

minnesota

MEDICINE

BREAK OUT OF YOUR BOX

15 WAYS TO PROMOTE COLLEGIALLY AMONG PHYSICIANS



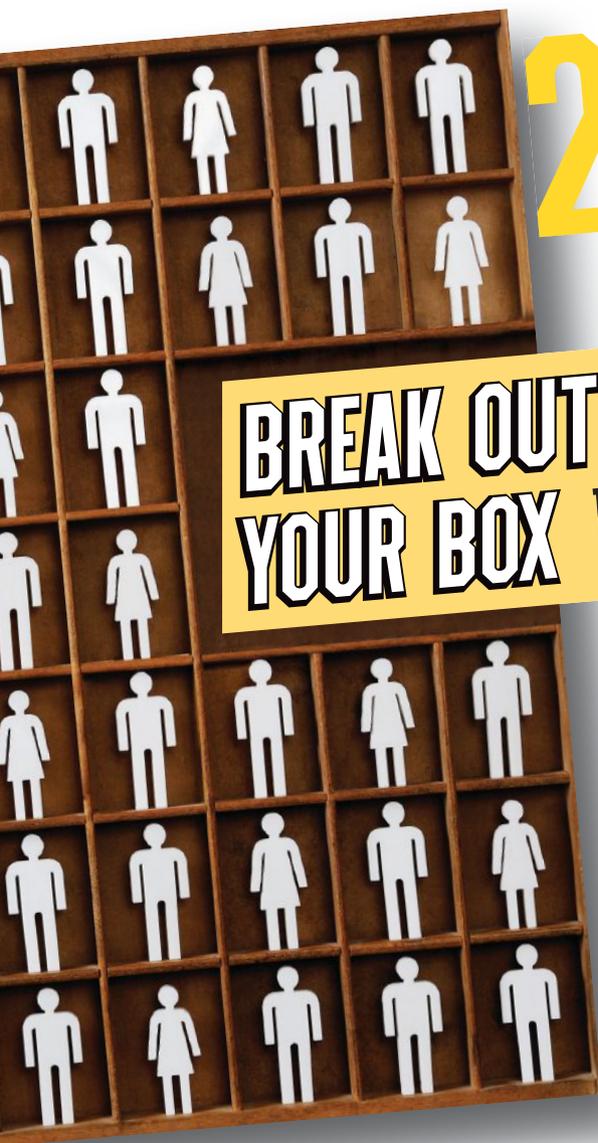
ALSO INSIDE:
Why go **Greek**
Was there ever a **golden age of medicine?**
Well-being takes center stage



MINNESOTA MEDICAL ASSOCIATION

SEPTEMBER 2012

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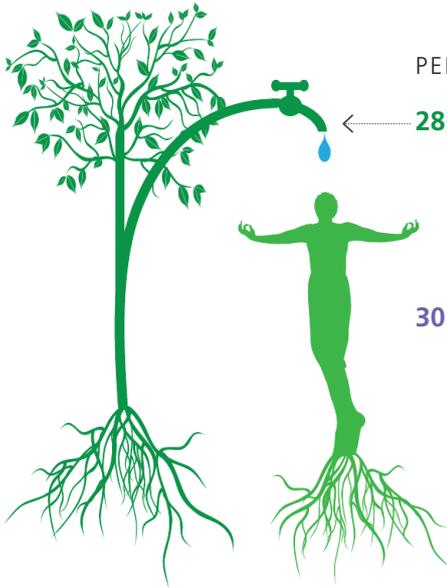
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Longing for the lounge

When I started in practice in 1977, I was a lounge-hopper. In those days, the common wisdom was that the way to build a practice was to get to know other doctors, and doctors' lounges were where they hung out. I logged hundreds of miles shuttling between three hospitals, Metropolitan Medical Center, Fairview Downtown and Fairview Southdale, drinking too much coffee and becoming a connoisseur of stale sweet rolls and physician demographics. Most of my fellow loungers practiced in small groups, did both office and hospital practice, and were male. Most, it seemed, had cabins and hunted and fished. Many mornings, when I was on my third doctors' lounge and 10th fish story, I would muse that all this activity seemed a terrible waste of time with talented, educated men sitting around shooting the bull when they could be doing what they were trained to do—saving lives and stamping out disease. But now, I think they were doing something very valuable. They were building collegiality, staking out common ground.

Admittedly, there was a lot of common ground to be had with the uniformity in demographic and interest profiles. Yet, as talk migrated to medicine and politics, my fellow lounge denizens shared “war stories” of patient illnesses and treatments, reminisced about the fascinating history of medical practice in the Twin Cities and beyond, and frequently inveighed against the looming threat of socialized medicine

As the radical reorganization of medical practice in the Twin Cities advanced in the 1980s, the dirty word “government” was replaced with the four-letter acronym HMOs. No longer was the clear and present danger a takeover of medicine by the federal government but a threat closer to home, as Group Health and SHARE health plans began hiring doctors

and signed competitive contracts with companies. These employed docs were “different;” they worked different hours and had different incentives. Suddenly, physicians' common ground was cracked by a temblor.

Since then, diversity has continued to shake medical practice in Minnesota. The physician gender divide is now about 50-50. Most Twin Cities physicians are employed by large organizations. With the number of two-doctor couples on the rise, more and more physicians are opting for part-time work. And the vast majority of primary care doctors have forsaken hospital practice. Despite fancier sweet rolls, designer coffee and served lunches, doctors' lounges are a shadow of their former selves, peopled primarily by surgeons and anesthesiologists waiting for their next case.

What's lost is the nurturing of collegiality, the fertilization of common ground. Primary care doctors still talk to their referral physicians but mostly by phone. Many primary care physicians couldn't identify the surgeons who operate on their patients in a police lineup. Today's diverse physician population needs a few minutes over a cup of coffee to get acquainted and rediscover their commonality.

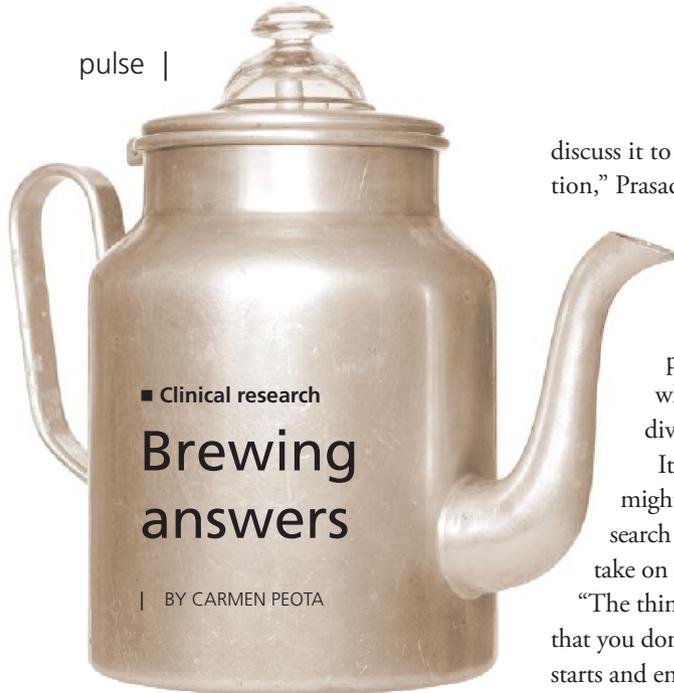
So health organizations, hospitals and physicians, adjusting to the changing landscape of medical practice, are bringing doctors together for educational and social events, or just that cup of coffee so that doctors can realize what they have in common.

Because of a recent job change, I joined the ranks of office-only doctors. After 35 years of daily stops at the hospital for rounds on my patients and sitting down next to my favorite infectious disease specialist and sharing a few stories, I now drive by the hospital. I won't miss the stale sweet rolls, but I will miss the stories.

.....
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Today's diverse
physician
population needs
a few minutes over
a cup of coffee
to get acquainted
and rediscover
their commonality.

Photo by Scott Walker



■ Clinical research

Brewing answers

| BY CARMEN PEOTA

One of the Accreditation Council for Graduate Medical Education’s requirements for residency programs is that faculty encourage residents to take part in scholarly activities. Just what those activities need to be isn’t spelled out, nor is it clear how faculty should support them.

Thinking residents did indeed need support if they were to engage in research during the busiest years of their lives, Shailendra Prasad, M.D., associate director of the University of Minnesota’s North Memorial Family Medicine Residency program, came up with the concept of “the percolator” two years ago. “The idea was that residents could come in with whatever idea they have, however half-baked the idea is, and then we sit and

discuss it to formulate a research question,” Prasad says. If they can’t find an answer in the evidence, the question then becomes fodder for their own research, and the percolator provides a venue where the residents can divvy up the work involved.

It turns out, residents who might hesitate to conduct research on their own are quick to take on parts of a larger project. “The thing with the percolator is that you don’t have to be the one who starts and ends a research project,” says faculty member Renee Crichlow, M.D. “One might do a systematic review. Another might do a trial. Another one might write the presentation or paper.”

Crichlow says multiple projects have been launched through the percolator, including one that started with a resident asking about how best to talk about contraceptives with certain patients. The group decided to design a study using focus groups.

Prasad’s goal is that residents will feel confident that they can engage in research throughout their careers. “People think you have to be a full-time researcher to do it. I think sharing the burden alleviates some of the concerns about it. At least, that’s our goal.”

An app for that question

In the past, when residents in the North Memorial family medicine residency program had questions they wanted to research, they would write them on a note card. Faculty member and co-founder of the percolator, Renee Crichlow, M.D., thought there had to be a better way. So she developed an app that allows residents to record their questions on their laptop, tablet or smart phone while they are working. They or their colleagues can retrieve them later on.

Crichlow hopes a future iteration of the program will one day allow physicians to help one another tap into the research base while they are caring for patients. “If you’re doing clinic one day, and I’m doing administrative work, I could see the question on the network and find the evidence and provide a good reference,” she says. “You’d have the info in a few hours without having to look it up yourself.” —C.P.



■ Resiliency

Act up

Retired physician Dale Anderson believes every physician ought to be a method

actor. Anderson says actors experience positive physiologic effects when they play upbeat roles—and negative ones when they don’t. He thinks acting happy will have the same healthful effects for physicians and that those effects will benefit patients as well. To learn more go to acthappy.com

check this out



Doximity (www.doximity.com) is a professional networking tool for physicians (sort of a LinkedIn for doctors) that allows you to maintain your profile; search for colleagues by specialty, location and special interest; and send HIPAA-compliant messages and attachments through your computer, tablet or smart phone. Doximity was created last year by the founders of Epocrates.



A scene from "Play What's Not There," presented last June at the Guthrie Theater in Minneapolis

■ Self-care

Well-being takes center stage

HealthPartners brings physician well-being in from the wings. | BY CARMEN PEOTA

“When people say they’re too busy, they speak a truth greater than they know,” the gray-haired physician says to the first-year internal medicine resident. Both are characters in a play that tells the story of young Dr. Long as she meets a set of talented mid-career faculty during the first days of her internship. As she sees the price each has paid to get to where they are, she questions whether she wants to be a physician at all: The head of her program is a jazz trumpeter who hasn’t played a note in years; one physician is losing his marriage; another is estranged from her teenaged son. When Dr. Long tells them she doesn’t want to have to give up all of her other interests in order to succeed in medicine, she’s rebuked. Nothing is more important than the lives of patients, she’s told. She needs to prove that she has the drive and commitment medicine demands.

Not long ago, the younger doctor’s pining for work-life balance would have seemed selfish. But there’s been a shift in thinking in recent years, and increasingly personal well-being is being considered a component of professional competence.

As “Play What’s Not There,” which was commissioned by HealthPartners and performed at the Guthrie in June, unfolds, Dr. Long, with the help of her older mentor, comes to see that physicians are less effective healers when they give too much to their career. As she embarks on her residency, she realizes her task is not to lose herself to her profession but to be herself within it.

Emerging issue

When educational leaders at HealthPartners were talking with staff at the Guthrie three years ago about the possibility of collaborating, the issue of physician well-being quickly surfaced,



Playwright Bill Thomas, M.D., (front right) with the Guthrie cast and director of "Play What's Not There."

says Debra Bryan, director of collaborative learning for HealthPartners' Institute for Education and Research. Both she and Carl Patow, M.D., executive director of

health professional education, were well-aware of the growing body of literature showing high rates of distress among medical students and stress and burnout among physicians. Patow and Bryan approached New York gerontologist Bill Thomas, M.D., about writing a play that got at the issue.

As plans for staging the play began to take shape, they had conversations with others at HealthPartners about what else could be done to educate physicians about the importance of well-being. The topic, it turns out, was bubbling up among HealthPartners residency program directors and clinic leaders. Bryan and Patow decided to hold a retreat on well-being for physician leaders last fall and to do a day-long conference on the topic for residents later on that would feature a talk by Duke University's J. Bryan Sexton, Ph.D., an expert on resiliency, and a performance of the play.

The conversations about physician well-being may have been occurring because of growing awareness of research

showing its effect on quality. Sexton, one of the world's authorities on the role of culture in patient safety, had become interested in the 10 to 15 percent of organizations that could not improve their performance despite their efforts to improve their culture and systems. He realized that the individuals in those systems often weren't performing well because of stress. In his June presentation at the conference, he noted that quality improvement slowed when organizations ignored the fact they were dealing with human beings. "It stops because of burnout."

Marcella de la Torre, manager of quality initiatives and faculty development for HealthPartners Institute for Education and Research, is one who was seeing the connection between quality and well-being. She had observed that how people were functioning personally hadn't really been part of the equation. "I think that what we do mostly with quality improvement is we put a patch here and there," she says, always focusing on the system. "To be able to produce quality work, your

A simple remedy

At a symposium on physician wellness in June, Duke University psychologist J. Bryan Sexton, Ph.D., shared a number of tips for becoming more resilient, one of which is the "three good things" exercise. You simply write down three good things that happened during your day, identify your role in them, and pick your favorite. Sexton says research shows this is most effective if done during the two hours before you go to bed. And, he says, research shows that if it's done for 14 consecutive days, it increases one's sense of well-being and satisfaction for as long as nine months.

well-being and mental being matter. Individual performance really affects systems performance. That's the connection."

Sexton pointed out that in the past 20 years, productivity in health care had gone up 21 percent and stress levels among workers had soared. Simply working in health care made anyone a candidate for burnout, he said. Adding to the stress are the technologies that make instant and nonstop communication possible and the demands of the quality movement itself. "There's no finish line," he told the audience. "It's a death march if we push it [quality] blindly."

Rather than focus on changing health care organizations, though, Sexton has put the onus on physicians. His main message is that it's up to caregivers themselves to do the things that will sustain them in today's complex and demanding health care environments. "No one is in the business of protecting your resilience," he said. "Your health care system, your hospital, is designed to suck you dry."

Refining resilience

Felix Ankel, M.D., director of the emergency medicine residency program at Regions Hospital, says he had been aware of Sexton's work for some time and supported the effort to bring him in for the conference. He especially appreciates Sexton's message that resilience can be developed. Ankel says it's something he's tried to instill in the residents in his program. In fact, he'd like to see his emergency medicine residents required to take a course on resilience similar to the one-day courses they're now required to complete on advanced cardiac and advanced trauma life support.

Ankel says learning to be resilient is important for anyone in a high-stakes profession but especially for those in emergency medicine. "In general, our everyday is most people's worst day," he says, noting that the suffering and emotions encountered in the ER are intense. And, he says, emergency physicians today feel additional stress because they work

in an environment that some say is inefficient and costly.

Karen Mackenzie, M.D., chief physician for HealthPartners North Suburban Family Physicians in Roseville and a participant in HealthPartners' leadership retreat last fall, says she thinks primary care physicians need to learn how to become more resilient as well.

Mackenzie is concerned about both recruiting and retaining physicians in primary care. She's seen some leave clinic positions to pursue hospital medicine in order to regain control over their schedules. She says HealthPartners as an organization is working on how to improve systems so that physicians can spend their time doing the things they do best rather than administrative work, which they may find not only time-consuming but also draining. But she thinks physicians themselves need to do things to care for themselves. "There are simple things to do that don't take much time," she says (see "A Simple Remedy").

Doctors have always had full lives, says Eugenia Canaan, director of undergraduate and graduate clinical education at Regions. But she thinks the demands are greater now than they've ever been. "It's not just, Here's the clinical information and take care of your patients," she says. "There's committee work, and everything is structured and appointments are limited in duration." Not to mention the demand for more documentation and changing national guidelines.

Canaan's goal for the young professionals she's charged with training is to let them know that it's O.K. to talk about feeling stressed, to seek help if they need it and to have a life outside of clinical practice. "I think there was a time when it was taboo. There was pressure that you had to be strong, you had to deal with everything, you had to be the healer for everyone and take care of everyone and one's personal life and family life suffered. I'd like us to move away from that." **MM**

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Photo courtesy of Phi Chi Medical Fraternity

Medical fraternities then and now: ABOVE: A Phi Chi chapter in 1948. RIGHT: The University of Minnesota chapter of Phi Rho Sigma at the Greek Olympics in 2010.



Photo courtesy of Phi Rho Sigma

■ Medical fraternities

Greeking out

Medical fraternities help students get through school by providing support, advice and a bit of fun. | BY SUZY FRISCH

Nicholas Dahl hadn't lived in the Twin Cities since he graduated from Eastview High School in Apple Valley in 2001. After attending the University of Wisconsin–Madison and spending nearly four years working clerical jobs at hospitals in Seattle and Ann Arbor, Michigan, he returned to Minnesota in 2009 to enroll in medical school. Dahl wanted a way to meet new people who could share his experience. Joining the Phi Rho Sigma medical fraternity on the University of Minnesota Twin Cities campus turned out to be the way to do that.

By living in the co-ed fraternity house, Dahl says he has made close friends. He's also found being in Phi Rho helps him achieve a healthy balance between studying, doing volunteer work and letting off steam with fellow students.

"It definitely added a lot to my medical school experience," says the fourth-year student, who intends to go into emergency medicine. "Everyone knew when it was time to buckle down and study. But there was always a good awareness that we need to forget about school once in a while and have a healthy social and personal life."

Although there are fewer medical fraternities at the university than in the past, these organizations still play an important role in the lives of many students. Unlike traditional undergraduate fraternities and sororities, which are known for parties, pranks and initiation rituals, medical fraternities mostly help students bond with fellow travelers along the often-grueling path to becoming a physician.

When Barbara Olson, M.D., was in medical school at the University of Minnesota in the late 1950s, she was one of four women in her class of 120. Joining Alpha Epsilon Iota (AEI), a medical fraternity for women, helped her build strong relationships with the other female medical students and provided access to alumna who offered support.

During her first year, Olson lived in the dorms, but she later moved into AEI's house. "I realized I didn't have much in common with the other students. I wanted to be where the medical

students were,” says the 1960 graduate who practices family medicine and geriatrics at the VA Hospital in St. Cloud. “It was a huge support group at the time. I really enjoyed being with the other women medical students who were going through the same stresses and joys in life.”

In Olson’s day, the majority of medical students belonged to a fraternity. There were six fraternities for men and one for women. Over time, a number of those fraternities faded away. AEI existed until 1979, when it sold its two houses and split into two organizations, the AEI Foundation and Minnesota Women Physicians. The AEI Foundation grants scholarships to female medical students, and Minnesota Women Physicians offers its members education and opportunities for networking and support.

Currently Greek

Today, medical students of either gender on the Twin Cities campus can join the Nu Sigma Nu, Phi Rho and Phi Chi fraternities—and roughly one-third of them do. (Neither the Duluth campus nor Mayo Medical School have medical fraternities.) Members are generally most active during their first and second years.

Each fraternity has a different personality; but they share a characteristic that is their main draw: the proximity of their houses to the Mayo Memorial Building, where a number of medical school classes are held. As the Nu Sigma website notes, this means “it’s entirely possible to get to class only 15 minutes after waking up, and still have time for breakfast! If you really push it, you can go from bed to lecture in 10 minutes.”

The location was one reason Jesse Fark joined Nu Sigma during her first year, in addition to her desire to forge connections with other students. Although the St. Cloud native attended the university as an undergrad, she spent her last semester in Ecuador and graduated in three years. She started medical school not knowing anyone in her class.

“It worked out terrifically,” says Fark, a fourth-year student who plans to pursue dermatology. “It’s evolved into a support



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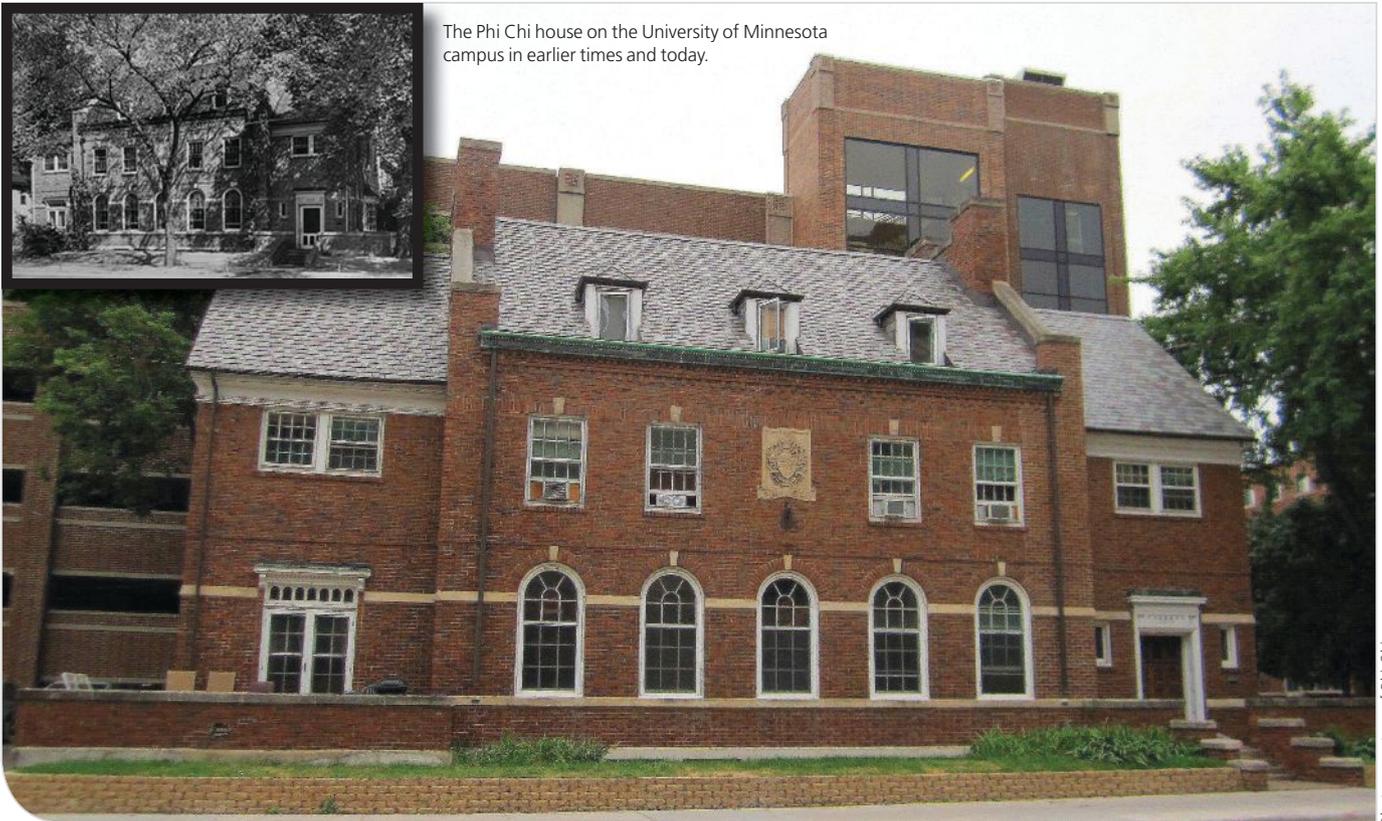


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The Phi Chi house on the University of Minnesota campus in earlier times and today.



Photos courtesy of Phi Chi

structure for medical students in terms of reasonable housing and closeness to campus, advice from upperclassmen, resources like books, a friendship network. It's more about supporting students through the stress of medical school and taking away all of the inconveniences."

For some fraternities, support also means food. Nu Sigma serves meals twice a month and Phi Chi four days a week. Members take turns cooking and serving, which helps build a sense of community.

For many students, being in a fraternity is about socializing. There are three parties a year for all medical school fraternity members (other medical students often attend as well) including one at Halloween and another around the winter holidays. The Greek Olympics, with events such as dodge ball, eating contests and five-legged races, provides friendly competition between the three houses.

Living with and getting to know fellow medical students has been invaluable to Phi Chi members Casey Yang and Amy Johnson. Both second-years who live in

the Phi Chi house, Yang and Johnson say that being in a medical fraternity has helped them cope with the stress of being a medical student. Whether it's outings to Gopher or Minnesota Twins games, playing intramural sports or volunteering at a free clinic in Minneapolis, there is generally someone around who's up for a stress-releasing activity, they say.

"I knew that four years of medical school was going to be pretty difficult, so I was looking to find a group of people to share the experience with, people who would understand all the stress and be a support system," says Johnson, a St. Olaf College graduate from Woodbury. "I also heard that people who live in medical fraternities like to be active in and outside of medical school, and it attracts people who like to be well-rounded."

Strong ties

Another benefit, Yang says, is the guidance and support that first-year students get from veteran students. Not only can Phi Chi residents save hundreds of dollars by using books from the house library—a perk the other fraternities offer, too—they also can tap upper classmen

for advice about classes, preparing for exams or selecting rotations. The morning of the first-years' mid-term exams, Phi Chi's other members made them a hearty breakfast. "It's a lot of support, and I feel privileged to be a part of that," says Yang, a Carleton College graduate from St. Paul.

In their third and fourth years, students' involvement in the fraternities tends to wane. However, as they move toward residency and practice, they appreciate the fact that the medical school fraternities provide opportunities for networking with alumni.

Acknowledging the value in maintaining ties to Phi Chi, Johnson is working on solidifying relationships between the Phi Chi chapter and its alumni. "There are many alumni who work in the Twin Cities," she says. "Having an affiliation with Phi Chi will just be one more connection you have with a physician. It will be helpful when you're looking for a job or mentorship opportunity to have that network." **MM**

■ Physician oversight

Policing the profession

An inside look at the Minnesota Board of Medical Practice. | BY TROUT LOWEN



When a colleague and former board member suggested to Jon Thomas, M.D., that he apply to serve on the Minnesota Board of Medical Practice (BMP) back in the 1990s, Thomas was less than enthusiastic. “My thought was, ‘Why would I want to be on the board? It sounds like a pain in the butt. Who wants to police doctors?’”

But Thomas, an otolaryngologist in private practice who had recently completed his MBA at the University of St. Thomas, decided to apply anyway. In 2001, he was appointed to the 16-member board by then-Gov. Jesse Ventura to represent Minnesota’s Fourth Congressional District.

More than a decade later, Thomas’ view of the BMP, which oversees the state’s 20,000 physicians, has changed. He is currently halfway through his third term and serves as its current president. Board service, he says, has turned out to be interesting, rewarding and even ... fun.

“I like systems,” he explains. “I like understanding how systems work. I like understanding how people think, looking at perception, how people perceive reality. ... The interesting thing to me about the board is that it’s a complex system. It’s this interplay between physicians and government and law.”

Thomas is one of 11 physicians who serve on the BMP. The board also has five nonphysician members. Board members are appointed by the governor and can serve two consecutive four-year terms. (Members can serve again after an absence.) The board is required to have one member from each of the state’s congressional districts and representatives from a variety of specialties, including psychiatry (see “BMP Basics”).

Board members receive \$55 per day to attend meetings plus expenses, which may be a disincentive for some physicians to serve. This year, the BMP has had a difficult time finding candidates for the Second Congressional District seat, which was held

until last November by Alfred Anderson, M.D., a pain medicine specialist.

No one seems to know why it has been hard to find candidates, except perhaps that many doctors are busier than ever. “I think it’s very difficult now for people to set aside enough time to work with the board,” Anderson says. “It’s a meeting every couple of months for the whole board, and if you happen to be on the complaint-review committee, then it’s every month. That’s a whole day out of your practice every month. So I can certainly understand why people would be kind of disinclined to volunteer for that kind of a position.”

Those who have served on the board speak highly of the experience and of the opportunity to give back to the community. Several board members, including three current ones, have elected to come back on the board after taking time off after their second term. The reward, Thomas says, is in knowing that you’ve contributed to the health and safety of the citizens of Minnesota. “It doesn’t compensate you for the time that you spend, but for most people that’s not the point. They do it because they feel they can contribute to society in a positive way.”

It is also a fabulous learning experience, Anderson says. “You might even look at a case and think, there but for the grace of God and good luck I could have gone.”

Adjudicating complaints against physicians is one of the board’s primary roles. There are two complaint-review committees, which are staffed by the board’s most senior members. Those committees review an average of 800 complaints per year, says BMP Executive Director Robert Leach. Two other committees oversee licensing issues and public policy and planning.

“We want [members] to have years of board experience, both on their committees and on the regular board before they are assigned to complaint review,” says Leach. “You usually don’t get on complaint review until your second term.”

The majority of complaints are dismissed after an initial review, Leach says. On average, 10 to 12 complaints per month are resolved through a conference process, where the physician comes before the committee to discuss the complaint. At that point, the committee can take one of several actions: It can conclude that there are insufficient grounds and close the investigation; enter into an agreement for nondisciplinary corrective action, which may include self-education; enter into a stipulation permitting the full board to order agreed-upon disciplinary action; or refer the matter for a contested case proceeding. The board typically hears four to six contested cases each year.

A contested case proceeding is a trial conducted by the Office of Administrative Hearings. Complaints are investigated by the state attorney general's office, and evidence is presented before an administrative law judge, who acts as fact finder. The judge makes a recommendation to the full BMP, which issues the final determination. Disciplinary action can include license revocation or suspension, imposition of conditions on the physician's practice, civil penalties or community service.

Criticism and scrutiny

Earlier this year, the board came under scrutiny for its handling of complaints. A series of critical articles published in the Minneapolis *Star Tribune* last February suggested the board "often shies away from punishing doctors whose mistakes harm patients or demonstrate a pattern of substandard care," and that it lags behind other states in providing the public with information about physician competency.

The articles also highlighted a report by the public-interest watchdog group Public Citizen, which ranked Minnesota's Board of Medical Practice last among state medical boards in terms of the number of disciplinary actions taken against physicians.

Public Citizen analyzed statistics gathered by the Federation of State Medical Boards (FSMB) on serious disciplinary actions taken by the boards of all 50 states and the District of Columbia, including revocations, license surrenders, suspensions and probations, or restrictions. Using a three-year average (2007 to 2009), they calculated an average rate of disciplinary actions per 1,000 licensed physicians in each state. Alaska had the highest number of actions (7.89 per 1,000). Minnesota had the lowest (1.07 per 1,000).

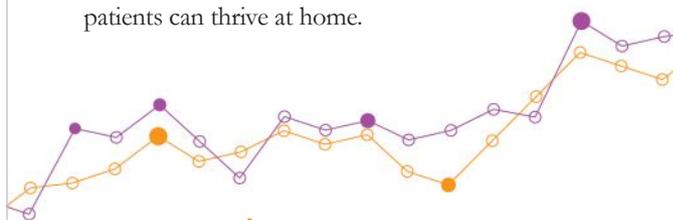
Lawmakers responded to these criticisms last spring by calling for a work group to study the state's Medical Practice Act. Thomas and other board members argue the Public Citizen rankings are misleading and bristle at the *Star Tribune's* contention that the BMP is ineffective or somehow less effective than other state boards. "I read that [article], and I can't believe that's the same board I served on," Anderson says. "Every single board member I know agonizes over every case."

In a counterpoint commentary in the *Star Tribune*, former board president James Langland, M.D., noted that Minnesota's BMP has won awards from the Federation of State Medical

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BMP basics

The Minnesota Board of Medical Practice is made up of 16 members, five nonphysicians and 11 physicians, one from each of the state's eight congressional districts, two at-large members and the board president.

Board members are appointed to four-year terms and can serve one additional consecutive term. Members can be reappointed after an absence.

The board meets every other month. In addition, members serve on one of its four committees. The public policy and planning committee meets quarterly. The licensure committee meets bimonthly, and the board's two complaint-review committees meet monthly. The time commitment for complaint-review committee meetings can be significant, says Executive Director Robert Leach.

When a board member's term expires or a board member resigns, the governor's office will file a notice of vacancy for the position with the Secretary of State's office. The Secretary of State then advertises the position in the *State Register*. Physicians can apply to serve on the board through the Secretary of State's website www.sos.state.mn.us.

The Secretary of State also notifies the Minnesota Medical Association of the vacancy. The MMA may recruit candidates for the board and provide endorsements. Minnesota statute requires the governor to consider the MMA's recommendations, although the governor is not bound by it. Candidates are vetted by the governor's appointments director, who consults with Leach on what type of physician might be needed to balance the current membership.

"I'm looking at things like Do we have enough general practitioners? Do we have a psychiatrist? Are there any applicants that fit that bill? Do we have enough female physicians, because we strive to be gender-balanced," Leach explains.

The appointments director then submits names for open positions to the governor. Occasionally, the governor rejects all the candidates and the process begins again.

Currently, there is a vacancy for a physician member from the Second Congressional District.—T.L.

Boards and is currently one of only two state boards to have two of its members elected to the 16-member national board. One of those is Thomas, who is chair-elect of the FSMB. Langland also pointed out that physicians in Minnesota must meet the high credentialing standards of the health insurers in the state in order to receive reimbursement and that most Minnesota physicians are in large group practices with active peer review. "The net effect is a high quality of medical care and less need for disciplinary action by the board," he wrote.

Thomas contends that the board's critics don't have the full story. They don't see how boards in other states operate. The Public Citizen ranking, too, fails to take into account the alternative approaches that different states, including Minnesota, use in handling physician disciplinary actions.

One of those is Minnesota's Health Professionals Services Program (HPSP), which Thomas says is responsible in large part for the small number of disciplinary actions taken by the board.

The HPSP allows physicians struggling with physical or mental health problems or drug addiction to seek help without threat of disciplinary action. If a physician successfully complies with the HPSP recommendations and monitoring, the issue won't even come before the board.

"In another state, that physician would come under the purview of the medical board. That would be a disciplinary order," Thomas says. "That's just an example of why Minnesota often falls low on that [Public Citizen] report. A lot of docs go to HPSP and bypass the board entirely."

Room for improvement

Thomas says there are things the BMP could do to improve the health and safety of Minnesotans. For example, he would like to see the state adopt more stringent standards for initial licensure. Currently, residents can apply for a license after completing just one year of graduate medical education. Some states require completion of a graduate residency program. In a small number of cases, Thomas says, the lower standard has allowed residents who have been kicked out of or who have dropped out of one program—whether because of incompetence, an illness or family commitments—to complete a year of residency by transferring to a different program, or to piece together a year of residency at multiple programs.

He says several states have a higher bar than we do when it comes to initial licensure. "What people don't understand is licensure is a minimum standard," he says. "You're not at excellence." Thomas believes changing the requirements for initial licensure would raise the floor.

Other changes are on the horizon nationally. The FSMB is developing a new framework for maintenance of licensure that will require a physician to demonstrate competency in his or her practice areas for license renewal.

Currently in Minnesota and most other states, physicians are only required to show they have obtained a certain number of continuing medical education (CME) credits and pay a fee

for license renewal. Physicians aren't required to earn the CME credits in their practice area, nor demonstrate what they've learned.

"Pilots don't get to submit CME credits and pay cash and then get to fly again," Thomas argues. "They have a rigorous re-evaluation process every few years... The idea that you just need to pay money and show some CMEs, that's going to go away and it should go away."

Several states will be testing new maintenance of licensure requirements as part of an FSMB pilot project, Thomas says. Minnesota is not among the test states. Physicians who are board-certified in their specialty are already required to take periodic competency exams, Leach notes.

"It's the individuals who are not board-certified, and who never will be board-certified, that you have to worry about," he says. Minnesota has a very small percentage of physicians who are not board-certified. In most cases, they cannot get hospital privileges and cannot work in a clinic.

Minnesota also has instituted a rule change that's being looked at nationally, in which the state allows the work required for obtaining Maintenance of Certification or Osteopathic Continuous Certification to count toward CME requirements for license renewal.

"It's a small step, but it's a step that other states are looking at," Thomas says. **MM**

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BREAK



OUT OF YOUR BOX

Practicing medicine can be a lonely job. With electronic medical records, conversations often take place on screen rather than in the hallway or doctor's lounge. Primary care physicians who rarely go to the hospital any more have few opportunities to get to know the specialists who care for their patients. More and more education takes place online—alone, rather than in conference halls. Productivity demands stretch the work day and family obligations consume evenings—all of which leaves little time and opportunity for connecting with colleagues.

Doctors are not unique. As Robert Putnam noted in his commentary about the decline of America's social institutions, *Bowling Alone: The Collapse and Revival of American Community*, we are becoming a society that is less connected

15 WAYS TO PROMOTE COLLEGIALLY AMONG PHYSICIANS

BY KIM KISER

to each other than ever before. We sign fewer petitions, belong to fewer organizations, barely know our neighbors and spend less time socializing with friends and family. We're bowling more, but not in leagues.

As medicine becomes more demanding and specialized, physicians are starting to think more about the importance of connecting with one another. They're realizing that talking with colleagues can help them solve problems, gain perspective and recharge their batteries.

So what can you do to build and nurture these connections that are so impor-

tant yet are becoming more and more elusive? Here are a few ideas physicians shared with us about how they or the organizations they work for are bringing together docs from different specialties and practice sites to get to know one another and discover common bonds within and outside of medicine. Some are simple, some are complicated. Some have been around for decades, and some are novel. We know these aren't the only ways physicians are connecting. If you or your organization are doing something to promote collegiality among physicians, please email us at mm@mnmed.org. Let's keep the ideas flowing.

1 HOLD A SPEED DATING EVENT

HealthPartners Medical Group has sponsored speed-dating-like evenings where specialty physicians sit at tables in a hotel conference room and primary care physicians rotate from table to table, spending a few minutes learning about each others' practices and getting to know one another. "It's a way to connect individuals who otherwise would be an anonymous consult," says Carl Patow, M.D., M.P.H., executive director of education for the HealthPartners Institute for Education and Research.

Patow participated in one such session, where he represented the institute as his "specialty." "You get to meet a lot of people and share what you're excited about and what you think would be helpful to them," he says, adding that later on some of the physicians he met at the event reached out to him about various educational offerings.

2 SHARE A STORY



In January, two physicians from Stillwater Medical Group brought together 10 of their colleagues and challenged them to write about their hopes and dreams and whatever else they wanted.

The group had held similar events for patients, where they used journaling to increase their sense of well-being. "We've done mind-body groups with patients for the last six years and found it was a successful model for developing interaction and collegiality," says Charles Bransford, M.D., an internal medicine physician who was one of the leaders of the group. "We thought it would be good for physicians to do something as well."

The physicians were encouraged to write in a journal daily. Then as a group,

they met for two hours every week for eight weeks and talked about what they had written about—work, family life outside the clinic and what brought them to medicine. "People could relate to each others' experiences," Bransford says. He adds that the sessions weren't intended to be gripe sessions or to focus on what's wrong with the system and how to change it. "It was about personal growth."

And about getting to know one another. "Some of the people had known each other, but always on a professional level. I didn't know the special stories that make people who they are," Bransford says. "That's what makes it fun."

3 BREAK BREAD TOGETHER



One of the things reproductive endocrinologist Lisa Erickson, M.D., likes best about Abbott Northwestern Hospital is eating in the doctors' dining room, a comfortable wood-paneled room with eight tables. "It's had a special place in my heart ever since I was a medical student," she says. "You can sit down next to a neurosurgeon, or an interventional radiologist, or a cardiologist and know that we all share the fact that we're on the front line with patients day in and day out."

During those meals, she says, it isn't unusual to get a mini-CME lesson. "While you're breaking bread, you're discussing what's on your mind and what you've seen in the morning clinic," she says. When a surgeon describes a procedure he or she performed that morning, "they tell you what it's like from their point of view. It's the inside story."

In addition, the dining room brings together physicians of all ages, leading to informal mentoring relationships between physicians who may not even be in the same specialty. "Everything falls away when we talk about our common bond, which is being on the front line," Erickson says.

4 START A BOOK CLUB



When John Scanlon, M.D., an internal medicine physician, was working for Aspen Medical Group in the early 1990s, the lunch-time conversation with his fellow physicians often turned to what they were reading. "Gradually, a core group of us decided to get together and start a book club," he says. The club included physicians from Aspen and other medical groups, and all agreed that they would not talk about medicine. "The focus has always been on literature," he says.

The book club continues to meet on the third Wednesday of every other month. "It's a sacred date," says Scanlon, who now works for HealthEast's Midway clinic and is the club's unofficial leader.

The group of 12, which includes family medicine and internal medicine physicians, two general surgeons, a cardiologist, a pulmonologist, a neurologist, a gastroenterologist, and a pediatrician, also meets once a year to choose a reading list. Among the works they have read and discussed: *Huckleberry Finn*, *Don Quixote*, *The Divine Comedy*, *The Greater Journey*, and *The Fallen Nightingale*.

5 PUT A FACE WITH A NAME



Getting faculty members from the University of Minnesota family medicine residency program's eight locations together for twice-monthly meetings can be challenging. Videoconferencing has made it easier—and allowed far-away participants who may not be able to attend in person to feel more connected to their colleagues than if they were just participating by phone. "There's a limit on how long you can take people away from their normal duties for meetings, but if they're not interacting, they become isolated and don't

know each other,” says Macaran Baird, M.D., head of the university’s department of family medicine and community health. “Seeing a face makes a difference.”

6 ATTEND A LIVE CME EVENT

Earning continuing education credits online may be convenient, but there is a downside: you’re doing it alone. “CME activities have an importance beyond transference of knowledge and learning best practices,” HealthPartners’ Patow says. “There’s the social importance.” He says one of the biggest reasons why physicians attend live CME events is to reconnect with old friends and meet new colleagues.

One thing his organization has done is to offer courses on more general topics that attract physicians from all specialties. For example, HealthPartners recently sponsored a symposium on reducing stress and improving resiliency.

Lisa Erickson thinks similarly. When she was a fellow at Mayo Clinic, she found midday grand rounds interesting in part because it drew physicians from all specialties. The sessions took place every Wednesday and included a case study—usually about a topic that was of interest to physicians from all specialties—and a discussion about diagnosis and treatment options. “It was a simple, formal event that provided CME, brought all fields together and caused us to focus on the one thing we love best, which is medicine—especially the art of medicine,” she says. The conversation didn’t always end when grand rounds did. Erickson says when those who attended would see each other later on, they would often talk about the case that was presented and what they learned. “It provided a common theme for the day,” she says.

7 DEVELOP A GUIDELINE

One way the University of Minnesota’s Baird has been able to connect with other physicians with similar interests is by getting involved with the Institute for Clinical Systems Improvement (ICSI). Baird and other faculty physicians were involved in several groups focused on finding ways to provide better care for patients with depression in the primary care setting. “ICSI is a very good neutral convener of people who want to learn from each other how to do something better and better,” he says. “I’ve met physicians from all around the state. We trade information and business cards and phone calls and emails. When someone has an insight on how to do something more efficiently or effectively, we learn from each other.”

8 PLAN A SOCIAL

Four times a year, HealthEast holds an evening social hour at each of its four Twin Cities hospitals for the physicians who have privileges at them. “The difficulty we face is that primary care physicians don’t come to the hospital anymore,” says Steve Kolar, M.D., senior vice president and chief medical officer for the organization. “We wanted to be intentional about how they’re involved with other physicians, and physician social hours are one way to do that.”

Kolar says the agenda is purely social—physicians drop in to have a drink and get to know each other. “We’re sort of resurrecting the feel of the doctor’s lounge, which no one goes to any more,” he says. Although convincing people to give up an evening is a challenge, he says they typically get about 25 physicians at each event.

9 BUILD A TEAM OF LEADERS



Three years ago, University of Minnesota Physicians chose the first cohort of 30 young physicians from various medical school departments to take part in the Emerging Leaders Program, which develops future leaders for academic medicine. (A second cohort of 30 started this year.) The physicians meet for a day and a half four times a year. During those meetings, they discuss assigned readings on topics not necessarily related to medicine and hear from guest lecturers. “It stimulates thinking outside their normal duties,” Baird says. A byproduct of these sessions is that the participants get to know fellow physicians they don’t work with every day. “I think they came to like each other very quickly,” says Baird, who is an adviser for the program. “By working together, they get a wider perspective on a relevant topic and become closer as colleagues. I think that’s healthy.”

10 GATHER OVER COFFEE



Some of HealthPartners’ primary care clinics have invited specialists to come in and give informal talks over coffee about what’s new in their field and how they can best work with primary care physicians. “It’s an opportunity for primary care and specialty physicians to share information and connect,” Patow says.

11 GET INVOLVED IN A CAUSE

When the Mankato Area Smoke-Free coalition was trying to pass a comprehensive ordinance prohibiting smoking

in workplaces, Dawn Ellison, M.D., an emergency physician, was one of the first physicians to get involved. In urging others to take up the cause, a fellow physician approached her at a meeting and asked if the local medical society could help. The cooperation among physicians eventually helped the coalition make Mankato workplaces smoke free. It also led to better relations among physicians in the area.

“One of the beautiful things about it was that there was contentious competition at the time between a couple of clinics in Mankato. People had no difficulty putting that aside and working together,” she says.

Ellison’s involvement had an unexpected outcome—she met a number of physicians whom she didn’t know before, and her connection with them ultimately aided her ability to care for patients.

“There was more trust between us and, therefore, we could better collaborate for our patients,” she says.

The University of Minnesota’s Baird says he has had similar experiences serving on MMA committees. “Most of the conversations we have are about how to help the public stay healthy and need less care. We can almost always find common ground there,” he says.

12 TAP A COMMON INTEREST

One of the ways Don Jacobs, M.D., a surgeon and chief of clinical operations at Hennepin County Medical Center, connects with fellow physicians is at band practice. Every other Wednesday night, he and the other members of HC/MC, a 10-piece group that plays everything from the Rolling Stones to Lady Gaga, get together at the hospital, in his basement or in a member’s garage to learn new songs and rehearse for upcoming gigs (they’ll be playing at the MMA annual meeting this month).

Jacobs, who plays lead and rhythm guitar and sings back-up vocals, is one of

six physicians who play in the band (the others come from different departments at the medical center). “The larger we get,” he says of the multispecialty center, “the more disconnect there is between individuals and the harder it is to get to know people. We’ve found the better we know each other, the easier it is to work together and the easier it is to handle difficult situations that come up.”

13 SOLVE A PROBLEM



At each of HealthEast’s hospitals, hospitalists, family physicians, internal medicine physicians and other specialists meet monthly for what are called “Adult Care Councils.”

During the meetings, physicians involved in the care of hospitalized patients discuss issues that have come up and look for ways to improve care. “It’s a connection for primary care physicians who don’t come to the hospital,” HealthEast’s Kolar says, adding that the organization has 13 such councils that focus on different specialties.

One improvement that has come of the meetings of the adult care group is the creation of “bridging orders.” Now when an adult patient is admitted to the hospital from the emergency department, emergency physicians can issue orders that are followed until the patient is seen by a primary physician—something that wasn’t done before. Participants are now working on creating a standard discharge summary.

14 SHARE IN A TRADITION



The Minnesota Academy of Medicine has been around since 1887 and was considered an exclusive venue where medicine’s

elite would gather to discuss new developments in medicine. Although potential members still must be recommended by a member and approved by the executive committee, the academy is currently seeking new members—especially younger physicians. The academy’s monthly gatherings consist of conversation over dinner and a lecture on some aspect of medicine such as heart health, neuroscience research or the role of a coroner.

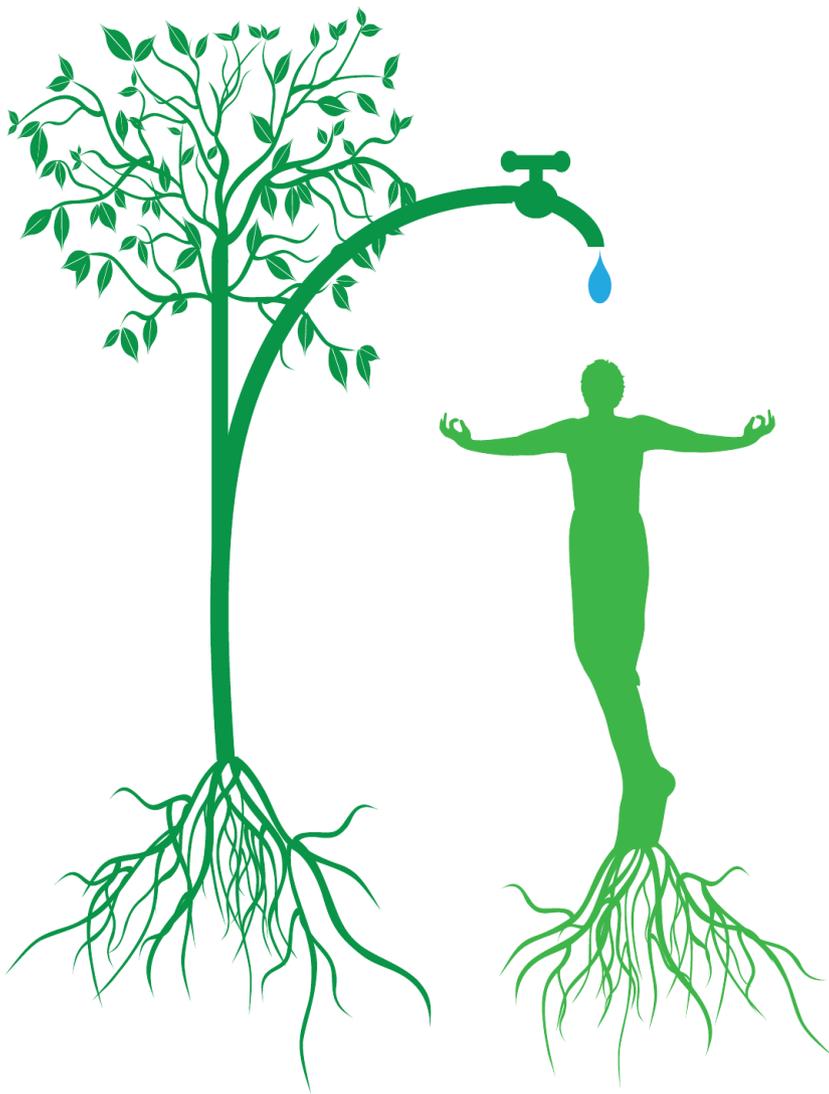
“It’s almost like being in a medical school classroom hearing the interesting lectures again,” says Lisa Erickson, who is a member. “The lectures rekindle everything I liked about medicine.” (To learn more, contact Marcy Cook at cookx013@umn.edu.)

15 SAY “THANK YOU”

At HealthEast’s hospitals and clinics, staff are encouraged to let leaders know about physicians who have gone out of their way to help a patient or reach out to a family member or who have just gone above and beyond. The physicians then receive a note describing what they did and thanking them for it. “So often, physicians don’t hear from people unless something went wrong,” says Kolar. “This is a way of recognizing physicians for the good things they do.” He adds that physicians appreciate the recognition. “I can’t tell you the number of times physicians have commented on being recognized in a note from someone.”

Although staff are the ones being urged to call out physicians at this point, Kolar says the next step is to encourage physicians to recognize each other. **MM**

Kim Kiser is senior editor of *Minnesota Medicine*.



On mentoring

Being a mentor is about listening, encouraging and just being there.

By Iris Wagman Borowsky, M.D., Ph.D.

It was our second meeting. We sat on the grass in a circle, reveling in our escape from the classroom and into the fresh air and sunshine. We would get to this week's lesson (The Medical Interview: Listen to the Patient and She Will Tell You the Diagnosis), but first, a family dinner ritual at my house called "rose, bud, thorn."

"Tell us about your rose—the best thing that happened to you this week; your thorn—the worst thing that happened; and your bud—something you are looking forward to," I said. Someone volunteered to start, and we made our way around

the circle, laughing and nodding empathetically as each student shared a glimpse into their first week of medical school. I took my turn and then turned to the student next to me. Smiling, she told us that her 10-month-old son took his first steps this week, and that both she and her husband were there to see it. A wave of excitement went through the group. She told how afterwards, she and her husband realized that they both had experienced the same fear—that they would be the one to miss this momentous event in their son's life. She became teary as she shared her thorn—the long days and demanding years ahead on the road to becoming a doctor. On anatomy lab days, she left before her son was awake and came home just in time to say goodnight. We hugged, she shared her bud—spending time with her family during the upcoming weekend, and the next student joked that he had no thorns worthy of mention after that.

As we continued, I knew that we were creating what past students have called the "safe zone," a welcoming space where this group of 10 students would come to learn, grow and share during their first year of medical school.

The importance of nurturing connections in the lives of young people is well-known to child and adolescent health professionals. These are the relationships with people who spend fun time with you, who get excited when you do something right, who are crazy about you; the people who are your role models. Central to my philosophy of mentoring is the value of these same nurturing connections for adults, as we follow our passions and seek satisfying and successful careers. In truth, these are the people we never stop needing.

As a clinician, I appreciate the similarities between building a mentoring relationship and building a patient-doctor relationship. Both are infused with generosity, respect, partnership, curiosity, empathy, trust, appreciation and safety. Both are structured relationships that develop over time and can have wide-reaching, positive outcomes for all who take part.

In mentoring as in doctoring, there is opportunity for gathering and sharing information, views and wisdom; recognizing families and support networks; encouraging questions; negotiating and managing conflict; giving feedback; and developing a plan of action. Both types of relationships flourish when there is active listening and cultural understanding, when strengths are fostered, and when ideas, feelings and values are acknowledged.

Like doctoring, mentoring is an incredible honor and privilege. They are humbling experiences that hold special moments we are invited to be a part of. As a mentor, I share many stories and experiences. I talk about the great joys of working with children and their families and of going the extra mile for patients. I talk about the challenges of balancing and integrating work and personal life, including what has worked for me and the very personal task of finding what is right for each individual.

I share my passion for pediatrics. And mostly I take time and listen. I listen to interests and priorities, needs and expectations, dreams and objectives.

As a researcher, I look to the literature on the science of mentoring for guidance. A cherished mentor of mine, the late Carole Bland, Ph.D., worked tirelessly in this area. I refer often to my now-tattered copy of the *Catalyst*, a publication for University of Minnesota Medical School faculty from summer 2008, where she summarized research on mentoring and provided guidelines for effective mentoring and setting up formal mentoring programs. The literature shows the positive outcomes of effective mentoring for both mentees and mentors, but suggests that not all mentoring is effective.

Mentoring that has a clear purpose, is conducted in the context of a structured and supportive relationship, and takes place at an organization that recognizes mentoring as an essential activity is most likely to have a positive impact on career success.

Dr. Bland's research clearly shows that having mentors is critical to the success of academic researchers. In guiding medical fellows through the creative, exciting, and at times challenging and even frustrating process of conducting a research project, I aim to turn what can be a lonely endeavor into one that is fun and collaborative. In his presidential address to the Academic Pediatric Association in 2008, Peter Szilagyi, M.D., M.P.H., presented the concept of the "academic sweet spot," the intersection between 1) what is important, 2) your strengths and 3) what you are passionate about. Another goal is to help medical students, residents and fellows find their sweet spot and begin to think about it as a career vision.

Perhaps most influential to me has been the example of others. I have been nurtured by the most talented, wise and generous mentors. They are role models for me: of doing tremendous work on behalf of children and their families, being extraordinarily accessible and helpful, and enthusiastically celebrating my successes with me. As a mentor, I enjoy sharing the many pearls that my mentors have passed on to me and want to truly be there for my mentees like my mentors have been there for me. **MM**

Iris Wagman Borowsky is an associate professor of pediatrics at the University of Minnesota.



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Residency reflections

By Charis Van Dusen Thatcher, M.D.

Perfection driven, high achieving meets feeling like an idiot every day.
Missed this. Forgot that. Dotting I's, crossing T's I didn't know existed.
Can't eat. Can't pee. Can't see enough, read enough, do enough.
Hours march on, bleary-eyed, clumsy.
Do you like it? they'd ask. If you do anything that much, it stops being all that fun.
Patients mad. Staff short. Really?
Am I not cut out for this? Did I just dupe enough people to get here?
Fellow residents, my comrades in arms, this never-ending boot camp. Faces feign strength; well-concealed wounds.

Missing my baby crawl, missing vacations, missing my spouse. Mom and dad both have cancer.
Fading concept of time: day, night, weekend, weekday, holiday. It's all the same here.
To and from the hospital in the dark. Only people I know working all the time. I work all the time.
Beginning to think the sun would never come out in this North Star state.
No groceries, no clean clothes, no desire to move from the bed or couch and change that.
Coming in at a high cost, hoping this is worth it.

Deliver a baby, reduce a broken arm, stop a seizure. Reassure a mom her toddler is all right.
Stop the pain, stop the bleeding, stop thinking you can fix it all.
Daily expressions of There's nothing wrong, I don't know what's wrong, or I can't fix what's wrong.
Get to the bottom of it, get hydrated, get out on time.
Disposition: the ICU, the cath lab, the OR, the morgue.
Learning to stop death, learning to allow it, learning not to let it stop you.

Finally. The thrill of re-entering the outside world,
Whose motion did not cease when years ago I checked out.
Giddy with pop culture silliness, twilights to *Twilight*,
Learning yoga postures, figuring out Facebook, letting things slow roast instead of broil.
Finding room in my memory and time for other important and unimportant things.
Reclaiming my life from medicine and finding a place in it again.

Charis Thatcher completed an emergency medicine residency at Regions Hospital in St Paul. She now works and lives in Colorado Springs with her husband and two boys.



THE PHYSICIAN ADVOCATE

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



This year's House of Delegates will weigh in on the governance of the MMA.

Work group proposes governance changes

For the past two years, the MMA has been exploring how it can remain strong and relevant to all of its members.

The work began after members indicated they felt the House of Delegates wasn't working well and that the MMA needed to be more nimble. Leaders and staff from the MMA then discussed the issue with component medical society leaders, members from across the state and representatives from other state medical societies. The Board of Trustees formed a Governance Work Group, and last year's House of Delegates adopted a resolution to continue this work.

After more than 18 months of inquiry, study and discussion, the Governance Work Group proposed a new governance model to the MMA Board of Trustees in July. The Board approved the

proposal (with a few revisions) and will present it to the House of Delegates at the Annual Meeting in the form of a resolution. Some of the proposed changes include:

- reducing the board's size from 33 to 12 to 14 members to ease decision making;
- changing the membership of the board from being solely geography-based to competency-based with a sensitivity to the location of various members;
- replacing the House of Delegates with Policy Council Forums to increase opportunities for member input;
- gaining a better understanding of member concerns by holding multiple "listening" sessions throughout the state; and
- giving all MMA members the opportunity to vote in elections.

The proposal will be discussed at the Annual Meeting on September 14 and 15.

"These changes all stem from the MMA's desire to remain relevant to its members," says Benjamin Chaska, M.D., chair of the Governance Work Group.

The Policy Council Forums will focus on important issues physicians are facing in their practices. They will be held at the Annual Meeting and at least one other time during the year. The Policy Council, which will preside over the forums, will consist of 40 members most of whom will be appointed by component medical societies, as well as the Medical Student Section, the Resident and Fellow Section, and the Young Physician Section. The MMA president-elect will serve as the council chair. The Policy Council will make recommendations to the MMA Board based on the discussions at the forums.

"The forums will attract all members, not just delegates," Chaska says.

For more information on the proposed governance changes, visit the MMA website, www.mnmed.org. You will find a number of background documents there.

THE 15 PERCENT

Helping physicians find common ground in a complex world

When Joseph Bujak, M.D., walks into a room of physicians, he's hoping to connect with 15 percent of them. That's it. Not 100 percent, not 75 percent, not even half.

Is he selling himself short? After all, organizations pay the physician to speak. Shouldn't he be hoping to relate to more than just a handful of people in the room?

Bujak sees his task as helping physicians view things differently, so he expects a certain amount of skepticism when he speaks to groups of physicians, as he will September 15 at this year's MMA Annual Meeting. Bujak will deliver the keynote address, "Bringing Physicians Together: A Journey from I to WE to US."

Provoking people

"I like to provoke people," Bujak said in a telephone interview from his Coeur d'Alene, Idaho, residence. "My job is to unfreeze people to try and imagine that the future is going to be different." He said the only way to get people to change their point of view is to present them with information that causes them to recognize their current assumptions and ask themselves whether they remain valid in light of new information.

Bujak began his speaking career as an academic and then started looking for ways to reach more people with his ideas about transforming health care. After university and hospital stints in Washington, Idaho, Florida and Colorado, he joined Lee Kaiser's consulting network.

"[Kaiser] was way too busy to be able to meet all of the requests for his presentation and so I kind of became his stand-in," Bujak said. After a few years on the circuit, he met Tom Atchi-

son, a consultant who works with health care organizations on managing change, teambuilding and leadership development. Together, they co-authored a book, *Leading Transformational Change: The Physician-Executive Partnership*, in 2001. In 2008, Bujak published his second book, this time solo: *Inside the Physician Mind: Finding Common Ground with Doctors*.

Finding that common ground is the topic on which he will try to engage 15 percent of the physicians who come to hear his talk.

Bujak uses the metaphor of a Slinky, the metal spring toy, to explain the logic behind influencing the 15 percent. "Rather than creating a push strategy, in which you create a message that appeals to everybody, the equivalent of trying to push a Slinky from behind, you invent pull strategies," he said. "If you are going to create change, you really have to appeal to the front end." Thus, his focus on the 15 percent.

Implementing the journey

Bujak acknowledges that finding common ground among physicians isn't easy. He points out they are trained to be solo musicians. But in order to transform health care, they need to be more like a jazz ensemble. "We have to make music together. We have to coordinate the hand-offs. We need to coordinate information. We have to maximize what we can do for the patient," he said.

Event details

"Bringing Physicians Together, a Journey from I to WE to US" will take place from 9:15 to 10:15 a.m. on Saturday, September 15 at the Marriott City Center in Minneapolis. Following the presentation, from 10:30 to 11:45 a.m., Bujak will lead a discussion on how to implement the tactics addressed in the keynote. CME credits are available.

To register:

Go online to www.mnmed.org/AbouttheMMA/AnnualMeeting. Free for members; \$40 for both sessions for nonmembers. Questions? Contact Tara Stone at 612-362-3764 or tstone@mnmed.org.



QUICK BIO: Joseph Bujak, M.D.

EDUCATION: M.D. University of Rochester (New York)

AREA OF FOCUS: Infectious diseases

EXPERIENCE: Director of Internal Medicine Residency Training, Sacred Heart Medical Center, Spokane, Washington

Clinical Assistant Professor of Medicine, University of Washington

Chief, Medical Service, Veterans Administration Hospital, Boise, Idaho

Private practice of Internal Medicine and Infectious Diseases, Coeur d'Alene, Idaho
Vice President, Medical Affairs, Voluntary Hospitals of America, Inc. VHA Florida, Tampa, Florida, and Boulder, Colorado
Vice President, Medical Affairs, Kootenai Medical Center, Coeur d'Alene, Idaho

VERBATIMS:

"If you want to change your future, you have to change your behavior. If you don't change the way you behave, nothing

will change in terms of what you get."

"[Physicians] are acculturated to be autonomous individuals, just 'I.' We have no collective identity. We need to become a 'we.' And I don't think that's good enough. We need to become one."

"[Physicians] are so quick to criticize. We can tell you in a heartbeat what needs to be fixed, but we are unwilling to be responsible for the fixing."

VIEWPOINT

| by Lyle Swenson, M.D.

Reflections

As my tenure as MMA president comes to a close, I can't help but reflect on the transformation of our profession that has occurred during the course of my medical career.

We are living in a time of profound change in medical care and health care policy. These changes are affecting our profession and how we practice medicine in very important ways.

As we move into the future, I wonder: Will physicians still be able to keep the best interest of their patients' as their highest priority over their own self-interest or the interests of their employers?

The tremendous advances in our understanding of and ability to treat disease, technical procedures and devices, pharmaceuticals and genetics have made medical care increasingly complex. This complexity has led to rapid growth in physician specialization and the development of a multi-faceted approach to care. With this approach, we involve a large number of health professionals and institutions in the care of each patient, and we rely less on the knowledge and expertise of individual physicians.

Scientific advances and the capabilities of modern medicine, along with the accompanying higher expectations of patients, have inflated the cost of medical care. With large amounts of money at stake, medicine has become big business, with the potential for large profits. Those involved in the business of health care have tremendous influence over how care is delivered and financed. While all this has been taking place, physicians have seen their role in determining how health care evolves in our country diminished.

We have seen increasing consolidation of health care institutions, with the development of large hospital/clinic systems, sometimes with their own health insurance plans, and, more recently, with the desire to take on insurance risk for large numbers of patients. These systems hire physicians, who sometimes assume the role of employee grudgingly and often see it as an economic necessity.

As we move into the future, I wonder: Will physicians still be able to keep the best interest of their patients' as their highest priority over their own self-interest or the interests of their employers? Will our patients still value their physicians' scientific knowledge, expertise, empathy and compassion? And what about the patient-physician relationship that has taken years to build? Will patients place more trust in their hospital, their clinic, their insurance company or their Accountable Care Organization than their physician?

How we, as physicians, respond will



Lyle Swenson, M.D.
MMA President

have a dramatic effect on our role in the country's health care. It is important that we come together and take our rightful place at the table when practice decisions are being made.

I hand the presidency to Dr. Dan Maddox, knowing that he will do his best to ensure physicians are heard in debates about the future of health care. But the MMA is only as strong as its members, so I encourage you to renew your membership or join when you receive your membership notice. Together, we can find answers to the major questions facing health care. **MM**

VITAL SIGNS

MMA NEWS IN REVIEW



Physicians can learn how to improve patient outcomes at an MMA-sponsored event.

Improving outcomes through “Collaborative Conversations”

When you successfully engage your patients, you can improve outcomes. Learning how to do that will be the focus of two sessions scheduled for October 2 and October 9 in Minneapolis and Duluth, respectively.

Jan Schuerman, team director for the Institute for Clinical Systems Improvement (ICSI), will lead both sessions,



Jan Schuerman

which will be interactive discussions on ICSI’s “Collaborative Conversations” model.

The events, hosted by the MMA, the Twin Cities Medical Society, the Range Medical Society and the Lake Superior Medical Society, will be held from 6 to 8:30 p.m. The October 2 event will take place at the Ramada Plaza Minneapolis, 1330 Industrial Boulevard, NE. The October 9 event will be held at the Greysolon Ballroom, 231 East Superior Street, in Duluth.

Both are free for MMA members; \$35 for nonmembers. For more information, visit the MMA website at www.mnmed.org/collaborative.

Avera medical staff can’t sue as a whole

In July, a Lyon County district court judge ruled that Avera Marshall hospital’s medical staff is not an independent legal entity—specifically, an unincorporated association—that could sue or be sued by the hospital.

The judge stated that the medical staff is simply a group of physicians who are

accountable to the governing authority of the medical center, and whose duties and obligations are set forth in the medical staff bylaws. Essentially, this means that if the judge determines that the medical staff bylaws do constitute a contract, then individual physician members of the medical staff (but not the medical staff as an entity) may sue the hospital for breach of contract should the hospital fail to follow the mutually agreed-upon bylaws.

Lawyers representing the chief of staff, chief of staff-elect and medical staff contend that Avera is bound by the medical staff bylaws that were agreed to and adopted by the members of the medical staff and approved by Avera, and that these bylaws constitute a contract.

A final decision in the case is expected in September.

Minnesota tops list in e-prescribing

When it comes to e-prescribing, Minnesota health care providers are No. 1—at least according to a national ranking that took into account prescription routing, utilization of benefit information and utilization of medication history.

The high ranking shouldn’t be too surprising. Minnesota law required providers, group purchasers, prescribers and dispensers to establish, maintain and use an electronic prescription drug program as of January 1, 2011.

“We’ve made significant progress in using e-prescribing in Minnesota; nearly 68 percent of all clinics are participating,” says Rebecca Schierman, quality manager for the MMA, which has been supportive of e-prescribing since 2008. “We see the potential for e-prescribing to improve the quality of patient care, reduce medication errors, and reduce the burden of callbacks and rework between pharmacies and clinics.”

The ranking was conducted by SureScripts, which works with pharmacies, payers, pharmacy benefit managers,

physicians, hospitals, health information exchanges and health technology firms.

Joining Minnesota in the top 10 are Massachusetts (previously No. 1), South Dakota, Delaware, New Hampshire, Iowa, North Carolina, Maine, Vermont and Michigan. Washington, D.C., ranked 51st.

Consumer publication reports on diabetes and cardiovascular care

Consumer Reports subscribers in Minnesota may have been surprised to open their latest issue and see content dealing with health care and not the usual laptop or Blu-Ray player reviews.

The publication is experimenting with health care this year. In fact, Minnesota is just the second state to work with the publication's editors to report on the topic. The 24-page insert, which focused on diabetes and cardiovascular care, was distributed specifically to Minnesota and border communities.

Earlier this year, Massachusetts became the first state to work with the magazine, reporting on patient experience. Wisconsin is following Minnesota, focusing on preventive care.

"We're looking to offer more information that patients can use," says Jim Chase, president of MN Community Measurement, which worked with the publication on the insert. "We hope this isn't a one-time thing." Chase noted that the publication's editors would like to eventually offer a nationwide report on health care.

Chase says the editorial content for the Minnesota issue was reviewed by a nine-member team that included MMA member Kurt Hoppe, M.D. In addition, final results of clinic data and rankings were sent to medical groups for an accuracy check before publication.

MMA: MDs need larger role with MN Community Measurement

Few physicians would dispute the importance of measuring the quality of medical care in our state. However, some are concerned with the processes for doing so.

An evaluation conducted by the MMA this spring found that physicians want to be more actively engaged by MN Community Measurement (MNCM).

"Active participants have real concerns about the strength of the physician voice at the committee and measure-development levels, the transparency of the process used to develop measures and the decision-making process during measure development," says Rebecca Schierman, MMA manager of quality.

The MMA, which has supported MNCM financially and has been an active member since 2005, sent out surveys and conducted in-depth interviews with physicians who have been involved with MNCM about their relationship with the organization.

Although physicians said they feel MNCM's work has had an influence on the quality of care in Minnesota, they also indicated that physicians don't always believe the publicly reported data accurately reflect the quality of care in their clinic and often feel they are held accountable for outcomes beyond their control.

As a result of the findings, the MMA will work with MNCM to ensure more balanced and equitable decision-making and will advocate for meaningful physician involvement in the group's processes and governance structures.

MINNESOTA MEDICAL ASSOCIATION **Insights**
TALKING ISSUES WITH MMA LEADERS

Welcome to *insights*! *Insights* is a new "blog-like" publication that will feature MMA leaders' views on the issues facing the organization and medicine. It will be published quarterly and feature short opinion pieces that we hope will start a dialogue with members. In this issue, Dave Thorson, M.D., chair MMA Board of Trustees, announces "Focused for Success" MMA's new strategic plan. We hope you enjoy the first issue and [send us your feedback](#).

Rolling out an association-changing plan
The MMA is rolling out *Focused for Success*, our new five-year strategic plan that will focus our resources on three major goals that will touch every physician in Minnesota:

- Making Minnesotans the healthiest in the nation
- Making Minnesota the best place to practice medicine
- Advancing professionalism in medicine

We work in a complex and changing health care environment. It's clear that physicians' practices and how the MMA interacts with them has changed. MMA leadership felt the association needed a fresh and relevant plan that acknowledges these changes and positions the MMA for long-term growth.

We developed *Focused for Success* after surveying physicians and talking with them in groups and individually. We wanted to better understand your frustrations and your changing needs in order to best serve you.

Although this plan is physician-oriented it's our patients who will ultimately benefit from its success. I'm confident that our efforts will reduce the time physicians spend on administrative activities, will improve patient health and will increase professional satisfaction.

How do we plan to achieve our goals? We will start by addressing several issues related to each goal.

Coming Up
"Bringing Physicians Together"

Special Presentation
Joseph Bajak, M.D.
Nationally-known expert on physician communication
2:35 CMEs
Saturday, Sept. 15
Part of annual meeting

Update
Health Care Reform Update

MMA has you covered with the latest updates on health care reform and Minnesota's Health Insurance Exchange.

Video - ACA Supreme Court Ruling Event

MMA Strategic Plan website

Upcoming:
Special publication on Minnesota's Health Insurance Exchange

MMA launches new publication

The MMA has launched a new quarterly publication called *Insights* that features MMA leaders' views on the issues facing the organization and medicine in general.

The electronic publication, which is delivered to MMA members by email, will include short opinion pieces that are intended to spur dialogue with members.

It can be found online at www.mnmed.org under the "Publications" tab.

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

We are also on Facebook, Twitter, LinkedIn and YouTube.



LEGISLATIVE REVIEW

Four MMA members appointed to peer grouping advisory committee

The MMA has solid representation on an advisory committee that will help the Department of Health implement the state's provider peer grouping system.

MMA members **Julie Anderson**, M.D., St. Cloud Medical Group; **William Davis**, M.D., Winona Health; **David Luehr**, M.D., Integrity Health Network; and **Daniel Trajano**, M.D., Park Nicollet, were appointed to the committee in August.

The group has 24 members representing health systems and hospitals, physician clinics, health plan companies, consumers, state agencies, employers, academic researchers and organizations that work to improve health care quality in Minnesota.

The committee will work with Health Commissioner Edward Ehlinger, M.D., to define what constitutes a peer group; review quality and cost-scoring methodologies; adopt patient attribution methods; select risk-adjustment models; choose service dates for cost and quality reporting; recommend the inclusion or exclusion of costs; and consider whether adjustments are necessary for facilities that provide medical education, are designated Level 1 trauma centers, or provide neonatal intensive care or inpatient psychiatric care.

State hires Maximus to develop exchange

Although the Minnesota Legislature did not make any new laws regarding a state-run health insurance exchange last session, the Dayton administration continues to move ahead with creating one.

The exchange has been described as an Orbitz-like tool that will allow users to research, compare and then purchase an insurance plan that fits their needs. Minnesotans also will use the exchange to sign up for Medicaid.

In July, the state announced a \$41 million contract with Maximus Inc. to design and develop the technical capabilities for Minnesota's health insurance exchange, including a consumer friendly website. More than 93 percent of the contract will be paid for with federal funds.

States must file their intent to run their own exchange by November of this year. By October 2013, the website must be ready to handle open enrollment, which would start January 1, 2014.

By 2016, approximately 300,000 Minnesotans who currently are without insurance are expected to obtain coverage through the exchange. Another 200,000 small businesses will use it to purchase insurance for their employees. In addition, some 700,000 Minnesotans will use the exchange to enroll in Medicaid.

MEDPAC continues to add to board

The MEDPAC board of directors has added **W. Alice Hulbert**,

M.D., as its newest member. Hulbert, a retired anesthesiologist from Edina, has been active in past MMA-led efforts related to clean indoor air and the Freedom to Breathe Act, and has been a frequent visitor to the Capitol to lobby legislators on health care-related issues. MEDPAC is the MMA's political action committee.

Hulbert joins three other new members: **Eric Crabtree**, M.D., **George Schoephoerster**, M.D., and medical student **Dan Carroll**.

The four new board members take their positions at a very important time.

"With dozens of seats open this November, physicians have a unique opportunity to have an impact on the debate in the next Legislature," says Dave Renner, the MMA's director of state and federal legislation.

Renner and Eric Dick, the MMA's manager of legislative affairs, have been meeting with candidates and discussing issues that the MMA has identified as important to physicians, including reimbursement rates, the physician workforce shortage, tobacco policy and public health initiatives.

Following these meetings, MMA staff will share reports with the MEDPAC board and discuss how to best support the candidates who share the MMA's positions. The MEDPAC board uses voluntary contributions to help elect pro-medicine candidates to the Legislature.

For more information on MEDPAC, go to www.mnmed.org/Advocacy/MEDPAC.

Medical Practice Act work group gets underway

A Department of Health-appointed work group that will evaluate Minnesota's Medical Practice Act met for the first time in mid-August.

The work group, which was created as a result of the health licensing disclosure bill (often referred to as the Board of Medical Practice bill) passed last session, is tasked with determining whether the state's Medical Practice Act effectively protects citizens and allows for transparency.

Work group appointees are **Jon Thomas**, M.D., M.B.A. (BMP president); **Joseph Willet**, D.O. (a member of the BMP); **Linda Van Etta**, M.D., and **Terry Cahill**, M.D., both of whom were appointed by the MMA; **Barbara Gold**, M.D. (University of Minnesota); **Darryl Pardi**, M.D. (Mayo Clinic); **Sen. David Hann** (R-Eden Prairie); **Sen. Kathy Sheran** (DFL-Mankato); **Rep. Carolyn Laine** (DFL-Columbia Heights); **Rep. Bob Barrett** (R-Lindstrom); Health Commissioner **Edward Ehlinger**, M.D.; **Thomas Webber**; **Malcolm Mitchell**; **Kathleen Brooks**, M.D.; and **Jack Davis**.



MEET A MEMBER

William Roberts, M.D.

| By Dan Hauser



On October 7, thousands of runners will gather in downtown Minneapolis for the 31st running of the Twin Cities Marathon. MMA member William Roberts, M.D., will be there, too. Not to run but to help those who do make it safely to the finish line.

As one might imagine, running 26.2 miles takes its toll on the body—blisters, cramps, strains and, sometimes, much worse.

“On race day, we are trying to pick up people who may be having difficulty and respond to people who have emergencies,” says Roberts, who since 1985 has served as the race’s medical director. In that capacity, he oversees 20 volunteers whose job is to plan for, and then execute, a sort of triage operation for the marathoners running through the streets of Minneapolis and St. Paul.

“Part of our function during the year is planning for race safety,” he says. “We try to mitigate the risk of problems for runners.” Roberts and the committee discuss and prepare for the best ways to treat the more common ailments—cooling down

runners who have overheated on the course or treating hyponatremia, which can occur when a runner consumes too much water and the level of sodium in his or her bloodstream drops abnormally low. They also have to prepare for more grave situations such as cardiac arrest, which affects one in 60,000 finishers, on average. “We do a lot of planning to make it safe for the runners,” he says.

Although a regular presence at the fall event, Roberts has never actually run the marathon. “I’ve never had the inclination to run that far,” he says. “One of my friends once said, ‘If you put two bed and breakfasts on the course I’ll run the marathon.’ I kind of agree with him.”

But don’t get the wrong impression. Roberts is usually quite active with other pursuits including inline skating, biking, hiking and cross-country skiing. Unfortunately, all of this physical activity is currently on hold as he recovers from hip replacement surgery. He is quick to point out that his problems were likely caused by genetics and not to overdoing it. “My mother has a similar problem, and several of my cousins have had hips replaced around the same age,” he says.

While he is on the mend, Roberts has plenty of sedentary activities to keep him busy. As a result of his marathon duties, the editors of *Runner’s World* approached Roberts a couple years ago to act as their online “sports doc.” In that role, Roberts answers running-related questions for the publication’s website. Questions deal with everything from osteoarthritis of the knee and hip to nutrition to osteoporosis to back, ankle, foot and knee pain. In other words, questions that are geared toward getting athletes moving again.

Just as he hopes to do soon himself.

AT A GLANCE

MEDICAL SCHOOL

University of Minnesota

RESIDENCY

University of Minnesota’s Smiley’s Family Medicine Clinic

CURRENT PRACTICE

Program director of the University of Minnesota’s family medicine residency program at St. John’s Hospital in Maplewood and professor in the department of family medicine and community health at the University of Minnesota Medical School. He is also residency program director at the Phalen Village clinic in St. Paul.

ADDITIONAL ROLES

Past president and current foundation president of the American College of Sports Medicine; charter member of the American Medical Society of Sports Medicine; a founding member of the American Road Race Medical Society; and chair of the Minnesota State High School League’s sports medicine advisory committee.

HOBBIES

Inline skating, skiing, biking, kayaking, sailing



LEFT: William Roberts with daughter, Kelly, and granddaughter, Claire.



RIGHT: Skiing with daughters Kelly (center) and Jessie.

MMA IN ACTION Happenings around the state



Eric Dick

Eric Dick, MMA manager of state legislative affairs, and **Dave Renner**, MMA director of state and federal legislation, attended the AMA's State Legislative Roundtable in early August in San Diego. Thirty-seven state medical societies and 20 national specialty societies met to discuss emerging legislative issues and strategies for representing physicians. The AMA Advocacy Resource Center hosted the meeting. Renner also served as vice chair of the Resource Center's Executive Committee. This committee is composed of 16 state medical society staff members who advise the AMA on state legislative issues.



Dave Renner

Dick joined members of the Raise it For Health Coalition in August to present the benefits of an increased tobacco tax to a group of key Republican state senators. The coalition includes the MMA, the Minnesota Chapter of the American Academy of Pediatrics, the Minnesota Academy of Family Physicians, as well as Mayo

Clinic, Clearway Minnesota, the American Cancer Society, the American Lung Association and other public health advocates. The coalition plans to pursue an increase in the tobacco tax during the 2013 legislative session.

In June, **Brian Strub**, MMA manager of physician outreach, attended a session at the University of Minnesota Physicians Smiley's Family Medicine Clinic on effectively working with medical interpreters. The MMA and the Minnesota Academy of Family Physicians Foundation hosted the event.

Strub and Lake Superior Medical Society Executive Director **Heather Opsahl** met with Gary Davis, Ph.D., dean of the University of Minnesota Medical School, Duluth, and professor and former MMA President Ray Christensen, M.D., to discuss ways the MMA can better involve and serve UMD medical students.

In mid-July, Strub joined current MMA President **Lyle Swenson**, M.D., past MMA President **Ben Whitten**, M.D., and MMA CEO **Robert Meiches**, M.D., at a presentation on the value of MMA membership at the Minneapolis Heart Institute.



MINNESOTA
MEDICAL
ASSOCIATION

“I’m a **doctor**,
not a policy expert”

Making the views of Minnesota physicians heard is our specialty.

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Lyle Swenson, M.D.

Cindy Firkins Smith, MD • Dermatology,
Affiliated Community Medical Centers, PA
Member since 1991

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The Doctor by Sir Luke Fildes.
Image licensed from Tate Images

Was There Ever a “Golden Age” of Medicine?

By Peter J. Kernahan, M.D., Ph.D.

■ Some observers consider the first half of the 20th century to be medicine’s golden age; others believe it began after World War II and ended in the 1970s. This article takes a look at the way medicine has been viewed over time and some of the events that have shaped the profession and the way it has been perceived.

Amid the uncertainties of the present, we tend to look to the past as a happier time—an earlier golden age. Medicine has not escaped this tendency. For some writers, the first half of the 20th century was the “golden age” of medicine,^{1,2} an age that ended as the profession came under increasing criticism from the 1950s onward.¹ Other observers have placed the beginning of the golden age after World War II and its end in the 1970s and 1980s, with the increasing corporatization of health care.^{3,4} With this commercialization came fears for the very survival of medical professionalism.⁵

Characterizing a “golden age” inevitably raises questions of definition and “for whom?” Writers who consider the first half of the 20th century a golden age point to the expansion of medical knowledge and the growing prestige of the medical profession during that time. Those who favor the post-war decades emphasize the professional independence, income and control that physicians enjoyed then. Both view the medical profession as a single, unified body. In many ways, however, over the last two centuries, the medical profession’s past has been as problematic as its present. ↪

1830 to 1900: A Tenuous Profession

For many, the ideal of 19th century medicine is captured in Sir Luke Fildes' painting *The Doctor* (1887). Probably created as a tribute to the physician who had cared for Fildes' dying son, the painting is deeply evocative. The setting is a poor working-class cottage. The child, lighted in the center of the picture, is a portrait of innocent suffering. In the background, reduced to anxious spectators, are the parents—the stalwart father placing a comforting hand on the shoulder of the weeping mother. Although the physician may have had only a limited armamentarium, reflected in the few bottles on the table, his concern, compassion and willingness to sit beside his young patient and wait for the “crisis” are evident.

But whatever their individual merits, for most of the 19th century, physicians in the United States had little prestige, less money and little effective therapy to offer. The health care marketplace was unregulated. Most state licensing laws had been repealed in the anti-elitist atmosphere of the Jacksonian Era (1828 to the 1850s). Medical schools, which typically offered a degree after two short courses of identical lectures, served as “finishing schools” after an apprenticeship. Even this sketchy formal education was optional. No law prevented anyone from calling him or herself a “doctor,” although a diploma might provide some credibility in the marketplace. Little effective therapy existed and, until the second half of the century, traditional “heroic” remedies such as bleeding, mercury and purging were still used in conjunction with quinine, morphine and strychnine. Although elite physicians such as Oliver Wendell Holmes (1809-1894) expressed skepticism about the value of these treatments, for most in the profession, the old ideas and the old therapeutics prevailed.

The majority of Americans received care for most illnesses within the family. Self-treatment was both feasible and economical—no laws regulated the sale of any medicine. Those who sought respite outside the home had a number of choices. The physician was only one. Childbirth remained a female-controlled event, and an uneasy relationship existed between midwives and physicians.⁶ Lay healers abounded. A number of health movements, including Thomsonianism (which stressed botanic cures) and the Grahamites (who stressed vegetarianism and gave the world the Graham cracker) proved immensely popular. The Eclectics, a medical sect that split off from the Thomsonians, would go on to found their own medical schools.

Another medical sect, homeopathy, reached the United States in the 1820s and would prove the greatest threat to conventionally trained (regular) physicians. Homeopathic physicians, many “converts” from orthodox medicine, followed the teachings of the German physician Samuel Hahnemann (1755-1843) that “like cured like.” (He also coined the term “allopathic” to describe regular physicians.) They offered infinitesimal dilutions of drugs believed to mimic the symptoms of a disease. Although critics such as Holmes could mathematically demonstrate that the dilutions would be nothing more than pure water, the gen-

erousness of the remedies (in contrast to allopathic therapeutics) proved appealing not only to German immigrants but also to the educated and wealthy. During the cholera epidemics of the 1830s and 1840s, the homeopaths could creditably claim better outcomes perhaps because, unlike bleeding and purging, their therapeutics did not further debilitate already dehydrated and hypotensive patients. The American Medical Association was founded in 1847 in part as a response to the inroads made by homeopathy.

All of these divisions were carried into the new territories of the West. Lay practitioners and allopathic, homeopathic and eclectic physicians all competed in Minnesota's medical marketplace. In 1855, the allopathic physicians organized the Minnesota State Medical Society. Reflecting both professional disunity and the disruptions of the Dakota and Civil Wars, no meetings were held until 1869. At the beginning of that year, a state convention in St. Paul re-established the moribund society. The regulars had been spurred into action when their arch rivals, the homeopathic physicians, formed their own society in 1867.

One of the Medical Society's first acts was to appoint a committee to collect the names and addresses of all physicians practicing in Minnesota, both regular and irregular (homeopaths, eclectics and those without an M.D. degree). The results showed the tenuous position of the allopaths—of the 212 physicians identified in the state, almost half (93) were “irregulars.”⁷ As a testimony to the strength of the irregulars, the University of Minnesota operated allopathic and homeopathic medical colleges side by side from 1885 until 1909. And the bequest for the university's first hospital, Elliot Memorial (1911), came from the estate of an eclectic physician.

The proceedings of the society's early meetings, recorded in the *Transactions of the Minnesota State Medical Society*, a predecessor to *Minnesota Medicine*, reflected the anxieties of the time. Addressing the society's annual meeting in 1872, William Worrel Mayo, M.D., stressed the importance of professional unity in the battle against “the brutal ignorance of the pretender to eclecticism or the subtle disciples of Hahnemann.”⁸ That same year, President Franklin Staples, M.D., complained that the “intelligent physician has been too often discouraged by the treatment which he has received at the hands of the community.”⁹

In Minnesota, as in other states, regular physicians turned to the state for assistance in bolstering their authority.¹⁰ The Minnesota Legislature passed the state's first medical licensing law in 1869. Lobbying by the politically influential homeopaths led to the bill's repeal at the next session. In 1883, the Medical Society tried again, this time in cooperation with the homeopaths, and the state's first successful licensing law passed, part of a wave of such laws being crafted across the country. Medical practice laws set requirements for licensure and also restricted competition with physicians (both allopathic and homeopathic) by other healers. These state regulations were progressively tightened over the coming years but not without fierce opposition from organizations such as the National League for Medical Freedom,



During the first golden age,
**wealth was not one of the
 rewards a doctor could expect.**

which represented both lay healers and those philosophically opposed to government regulation.

At the same time, medical knowledge underwent a profound change as a result of a series of developments that had taken place largely in Europe. Scientific medicine came of age. The medicine of 1912 would be far closer to the medicine of 2012 than to that of 1812.

..... 1900 to 1950: The First Golden Age?

“We are living,” Dr. David Cheever told the Massachusetts Medical Society in 1925, “in the Golden Age of Medicine.”¹¹ As Cheever explained to his audience, scientific inquiry had replaced dogma, and the progress of medical science appeared limitless. The achievements of this new scientific medicine were indeed remarkable. Bacteriology had identified the causes of many of humankind’s most lethal diseases. With anesthesia and asepsis, the curative powers of surgery expanded. Vaccines, anti-sera and new chemical drugs offered new therapeutic options. In theory, the glory of the laboratory was reflected in a new-found admiration and respect for the ordinary physician.

Despite the scientific achievements of this first golden age, “among the rewards which the doctor cannot expect is wealth,” Dr. Richard Cabot of Harvard Medical School warned those contemplating a medical career in 1918.¹² Even in 1929, at the peak of post-war prosperity, while the average income for physicians in private practice (the great majority of the profession) was about \$5,000, half made less than \$3,800 and a quarter less than \$2,300.¹³ By comparison, the average income of all employed persons in the United States was \$1,800. A locomotive engineer could earn \$4,700, and an entry-level streetcar worker in New York \$1,700.¹⁴ And although the average income of physicians compared favorably with those of other educated professions (scientists, college

professors and engineers), the medical profession had a larger percentage with inadequate incomes.¹³ Only a handful of physicians were among the “one percent” of the day.

For general practitioners, still the majority of physicians, the situation could be particularly dire, especially in the small towns and rural areas of the country where almost half of the population lived. Older and more isolated, these rural practitioners comprised 30% of the profession but collected only 18% of its fees.¹³ Even in larger cities, 25% of the GPs earned less than \$2,000 a year and the top 10% only around \$5,000. By comparison, the top 25% of specialists earned between \$16,700 and \$31,300 per year depending on the size of the city in which they practiced.¹³ The Great Depression made things worse. General practitioners saw a 20% decline in collections compared with 13% for specialists. GPs with marginal practices suffered the most.¹³

Small wonder that fewer and fewer graduates chose general practice, particularly in rural areas, as a career. By 1929, of the country’s 121,000 private practitioners, only 56% remained in true general practice. Another 21% of GPs partially restricted their practice to a specialty. Almost a quarter of physicians in the United States limited their practice entirely to a specialty.¹³ The uneven rewards of practice and the competition to establish a specialty practice encouraged fee-splitting, unnecessary surgery and other abuses. Cheever warned his audience that such corruption only gave ammunition to medicine’s critics.¹¹ Medicine as a vocation and medicine as a business have had a long and uneasy history together.

In fact, medicine did not escape public censure and criticism throughout this period. Popular books, from Norman Barnesby’s muckraking best seller *Medical Chaos and Crime* (1911)¹⁵ to Hugh Cabot’s *The Doctor’s Bill* (1935), kept the failings of the profession in public view. And although popular movies of the day often idolized individual physicians, they

did not necessarily idolize the profession. *Men in White* (1934) hinted that the driven young physician protagonist (Clark Gable) had impregnated a nurse, leading to her death from an illegal abortion. The Academy Award-winning *The Citadel* (1938) dealt with money corrupting an idealistic physician, while both *The Story of Louis Pasteur* (1936) and *Sister Kenny* (1946) portrayed the medical establishment as stubborn, reactionary and closed-minded.

1950 to 1970: The Second Golden Age?

The other candidate for medicine's golden age is the 1950s and 1960s. Solo private practice fee-for-service medicine remained the norm. During this time, physician incomes rose to six times that of the average worker, and, at least during the 1950s, the income gap between the GP and the specialist began to narrow. In 1964, the year before Congress enacted Medicare, economist Seymour Harris attributed this rise to a combination of increased collections (41%), increased services (30%), increased prices (23%) and decreased business costs (6%).¹⁶ The expansion of voluntary health insurance helped, even if most plans did not cover outpatient treatment, which placed the primary care physician at a disadvantage when compared with the surgeon. Regulation was minimal. Physicians controlled hospital admissions, giving the medical staff power over administrators. At least superficially, the profession had an unprecedented degree of unity, authority and prestige.

Several factors, not all benign, contributed to this apparent cultural unity. First, of the nation's 220,000 licensed physicians, 175,000 belonged to county and state medical societies and 164,000 to the AMA.¹⁷ Second, the reforms of the Flexner era, while increasing the quality of medical education, decreased the diversity of the profession. The increasing cost and length of medical education put a medical career out of the reach of many from poorer backgrounds. Only one women's and two African-American medical colleges survived the reforms. Even those schools that did admit women and religious or racial minorities had quotas that severely restricted their numbers.¹⁸ Third, medical schools gave preference to the sons of physicians, arguing that these students had already been acculturated into medicine. Fourth, racial discrimination in medical society membership, which affected practice and educational opportunities, persisted well into the Civil Rights era.¹⁹ As a result, by mid-century the medical workforce was less diverse than it had been in 1900 or would be in 2000. The "golden age" was not for everyone.

Or perhaps anyone: Despite superficial unity, there were many divisions and tensions during this time. In the late 1940s, doctors still felt threatened by "overcrowding"—particularly as veterans returned from World War II. Medical societies vigorously opposed physicians in prepaid group practice. As the full-time academic model spread because of increased federal funding after the war, the division between town and gown widened. The latter sometimes argued that they practiced a higher form of medicine.²⁰ More prosaically, in many places the move to the

full-time system precipitated a series of power struggles within the hospital and the medical community.^{21,22}

For practicing physicians, career satisfaction depended on their specialty. In a 1966 survey, *Medical Economics* found that while 93% of ophthalmologists were very satisfied with their careers, only 48% of pediatricians were.²³ General surgeons, internists and GPs fell somewhere in the middle (74%, 68% and 64% respectively, were very satisfied). General surgeons complained of overcrowding and of being squeezed between GPs who operated and other surgical specialists. Pediatricians complained of long hours and low pay. GPs complained of a lack of prestige and respect from both patients and specialists. Neither the financial nor the psychic rewards of practice were evenly shared among specialties.

Further divisions occurred in medicine during the 1950s. General practitioners, fearing extinction and under-represented in the AMA, formed the American Academy of General Practice (AAGP). The new organization began a campaign to have general practice recognized as a specialty by both the profession and the public. In 1955, for the first time in 65 years, a GP became the president of the AMA.¹⁷ At about the same time, under its first permanent director since 1935, the American College of Surgeons (ACS) took its campaign against fee splitting, unqualified surgeons and other abuses to the public. An angry reaction from many in the profession, particularly the AAGP, followed.

The dispute became national news. *US News and World Report* took up the story, publishing lengthy interviews with both the ACS director and the AAGP president.^{24,25} In February 1954, *Fortune* magazine ran a widely read article "The M.D.'s Are Off Their Pedestal," which detailed clandestine fee splitting, unnecessary surgery and hospitalizations, and the abuses of physician-owned hospitals.²⁶ A popular indictment of organized medicine, Richard Carter's *The Doctor Business*, appeared in 1958. Similar books soon followed, including Fred Cook's 1967 *The Plot Against the Patient*. Criticism that was once confined to the academic press^{27,28} had now entered public consciousness. Waning public confidence in the profession as a whole appeared as early as 1956 in an AMA survey.^{17,29} By 1971, the president of the MMA would publicly muse about whether he would have been wise to discourage his sons from seeking medical careers given the "vicious and seemingly concerted" attacks on the profession.³⁰

Medicine's political environment also changed significantly during the post-war decades. At the turn of the 20th century, governments ("the state"), through licensing and practice laws, had been the allies of regular physicians in their attempt to consolidate the position of the profession.³ From the 1940s onward, this began to change. During the 1940s and 1950s, organized medicine suffered a series of defeats at the hands of the courts in its attempt to prevent prepaid group practice. Courts overturned laws banning the corporate practice of medicine. Local medical society membership could no longer be required for hospital privileges. The defeat of Truman's National Health Program in

1948 would mark the high point of organized medicine's political power. (Even then, the AMA could not have succeeded without allies in organized labor and business. By the time of the Medicare debate in the 1960s, those allies had been lost.)³¹ This withdrawal of state support continues to the present day.³

1970-2012: The Present Predicament

Initially, Medicare was a financial boon to physicians as were new diagnostic and therapeutic technologies. The gains, however, were not evenly distributed among specialties, setting the stage for future conflicts. Hand in hand with these developments came concerns about rising costs and quality. Other interest groups—insurers, government agencies, buyers' coalitions, administrators and other health care providers with their own professional agendas—began to challenge the medical profession's position in the health care marketplace.

Medicine itself became increasingly fragmented; by specialty, by practice and politically. Solo fee-for-service private practices no longer dominated the medical marketplace. After the 1960s, specialists turned increasingly toward their specialty societies for representation rather than to the AMA. In 1980, for example, the ACS withdrew from the AMA's House of Delegates for a decade and established its own Washington office.³² The once-dominant AMA now represents less than a quarter of the nation's physicians.³³

Conclusion

Medicine has a long history of fragmentation, internecine disputes, and an equivocal relationship with the public and the government. Although there may never have been a true golden age of medicine, one in which all of its constituent members were happy, as we confront the always uncertain future, we should consider why Fildes' painting still retains its power as inspiration and exemplar. **MM**

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Which is Feared More: Harm to the Ego or Financial Peril?

A Survey of Anesthesiologists' Attitudes about Medical Malpractice

By Christopher M. Burkle, M.D., J.D., David P. Martin, M.D., Ph.D., and Mark T. Keegan, M.D., M.Sc.

■ This article reports the results of a study of anesthesiologists to assess their concerns regarding medical malpractice liability risk. Specifically, it explored whether their fears stem more from being named as a party to a suit or from the financial impact of damage awards. According to the respondents, their reputation among patients and colleagues is of greater concern than the financial impact of a malpractice suit. Forty-six percent of the 149 respondents reported a constant fear of malpractice risk; 43% were concerned about their reputation among colleagues and 57% feared their reputation would be compromised among patients. A large majority voiced concern about potential inclusion in the National Practitioner Data Bank (83%) and their rankings on online physician-grading sites (85%). Forty-one percent said financial consequences were a concern, and 54% indicated that obtaining affordable liability coverage was an issue.

Across medical specialties, there is substantial variation in both the likelihood of a medical malpractice claim being brought against a physician and the average amount paid in a settlement.¹ Although the cumulative risk of being named in a malpractice claim remains high, most claims do not result in payment.¹ Despite this, physicians continue to voice concern about the effect that liability suits have on their economic security.²

Surveys of physicians have found the prevalence of concern regarding the negative impact of future litigation ranges from 35% (family medicine) to 72% (neurosurgery).³ We sought to assess the relative concerns of physicians regarding medical malpractice liability risk. Specifically, we investigated whether their fears stem more from being named as a party to a suit or from the economic impact of damage awards. We chose to survey anesthesiologists because as a specialty an-

esthesiology sees a fairly average number of claims and the amount of monetary awards is around the average for all specialties.¹ For that reason, our assessment of anesthesiologists' concerns may reflect the fears felt by physicians in a wide range of specialties. Unlike several other states, Minnesota has not passed legislation imposing caps on either economic or noneconomic damage awards. By surveying anesthesiologists practicing only in Minnesota, the financial impact of being named in a malpractice claim may be assessed independently of award caps.

Methodology

Following Institutional Review Board approval, we surveyed the membership of the Minnesota Society of Anesthesiologists (MSA) in May 2011 using an electronic survey tool. Physicians from all membership categories (full members, retired members, resident members and others) were invited to participate. Two email requests, an initial one and a

follow-up one, were sent to each member. Anonymity of those surveyed was preserved.

The survey included 14 questions; some were open-ended and others required respondents to indicate the extent to which they agreed with a statement or felt it was important (Table 1). Questions were designed to establish whether length of time in practice, previous involvement in a medical liability action and/or previous experience as an expert witness influences the level of anxiety associated with medical liability action. The survey also assessed anesthesiologists' level of concern that future litigation might 1) adversely affect their reputation among colleagues and patients; 2) lead to their name being included in the National Practitioner Data Bank (NPDB), an electronic repository of data on all payments made on behalf of physicians in connection with medical liability settlements or judgments; and/or 3) negatively affect their personal

TABLE 1. Survey Questions

Q1	Please indicate the best description of your practice: <input type="checkbox"/> Resident physician in anesthesiology <input type="checkbox"/> Private practice anesthesiologist (urban setting) <input type="checkbox"/> Academic practice anesthesiologist <input type="checkbox"/> Private practice anesthesiologist (rural setting) <input type="checkbox"/> Retired anesthesiologist <input type="checkbox"/> Prefer not to answer												
Q2	Please indicate any previous medical malpractice experience: <input type="checkbox"/> Never been named as a party to a medical malpractice suit <input type="checkbox"/> Named as a party to a suit without a final settlement or judgment against me <input type="checkbox"/> Named as a party to a suit with a final settlement or judgment against me <input type="checkbox"/> Prefer not to answer												
Q3	Please indicate any previous experience in providing expert witness testimony during malpractice litigation involving anesthesia care: <input type="checkbox"/> I have provided expert witness testimony <input type="checkbox"/> I have never provided expert witness testimony <input type="checkbox"/> I prefer not to answer												
<i>Please indicate your level of agreement or disagreement with the following statement:</i>													
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Q4	I have a constant fear that I will be named in a malpractice suit at some point during my career. 1 2 3 4 5 6												
<i>Please indicate your level of importance for the following concerns involving medical malpractice claims:</i>													
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Q5	Whether or not in the end a medical malpractice settlement or judgment is ever made against me, simply being named as a party to a suit will damage my reputation among colleagues. 1 2 3 4 5 6												
Q6	Whether or not in the end a medical malpractice settlement or judgment is ever made against me, simply being named as a party to a suit will damage my reputation among patients. 1 2 3 4 5 6												
Q7	I fear that following a medical malpractice settlement or judgment against me, my name will be added to the National Practitioners Data Base. 1 2 3 4 5 6												
Q8	I fear that following a medical malpractice settlement or judgment against me, this information will be listed in a public-accessible physician grading site on the internet. 1 2 3 4 5 6												
Q9	The amount of damages that may be awarded during either a medical malpractice settlement or judgment against me may cause me financial ruin. 1 2 3 4 5 6												
Q10	A medical malpractice settlement or judgment against me will negatively impact my ability to attain liability insurance coverage at an affordable premium. 1 2 3 4 5 6												
<i>Please rank your relative concern related to the following aspects of being named as a party to a medical malpractice claim. Use each number only once.</i>													
	<table border="1"> <thead> <tr> <th>MOST IMPORTANT</th> <th>2ND MOST IMPORTANT</th> <th>3RD MOST IMPORTANT</th> <th>LEAST IMPORTANT</th> <th>PREFER NOT TO ANSWER</th> </tr> <tr> <th>1</th> <th>2</th> <th>3</th> <th>4</th> <th>5</th> </tr> </thead> </table>	MOST IMPORTANT	2ND MOST IMPORTANT	3RD MOST IMPORTANT	LEAST IMPORTANT	PREFER NOT TO ANSWER	1	2	3	4	5		
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Q11	Impact on professional reputation 1 2 3 4 5												
Q12	Impact on personal finances 1 2 3 4 5												
Q13	Impact on liability insurance premium availability or affordability 1 2 3 4 5												
Q14	Impact on personal feelings of professional merit 1 2 3 4 5												

finances and their ability to obtain affordable liability insurance coverage.

Responses in which the participant indicated they “prefer not to answer” were treated as missing data. For the purpose

of analysis, the responses indicating the strength of agreement or disagreement with statements were treated as ordinal data. Data were analyzed using descriptive statistics and the Cochrane Armitage

trend test. Responses to Question 1 were grouped into two categories—private practice/academic practice and resident/nonresident—for separate analyses. Responses to Questions 2 and 3 were

grouped as “never or previously named as a party to a malpractice suit” and “never or previously provided expert witness testimony.” *P* values of less than 0.05 were considered significant.

Results

Of the 398 MSA members for whom we had email addresses and to whom we sent the survey, 149 completed it (response rate 37%). This represented approximately 30% of the MSA’s membership.

Information about the practice status of the 149 respondents and their experience with malpractice suits is shown in Table 2.

■ **Fear of Being Named in a Malpractice Suit**

Sixty-nine respondents (46%) agreed or strongly agreed with the statement “I have a constant fear that I will be named in a malpractice suit at some point during my career.” The level of agreement with this statement was not influenced by the respondents’ level of training (*P*=0.33), previous malpractice experience (*P*=0.23) or previous experience as an expert witness (*P*=0.15). It *was* influenced by whether an anesthesiologist was in an academic or private practice setting, with those in private practice more likely to agree or strongly agree with the statement (51%) than those in an academic setting (29%) (*P*=0.02).

■ **Potential Repercussions of a Malpractice Suit**

Table 3 shows the number of anesthesiologists who agreed or strongly agreed with statements indicating that malpractice suits against them would have adverse effects on their professional reputation and financial well-being.

Respondents’ answers to questions concerning their reputation (Questions 5 and 6) were not affected by their practice status (*P*=0.14, 0.15 for private/academic practice, respectively, and 0.84 and 0.84 for resident/nonresident, respectively). Similarly, questions about reputation were not affected by their previous experiences regarding involvement as a named

Resident physician in anesthesiology	26 (17%)
Private practice anesthesiologist	72 (48%)
Academic anesthesiologist	43 (29%)
Retired anesthesiologist	8 (5%)
Never named in a malpractice claim	108 (72%)
Named in a malpractice claim without judgment or settlement against	33 (22%)
Named in a malpractice claim with judgment or settlement against	8 (5%)
Provided expert witness testimony in the past	33 (22%)
Never provided expert witness testimony	116 (78%)

party in a malpractice suit (*P*=0.85, 0.20, respectively, for Questions 5 and 6) or as an expert witness (*P*=0.81, 0.94, respectively).

Concern that a malpractice settlement or judgment would result in inclusion in the NPDB (Question 7) and poor ratings on physician-grading websites (Question 8) was almost universal, as indicated by more than 80% of respondents. These concerns were not affected by previous experience as a named party in a suit (*P*=0.58, 0.74 for Questions 7 and 8, respectively) or being an expert witness in a case (*P*=0.35, 0.51 for Questions 7 and 8, respectively).

Both resident and practicing anesthesiologists were similarly concerned about inclusion in the NPDB (*P*=0.40) or ratings on online physician-grading sites (*P*=0.45). Physicians in private practice were more likely to be worried about those issues than those in academic settings. Ninety percent of anesthesiologists in private practice agreed or strongly agreed with the statement expressing concern about inclusion in the NPDB compared with 75% of academic anesthesiologists (*P*<0.01). Ninety-one percent of anesthesiologists in private practice and 78% of those in academic settings agreed or strongly agreed with the statement of concern about public reporting on web-

sites (*P*=0.04). Although there were some differences, more than three-quarters of the respondents in both groups agreed or strongly agreed with the statements expressing fear of being named publicly.

Forty-one percent of respondents agreed or strongly agreed that damages resulting from a suit might cause them “financial ruin.” Both residents and practicing anesthesiologists answered this question similarly (*P*=0.11). However, anesthesiologists in private practice were more concerned about this than those in academic settings (*P*=0.02). The responses to the statement regarding subsequent ability to obtain affordable malpractice insurance were similar, with private practitioners more concerned about a negative impact on malpractice insurance than academic anesthesiologists (*P*< 0.01).

Respondents’ perception of their ability to obtain affordable liability insurance was also influenced by their previous experience with medical malpractice suits. Fifty-nine percent of physicians who had never been named as a party to a medical malpractice suit agreed or strongly agreed that a judgment against them would compromise their ability to obtain affordable insurance, compared with 36% of those who had once been named in a suit (*P*=0.04).

TABLE 3. **Adverse Effects of Malpractice Suits—Response to Survey Statements**

STATEMENT	NUMBER (% OF TOTAL) OF RESPONDENTS WHO AGREED OR STRONGLY AGREED WITH STATEMENT
REPUTATION	
“Whether or not in the end a medical malpractice settlement or judgment is ever made against me, simply being named as a party to a suit will damage my reputation among colleagues.” (Question 5)	64 (43%)
“Whether or not in the end a medical malpractice settlement or judgment is ever made against me, simply being named as a party to a suit will damage my reputation among patients.” (Question 6)	85 (57%)
“I fear that following a medical malpractice settlement or judgment against me, my name will be added to the National Practitioners Data Base” (Question 7)	123 (83%)
“I fear that following a medical malpractice settlement or judgment against me, this information will be listed in a public-accessible physician grading site on the internet.” (Question 8)	127 (85%)
FINANCIAL WELL-BEING	
“The amount of damages that may be awarded during either a medical malpractice settlement or judgment against me may cause me financial ruin.” (Question 9)	61 (41%)
“A medical malpractice settlement or judgment against me will negatively impact my ability to attain liability insurance coverage at an affordable premium.” (Question 10)	81 (54%)

The experience (or lack thereof) of offering expert witness testimony in the past had no bearing on the questions relating to financial ruin or insurance affordability ($P=0.81$).

■ Relative Concern Assessment

A review of queries to assess the relative fear concerning personal merit, professional reputation, impact on personal finances, and the effect on availability and affordability of liability insurance found that 61 individuals answered those questions in error by stating the same level of concern for more than one of the options offered. Their responses were excluded from analysis of Questions 11 through 14.

For those responses available for analysis (almost 60% of respondents), impact on professional reputation was most often chosen as their first or second most important concern. Seventy-seven percent of respondents chose impact on professional reputation as their first or second most important concern, followed by impact on personal feelings about professional merit (65%), impact on personal finances (36%) and, finally, impact on availability and affordability of liability insurance (21%). These results were not affected

by practice setting, previous malpractice experience or previous experience as an expert witness.

Discussion

Our study is limited by the nature of the survey data and the small size of our sample population. These factors may limit the ability to generalize our results to all physicians. Recall bias and selection bias may apply as well. Nonetheless, the study of MSA members provides a snapshot of the feelings of a diverse group of anesthesiologists practicing in a state in which few tort reform measures have been implemented.

We found almost half (46%) of the anesthesiologists who responded to our survey have a “constant fear” that they will be named in a malpractice suit at some point during their career. The percentage of those reporting a fear of litigation is higher than the percentage (27%) who had been involved in prior litigation. Furthermore, the potential repercussions of a malpractice suit weighed heavily on the minds of the anesthesiologists in our sample. Many feared the negative impact litigation might have on their reputation with patients and colleagues. This finding

is consistent with findings from a 2008 survey of Massachusetts anesthesiologists in which 51% reported being very concerned about the negative impact that a medical malpractice lawsuit would have on their practice.³

Our data demonstrate physicians’ concern over the possibility of being listed in the NPDB and/or (presumably negative) comments on physician-grading websites, independent of previous exposure to the medico-legal system. Although anesthesiologists represent approximately 4.4% of the physician workforce in the United States,⁴ anesthesia-related malpractice cases account for only 3.3% of all claims reported to the NPDB.⁵ We speculate that the very public nature of these two mediums and the inability of individuals to offer explanations or corrections leads to high anxiety.

Despite the prevalence of fear for their reputation, fewer than half of the physicians we surveyed were concerned that future litigation might cause them “financial ruin.” Those in private practice were more concerned than those in academia. This may reflect that physicians who do not have a large academic center to support them in legal matters perceive financial

vulnerability. Although the median payment following an anesthesia-related mishap is similar to the average for all specialties (\$100,000 to \$200,000), this amount includes pay-out limits implemented in several states through damage cap legislation.¹⁵ The average cost of medical malpractice insurance premiums for anesthesiologists has declined from \$32,502 in 1985 to \$19,558 in 2006.⁵ Nonetheless, a majority of those we polled remained concerned that future litigation might affect their ability to attain affordable liability insurance. This fear was more prevalent among those who had never been named in a suit, perhaps suggesting that a fear of the unknown may exist to a degree.^{6,7}

The effect of previous malpractice experience is a matter of debate. In 1985, Charles et al. demonstrated that impending legal action would have a greater impact professionally and emotionally on physicians who had previously been sued compared with those who had not.⁸ More recent studies, however, looking strictly at defensive medicine practices, have found the opposite effect.^{6,7} The unreliability of the current tort system is highlighted by the fact that many plaintiffs are awarded a judgment despite lack of physician negligence.⁹ The large number of claims may affect the level of fear reported by physicians. The chance that a physician will face a malpractice claim by age 45 is reported to be between 36% (low-risk specialties) and 88% (high-risk specialties); that increases to 75% and 99% by age 65.¹ Approximately 5% (low-risk specialties) to 33% (high-risk specialties) of physicians make their first medico-legal payment to a patient by age 45, with that percentage increasing to 19% and 71% by age 65. In our study, apprehension over litigation was no more pronounced among those anesthesiologists who had already defended a suit than among those who had not.

The fear of litigation may have many untoward effects on the professional choices physicians make.^{8,10,11} Strategies that physicians have used include transferring their medical practices to states

with a better malpractice environment, eliminating certain high-risk services and practicing defensive medicine.^{8,10} Several reviews show that more than 90% of physicians claim they regularly practice defensive medicine because they fear potential litigation.^{7,12} In a recent article, it was estimated that defensive medicine practices accounted for \$45 billion of the total \$2.3 trillion spent on health care in the United States per annum.¹³

Perhaps the greatest concern arising from this study is the implication of physicians' fears of malpractice liability for patient care. Patients may be left with inadequate access to quality health care as physicians limit both the type of patients they are willing to care for and the geographical area for which they will provide coverage.^{6,8} In addition, future research will be needed to determine what impact liability fears may have on physicians' willingness to enter professional relationships with practitioners such as certified registered nurse anesthetists, nurse practitioners and physician assistants.

Conclusion

Malpractice litigation remains a concern for most physicians. Understanding the fear that is associated with being involved in a medical malpractice claim may help those who counsel physicians about how best to manage their concerns. Furthermore, those involved in tort reform efforts may benefit from understanding that among a representative group of anesthesiologists, reputation among patients and colleagues is of greater concern than personal finances or the cost of liability insurance, although the financial consequences of a malpractice claim should not be understated. This finding may lend support to the idea of reforming the medical malpractice system so that it is less about identifying negligence and assessing blame and more a means for compensating patients for injuries they sustain. **MM**

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Creating Our Future Together

If we cultivate our relationships, we can face the fears that come with change.

By Val Ulstad, M.D., and Kathy Ogle, M.D.

Many of us respond to the changes we see taking place in health care with fear. The challenge of change itself is not what frightens us; change is inevitable in any living system. But the current pace, volume and chronicity of change have worn us down. Fear—perhaps hidden beneath anger, exhaustion and apathy—threatens what lies at the heart of good medicine: relationships. Relationships—between primary care physicians and specialists, across professional interdisciplinary lines, and with our patients and their families—are the pulse of our profession. Healthy relationships are fundamental to meaningful communication, to excellent quality of care and to healing itself. Yet signs of fear, strain and even failure of relationships—the heart of health care—are everywhere we look today. In these rapidly changing times, we need sustaining professional relationships more than ever.

Reflexes Thwart Us

Our own physiology offers a metaphor for the current state of our profession. Human beings developed resilience to the most common threat to life in primitive times, decreased blood flow to the body resulting from trauma or childbirth. The body's response to blood loss is to preserve perfusion to vital central organs at the expense of the periphery. Activation of the neurohormonal system leads to constriction of blood vessels to maintain perfusion pressure; activation of the sympathetic nervous system makes the heart beat faster and harder; and retention of salt and water helps restore blood volume. The physiologic "assumption" is that the underlying heart muscle is strong and healthy. Thus, prehistoric humans could compensate, crawl back to the cave and heal.

Today, heart failure is the most common condition for which older people in the United States are hospitalized. Yet the body's ancient reflex response remains the same. Vasoconstriction and salt and water retention are triggered by the decreased output from the failing pump. This leads to a downward spiral, the vicious cycle of heart failure, with reflex responses further straining the heart (Figure 1). Medical therapy for heart failure aims to counteract these responses, for example, by decreasing pump load through vasodilating with angiotensin converting enzyme inhibitors. Interrupting our ancient but now counterproductive

reflex response has been the key to making a difference in survival for millions with this condition.

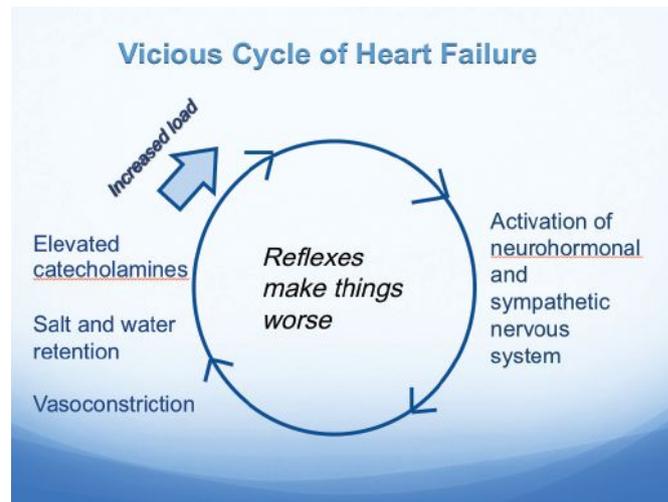
How might other reflex responses to threat affect us today? Our fast-paced, fragmented and distressed profession is under severe strain. Decreasing reimbursement, new accountabilities for care, changing reimbursement strategies intending to reward the value of care and not the volume of care, transparency in cost and quality information, public reporting, evidence-based medicine, accountability for patient experience, the focus on avoiding and reducing readmissions to hospitals, and regulatory search for waste and fraud leave a busy clinician wondering, "How will I deal with all of this and continue to thrive in the practice of medicine?"

Everywhere we look, the strain is palpable. With a constant emphasis on increasing productivity, we struggle—against rising suspicion, with fragmentation of care, and with managing finite resources, particularly our time and energy. Collegiality has lost out to competition and efforts to simply cope. Our reflex response to these changes is fear.

The Toxicity of Fear

A clinician's fear might manifest in questions such as: Is my practice viable? What will be reimbursed and how can I do more of that? Can I keep up with the pace? Will I have to work harder

FIGURE 1



to make less? Will I lose the support that I have? Will my patients sue me? What will my colleagues think of me? How did it happen that I have given up control but still have all the responsibility? A physician leader may lose sleep wondering: How can we meet the financial challenges ahead? How can I recruit and retain good people? How do I get any new initiatives going when I am always reacting to something else? Which roles and responsibilities should I keep and which ones should I delegate? How will I learn what I need to know? What do I do when I feel caught between competing loyalties? Where will I find the time to think about all of this?

A fearful person literally will constrict the range of possible responses he or she will consider in the face of a threat. Fear stimulates the sympathetic nervous system, the so-called fight or flight mechanism, which like our cardiovascular response to traumatic blood loss, evolved for relief of the acute and transient stresses of prehistoric times. Yet analogous to our “modern” medical problem of heart failure, this reflex response becomes toxic when applied chronically.

A sense of increased vulnerability reflexively leads to anger, suspicion and withdrawal. This tightens the downward spiral and further strains our relationships. Our focus on self-protection and concern about our individual needs intensifies, further eroding the strength of our relationships with others. Angry and suspicious, we might think, I’m tired of being the one to give something up; I have no control over my life; I am not a widget; I don’t know who I can trust; I no longer find my work meaningful; I made a mistake becoming a doctor; I must prevent the drain on my energy; I’m exhausted and have nothing left for my family; I don’t have time or energy for committee meetings; I cannot hear another sad story; if I send a patient for a test, I don’t have to talk to him; I don’t care anymore; or I’ll put up with this until I have enough money saved and quit. We then add pressures of our own to the system: We demand more money, time and autonomy; dig in for fights; withdraw; or simply give up. We might distract ourselves by overworking or focusing on gaining recognition; give in to poor health habits; quit or, worse yet, quit and stay on the job. A strained leader may over-commit, feel isolated, search for quick fixes rather than meaningful approaches to solving problems, have poor insight into how his or her intentions are perceived and use fear as a “motivational” tool.

Fear is a normal response to a high volume of change. Fear will exist. Yet it’s the reflex response to fear that thwarts us (Figure 2).

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Making Choices in the Face of Fear

How can we respond to the dramatic changes occurring in health care today? In his powerfully insightful book about his experience as a prisoner in the camps of Nazi Germany, *Man’s Search for Meaning*, Dr. Victor Frankl describes what it takes to survive and perhaps even thrive in extraordinarily challenging times.¹ Frankl concludes that one must face reality and remain

FIGURE 2



hopeful. The important word is “and.” Social activist Dr. Parker Palmer would say that emphasizing one at the expense of the other leads to “corrosive cynicism” or “irrelevant idealism.”² But holding and maintaining tension between these extremes, optimally facing reality and seeing what is and imagining what can be, allows us to continue and weather the most tumultuous storms of change despite our fear.

Harvard’s Dr. Ronald Heifetz says human beings can more successfully adapt to frightening, changing environments by facing painful circumstances and developing new attitudes and behaviors in order to cope.³ He calls this “adaptive work.” In adaptive work, there is a gap between the way things are and the way we want them to be; there are many different and competing points of view about how to make progress; and there will be a sense of loss of the familiar past, a need for difficult learning, a need for experimentation and, inevitably, resistance. Heifetz contrasts this with what he calls “technical work,” where the solution is known and simply needs to be applied to the problem. For example, placing a stent in an acutely occluded coronary artery would be a technical fix for a patient who has had an acute myocardial infarction (AMI). The patient making the lifestyle and behavioral changes necessary to prevent another AMI—facing mortality, repairing broken relationships, addressing depression and changing lifelong habits—is doing adaptive work. Technical fixes aren’t bad and may require significant expertise—and are often necessary steps for progress; but they are insufficient to really correct underlying problems. Yet the most common reason we fail in addressing our tough problems is that we choose a technical (quick) fix for problems that demand adaptive work.

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Creating a Future through Relationships

There is no quick fix for what we face in health care today. Nobody knows how to reinvent our system. Given this, we must recognize that our reflex response—I feel at risk, something is wrong, I need to protect what is mine, I must escape—is inevitable. Fear is a given, but we have options for how we deal with it. As in chronic heart failure, understanding and learning

to recognize that our reflexes are poised to react offers us an opportunity to intervene and change our patterns of response. When we feel fear, we can recognize it as a signal—a response to the strain of change. The sources of strain then need to be identified, acknowledged and confronted. In addition, we need to maintain hope and make intentional, constructive choices instead of succumbing to our reflex responses. We need to interrupt old pathways that hinder rather than help us. Relationships are where this work can be done.

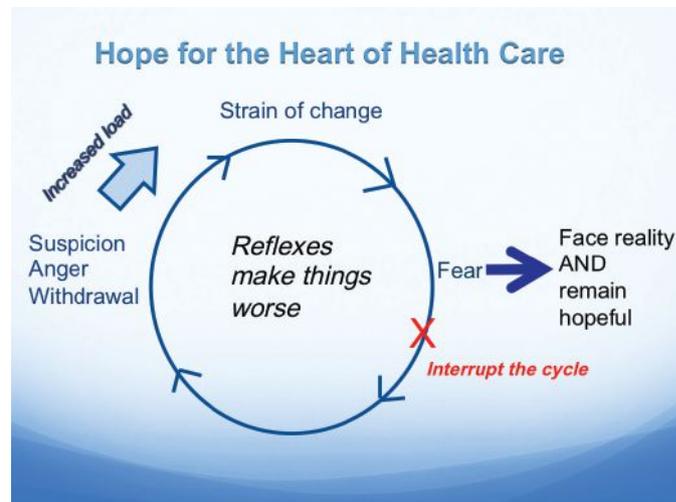
An obvious parallel exists between the choices that we face as a profession and those our patients have when they confront a serious health issue. We can allow fear to overtake us, or we can face reality and remain hopeful as we craft new professional partnerships to provide high-quality care, use resources responsibly, and give patients the real sense that we care for and about them. In doing this, we can reinvigorate our sense of joy, commitment, creativity, integrity and courage. We must find ways to thrive as professionals or nothing else we need to do to transform our work will be possible.

Healthy relationships are the heart of healing work, and our organizations are nothing but groups of relationships. Within them, we need to develop a sense of what we are trying to do together. We must start with shared clarity about what we are trying to accomplish. We must break down the work to a size where it is big enough to be meaningful and small enough to be manageable. Making progress together, we will build our collective confidence so that we *can* make further progress. Our futures are interconnected whether through bundled payments, accountability for the health of a population of patients, agreement on roles to find synergy instead of duplicating services, or finding and agreeing upon effective standards for communication.

We need to strengthen our abilities to speak honestly and listen well. Our professional tendency to interrupt is legendary. Playwright and Nobel Laureate George Bernard Shaw said, “The single biggest problem with communication is the illusion that it has taken place.” Genuinely hearing others’ perspectives and being willing to adjust our understanding of what it will take to make progress on the work at hand will be critical. With clarity of purpose, we can be present and attentive to each other, show each other genuine curiosity and ask thoughtful questions, recognize and suspend our judgments, speak honestly and passionately, and commit to learning together. It will be important to offer each other appreciation along the way. All too often, we offer little but criticism or silence. Most of us would move mountains in response to genuine appreciative recognition from our peers.

This will require us to slow down enough to take time for conversations. In our discussions with each other, it will be important to cultivate ways to disagree, debate and avoid the default behaviors of opting out and disengaging. The fundamental idea in the book *Crucial Conversations* is this—we can talk about

FIGURE 3



anything in conditions where all have a sense of mutual purpose and behavior demonstrates mutual respect.⁴

We often misread another’s resistance to change as evidence that the person doesn’t care. Heifetz reminds us that not caring and being overwhelmed can appear the same. In health care, what looks like laziness or disengagement is often exhaustion. How might our relationships flourish if instead of continually increasing expectations, we helped one another by offering empathy, by breaking the work down into smaller steps, and offering ourselves as a resource to one another?

Health care is full of challenges that are festering because they have been treated with technical fixes rather than by doing the adaptive work that takes time and attention. Acknowledging and interrupting the reflex response to our understandable fear of change is the first step. The hope for a better future in health care hinges on our making progress together on tough, complex adaptive work (Figure 3).

Relationships can be a tremendous source of transformative energy for such work. Developing a sense of shared purpose in our work, developing our ability to have tough conversations in productive ways, helping each other instead of judging each other and taking care of ourselves will give us the ability to face reality *and* remain hopeful in the face of fear as we attend to the heart of health care and create our future together. **MM**

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Kidney Donation and Chronic Kidney Disease

Kidney donors should not be denied health insurance coverage.

By Arthur J. Matas, M.D., and Hassan Ibrahim, M.D., M.S.

A recent *New York Times* article, “The Reward for Donating a Kidney: No Insurance,”¹ detailed the plight of a 53-year-old Minnesota kidney donor. The man, a retired teacher, was “in good health” but was unable to obtain private health or life insurance after tests found he had a low glomerular filtration rate (GFR), a phenomenon not uncommon among people with one functioning kidney. The article documented that other donors had had similar experiences. How can something like this happen? Why are some donors (wrongly) denied insurance? Understanding what has transpired requires a review of a number of developments.

GFR and Chronic Kidney Disease Staging

People considering kidney donation undergo extensive medical and psychosocial evaluations.² Criteria for acceptance include having two kidneys, normal kidney function, having no identifiable risk of disease transmission (eg, hepatitis C) and being able to tolerate the procedure with no or minimal increased risk, compared with the age-matched general population. The operative risks for a healthy donor cohort include a perioperative mortality rate of about 0.03%, or three in 10,000, and a morbidity rate of <1%.^{3,4}

Considerable data support the concept that an individual can live a normal life with one kidney. People who are born with one normal kidney have a normal lifespan. Baudoin et al. reported a 50-year

follow-up of patients who underwent unilateral nephrectomy in childhood and noted that their kidney function was well-maintained.⁵ Similarly, a study of World War II veterans who had undergone unilateral nephrectomy following trauma showed no increased risk after 45 years.⁶ Most important, every long-term follow-up study of kidney donors to date has shown that donors have the same or better long-term survival rates and the same long-term medical risks as age-, ethnicity- and gender-matched members of the general population.^{4,7-17}

Numerous other studies, none of which involved kidney donors, have shown an association between reduced kidney function and an increased risk of cardiovascular disease and death.^{18,19} In 2002, the National Kidney Foundation and the Kidney Disease Outcomes Quality Initiative (KDOQI) Clinical Practice Guidelines provided a definition of chronic kidney disease (CKD) and a classification of severity based on GFR (Table).^{20,21} Chronic kidney disease was defined as kidney damage or a GFR of <60 mL/min/1.73m² for three months or more, irrespective of cause. The two principal outcomes of CKD were noted to be the progressive loss of kidney function over time and the development and progression of cardiovascular disease. Decreased GFR is also associated with hypertension, anemia, malnutrition, bone disease and decreased quality of life. The authors of the KDOQI guidelines wrote that they developed the classification scheme be-

cause “therapeutic interventions at earlier stages can prevent or ameliorate most of the complications of decreased kidney function as well as slow the progression to kidney failure.”²¹

In order to be eligible for kidney donation, most transplant centers require a minimum GFR of 80 mL/min/1.73m². Given that there is an age-related decline in GFR, some centers will accept donors over the age of 60 with a GFR between 70 and 80 mL/min/1.73m². Donor nephrectomy results in an immediate loss of 50% of GFR; because the remaining kidney adapts, GFR returns to 70% to 80% of its original value by six weeks post donation. Subsequently, GFR is stable and subject to normal age-related decline, although some donors actually show an increase in GFR over time.^{13,22,23}

By simply donating one kidney plus having some age-related loss of kidney function, 15% to 40% of kidney donors will meet the KDOQI definition of stage 3 CKD, which is having a GFR between 30 and 59 mL/min/1.73m², even though they have no other evidence of kidney damage or progressive deterioration of kidney function.^{13,24} In one study from Japan, 85% of donors met the definition of having stage 3 CKD.²³ Presumably, denial of insurance to healthy donors is related to the risks associated with stage 3 CKD. Yet, in the general population, stage 3 CKD is a result of kidney disease or a systemic disease that affects the kidney (eg, hypertension, diabetes). The increased risk to these individuals is likely

caused by the underlying disease rather than the mild decrease in GFR.

Long-Term Follow Up

General population studies showing the increased cardiovascular and all-cause mortality risks associated with reduced GFR have a median follow-up of <10 years.^{18,19} An increasing number of former kidney donors who have been followed for more than 20 years are, however, not experiencing increased disease and mortality risk. In Sweden, Fehrman-Ekholm et al. noted that long-term survival of former donors (follow-up one to 40 years) was better than that in the matched populations.⁹ Long-term follow-up studies from Japan (up to 35 years), Norway (up to 40 years) and France (>30 years) also have shown no increased risk.¹⁴⁻¹⁶

A matched cohort study from Canada that included 2,028 donors found no increased cardiovascular risk in donors.¹⁷ In the largest cohort to date, we ascertained the vital status and lifetime risk for end-stage renal disease in 3,698 donors who were matched for age, sex, and race or ethnic group with population controls.¹³ Survival was similar to the controls; in addition, the rate of ESRD was similar to or lower than that for the general population. Reported long-term survival after donation for donors in these studies (mean age at donation about 42 years) is shown in the Figure.

Chronic kidney disease staging was an important step forward in diagnosing early disease and developing protocols to minimize progression. However, data suggest that reduced GFR that is the result of donor uninephrectomy does not have the same consequences as reduced GFR that is the result of disease.^{7-17,23-25} This is of critical importance to donors, as they apply for health or life insurance, or consider a job change that would require that they reapply for insurance.

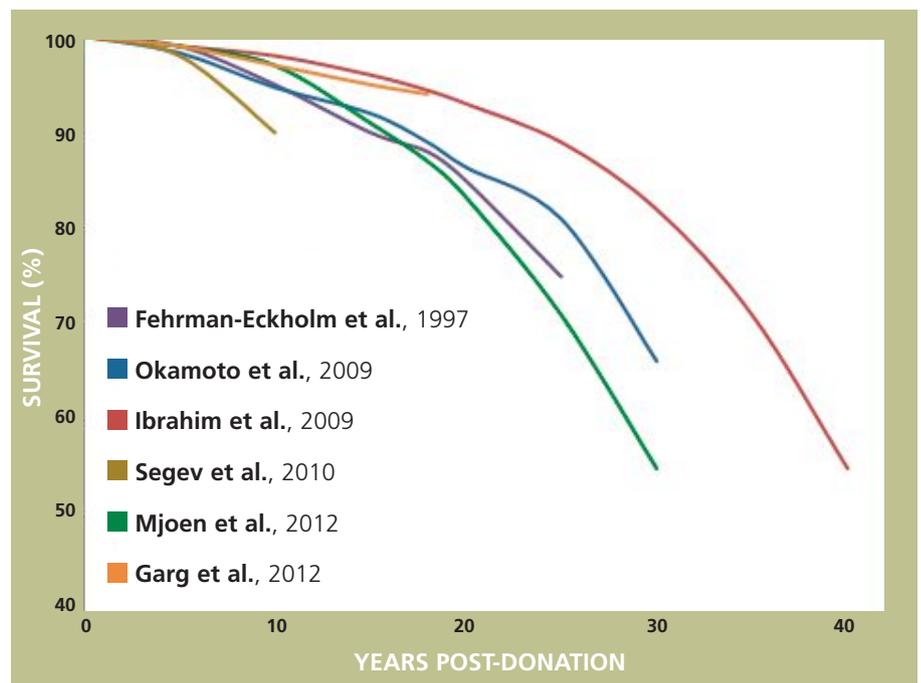
There is no doubt that additional long-term follow-up studies need to be done, especially in ethnic subgroups and in those donors approved although not meeting standard acceptance criteria.²⁵ And, just like the rest of the popula-

TABLE
Classification of **Kidney Disease***

STAGE	DESCRIPTION	GFR
1	KIDNEY DAMAGE WITH NORMAL OR ↓ GFR	≥90
2	KIDNEY DAMAGE WITH MILD ↓ GFR	60-90
3	MODERATE ↓ GFR	30-59
4	SEVERE ↓ GFR	15-29
5	KIDNEY FAILURE	<15 (OR DIALYSIS)

* Modified from Levey AS, Eckardt K-U, Tsukamoto Y, et al. Definition and classification of chronic kidney disease: A position statement from Kidney Disease: Improving Global Outcomes (KDIGO). *Kidney Int.* 2005;67(6):2089-100.

FIGURE
Postdonation Survival Probabilities of Kidney Donors in Six Studies.*



* In each study, long-term survival was similar to population controls.

Sources: Fehrman-Ekholm I, Elinder CG, Stenbeck M, et al. Kidney donors live longer. *Transplantation.* 1997;64(7):976-78; Okamoto M, Akioka K, Nobori S, et al. Short- and long-term donor outcomes after kidney donation: analysis of 601 cases over a 35-year period at Japanese single center. *Transplantation.* 2009;87(3):419-23; Ibrahim HN, Foley R, Tan L, et al. Long-term consequences of kidney donation. *NEJM.* 2009;360(5):459-69; Segev DL, Muzale AD, Caffo BS, et al. Perioperative mortality and long-term survival following live kidney donation. *JAMA.* 2010;303(10):959-66; Mjoen G, Reisaeter A, Hallan S, et al. Overall and cardiovascular mortality in Norwegian kidney donors compared to the background population. *Nephrol Dial Transplant.* 2012;27(1):443-7; Garg A, Meirambayeva A, Huang A, et al. Cardiovascular disease in kidney donors: matched cohort study. *BMJ.* 2012;344:e1203.

tion, former donors should have regular preventive care. Kidney donors are not immune from developing kidney disease and, therefore, any donor with estimated GFR<60mL/min/1.73m² should be screened for proteinuria, hematuria,

hypertension, diabetes and, if indicated, have imaging done of the remaining kidney. However, a healthy donor with an isolated finding of an estimated GFR <60 mL/min/1.73m² should not be treated like a patient with CKD. Classifying

otherwise healthy donors as having stage 3 CKD is a disservice to these heroes who have literally given of themselves. **MM**

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Words to a young graduate

By Margaret M. Barnes, M.D.

The dead and the children
the youth and the aged
hold out a flame
for us to see by

Our patients, our families,
lovers and friends
expect a flame
from us for them

And we, with one another,
look for kindling in the darkness
friendship in the terror
of learning our limitations
and we, with one another,
are sometimes too distant
and sometimes too close
to see what we need

But there's laughter in the hallways
solace in the work
challenge in the chance to change destiny

Margaret Barnes is a radiation oncologist in Fergus Falls, Minnesota.