentation varies and many cases are unfortunately discovered during autopsy. NBTE should be suspected in a patient with valvular vegetations, lack of systemic infectious signs, and multiple embolic strokes to numerous organs[2]. Our patient's case was particularly interesting in that she suffered a multifocal stroke due to NBTE

while anticoagulated with rivaroxaban. Direct oral anticoagulants have not been extensively studied in this clinical role; this report and a few similar cases further probe the question of their efficacy[1]. After malignancy the next most common etiology of NBTE is systemic lupus erythematosus and other rheumatologic diseases. In rheumatoid arthritis (RA), many pro-inflammatory cytokines are increased, including interleukin-6, interleukin-8, and tumor necrosis factor-alpha. A study of 30 patients with NBTE at Mayo Clinic from 1985 to 2000 found that only two patients had RA. It is known that RA increases risk for many cardiovascular diseases but the relationship to endocarditis is not well known[3].

The management of NBTE involves anticoagulation, treatment of underlying disease, and surgery if indicated[5]. The coordination of care between many specialists is complex and can be significantly impacted by social determinants of health without help from the efforts of an extensive, dedicated team.

Conclusion

The relatively uncommon and complex relationship between NBTE, rheumatoid arthritis, and anticoagulation leaves many questions. What is the appropriate anticoagulation for properly treating NBTE? How do we further evaluate the relationship between rheumatoid arthritis and NBTE? What is the best way to coordinate this complex care with multiple specialties? Ideally, this case report will spur further investigation into these concerns and questions to provide more efficacious and safe medical care in the future for patients with NBTE. **MM**

Megan Kindom, MD, is a Mayo Clinic Mankato family medicine resident—PGY2. John McCabe, MD, is Mayo Clinic Mankato family medicine residency associate director.

REFERENCES

1 Basnet, S, Stauffer, T, Jayswal, A, and Tharu, B. (2020). Recurrent nonbacterial thrombotic endocarditis and stroke on anticoagulation. Journal of Community Hospital Internal Medicine Perspectives, 10(5), 466–469. https://doi.org/10.1080/20009666.2020.1791028

2 Bauer, K. (2022, October 31). Nonbacterial thrombotic endocarditis. UpToDate. https://www.uptodate.com/contents/nonbacterial-thrombotic-endocarditis?search=Nonbacterial%20thrombotic%20endocarditis&source=search_result&selectedTitle=1~23&usage_type=default&display_rank=1

3 Choi, J-H, Park, J-E, Kim, J-Y, and Kang, T. (2016). Nonbacterial thrombotic endocarditis in a patient with rheumatoid arthritis. National Library of Medicine, 425–428. https://doi.org/10.4070/kcj.2016.46.3.425

4 Chu, V, and Wang, A. (2023, September 28). Clinical manifestations and evaluation of adults with suspected left-sided native valve endocarditis. UpToDate. https://www.uptodate.com/contents/clinical-manifestations-and-evaluation-of-adults-with-suspected-left-sided-native-valve-endocarditis?search=dukes%20criteria§ionRank=1&usage_type=default&anchor=H1380899019&source=machineLearning&selectedTitle=1~17&display_rank=1#H1380899019

5 Tamura, Y, Sakata, K, Terada, K, Usui, S, Kawashiri, M, and Takamura, M. (2021). Treatment with a direct oral anticoagulant for nonbacterial thrombotic endocarditis. Internal Medicine, 60(12), 1881–1885. https://doi.org/10.2169/internalmedicine.6368-20

UNITED STATES POSTAL SERVICE®

Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

1. Publication Title	2. Publication Number	3. Filing Date
MINNESOTA MEDICAL ASSOCIATION - MINNESOTA MEDICINE	351900	09/18/2024
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 *(Not printer) (Street, city, county, state, and ZIP+4®)*
3433 BROADWAY ST NE, STE 187
MINNEAPOLIS, MN 55413-2199
Contact Person: DAN HAUSER
Telephone *(Include area code)*: (612) 378-1875

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
3433 BROADWAY ST NE, STE 187
MINNEAPOLIS, MN 55413-2199

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*
Publisher *(Name and complete mailing address)*
MINNESOTA MEDICAL ASSOCIATION
3433 BROADWAY ST NE, STE 187, MINNEAPOLIS, MN 55413-2199
Editor *(Name and complete mailing address)*
GREG BREINING
3433 BROADWAY ST NE, STE187, MINNEAPOLIS, MN 55413-2199
Managing Editor *(Name and complete mailing address)*
GREG BREINING
3433 BROADWAY ST NE, STE187, 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 the 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 ST NE STE 187 MINNEAPOLIS, MN 55413-219

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☑ None

Full Name	Complete Mailing Address

12. Tax Status *(For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ 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**, July 2014 *[Page 1 of 4 (see instructions page 4)]* PSN: 7530-01-000-9931 **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: 09/01/2024	
15. Extent 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 Number of Copies *(Net press run)*		3761	**3438**
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)	3503	3157
	(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), and (4)]*		3503	3157
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	48	60
	(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)*	88	104
e. Total Free or Nominal Rate Distribution *(Sum of 15d (1), (2), (3) and (4))*		136	164
f. Total Distribution *(Sum of 15c and 15e)*		3639	3321
g. Copies not Distributed *(See Instructions to Publishers #4 (page #3))*		123	117
h. Total *(Sum of 15f and g)*		3762	3438
i. Percent Paid *(15c divided by 15f times 100)*		96.26%	95.06%

* If you are claiming electronic copies, go to line 16 on page 3. If you are not claiming electronic copies, skip to line 17 on page 3.

PS Form **3526**, July 2014 *(Page 2 of 4)*

UNITED STATES POSTAL SERVICE®

Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

16. Electronic Copy Circulation	Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Paid Electronic Copies	0	0
b. Total Paid Print Copies (Line 15c) + Paid Electronic Copies (Line 16a)	3503	3157
c. Total Print Distribution (Line 15f) + Paid Electronic Copies (Line 16a)	3639	3321
d. Percent Paid (Both Print & Electronic Copies) (16b divided by 16c × 100)	96.26%	95.06

☐ **I certify that 50% of all my distributed copies (electronic and print) are paid above a nominal price.**

17. Publication of Statement of Ownership
☑ If the publication is a general publication, publication of this statement is required. Will be printed in the 11/1/24 issue of this publication. ☐ Publication not required.

18. Signature and Title of Editor, Publisher, Business Manager, or Owner	Date
DAN HAUSER - BUSINESS MANAGER	09/18/2024

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**, July 2014 *(Page 3 of 4)* **PRIVACY NOTICE:** See our privacy policy on *www.usps.com*.

UNITED STATES POSTAL SERVICE®

Statement of Ownership, Management, and Circulation (All Periodicals Publications Except Requester Publications)

1. Publication Title: MINNESOTA MEDICAL ASSOCIATION - MINNESOTA MEDICINE; 2. Publication Number: 351900; 3. Filing Date: 09/18/2024
4. Issue Frequency: BI-MONTHLY; 5. Number of Issues Published Annually: 6; 6. Annual Subscription Price: $45.00
7. Complete Mailing Address of Known Office of Publication (Not printer) (Street, city, county, state, and ZIP+4®): 3433 BROADWAY ST NE, STE 187 MINNEAPOLIS, MN 55413-2199; Contact Person: DAN HAUSER; Telephone (Include area code): (612) 378-1875
8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not printer): 3433 BROADWAY ST NE, STE 187 MINNEAPOLIS, MN 55413-2199
9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do not leave blank)
Publisher: MINNESOTA MEDICAL ASSOCIATION 3433 BROADWAY ST NE, STE 187, MINNEAPOLIS, MN 55413-2199
Editor: GREG BREINING 3433 BROADWAY ST NE, STE187, MINNEAPOLIS, MN 55413-2199
Managing Editor: GREG BREINING 3433 BROADWAY ST NE, STE187, MINNEAPOLIS, MN 55413-2199
10. Owner: MINNESOTA MEDICAL ASSOCIATION, 3433 BROADWAY ST NE STE 187 MINNEAPOLIS, MN 55413-219
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☑ None
12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates) (Check one)
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☑ 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, July 2014 [Page 1 of 4 (see instructions page 4)] PSN: 7530-01-000-9931 PRIVACY NOTICE: See our privacy policy on www.usps.com.

MEDPAC

KEEP ORGANIZED MEDICINE ENGAGED ON THE CAMPAIGN TRAIL AND AT THE CAPITOL

Support MEDPAC today!

MEDPAC, the political action committee of the MMA:

- **Endorses** pro-medicine candidates for state office
- **Contributes** to the campaigns of endorsed candidates
- **Generates** grassroots action
- **Recommends** candidates for national office to AMPAC, the AMA's political action committee

Why join MEDPAC?

As an integral part of the MMA's advocacy efforts, MEDPAC enhances organized medicine's ability to affect the political atmosphere at the Capitol. MEDPAC works tirelessly to elect candidates who support our policy positions, then continues to work with elected officials on behalf of physicians and patients throughout their elected terms.

Contributors to MEDPAC receive regular updates from the MMA's lobbyists during the legislative session. These exclusive "behind the scenes" updates offer a special glimpse into the action at the Capitol.

How does MEDPAC make decisions?

MEDPAC is governed by a Board of Trustees made up of physicians, residents, and medical students from around the state and from across the political spectrum, and physicians from all types of practices. Contributions and endorsements are based on a candidates' position on issues identified by the MMA as critical to physicians and patients.

Thank you MEDPAC contributors!

David Agerter, MD
Robert Aby, MD
Macaran Baird, MD
John Bohman, MD
Aleta Borrud, MD
David Bucher, MD
Magda Bushara, MD
Lindsey Chmielewski, MD
Lynn Cornell, MD
Patrick Crowley, DO
Stephen Darrow, MD
Dale Dobrin, MD
David Estrin, MD
Pamela Fisher, MD
Carol Grabowski, MD
Joel Greenwald, MD
Mark Holm, MD
Dania Kamp, MD
Robert Koshnick, MD
Kathryn Kramer, MD
Kimberly Krohn, MD
Mary Lawrence, MD
Lisa Mattson, MD
Catherine McGinnis, MD
Benjamin Meyer, MD
Robert Nesheim, MD
William Nicholson, MD
Marilyn Peitso, MD
Randy Rice, MD
Laurel Ries, MD
Kenneth Ripp, MD
George Schoephoerster, MD
Amrit Singh, MBBS
David Smith, MD
Angela Smithson, MD, MPH
Keith Stelter, MD
Benjamin Whitten, MD

Support MEDPAC today!

Dr. Glaucomflecken entertains conference-goers with his hilarious take on the state of healthcare today.

Beth Kangas, PhD, (left), executive director of the Zumbro Valley Medical Society, and Dionne Hart, MD, enjoy the show.

Medical students Mary Lang (left) and Roma Sonik share a laugh.

Dr. Glaumcoflecken received a standing ovation for his keynote.

The conference took place at the American Swedish Institute with its iconic Turnblad Mansion.

EMPOWERING PHYSICIANS CONFERENCE 2024

Physicians and physicians-in-training gather for education, networking, and laughter

PHOTOGRAPHY BY KATHRYN FORSS

This year's Empowering Physicians Conference offered a mix of skills-building, humor, and a look at the future of medicine in Minnesota.

The event, held September 27 at the American Swedish Institute in Minneapolis, attracted more than 150 physicians and physicians-in-training.

The conference kicked off with a look at innovations in medicine, beginning with Michael Pitt, MD, FAAP, the CEO and founder of Q-rounds, a virtual queue that sends real-time notifications of when to arrive for rounds.

The innovation session also included presentations by:

- Joshua Degallier, MD, the creator of Roundr, a mobile app that provides physicians with intuitive note-taking and charting features, designed to enhance their efficiency and improve patient care.
- L. Pearce McCarty III, MD, MBA, a co-founder of DOCSI, a company devoted to developing digital tools that lower cost and improve operations in surgical procedural environments at scale.
- Yingling Fan, PhD, a cofounder of the technology startup Daynamica, which has developed smartphone apps to collect human behavior and well-being data for academic institutions and government agencies. Fan was joined by Anne Blaes, MD, MS, Julian Wolfson, PhD, and Guang Yang, PhD.

Following the innovations session, attendees took part in a hands-on, skills-building workshop with Danielle Hansen, MBA, vice president of global sourcing—direct materials for JBT Corporation, a global food tech company. Hansen is

The conference featured a session on innovations in medicine including: Julian Wolfson, PhD (left); Guang Yang, PhD; Michael Pitt, MD, FAAP; Yingling Fan, PhD; Joshua Degallier, MD; and L. Pearce McCarty III, MD, MBA. Not pictured: Anne Blaes, MD, MS.

part of the Carlson Educator Network and has taught supply chain and operations management as a senior lecturer at the University of Minnesota Carlson School of Management.

After the workshop, attendees reviewed posters featuring research by medical students, residents, and fellows.

Danielle Hansen, MBA, led a session on negotiating contracts.

The day concluded with dinner, an address from incoming MMA president, Edwin Bogonko, MD, MBA, and a keynote speech by social media star Dr. Glaucomflecken (aka Will Flanary, MD), who offered his hilarious take on the future of healthcare. Flanary, who practices ophthalmology in the Portland, Oregon, area, has become known for his satiric medical videos on X/Twitter, TikTok, and YouTube.

He joked about the frustrations of dealing with prior authorization as well as providing insight on some of his own health scares as a patient. After speaking for more than an hour, he took questions from the audience, offered to help use his social media platforms to promote future legislation that could improve the practice of medicine in Minnesota, and then stood for selfies with attendees.

The premier conference sponsor was Copic. Exhibitors included: Abbott; Amgen; Be Smart; Concentra; Dexcom; MedPAC; Meridian Behavioral Health; Minnesota Rare Disease Advisory Council; Minnesota Alliance on Problem Gambling; MMA Foundation; Pfizer; Physicians for a National Health Program, Minnesota; RoundtableRx; Twin Cities Pain Clinic; VITAL WorkLife; and WeCare. MM

New MMA President Edwin Bogonko, MD, MBA, addresses his fellow members.

Medical student Caleb Grenko (right) explains his poster on neural networks.

Medical Student Leadership Award winner Rashika Shetty (right) poses with Angela Cao.

News Briefs

New MMA leadership emerges from August elections


Lisa Mattson, MD, FACOG


Amrit Singh, MBBS

Lisa Mattson, MD, FACOG, has been elected as the MMA's president-elect in this year's leadership election, which was held electronically in August.

Amrit Singh, MBBS, was re-elected as a trustee. He also serves as the board's secretary-treasurer.

Hunter Cantrell won the contested election for the medical student trustee.

Two incumbent members of the Minnesota delegation to the AMA were also reelected: JP Abenstein, MD, delegate, and Laurel Ries, MD, alternate delegate.

Board member terms began October 1, and AMA delegation terms begin January 1. This year's ballot also included a board-recommended change to MMA articles of incorporation and bylaws. The proposed bylaws change was approved 85% to 15%.

The change grants the board the authority to amend bylaws with a majority vote, subject to an advance 30-day member notice and comment period. This change aligns with governance best practices that place authority for bylaws changes with organization fiduciaries, which in MMA's case are the elected trustees and officers.

MMA honors physicians, physicians-in-training, advocates

Four physicians, two physicians-in-training, a state representative, and the Minnesota Rare Disease Council 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.


David Estrin, MD, and MMA Board Chair Kimberly Tjaden, MD

David Estrin, MD, of Golden Valley, received the MMA's highest honor, the Distinguished Service Award, for his years of service to the association and to medicine.

Natalia Dorf Biderman, MD, SFHM, and **Colin West**, MD, PhD, received the MMA's President's Award, which recognizes those who have given much of their free time to help improve the association.


Colin West, MD, PhD, and Natalia Dorf Biderman, MD, SFHM


Rashika Shetty


Jack McHugh, MB BCh, BAO


Beverly Razon of Copic, Tori Bahr, MD, and George Schoephoerster, MD


State Rep. Tina Liebling


Erica Barnes (center) and Maureen Alderman of the Minnesota Rare Disease Advisory Council

Rashika Shetty 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. Shetty is a third-year med student at the University of Minnesota.

Jack McHugh, MB BCh, BAO, 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. McHugh is based in Rochester.

Tori Bahr, MD, 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.

State Rep. **Tina Liebling**, of Rochester, received the James H. Sova Memorial Award for Advocacy. Sova was the chief lobbyist for the MMA from 1968 until the time of 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.

The Eric C. Dick Memorial Health Policy Partner Award was given to the **Minnesota Rare Disease Advisory Council**. This award is given to an individual, group of individuals, a project, or an organization that demonstrates a commitment to pursuing sound public policy, building coalitions, 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.

Well-being protection put into place on August 1

Since August 1, Minnesota's health system credentialing applications have been prohibited from inquiring about an applicant's past health conditions.

This protection is part of the MMA's well-being legislative package, a top MMA priority in the 2024 legislative session. The MMA has long argued that these questions have no impact on a person's ability to practice and too often discourage physicians from seeking treatment.

Additionally, the 2024 law now requires that participation in the MMA's SaveHaven program be confidential. Through MMA's SafeHaven program, physicians may seek and obtain confidential care for career fatigue and well-being.

The program provides a full suite of resources for career fatigue and work-life balance; as of August 1, participation in it is protected from discovery, subpoena, or reporting to the licensing board, unless the person voluntarily provides for written release of the information or disclosure is required to meet a licensee's obligation to report under Minnesota statute. This is related to reporting conduct that the person believes constitutes a grounds for discipline or a licensee's ability to engage safely in the practice of medicine.

The MMA's SafeHaven program (www.mnmed.org/resources/safehaven) aims to support physicians and their family as they navigate the demands of work and life. In partnership with VITAL WorkLife, the program offers clinician peer coaching, virtual or in-person counseling, work-life concierge services, access to the VITAL WorkLife App, and more.

To test the concept, the MMA subsidized the majority of the costs of the program for a pilot period. A limited number of subsidized spots are still available for $99 for a subscription good through the end of the year.

MMA sponsors health equity conference in Washington

In August, the MMA sponsored and attended a national conference on issues of diversity, equity, and inclusion in healthcare in Washington, D.C.

The Mayo Clinic-hosted RISE for Equity: Reflect, Inspire, Strengthen, and Empower included hundreds of healthcare professionals.

The conference covered topics such as using data and digital tools to advance belonging, systematically addressing social drivers of health, restorative justice, disparities in LGBTQ+ health, AI as an equity accelerant, and many more.

Haley Brickner, MMA's health equity coordinator, staffs a booth at a Washington, D.C. conference on health equity.

The conference included keynotes, fireside chats, and breakout sessions.

MMA wins award for its advocacy efforts

The MMA received an advocacy award in August for its Health Policy and Advocacy Elective that it created with the University of Minnesota Medical School in 2021.

The course, which is offered to fourth-year medical students, offers medical students a hands-on opportunity to learn more about health policy and advocacy, and learn how the MMA functions as the unified voice of physicians and physicians-in-training for advancing the practice of medicine, the profession, and patient health.


Mandy Rubenstein, MMA's director of membership and engagement (right), receives the POE award from AAMSE President Catherine Johannesen.

Course directors include Juliana Milhofer, JD, MMA's public health and policy engagement manager, and David Power, MD, MPH, professor and director of family medicine and community health medical student education at the University of Minnesota Medical School.

The primary objective of the course is to create a mode of exposure to health policy and advocacy for medical students—outside of what is included in the traditional medical school curriculum. Health policy and advocacy have not been traditionally included in the medical curriculum in any significant way. This limited exposure has begun to become apparent to medical students who want to be able to connect the care they were providing their patients in the clinic with the social drivers outside the clinic that influence health outcomes.

The advocacy award presentation was part of the American Association of Medical Society Executives' (AAMSE) annual conference held July 31 to August 2 in Savannah, Ga.

AAMSE's Profiles of Excellence awards, which acknowledge the work of medical societies that make positive impacts on their members and in their communities, are handed out annually in the categories of advocacy, education, membership, leadership, communications, and diversity, equity, and inclusion.

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 board member joins national psychiatric board

MMA Board of Trustee member Dionne Hart, MD, has been named as a trustee to the American Psychiatric Association (APA) Board of Trustees. She is the first Mayo Clinic–trained female physician and person of color elected to the board.


Dionne Hart, MD

Hart, a graduate of the Mayo Clinic Psychiatry Residency Program, is also the first Black woman elected to the MMA's board and to serve as president of the Zumbro Valley Medical Society.

As an APA trustee, Hart's priorities will include expanding access to mental healthcare for underserved patient populations including rural, minoritized, and justice-involved communities throughout the nation.

MMA board adopts policies on collective bargaining, PFAS

The MMA Board of Trustees adopted two policies at its July meeting—one supporting the right of physicians and physicians-in-training to take part in collective bargaining, which was proposed by the MMA Policy Council, and another advocating for phasing out the manufacture and commercial use of per- and polyfluoroalkyl substances (PFAS), which was proposed by the MMA Public Health Committee.

Prior to the Board action, both policies were routed for member input and comment via The Pulse, the MMA's online policy tool. For the collective bargaining proposal, 87% of Pulse participants voted yes, 9% voted no, and 4% were neutral. For the PFAS proposal, 96% of Pulse participants voted yes for the proposal, 1% voted no and 3% were neutral.

The adopted collective bargaining policy is as follows: "The MMA supports the right of physicians and physicians-in-training to engage in collective bargaining, including physician unionization, and supports the expansion of the number of physicians and physicians-in-training eligible for that right under state and federal law."

The adopted PFAS policy is as follows: "Per- and polyfluoroalkyl substances (also known as PFAS), defined as any substance that contains at least one fully fluorinated methyl (CF3-) or methylene (-CF2-) carbon atom (without any H/Cl/Br/I attached to it), have health impacts from environmental and manufacturing exposure. The MMA acknowledges the efforts that have been taken to position Minnesota as a national leader in PFAS pollution prevention. The MMA encourages Minnesota to continue to take the steps necessary to ensure that PFAS exposure is reduced in the environment and in consumer goods. As such, the MMA supports the phase-out of PFAS and similar 'forever chemicals' from manufacturing and processing of goods. To raise awareness of the health impacts of PFAS, the MMA will disseminate evidence-based resources to physicians and their patients."

MEDPAC makes endorsements for 2024 election cycle

All 134 seats of the Minnesota House of Representatives are up for election November 5. The board of directors for MEDPAC, the political arm of the MMA, recently voted to endorse 12 incumbent candidates for reelection, including:

Rep. Jeff Backer (R) for House District 9A
Rep. Kristen Bahner (DFL) for House District 37B
Rep. Dave Baker (R) for House District 16A
Rep. Robert Bierman (DFL) for House District 56A
Rep. Ned Carroll (DFL) for House District 42A
Rep. Steve Elkins (DFL) for House District 50B
Rep. Mike Freiberg (DFL) for House District 43B
Rep. John Huot (DFL) for House District 56B
Rep. Tina Liebling (DFL) for House District 24B
Rep. Matt Norris (DFL) for House District 32B
Rep. Dave Pinto (DFL) for House District 64B
Rep. Liz Reyer (DFL) for House District 52A

The MEDPAC board is made up of physicians, residents, and medical students from around the state and from across the political spectrum and various types of specialties and practices. MEDPAC receives no money from the MMA or from MMA member dues and is supported by voluntary contributions from individuals. For more information on MEDPAC, please visit www.mnmed.org/advocacy/MEDPAC.

MMA code of conduct ensures all are welcome

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

FROM THE CEO

An election with a Minnesota twist

Ah, campaign season! That glorious time of year when political ads inundate our screens, candidates make bold promises, and we aggressively screen phone calls and text messages. And this year's campaign season, particularly for the office of U.S. president, is unlike any we have ever seen.

I was a young college student the last time a Minnesota politician, Walter Mondale, was on a presidential ticket. I distinctly remember a sense of pride in seeing a fellow Minnesotan running for the top office. When Vice President Kamala Harris selected Gov. Tim Walz to be her running mate, I felt a similar sense of pride. Minnesotans love finding the Minnesota connection to famous people, events, or news stories. With the presidential campaign, Minnesota was suddenly in the national, and international, spotlight on a near-daily basis.

As I write this column, the election is still more than a month away. Healthcare issues have been critical topics of debate in this election, both locally and nationally. Healthcare issues will, and should, continue to dominate public policy debates, regardless of the election outcome. Healthcare touches everyone's life and pocketbook. Nationally, healthcare spending accounts for more than 17% of the national economy and exceeds $60 billion in Minnesota.

At the same time, the return on the dollars invested continues to underwhelm. The U.S. ranked a distant 10th (and last) in a recent study comparing the performance of health systems in 10 countries in five areas—access to care, care process, administrative efficiency, equity, and health outcomes (The Commonwealth Fund. *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System: Comparing Performance in 10 Nations*, September 2024).

Relatively speaking, Minnesota has much to be proud of in terms of healthcare. According to America's Health Rankings, Minnesota ranks fifth in overall health, with notable persistence of racial inequities and a high prevalence of excessive drinking (*2023 Annual Report,* United Health Foundation). In 2024, Minnesota ranked second in the nation as the best place to practice medicine (Medscape's "Best and Worst Places to Practice" report, May 2024).

All elections, of course, matter. Should the Harris-Walz presidential ticket prevail, Minnesota will see a new governor in Peggy Flanagan. Her priorities will then influence the state budget and legislative agenda. Should the Trump-Vance ticket prevail, a new federal administration will influence national and state policies.

Regardless of the outcome, the MMA will continue to advance its mission to make Minnesota the healthiest state and best place to practice. As noted, more work remains. Your voice and support are critical to that work. After you vote on November 5, add February 19 to your calendar and plan to attend the 2025 Physicians' Day at the Capitol event. I look forward to seeing you there! **MM**

Janet Silversmith
JSilversmith@mnmed.org

VIEWPOINT

You are not alone

PHOTO BY KATHRYN FORSS

Edwin Bogonko, MD, MBA
MMA President

It is an incredible honor to serve Minnesota physicians as the 158th president of the MMA. With that comes the responsibility of sharing thoughts about the environment in which we ply our trade and the challenges we face, as well as celebrating the accomplishments of so many of us.

There is no shortage of challenges for physicians today: Administrative burdens. A pandemic that refuses to end. Nonphysicians trying to legislate how we practice medicine. Working longer hours for lower reimbursement. Facing patients who, because of what they read on social media, no longer trust us. It's hard not to feel overwhelmed.

But, you are not alone. As your new president, I want to assure all Minnesota physicians and physicians-in-training that the MMA has your back.

Physician well-being is on our radar. We are heartened to know that The Physicians Foundation, the Dr. Lorna Breen Heroes Foundation, the National Academy of Medicine, the U.S. surgeon general, and others have all called for systemic change and investments to decrease health worker burnout and improve well-being.

The MMA is making changes, too.

This past May, our Board of Trustees unanimously approved a set of recommendations from the MMA's Physician Well-being Advisory Committee to help physicians and physicians-in-training foster well-being, avoid burnout, and achieve an improved quality of life.

In addition, in 2023, the MMA launched its SafeHaven program after recognizing a greater need to help physicians struggling with stress, burnout, and the effects of COVID-19. SafeHaven, a confidential and independent resource, is designed to help physicians get the help they need to reduce stress and burnout, promote work-life integration, and support their own well-being. You can find more about SafeHaven at www.mnmed.org/safehaven. Give it a try and share with a colleague any meaningful outcome you would hope others would glean from participating.

I've wanted to be a physician and serve the sick since I was 12 years old. Over the years, I have seen firsthand what physicians endure. From losing a classmate to suicide or COVID-19, to understanding that however great we are as physicians—bad healthcare policy costs lives. That has been my reality. We have to sustain our advocacy efforts to protect the physician-patient relationship and our practice autonomy while making sure our care partners at the clinic or bedside in the hospitals are equally well equipped and safe. Violence towards healthcare workers has reached a new level. We continue to lobby our congressional delegation to pass legislation that is pending: The Safety from Violence for Healthcare Employees (SAVE) Act, or H.R. 2584, is a bill that would provide federal protections for healthcare workers from workplace violence.

In these times, physicians are bearing the brunt of the burden to keep our health systems going and remaining viable. We are more vulnerable than ever. So, take a moment and appreciate your colleagues across the clinic cubicle, in the hospital lounges, or across the parking lot; elevate those dedicated to their patients beyond compare, and foster the bonds of connections that unite us. Take time to be your brother's and sister's keeper.

I look forward to working with many of you in the coming year as we relentlessly strive to keep Minnesota the healthiest state and the best place to practice medicine in these United States.

I, with your help, have the solemn duty and responsibility of elevating the voice of physicians and their patients across our great state. I am grateful to those who have served the MMA over the years—they have earned our eternal gratitude. Our association has accomplished many things in its more than 170-year history, so please join me as we, together, continue to add to that tradition.

At your service! **MM**

As your new president, I want to assure all Minnesota physicians and physicians-in-training that the MMA has your back.

PHYSICIANS' DAY AT THE CAPITOL

SAVE THE DATE

Wednesday, February 19, 2025

ADVOCATE FOR YOUR PROFESSION

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

MARISSA WHEELER, MD

Marissa Wheeler, MD, is a family medicine physician and recently just began her first job out of residency at Alexandria Clinic, part of Alomere Health, in Alexandria. She joined the MMA in 2021.

Where did you grow up, do your undergraduate and grad work, medical degree?

I grew up in Alexandria, which a lot of people know for its beautiful, clear lakes. I went to undergraduate at the University of Minnesota Duluth and majored in biomedical sciences. During undergrad, I worked at a group home for people who had experienced traumatic brain injuries. After graduation, I started at the University of Minnesota Medical School. I began my journey at the Duluth campus and ended up staying in the area to complete my family medicine residency, which I just finished this past June.

Tell us about your family.

I have a wonderful husband, Mark, and an 8-month old daughter, Ada. We have a spunky little dog named Indy as well as four egg-laying chickens (Pot Pie, Nugget, Patty, and Noodle).

Hobbies or side gigs?

We just bought a house on one of the lakes in town, so I spent a lot of time this summer enjoying boat rides, fishing, and water-skiing. In the winter, I spend time cross-country skiing, ice fishing, and staying warm with a good book (preferably science fiction or fantasy).

Why did you decide to become a physician?

I started to really consider becoming a physician at the start of my undergraduate career. I loved all of my science courses as well as working with people on their health at my job at a group home and knew that being a physician could combine these interests and be very rewarding.

What was the greatest lesson of your medical education?

I think that good health starts with ensuring basic needs are met. If someone doesn't have access to safe housing, reliable transportation, or is struggling with a lot of stress from everything life is throwing at them, then worrying about chronic medical conditions is not a priority. I think it is very important in meeting people at their point of need, whatever that may be.

What's the greatest surprise that your education left you unprepared for?

Being that I am only a few weeks into my first post-residency job, I am not sure yet!

What's the greatest challenge facing medicine today?

One big challenge is the amount of misinformation being spread online. The internet is an amazing tool and resource, but I recently have been experiencing more and more people making their healthcare decisions based on something they read online. I worry about this because a lot of the information out there is not accurate and spread by people looking to make a profit. I want my patients to come to me with questions about something they've seen or read and we can have a discussion about it before they make any big decisions.

How do you keep life balanced?

I try my best to not bring any work home, even if it means staying late to finish. I put a big focus on spending time with family and friends, as well as keeping up with hobbies I enjoy.

If you weren't a physician—?

If I wasn't a physician, I would open my own doggy daycare. It'd allow me to get some more exercise in and spend all day with dogs—what could be better! MM

MMA
Mentorship
Program

Share your expertise - become a mentor today!

The MMA Mentorship Program connects pre-med students, medical students, and residents/fellows, with mentors who help answer questions, provide advice, and offer career guidance.

mnmed.org/mentorship

Minnesota Medical Association

You're not a policy number. You're a human.

We see you. And we understand your challenges. Our relationship doesn't start when there's a claim. From day one with Copic, we bring you insights designed to improve patient safety, help reduce risk, and let you focus on what you do best. We're here for the humans of healthcare.

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

copic

copic.com | 800.421.1834