

# MEDICINE



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## THE *outs* ISSUE

— WINNERS of our ANNUAL —

## PHOTOGRAPHY & WRITING CONTESTS



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Local doctors dive into **CREATIVE ENDEAVORS** PAGE 6

**FISCH AWARDS** enable artistic exploration PAGE 10

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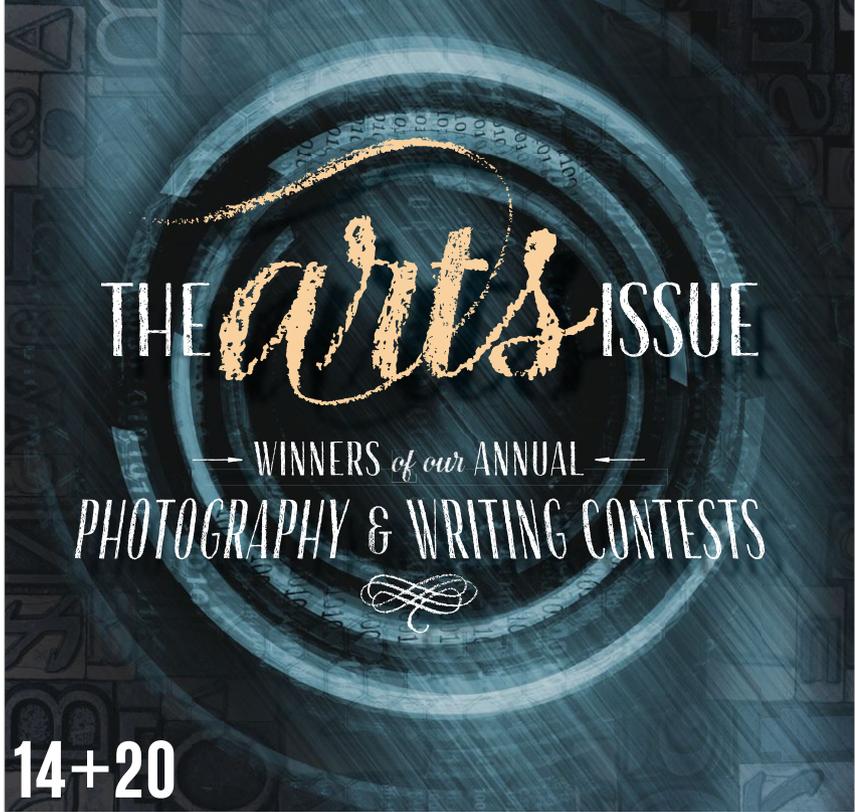
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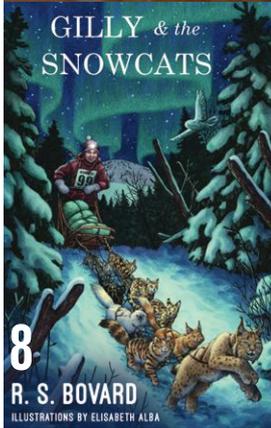
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PHOTO BY SCOTT WALKER

Charles R. Meyer, MD, Editor in Chief

The practice of medicine  
is a full, sometimes  
overwhelming  
immersion in the human  
condition that can't just  
fit into the confines of  
an Epic record.

## Thorough examination

The main lecture hall at Northwestern University Medical School when I attended was a one-story stone building set on Lake Shore Drive overlooking Lake Michigan. We frequently dubbed it “the mausoleum,” partly because of architectural similarities to cemetery structures, but partly because some of the activities therein were so deadly. Most days during our first two years, we would trudge into it lugging our weighty textbooks, sit in its musty seats, and listen to lecture after lecture covering anatomy, physiology, histology and biochemistry. By the afternoon, the air inside was truly mausoleic, a depressing contrast to the cool lake breezes just outside the front door. Our lecturers did their best with the teaching materials then available, which in the pre-PowerPoint era included chalkboards, lantern slides and overhead transparencies with erasable marker. But eight hours of dense medical material delivered in a dingy atmosphere was truly stifling, if not soporific.

I quickly decided that if my mind was going to avoid fatal petrification, I needed nonscientific diversion. So I read. I read *Time* magazine, whose medicine section was my closest contact with clinical medicine during those years. I read novels—some escapist, some literary. My wife and I attended free old movies put on by a local art museum. And I wrote some poetry, the lines of which remain forever hidden in notebooks that will never see the light of publication. The panoply of arts was a tasty dessert following the daily rigid diet of medical science.

Such desire for diversion may, in part, explain the response to our annual arts issue. Despite the busy, if not hectic, lives of medical students, residents and physicians, 37 of them invested time and mental anguish this year to create poetry or prose pieces and submit them to our writing

contest. In these submissions, the authors glimpsed patients with a new chance at life and those at the end of life. They walked with people living with puzzling diseases and those with intractable pain. They helped welcome new life and say goodbye to a long life. In short, they painted the pathos and privilege of being a practitioner of medicine.

Which explains the more compelling reason why, each year, our writing contest contributors take fingers to keyboard and students apply for the University of Minnesota's Fisch Art of Medicine awards. The practice of medicine is a full, sometimes overwhelming immersion in the human condition that can't just fit into the confines of an Epic record. It needs airing; it needs expansion; it needs art.

My wife and I have a daily ritual, during which we sit down with our evening beer and she asks the leading question, “How was your day?” Sometimes my response is a mundane litany of number of patients seen, picky irritations conquered and routine office news. But many times, it is a story of a longtime patient dying, a young woman devastated by her first STD, or a touching note from a grateful family. In short, it is an artful, far from soporific recounting of life moving through my exam room—the drama of humanity through the lens of medical science.

*Minnesota Medicine* Editor-in-Chief  
Charles R. Meyer can be reached at  
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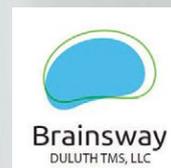
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# Song for Syrians

ER doc seeks self-expression—and help for refugees—through music

In 2015, as millions of people fled Syria to escape their country's civil war, Dave Dvorak, MD, watched in disbelief from Minneapolis, feeling helpless. News photos of a drowned 3-year-old Syrian boy on a Turkish beach sickened him. The emergency medicine physician decided he needed to get involved.

So last year, Dvorak took two trips to the Greek island of Samos, where he worked in a refugee camp providing medical care to the roughly 1,400 people staying there. Uprooted from their homes, traumatized, and living in overcrowded, poor conditions, many of Dvorak's patients struggled with physical and mental ailments, from respiratory troubles and infections to post-traumatic stress disorder.

"To come face-to-face with the crisis and the people and hear their stories—you can't help but be moved by what they've endured," Dvorak says. "So many came from middle-class families and were professionals like nurses, teachers, pharmacists and businesspeople. What I really took home from these trips is how alike the Syrian refugees are to us."

He also returned with a desire to do more. This time, he got creative. He wrote a song called "Refugee Lullaby."

"When you get back, it's hard to put into words your experience and how these other people are living," Dvorak explains. "That song is about a father and son who are escaping the war in Syria, up against a



To see the video for "Refugee Lullaby," visit [mnmed.org/refugeelullaby](http://mnmed.org/refugeelullaby). To purchase *Things You Cannot Measure* and learn more about the Boat Refugee Foundation, visit [davedvorakmusic.com](http://davedvorakmusic.com).

world that doesn't seem to care. The song practically wrote itself."

"Refugee Lullaby" wasn't Dvorak's first try at songwriting. For the past decade, he's used music as a creative outlet and a

way to process some of his experiences as a physician. Dvorak regularly attends a meetup group for singer-songwriters, and his work impressed the group's founder, Don Strong, a music producer. Strong asked Dvorak if he'd like to record some of his original material in a studio. That was a no-brainer, Dvorak says. The opportunity offered a long-sought life experience and a way to bring attention to the refugees' plight.

So last fall, Dvorak and Strong recorded a 10-song album, *Things You Cannot Measure*, including "Refugee Lullaby" and other songs about love, loss, relationships, living in a materialistic society, and the politics of fear. The pair also made a music video for "Refugee Lullaby" that includes images of refugee camps and the Syrian war, along with footage of Dvorak singing.

Since releasing *Things You Cannot Measure* in December, Dvorak has been making the rounds at open microphone nights and other events to play songs and generate album sales. As he performs "Refugee Lullaby," he's raising awareness of



Dave Dvorak, MD, performs locally to support his first album, *Things You Cannot Measure*, and to raise money to aid refugees.

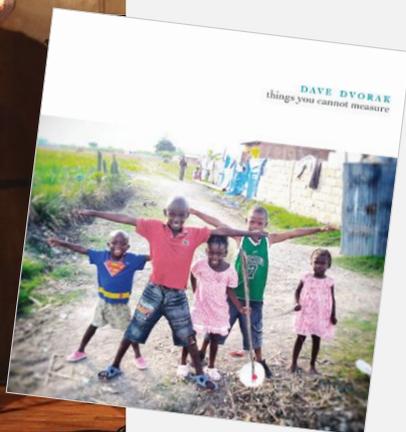


PHOTO BY MARY BETH SOBOLEWSKI

# Work in pictures

*A physician-photographer exposes the realities of child labor*

**D**avid L. Parker, MD, nearly took up ceramics. Seeking a creative outlet in the early 1990s, the occupational medicine physician and epidemiologist briefly mulled working in clay before he instead decided to revisit a past pursuit. Parker had been the photo editor at his high school newspaper and he'd taken photography courses in college, so grabbing a camera wasn't a stretch. His choice of subject matter also made sense. Parker was employed at the Minnesota Department of Health, where he routinely pored over data about child labor. So he focused his artistic energies on that very topic.

Parker has since traveled to India, Nepal, Nicaragua, Sierra Leone and many other far-flung destinations to photograph children engaged in difficult, demanding and often dangerous work. His stark, unflinching images of young brick workers, carpet weavers, leather tanners, cigar makers and others have filled three books and appeared in materials from academic,



David L. Parker, MD, took this photo during a trip to Sierra Leone. To see more of his work, visit [childlaborphotographs.com](http://childlaborphotographs.com).

government and social service institutions. The Library of Congress, the Weisman Art Museum at the University of Minnesota, and the Minneapolis Institute of Arts (MIA) all count work by Parker among their collections. Recently, the MIA fielded a request to provide several of his images for display at the Minnesota governor's mansion.

Through his photography, Parker sheds light on alarming conditions and public health threats that children face throughout the world. The reality he captures is often harsh; but he's not motivated by catching "gotcha" moments in the factories, fields and mines that he visits.

"My goal is not to say the people in these places are bad," he explains. "I don't want people thinking I'm there to put them in jail." Parker recognizes that extreme poverty and complex socioeconomic factors contribute to the circumstances he observes, and he tries to convey those elements in his photos. Parker believes such documentation can spur social change. As evidence, he cites Lewis Hine's photos of U.S. child workers during the early 20th century—iconic images credited with swaying public opinion and influencing enactment of state child labor laws.

Parker balances his photography career with his role as a senior medical researcher for  
*(continued on next page)*

## Song for Syrians ...

the people and circumstances he observed in Greece—and he's raising money. All proceeds from Dvorak's CD sales benefit the Boat Refugee Foundation, the Dutch nonprofit relief organization he worked with in Greece. So far, the project has raised about \$7,000.

Dvorak spent 22 years working in the Fairview Southdale Hospital emergency department before leaving this year to moonlight and pursue other interests, including music and more volunteering.

(He again served at a refugee camp in March.) He now works shifts at the Minneapolis Veterans Affairs Medical Center, the NorthPoint clinic in Minneapolis, and FirstLight hospital in Mora, Minnesota.

Dvorak taught himself guitar during his residency and played in a cover band with friends for fun. Taking up songwriting built on his existing love of writing. (An essay he wrote about an uninsured patient diagnosed with lung cancer won a

2012 *Minnesota Medicine* writing contest award.)

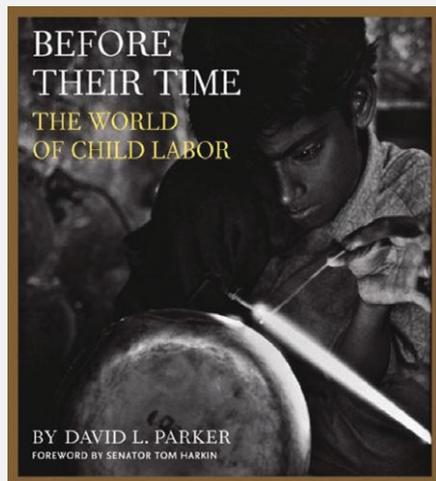
"Writing songs speaks to the same part of me as writing a piece about a powerful patient encounter," Dvorak says. "Completing it and revising it 100 times and finally getting it where you like it is very satisfying, whether it's a piece of prose or a song. There is a sense of accomplishment in getting the story out. It's a form of self-expression that I find gratifying."

— SUZY FRISCH

## Work in pictures...

(continued from previous page)

HealthPartners Institute in the Twin Cities. He also aims for a delicate balance in the images he creates. Despite his emphasis on subjects that can be unsettling, Parker always strives for some degree of visual appeal.



Parker published *Before Their Time* in 2007.

"Nobody is interested in work that doesn't have some kind of aesthetic value," he acknowledges. "It's an ingredient. It's not the whole thing, but it's necessary."

As a social documentarian, Parker doesn't have the luxury of composing scenes before pressing the shutter button. "You don't have a lot of time. People are moving quickly and the physical environment can be dangerous," he says. But the nature of his locations often helps him anticipate where and when to point his lens.

"In many places—whether it's a diamond mine or a factory—work tends to be repetitive," he notes. "People carry out roughly the same process, time and again. Sometimes I see work as a dance. I try to combine that movement and the landscape that exists around it. I try to capture a moment that defines the work itself."

— SCOTT A. BRIGGS

Shown here in Antarctica during a late-1990s stint with the National Science Foundation, Ralph Bovard, MD, drew inspiration for his new novel from past experiences working in rugged, remote locations around the world.



## A new adventure

Ralph Bovard, MD, introduces young readers to *Gilly and the Snowcats*

As an author, Ralph Bovard's oeuvre is pretty expansive in scope. The occupational and environmental medicine physician has penned articles on bone health, back pain and musculoskeletal imaging, along with such titles as "Altitude Illness in Skiers: A Worldwide Concern" and "Paragliding Injuries: How Dangerous Is This Growing Sport?"

Recently, Bovard added to his canon with a debut in one of contemporary publishing's hottest categories: young adult fiction. His self-published 160-page novel *Gilly and the Snowcats* is about a 12-year-old girl who enters Alaska's famed Iditarod Trail Sled Dog Race—with a team of cats.

Inspired by Freya, a Swedish goddess who traveled in a chariot pulled by felines, the book's lead character embarks on a journey that includes

encounters with treacherous ice floes, a belligerent moose, a savage wolverine, a pod of killer whales and—Bovard's favorite adversary—the grotesque, mysterious Wendigo. The author sees *Gilly and the Snowcats* as a coming-of-age story about a young woman seeking freedom and success.

"I've always been a closet writer," says Bovard, an Iowa native who entered St. Olaf College in Northfield as a pre-med student but graduated in 1976 with a degree in literature. "And I've always been drawn to writers who were also doctors." Among his favorites are William Carlos Williams, Arthur Conan Doyle and Somerset Maugham—all of whom trained in or practiced medicine at some point in their lives.

While an undergrad, Bovard became disenchanted with his pre-med requirements. But his grandfather had been a physician, and his father had been ac-



cepted to medical school before deciding at the last moment to pursue a career in law. So Bovard couldn't shake the feeling that perhaps he was called to be a doctor.

"I thought there was a family destiny in medicine," he says. While serving in the U.S. Army Reserve, Bovard was posted at Fort Snelling and assigned to the Medical Corps. He eventually earned an MD from the University of Minnesota and a master's of public health from the University of Arizona.

Bovard began writing *Gilly and the Snowcats* during a six-month

hiatus from practice, between positions at University of Minnesota Physicians and at HealthPartners, where he now works as director of the Occupational and Environmental Medicine Residency program. His source material included memories of researching high-altitude injury and frostbite in Alaska during medical school. He'd also heard tales about the Iditarod from his brother, a Montana veterinarian who cared for sled dogs used by four-time race winner Doug Swingley. When conversations with his teenage niece got Bovard thinking about young adult readers, he began jotting down notes, then sentences, then chapters.

"You just start scribbling away, and suddenly, you end up with something," he says.

Bovard didn't find it particularly difficult to write for middle schoolers rather than fellow physicians. When adult friends who reviewed his drafts worried that the vocabulary levels were too high, Bovard shrugged it off. "I don't believe in talking down to anyone," he says. "I think kids understand more than we know."

Reviewers on Amazon.com, where *Gilly and the Snowcats* is available for purchase, call the book "delightful," "engaging and

original," and "an inspirational tale for children and adult adventurers of all ages."

The author knows firsthand how seductive epic journeys and exotic destinations can be. Bovard has climbed Denali and worked on Mount Everest as an expedition physician; served as a ship's doctor aboard an oceanographic research schooner; worked as a base physician at Palmer Station in Antarctica; and been a set physician on the films *Cliffhanger* and *The River Wild*. His time as a missionary doctor in Papua New Guinea inspired him to collaborate on a screenplay called *The White Shaman*,

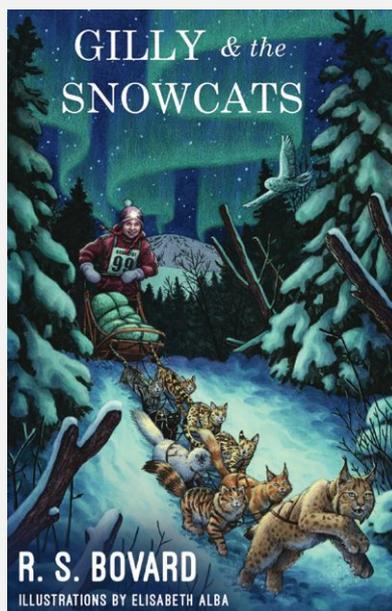
a runner-up in the 2013 Scriptapalooza screenwriting competition.

Currently, Bovard is at work on a book about health care, reflecting on his 34-year career. Meanwhile, he also has ideas for more young adult novels. As Bovard sees it, medical practice and literary pursuits are highly compatible.

"Good physicians must have an ability to describe and compare. They must also find beauty in the ordinary and appreciate the wonder of unseen things. And of course, empathy is important," he says. "All of those

traits are essential to writing as well."

— JOEL HOEKSTRA



Bovard published his first young-adult novel in December 2016.

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# MEDICAL STUDENTS

*exhibit*

# artistic ambitions

*Celebration caps a decade of  
fostering creativity in future physicians*

BY SCOTT A. BRIGGS

**A**s early-evening sunshine pierced the windows of a Weisman Art Museum gallery in Minneapolis on May 2, an audience inside warmly welcomed the University of Minnesota medical students who came to shed light on their recent creative pursuits. The presenters were winners of the Fisch Art of Medicine Student Awards, a program that provides funds to help people studying medicine devote some attention to their artistic sides.

Marking its 10th year in 2017, the Art of Medicine program has given dozens of students \$250 to \$2,500 apiece to nurture their talents in traditional creative disciplines—such as music, dance, photography and sculpture—as well as in less orthodox arenas, which have included magic, clowning and aerial arts. The program was named to honor Robert O. Fisch, MD, a retired pediatrician and longtime painter who, at 92, remains involved with the program as mentor and cheerleader-in-chief for award recipients.

“By opening new doors,” he says, “the Fisch awards create new opportunities for medical students.”

Eight students—including six individuals and a team of two—received Fisch awards for 2016-17. Most of them appeared at the May celebration to showcase their funded efforts.

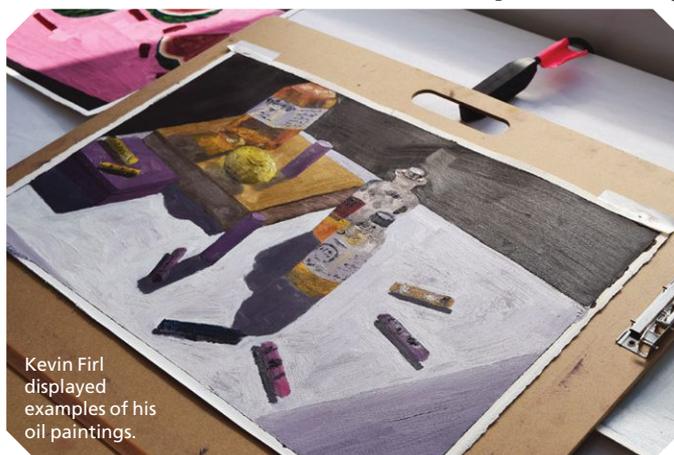
### Departing shots

Two Fisch award-winners—**Kevin Firl**, who studied **oil painting**, and **Kelly Setterholm**, who worked on a **writing** project—were three days shy of graduation when they presented their work at the Weisman.

Firl, bound for a one-year surgery rotation in Tulsa, Oklahoma, followed by a three-year ophthalmology residency at George Washington University in Washington, D.C., used his award money to take painting classes at the Minneapolis College of Art and Design and at The Art Academy in St. Paul. He learned to contend with oil paint's slow drying time, which forced him to work in a single layer rather than add foreground objects on top of a background completed earlier, as he'd done with acrylics.

In a figure painting class, Firl was surprised to learn of the level of expertise many great artists have about individual muscles. However, he also took classmates aback with his own first-hand knowledge gained during the OBGYN rotation he was in at the time. "As we looked at different muscle groups," he recalled, "I said, 'Oh, I actually saw that muscle today in surgery!'"

Setterholm, preparing for a psychiatry residency at Strong Memorial Hospital in Rochester, New York, appeared at the awards celebration carrying a large, leather-bound album of photos, letters and other keepsakes that inspired her highly personal writ-



Kevin Firl displayed examples of his oil paintings.

ing project. She'd delved into journal entries written by her late mother—a longtime artist, herself—and had begun composing an exploration of her family's clouded history.

An English major as an undergrad, Setterholm wrote little during medical school due to time constraints. The Art of Medicine award allowed her to enroll in classes at the Loft Literary Center in Minneapolis. During her presentation, she thanked Dr. Fisch

for enabling her to re-engage in a treasured creative outlet. "I feel like I'm coming back to be the person I used to be," she said.

### Word work

Third-year student **Augie Lindmark** also attended Loft classes, where he polished **poetry** skills. At the awards celebration, flashing a sheepish smile, he apologized ahead of time for swearing "in such a nice museum." Then he launched into an animated, rhythmic spoken-word performance of a poem titled "26," which related his experiences learning to spell during kindergarten, motivated by what he believed was

a pressing need to rescue the superhero Batman.

"When you rearrange the word alphabet, it forms a message: Help a bat," Lindmark's performance explained. "We curled over our papers and wrote letters to Batman because we thought he'd like to know we were on our way."

**Nathan Ratner** drove to the Minneapolis event from the U of M's Duluth medical school

campus, where he was finishing his second year. Ratner's medium was **audio**. He used his Fisch award to attend the Center for Documentary Studies at Duke University in Durham, North Carolina.

Ratner attributed his passion to the years he spent listening to public radio commentaries by Jon Hallberg, MD, a Twin Cities family medicine physician who manages the Fisch awards and was at the celebration to introduce presenters. Ratner then played selections from an interview he recorded with Roger MacDonald, MD, a former associate director of the U of M's Rural Physician Associate Program (RPAP), which places medical students in rural communities for clinical training. In what Ratner calls an "audio portrait," MacDonald recounted the sacrifices and rewards that came with his long career as a country doctor in rural Minnesota.



“There’s a whole generation of doctors that did this,” said Ratner, who majored in anthropology as an undergrad. “If we don’t

Nathan Ratner produced audio recordings to share a physician’s stories about practicing medicine in rural Minnesota.



capture their stories, we’ll just lose them. We’ll lose the perspectives of those who walked the path before us.”

### *Excused absences*

Award-winner **Evan Eide** couldn’t make the May celebration event because the third-year student was in Perham, Minnesota,

training through RPAP. Eide applied his Fisch funds toward online courses in **computer coding** and **audio/video editing**.

**Robin Sautter** also missed the awards showcase for a reason that underscored her broad range of interests: She’d just run the Boston Marathon. With her Art of Medicine award, the fourth-year student pursued **abstract painting**. As Hallberg relayed to the Weisman audience, Sautter hoped the work would help her counter a tendency—common among doctors—to resist seeing things “outside the lines.”

### *Fisch finale*

The Art of Medicine awards celebration concluded with a few words from Fisch himself. His presence was a particular treat for attendees this year—not only because the program that bears his name was hitting its 10-year mark, but also because he’d suffered a heart attack just a few weeks earlier.

Fisch praised the breadth of creative output he’s seen honored over the years, and he stressed his primary objective for all winners. “We’re not looking for geniuses,” he insisted. Rather, he explained, the awards are to support people who long to address untapped creative urges or reacquaint themselves with avocations that have gone dormant during their medical studies.

“We want them to have fun,” Fisch declared—a familiar rallying cry to those who know him well. He wrapped up with a grin, joyfully raising his arms as attendees broke into a standing ovation.

Fisch was played off by the **Ari Nahum** Trio, fronted by a 2010-11 Art of Medicine award winner who studied **piano improvisation** and is now a chief resident with the University of Minnesota’s Internal Medicine Residency program at the Minneapolis Veterans Affairs Health Care System. Nahum closed with a selection that longtime fans of the Fisch awards likely found fitting: a jazzy arrangement of Paul Simon’s “Still Crazy After All These Years.” MM

# REVISITING *Inseparable*



## *Reflections on a physician’s call for creativity—and fun*

BY JON HALLBERG, MD

A physician’s daily work is often dominated by community measures, electronic health records, evidence-based medicine guidelines, big data and ICD-10 coding nightmares. During patient encounters, as our fingers dance and stumble across keyboards, it’s easy to lose sight of the notion that medicine remains—and must be viewed as—both an art and a science.

On our most harried days, perhaps it would help to have in mind a concrete image that captures our field’s dual nature. Robert O. Fisch, MD, a retired University of Minnesota professor of pediatrics, gives us one such image with his painting *Inseparable*.

Dr. Fisch has led a productive life with one foot firmly grounded in the world of medicine and the other in the realm of art. A Holocaust survivor, he began an internship in 1958 at the University of Minnesota Medical School, where he worked until 1997. Known internationally for his pioneering research on phenylketonuria (PKU), Fisch is also the author of five books, and he’s an award-winning painter. His art has been exhibited throughout the U.S. and in Europe and Israel.

*Inseparable* first appeared in November 1990 on the cover of *Minnesota Medicine*. In the painting, two hands—one holding a scalpel, the other a paintbrush—form a circle bisected by the caduceus. The scalpel (cold, hard, sharp and precise) can be seen to represent the scientific method, data, evidence, and medicine’s can-do ability to treat, cut and cure.

The paintbrush (soft, yielding, a little unpredictable—and ultimately freeing) is, of course, the “art.” The tip of the scalpel touches the caduceus snake’s mouth; the tip of the brush touches the snake’s tail.

This composition evokes the Chinese philosophical concept of yin and yang—the interconnectedness of forces in the world, creating an endless cycle. *Inseparable* reveals such a cycle within the practice of medicine.

As Fisch wrote in “Sustaining Life Through Art and Medicine,” an article that appeared in the same issue of *Minnesota Medicine* that carried

*Inseparable* on its cover, “Living is an art, and medicine is an art form to make life a little better and a little longer. Art and medicine are two consequences

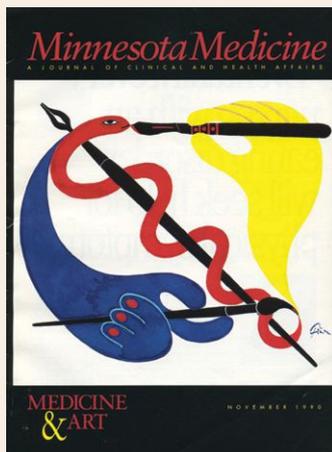
of the same desire to sustain life.”

*Inseparable* is not studied; it does not hang in a gallery. It was created for a journal cover. Still, it found renewed life ten years ago when it became the symbol of the Fisch Art of Medicine Student Awards. This popular program for University of Minnesota medical students sprang from a desire to honor physician-artist Fisch and all that he stands for, while also encouraging the next generation of healers to infuse their lives and work with creativity—and with fun.

The concept for the Fisch awards is simple. The annual program provides funds that allow medical students to pursue creative endeavors outside the medical school curriculum. A brief application asks students about their interest, their goals and a budget. Acquisition of new skills and experiences is encouraged. Typically, after a selection committee of faculty and community members reviews the applications, about half the applicants receive awards.

Once winners are notified, Dr. Fisch gathers them together at his Minneapolis apartment, where he encourages them to have fun with their projects. Later, each student meets individually with Fisch for dinner and conversation. An Art of Medicine award doesn’t require a final paper or project. Instead, recipients are invited to a celebration event, where they may demonstrate or display what they’ve learned to an audience of friends, family members, classmates and medical school faculty. During the presentations, the students invariably talk about how their supported pursuits have affected them. It’s not unusual to hear someone say, “It truly changed my life.”

Since the Fisch awards debuted in 2007, nearly 90 students have received \$250 to \$2,500 each, totaling more than \$90,000. These recipients have explored music (from voice to violin; from drums to dulcimer), writing, theater, dance (including ballet,



*Inseparable* debuted on the cover of *Minnesota Medicine* in November 1990.

salsa and zouk styles), visual arts, computer-based work, and crafting techniques using wood, metal, textiles and other materials. Among the more offbeat avocations to get the nod from the Art of Medicine program: magic, clowning, aerial arts, hand balancing and bicycle-wheel making.

Fisch, now 92, is excited to see medical students explore such activities at a time when medicine so desperately needs creative thinkers. The students who receive the Art of Medicine awards are equally enthused. Some credit the program for a personal transformation: new happiness, more self-confidence, a reawakening of old passions,

or stress reduction. Few see their efforts as a one-time-only experience. And always, it seems, they say their opportunities were fun. For Dr. Fisch, that fact alone is music to his ears. **MM**

Jon Hallberg is an associate professor in the Department of Family Medicine and Community Health at the University of Minnesota Medical School in Minneapolis, where he manages the Fisch Art of Medicine Student Awards. He is also a member of the *Minnesota Medicine* advisory committee.



## Measuring the Path to Better Outcomes

### ANNUAL SEMINAR 2017

8AM-5PM WEDNESDAY, SEPT. 13

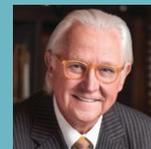
Earle Brown Heritage Center, Brooklyn Center, MN

Keynote speakers include:



NQF CEO

Shantanu Agrawal, MD



Broadcasting Legend

Don Shelby

Learn more & register at  
[seminar2017.mncm.org](http://seminar2017.mncm.org)



## Visual Acuity

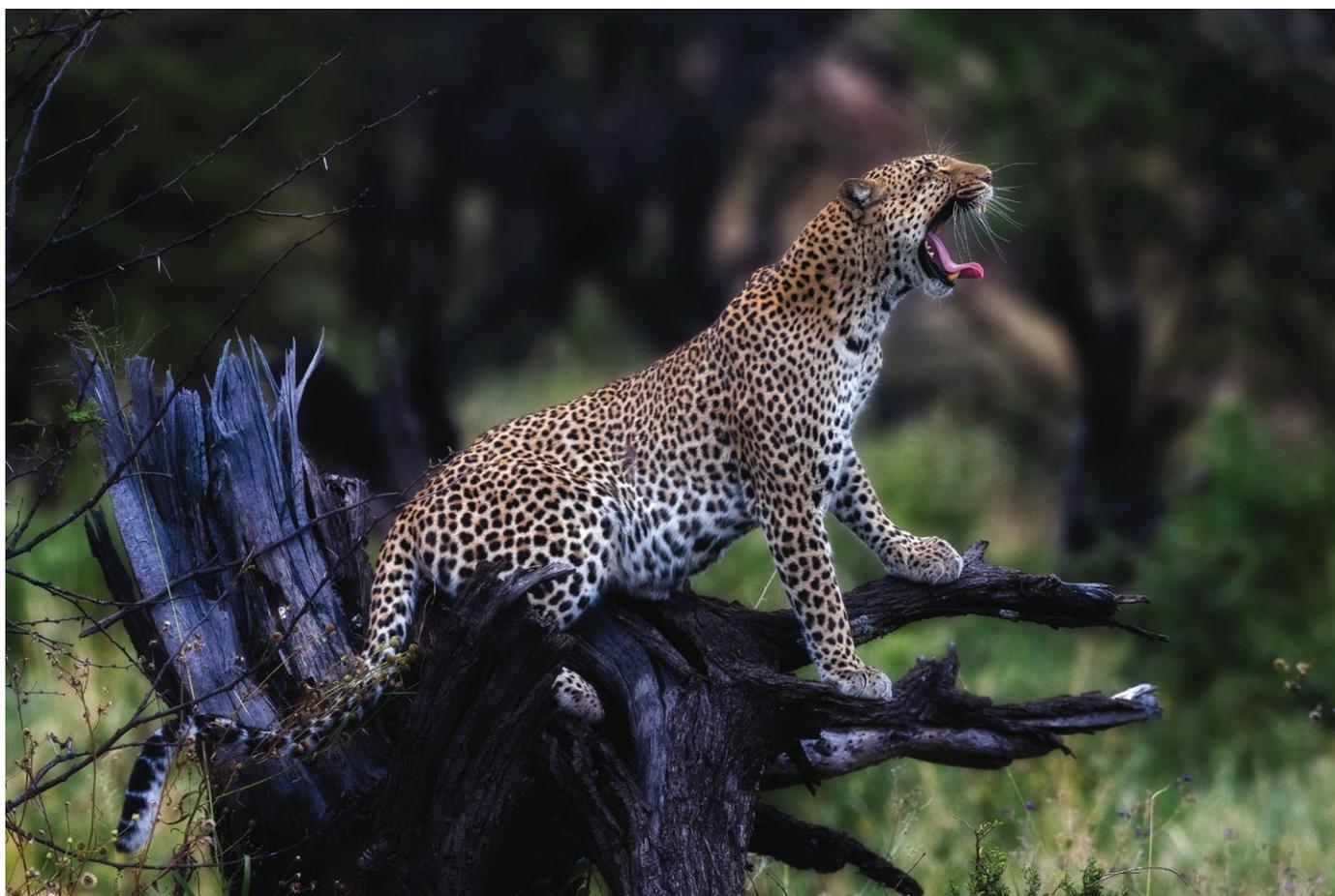
### THE WINNERS OF OUR 2017 PHOTOGRAPHY CONTEST

When a doctor asks a patient to stand across the room from a standard eye chart and start rattling off letters, largest to smallest, top to bottom, the test provides a measure of visual acuity—the clarity of that patient’s vision. Visual acuity is largely determined by sharpness of focus within the eye and by sensitivity and interpretive ability within the brain.

That’s not so different from what we saw in this year’s crop of photo contest entries. Camera lenses—and creative intentions—were sharply focused. Photographers displayed sensitivity toward

their subjects and offered interpretations of what appeared before their eyes.

Our judges—*Minnesota Medicine* art director Kathryn Forss and professional photographer Mike Krivit—evaluated 87 submissions from physicians, residents and medical students. We’re publishing three winners from each group here. We’ll look for opportunities to showcase more of the entries in the near future. Many are worthy of public display. Thanks to everyone who chose to share their work with us.



## PHYSICIANS

### First Place

#### Leopard

Alex Sneider, MD, urologist,  
Mayo Clinic Health System, Owatonna

**FROM THE PHOTOGRAPHER:** “It was taken on the final day of an amazing photo safari in Tanzania. Up to this point, the day had been the only disappointing one of the trip because there’d been no large mammal sightings. As the sun was rapidly dropping and we were returning to camp, I spotted a leopard sitting on a tree stump a short distance from our path. We stopped and captured a wonderful set of images. Ultimately, this became my favorite photo of the whole trip.”

**JUDGES’ COMMENTS:** “This image shows a combination of attributes that make it a clear winner: It’s well-composed and well-executed, and the moment is captured perfectly. It’s no small feat to be on the proper side of the light, to have the knowledge to control your depth of field, and to trip the shutter at exactly the definitive moment. Excellent shot and very well done.”

PHYSICIANS  
*Second Place*

*Reflections on Time*

Ryan Kroschel, MD, family medicine physician,  
FirstLight Health System, Mora and Pine City

**FROM THE PHOTOGRAPHER:** “The circular nature of life and time can be seen in most anything if we wait long enough and are present enough to see it. Even while we stand as still as possible, there is movement. And that’s OK because it can be beautiful.”

**JUDGES’ COMMENTS:** “The curvature of the star trails makes a nice visual connection with the curvature of the building’s roof, and the choice to convert to black and white was a wise one. Nicely done.”



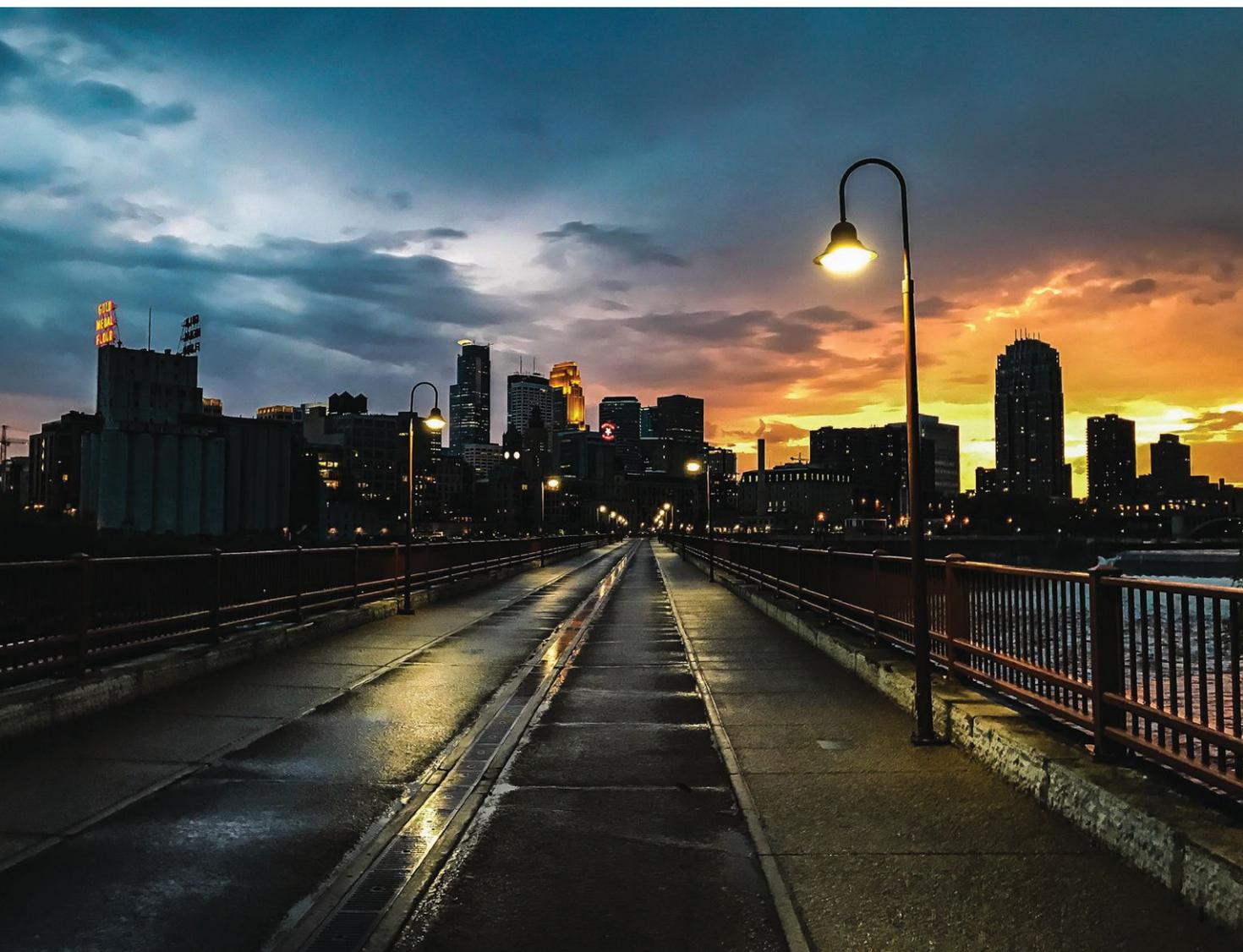
PHYSICIANS  
*Third Place*

*Winter Tree Reflection*

June M. Fahrman, MD, family medicine physician

**FROM THE PHOTOGRAPHER:** “Reflections of bare trees have a mystical appeal to me, and this tree caught my eye just as the sun broke through on a cloudy afternoon.”

**JUDGES’ COMMENTS:** “Interesting, abstract image and well-captured. It draws viewers in, arrests the eye and inspires curiosity.”



## RESIDENTS *First Place*

### *Stormy Stone Arch*

*Michael Brydone-Jack, MD, transitional year resident, Hennepin County Medical Center, Minneapolis*

**FROM THE PHOTOGRAPHER:** “I captured this on a beautiful stormy night while running across the Stone Arch Bridge in downtown Minneapolis.”

**JUDGES’ COMMENTS:** “A rain-dampened sidewalk at night, a single, lonely streetlight and lovely leading lines bring viewers directly into this image, encouraging them to imagine their own story in the scene. This is a thoughtful photograph. It is imaginatively composed and well worth our highest honor.”



RESIDENTS  
*Second Place*

*Minnetonka Barred Owl*  
Dan Larson, MD, pathology  
resident, Mayo Clinic, Rochester

**FROM THE PHOTOGRAPHER:**  
“This barred owl joined me for an impromptu study break one afternoon. Who knew you could see such a beautiful nocturnal bird out in the daylight?”

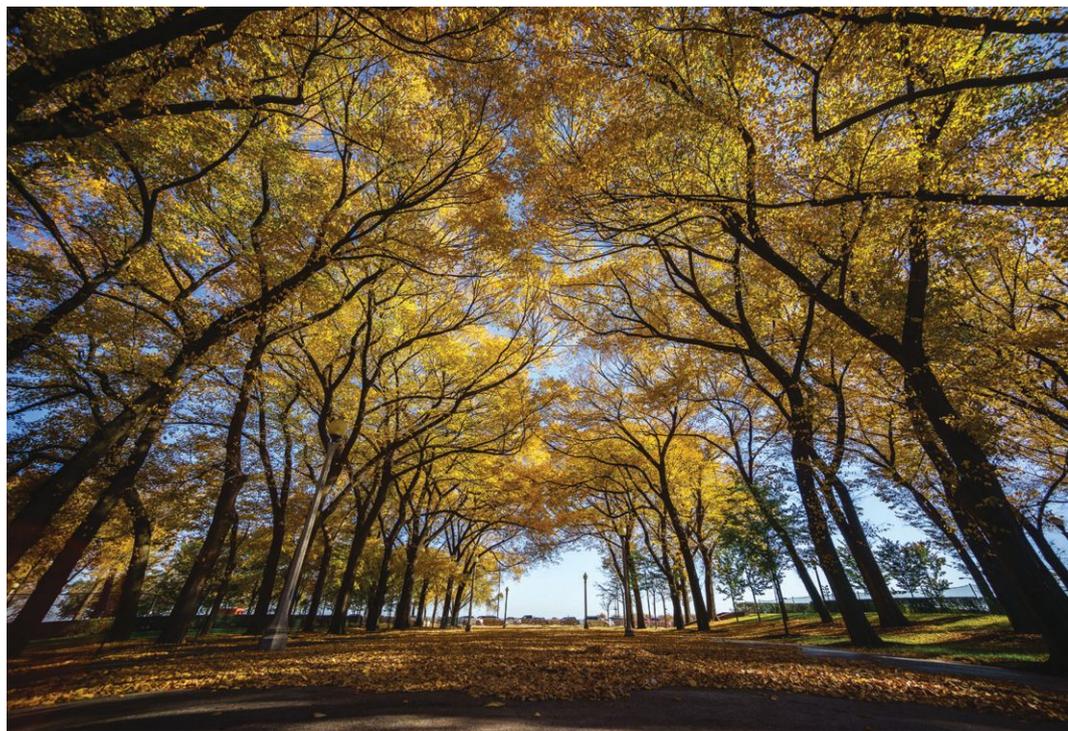
**JUDGES’ COMMENTS:** “Anyone who has ever attempted nature photography knows the patience and vigilance it took to get this image. The bird is tack sharp in the scene, compellingly composed and beautifully captured.”

RESIDENTS  
*Third Place*

*Autumn in Chicago*  
Gregory Pajot, MD, internal medicine  
resident, Mayo Clinic, Rochester

**FROM THE PHOTOGRAPHER:** “On my first vacation as a resident, I stopped in Chicago to visit a friend. After all the long hours in the hospital, it felt amazing to be outside and take in such a beautiful autumn day. While walking around these trees, the sharp contrast between their wavy branches and golden yellow leaves caught my eye.”

**JUDGES’ COMMENTS:** “The symmetry of this image and the use of a wide-angle lens cause the trees to angle in on the viewer, creating interest in the scene. A lovely photograph.”





## STUDENTS

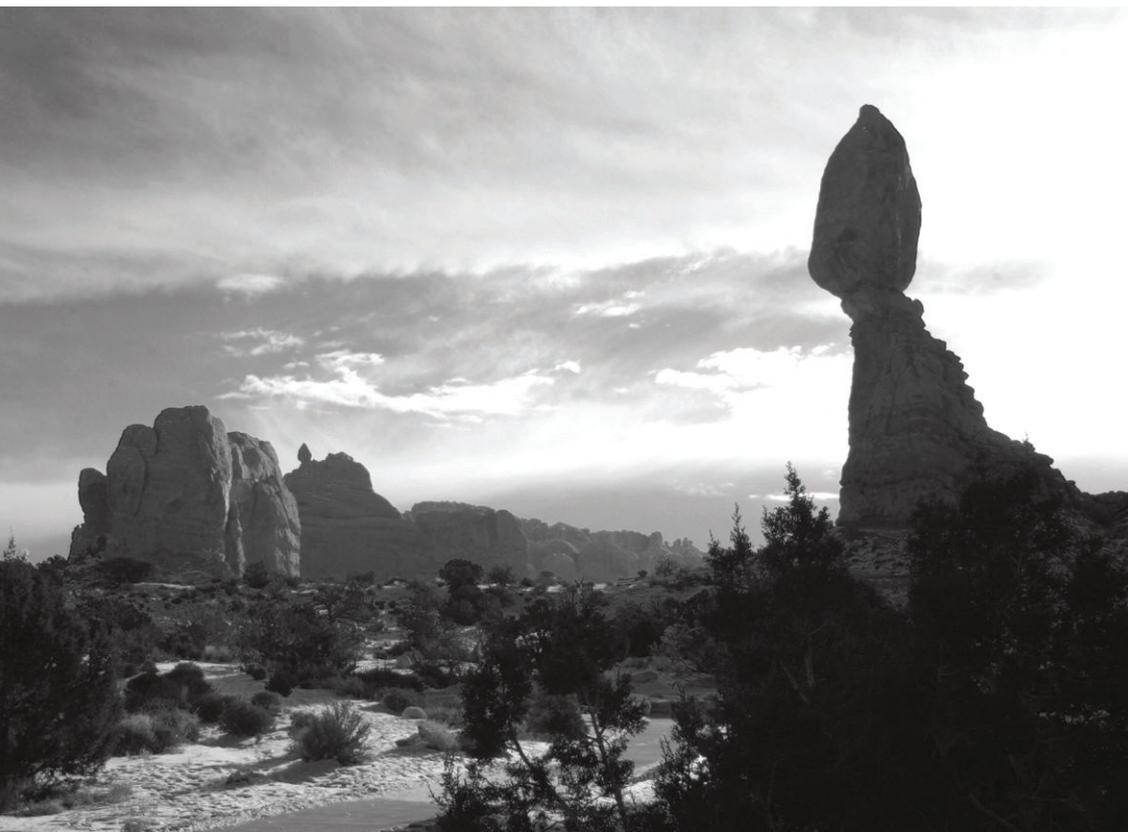
### *First Place*

#### *Man in the Realm of Nature*

*Mishy Roy, class of 2019, University of Minnesota Medical School, Minneapolis*

**FROM THE PHOTOGRAPHER:** “As I stood there in search of the incredible, something caught my eye. An epiphany of sorts engulfed me with such force and took my breath away! I have always marveled at the intensity of power that man unleashes around him. But in this fast-paced world, where resources are depleted at an unprecedented rate, this is as good a time as any to stop and think: Where is our place in the realm of nature?”

**JUDGES’ COMMENTS:** “This is an interesting scene, and it’s well-captured. We appreciated the story this image is telling, as well as its spot-on composition and interesting color manipulation. Very well done.”



## STUDENTS *Second Place*

*A Balancing Act*  
Natasha Gallett, class of  
2020, University of Minnesota  
Medical School, Duluth

**FROM THE PHOTOGRAPHER:**  
“A moment of peace and majesty graces even the most fragile or hostile of environments.”

**JUDGES’ COMMENTS:** “This striking composition conveys depth and feeling. It is well-composed and maintains interest from front to back. Excellent capture and excellent photographic storytelling.”

## STUDENTS *Third Place*

*Respite in Sipi Falls, Uganda*  
Rose Olson, class of 2018,  
University of Minnesota  
Medical School, Minneapolis

**FROM THE PHOTOGRAPHER:**  
“Medical students from Lebanon, Rwanda, Uganda, the U.S. and Zimbabwe join and learn together for a course in social medicine, focused on our partnership in the struggle for health equity.”

**JUDGES’ COMMENTS:** “This photo tells an interesting story and provides ample context for the viewer. Very nicely done.”



# Inspiring Encounters THE WINNERS OF OUR 2017 WRITING CONTEST

It's easy to think about medicine as a one-way relationship in which patients benefit from the time they spend with their doctors. But in reading the submissions to this year's *Minnesota Medicine* writing contest, it's clear the reverse is also true. Many physicians, residents and medical students sent us reflections on profoundly moving moments and edifying encounters they've experienced in the course of caring for their patients.

In 2017, we tied last year's record-high number of entries (40), submitted by 37 writers. From each of three groups—physicians, residents and medical students—we selected a first-place winner. You'll find those pieces in the pages that follow.

Among residents' entries, scoring was so close that we also named a second-place winner, which appears as this issue's End Note on page 48.

Finally, we awarded several honorable mentions, which are noted on this page. We'll look for opportunities to publish those pieces in future issues.

Thanks to everyone who shared their creative, thoughtful work with us. Thanks also to our judges: Dominic Decker, MD, Ruth Westra, DO, Charles R. Meyer, MD, Siu-Hin Wan, MD, and Dan Hauser, MMA director of communications.

## 2017 Writing Contest Selections

### PHYSICIANS

#### First Place

*A Lesson From a Young Child*

John W. Wilson, MD  
Mayo Clinic

#### Honorable Mention

*Medical Practice Meets the Law*

A. Stuart Hanson, MD  
Retired

*Publish or Perish*

E. Kenneth Weir, MD  
University of Minnesota

### RESIDENTS

#### First Place

*Just Down the Hall*

Kacia Lee, MD  
Hennepin County Medical Center

#### Second Place

*The Veteran*

Lisa Friedman, MD  
University of Minnesota

#### Honorable Mention

*Panel Management*

Chas Salmen, MD  
University of Minnesota

*The Only Time I Ever Did Anything*

Benjamin Marsh, MD  
University of Minnesota

### STUDENTS

#### First Place

*In Color*

Elizabeth Ender  
University of Minnesota Medical School

#### Honorable Mention

*Off Script*

Hope N. Ukatu  
University of Minnesota Medical School

*Toenails and Teenage Drama*

Carly Dahl  
University of Minnesota Medical School



PHOTO COURTESY OF MAYO CLINIC

## PHYSICIAN *First Place*

**JOHN W. WILSON, MD**, is an infectious diseases physician and associate professor of medicine at the Mayo Clinic in Rochester. John leads Mayo's Program in Underserved Global Health, which focuses on public health and provider education strategies in resource-deprived settings. His areas of focus include tuberculosis and other mycobacterial diseases, fungal infections, and HIV. John's hobbies include cycling, rowing and reading about the history of the American West.

**ON WRITING:** "I enjoy writing to express my thoughts and to chronicle pivotal moments in my life so that they do not become lost in the 'pages of time.' Writing enables me to relive such moments while capturing an evolving meaning of select events. While some experiences during my life have had immediate profound meaning, I often find others are more subtle and provide more reflection and relevance years later. Writing about these experiences provides an opportunity to extract both meaning and significance that I hope strengthens the set of values and principles that I aspire to live by."

**ABOUT THIS PIECE:** "The events of this story took place a few years ago in the central mountains of the Dominican Republic, where I was spending some time working as a rural/village physician and teaching through the Institute for Latin American Concerns (ILAC). Shortly afterward, I scribbled a few notes during evening hours while watching a Dominican sunset and swatting off mosquitos, but it was not until this opportunity to write for Minnesota Medicine that I was able to compose a more complete version. I am grateful for this opportunity."

# *A Lesson From a Young Child*

BY JOHN W. WILSON, MD

The morning hours pass by as Dominican villagers and farmers patiently wait to be seen.

Many have arrived at our medical clinic before sunrise. The line outside runs in a serpentine pattern down the hill and toward a nearby river. Some patients have walked overnight from neighboring rural settlements, with serious maladies, while others have brought the entire family for a simple checkup. We work as efficiently as possible, seeing one patient right after another with no breaks in between.

We have been spending a few weeks running a medical clinic and health training center in the small village of El Añil, nestled within the rural central mountains of the Dominican Republic. The work is both inspiring and frustrating, as many readily treatable conditions in the U.S. are often fatal here within the surrounding underserved and often impoverished communities. In addition to providing patient care, our primary role is to teach local health care workers—medical “ayudantes”—first aid, principles of wound management, preventive health care and a few basic skill sets. With each passing day, as I learn from my compassionate and dedicated Dominican health colleagues, I feel more like a student than an experienced physician-educator from Minnesota.

As I take a quick five-minute break in the afternoon to eat a sandwich, I look outside at the line of waiting patients and still cannot clearly see the end. No doubt, the news of our clinic has spread through all the surrounding communities and has transformed our clinic into “the” social and health care event of the season. I wonder how we can possibly get through the afternoon and see all the remaining patients while there is still daylight. Fatigue and frustration grow during the late afternoon as I try to identify and prioritize the patients most in need.

A series of questions then enters my mind: What am I really doing here? Am I honestly helping anyone in a meaningful way? I ponder whether any of our interventions has subsequently reduced the burden of illness or whether our actions serve more as a metaphorical Band-Aid until the next clinic opens months later. I wonder if our actions have really enhanced quality of life for the local villagers. I persevere over whether we have really addressed the more fundamental social, economic and educational boundaries in order to realistically implement sustainable community health improvement. I then remember last Sunday’s Mass.

I need to admit that over the past number of years in the U.S., my attendance and attitudes regarding Sunday Mass have been ... well ... less than ideal. But here in the rural community of El Añil, Sunday Mass is an event that the entire community attends; no exceptions and no one is left out. Reflecting on my college years long ago, I suppose this situation is similar to how the students at the University of Notre Dame feel about autumn Saturday home football games. While the library may be open, it’s empty, as all the students

are in the stadium watching the game and cheering on their team. Again, no exceptions!

Sunday Mass was performed in the town’s community center, a small multi-purpose one-room building in the center of El Añil. During this particular Sunday, colleagues from our sponsoring organization, the Institute for Latin American Concerns (ILAC), made a surprise visit to our village with toys for the children. Following Mass, the toys were spread across the altar in the front of the room for all the children to see. Soccer balls, stuffed animals, coloring books and many more treasures were on full display. To avoid causing a stampede of enthusiastic children, an orderly process of toy selection was created using individually numbered tickets. A ticket would be handed out to each child, who would then come up to the altar to select a toy when their number was called.

Among the large group of children present, there was one little 8-year-old girl named Juanita who was very shy and timid. Juanita lived with her parents in a small hut composed of dilapidated wooden planks fastened together under a thatched roof, with a floor of packed-down dirt. The family was among the poorest in the village. Juanita’s father was away most days, working in the nearby cane fields. Therefore, when not in school, Juanita spent most days with her mother at home, helping with any needed work. I could not recall actually ever seeing her away from her mother. Their home had one bed, a table, and a few pans for cooking, with other simple culinary utensils,

but no toys or other notable items to entertain a young girl. Despite their poverty, Juanita's mother always made sure her daughter's dress was clean for Sunday Mass and that her long black hair was highlighted with multiple colorful bows. It therefore seemed quite fitting that, among all the children, little Juanita was called first that day to select a toy.

Juanita very nervously walked up and surveyed all the toys on the altar. She then made her choice ... a ballpoint pen. One of the ILAC staff had inadvertently left it on top of the altar with the toys and had used it to document each toy placed on the table. After picking up the pen from the altar, Juanita quickly returned and gave it to her mother. I simply thought Juanita was too nervous to take a toy from the altar with everyone in the room watching her. I then learned that Juanita's mother had no pencils or pens at home to write with. The family could not afford to buy one. Rather than choosing a toy for herself, little Juanita instead picked up the pen and gave it to her mother because she knew her mother needed one.

Everyone in the room stood silent, frozen in time by what they had just witnessed. How could an 8-year-old child with minimal possessions at home pass over rows of colorful new toys and select a rather simple item we consider to have minimal worth and be readily disposable? The value proposition was simple: Her mother needed a pen and Juanita wanted to do something meaningful for her mother. She loved her mother. It was an act of innocence and pure selflessness by an 8-year-old girl living in a home with a dirt floor. I struggled to hold back tears as I watched this event unfold. I love my parents very much, but I know if I had been

8 years old again and in Juanita's position, I would have immediately grabbed for the soccer ball!

Back in the clinic, I again gaze out upon the long line of patients still waiting to be seen. I think about little Juanita's actions from the prior Sunday. For Juanita, choosing a pen for her mother over a toy for herself was a gesture of love for her mother. This act of devotion and sacrifice by an apprehensive child with minimal possessions reminded me of a particular statement within the Hippocratic Oath that all medical students recite upon graduation:

*"I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug."*

Juanita reminded me of a fundamental principle of being an effective health care provider. I am repeatedly humbled, knowing all too well there are many illnesses and diseases that I am not able to cure. However, as wonderfully exemplified by Juanita, I can deliver warmth, sympathy, respect and understanding to my patients for who they are and the difficulties they endure. Whether in the U.S. or abroad, having the opportunity to take care of patients remains a blessing and a privilege that I sincerely value, acknowledging a trusted responsibility that combines the science of medicine, the humility of a practitioner and the compassion of a healer. Indeed, the very compassion shown by an 8-year-old child reignites my eagerness and excitement to see the next patient waiting in line.



PHOTO BY KATHRYN FORSS

## RESIDENT *First Place*

**KACIA LEE, MD**, just completed her residency in internal medicine at Hennepin County Medical Center (HCMC) in Minneapolis, and she is beginning a chief resident year, after which she plans to stay on at HCMC as a primary care physician. She lives in south Minneapolis with her husband and three cats.

**ON WRITING:** “I’ve never thought of myself as a poet, but there are some experiences as a physician that just won’t leave you alone until you get them down on paper, and this one came out as a poem.”

**ABOUT THIS PIECE:** “This poem was inspired by a patient I cared for in the ICU during my PGY2 year. After the family conference, wherein we decided to withdraw care, I just couldn’t stop thinking about my patient and his daughter. Even at age 98, he was still her dad—their parent-child relationship so many decades in the making—and the love that had nurtured her in childhood and through adulthood now carried her through the decision to help him die comfortably and with dignity. I was also struck by how the words we use as physicians have such power and how a simple slip of the tongue can have profound effects.

I am grateful to Dr. Craig Garrett and Dr. Samuel Ives for their editorial assistance and, most importantly, to my patient’s daughter for giving her blessing to publish my account of this intimate moment.”

# Just Down the Hall

BY KACIA LEE, MD

He is 98,  
a World War II veteran,  
a widower, a quiet man of faith  
who sang in the choir  
and dedicated his life to serving others.  
And now, no less than when he first  
welcomed her, squalling, into the world,  
he is father to an only daughter —  
her own hair now graying,  
face weary with worry and  
    sleepless nights,  
lips buttoned tightly,  
heart opened wide.

She sits surrounded by doctors in this  
    tiny room,  
its chairs, table, tissue boxes, muted colors  
all thoughtfully designed to comfort  
her and countless others  
before and since,  
as they face the impossible task  
of channeling a loved one's wishes.

Down the hall he lies quietly, alive still —  
broad shoulders in a patterned gown  
stark against white sheets,  
each of his 98 years  
stacked one atop the other  
to build a frame that fills the bed  
from top to bottom,  
his height a jarring reminder  
of the vibrant life he led  
before he came to us.  
And now surrounded, crisscrossed  
by this masquerade of  
ventilator tubing,  
telemetry leads,  
central, peripheral, arterial lines,  
Foley, esophageal thermometer ...  
each warp and weft deftly placed  
by skilled fingers  
yet together a dizzying tangle —  
the weaving awry —  
in a false promise of healing.

Tell us about who he was,  
prompts the attending.  
*Was.*  
His careless slip  
drives a nail, unbidden, into the coffin  
that we decline, just yet,  
to acknowledge we are building  
for this man whose heart still beats  
just down the hall.

Tell us about who he *is* —  
a correction — too late, it cannot  
    be unsaid.  
Her wan smile and grateful nod  
at the attempted redaction  
belie her grim knowledge and ours  
that his fate was sealed  
before he came into our care.  
It was etched already in headstone granite  
by the bacteria swirling,  
multiplying,  
overtaking the vessels  
that feed the heart  
still beating down the hall.

She takes a deep breath:  
He has always been strong and  
    independent.  
These last months have been so hard.  
He needs so much help now.  
He left the hospital just yesterday —  
now back and in the ICU —  
it all happened so fast.  
All these tubes and wires ...  
recovery so unlikely ...  
he would not want  
to keep going  
like this.

We step our way gently, carefully,  
through this painful conversation —  
slowly and solemnly  
bearing witness to the life  
awaiting death  
just down the hall.

And though my own heart aches  
for this gentle man I never got a chance to  
    know,  
the lump in my throat does not rise until  
his daughter inquires  
calmly, in a voice full of love,  
“Tell me, doctor,  
when we take out the breathing tube,  
when we stop the medicines —  
what will my dad feel?”



PHOTO BY JEFF FREY

## STUDENT *First Place*

**ELIZABETH ENDER** graduated from the University of Minnesota Medical School in 2017. She will soon start a Med-Peds residency in Marshfield, Wisconsin, and is looking to a future in rural primary care.

**ON WRITING:** “I write first to glorify God and second to better understand my experiences and those of others and to share them with whoever reads my writing. I have been telling stories since I was 4 years old, and I published an illustrated children’s story, *Ransomed*, before starting medical school.”

**ABOUT THIS PIECE:** “I wrote this poem the night before one of my residency interviews, while reflecting on the past year and a half of clinicals. The ‘Red’ paragraph was inspired by my first day in a hospital as a medical student, a moment I tried to write about multiple times. That night, thinking about my time in medical school and the patients whose lives touched mine, I returned to that first day, and the rest of the poem fell into place.”

## In Color

BY ELIZABETH ENDER

### Red.

Come quickly, the nurse says. The resident runs. Then he calls the attending. Red light, says the attending, and then everyone is running. Red for a birth going wrong, red for a mother bleeding out, red for a baby's missing pulse, red for the first cut of the scalpel, red for baby's first breath. Red for two lives saved.

### Blue.

I want to be DNR, he says. No, she says. Do everything, he says, but he means *I love her*. He's going to get well, she says. He is moved from the floor to ICU, and then they are calling Code Blue. Blue for the veins, stark against his paper-white abdomen, blue for the hospital bracelet on his wrist, blue for the bruises blossoming on his chest, blue for the eyes he loved shattering as she understands at last, blue for the sheets pulled over his face. Blue for the emptiness beside her as she sobs.

### Yellow.

It's so sudden, he says. A physician son, who knows the cause, but who cannot understand the why of his mother's diagnosis. Guess I should have come in earlier, says the mother, before I started turning yellow. Yellow for the skin jaundiced by alcohol and hepatitis, yellow for the precaution gowns required to enter her room, yellow for the sunlight spilling through the window and showing only the shock on their faces. Yellow for the highlighter on the social worker's page, marking Palliative Care.

### Pink.

Do you want to listen to your heart, the medical student asks. She nods excitedly and tilts her head so the stethoscope can be placed in her ears. I can hear it, she cries, surprise overcoming any final shyness, her mouth open in a pink-lipped O of delight. Pink for the ribbon in her hair, pink for the sparkle-heart on her shirt, pink for the lights in her shoes, pink for the birthday party she wants to talk about, pink for the fever-flush in her cheeks. Pink for the relief on her mother's face to hear it is not pneumonia this time.

### Gray.

Remember, says the daughter. Remember this, when you're a doctor. Perhaps it is not why, but *perhaps it is*, and if her father is dying because she pushed him to agree to a surgery without understanding the possibility of *this*, she does not want the medical student to forget it, and she will speak, though her voice is gray with regret. Gray for the shadows stretching out along the bed, gray for the monitor marking the labored breathing, gray for the hand she holds so tightly, gray for the face so still upon the pillow. Gray for the family losing him by inches.

### Orange.

I'm beepin', he says, calling the nurses' station as easily as most 6-year-olds raise their hands in first grade, and then going back to his game as if the IV in his arm was not present. He pounces on his favorite—he's going to play the medical student, the aide, his mother, whoever has time to use the Wii with him—and picks the orange character. Orange for the pill bottles stacked around the room, orange for the overnight bag his mother is by now an expert at packing, orange for the poster on the wall, covered with the names of family and friends. Orange for the band on his wrist that says *I beat cancer*.

### Black.

When will we know, the daughter asks, standing with her mother in the family room. We're doing everything we can, the doctor says. You should be able to come back and sit with him soon. The daughter folds her mother's hands in hers, a black rosary wrapped between their fingers. Black for the halls that lead to empty call rooms, black for the coffee the nurses are drinking, black for the quiet murmur of the staff at 4 a.m., black for the stillness outside the ICU. Black for the nights of wondering and watching and waiting for dawn.



MINNESOTA  
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# 2017 legislative session in review: a disjointed assembly

Over the course of 20 weeks of this year's legislative session, legislators alternated between progress and impediment. The Republican-led Legislature and the Democratic Gov. Mark Dayton butted heads on a number of issues. In the end, lawmakers were unable to complete their work on time, and it took a four-day special session to finally reach an agreement on budgets—an agreement that was still in question as this issue went to press.

The good news for physicians is that legislators avoided Medicaid/MinnesotaCare provider payment reductions and did not make cuts to eligibility. (Earlier versions of House and Senate budget bills had called for sizeable payment cuts.) The bad news, however, is that the Legislature once again tapped into the Health Care Access Fund (HCAF) and expanded its use for health care programs traditionally paid for with General Fund dollars.

At a time when the state had a \$1.65 billion surplus, legislative leaders resorted to gimmicks like

drawing money from the HCAF so they could use more General Fund money in other areas of the budget and give larger tax

“We were able to maintain the provider tax repeal, align state and federal quality measures, and pass several bills that will help us fight

*At a time when the state had a \$1.65 billion surplus, legislative leaders resorted to gimmicks like drawing money from the HCAF so they could use more General Fund money in other areas of the budget and give larger tax cuts.*

cuts. It is disappointing that the Legislature did not use any of the surplus dollars to increase payments in the Medical Assistance and MinnesotaCare programs, even though payments are so low that many clinics lose money when they care for patients covered by those programs.

The agreement between legislators and the governor reduced overall spending for Health and Human Services (HHS) programs by \$63 million.

the opioid epidemic,” reports Dave Renner, the MMA's director of state and federal legislation. “So, in that sense, it was a good session. But the House's resistance to moving our medication prior authorization legislation forward continues to be a frustration. Patients deserve better. We'll continue to strategize over the coming months on ways to get movement in the House.”

***Here's a review of the 2017 session, including reports on MMA priorities as well as other health care-related legislation.***

# The MMA's priority issues at the Legislature

## Maintaining the repeal of the provider tax and replacing its revenue with more broad-based sources *MAINTAINED*

Gov. Dayton proposed canceling the repeal, but his efforts never gained traction. Repeal is still set for December 31, 2019.

## Addressing the opioid epidemic in Minnesota *PASSED*

The Legislature will fund two demonstration projects to treat pain without opioids. Legislation also establishes opioid abuse prevention pilot projects throughout the state. These pilots will focus on reducing opioid abuse through the use of care teams and communitywide coordination of abuse-prevention initiatives.

Legislators established a four-day dose limit (with exceptions) for opioids prescribed following treatment of acute dental pain or acute pain associated with refractive surgery.

To reduce the pressure on physicians to prescribe more opioids, measuring pain management is now prohibited if the results from the patient satisfaction survey are used to determine provider compensation or quality incentive payments.

The MMA also successfully argued against proposals that would have led to mandatory use of the Prescription Monitoring Program and opioid-specific CME for prescribers, arguing that there was no evidence that these additional burdens would alleviate the opioid epidemic.

## Aligning state and federal quality measurement requirements *PASSED*

The health department is now required to cap the number of mandated statewide quality measures (SQRMS) at six for a single-specialty clinic and at 10 for a multispecialty clinic. These measures must also align with the measures defined by the new Medicare physician payment system (MACRA). The measures shall be selected in consultation with a stakeholder group for implementation no later than December 15, 2018.

## Medication prior authorization (PA) reform *STALLED*

PA reform progressed swiftly and in a bipartisan fashion through the Senate, but again faced resistance in the House. Near the end of the session, the MMA was able

to get an informational hearing in the House HHS Finance Committee, where there was overwhelming support, but no votes were taken.

## Maintaining the progress made on health care reform *TO BE DETERMINED*

In light of possible changes in federal and state health policy, the MMA has reasserted its commitment to health care reform. The MMA has urged Minnesota's congressional delegation to support solutions consistent with these core principles:

- Preserve patient-physician relationships.
- Ensure insurance coverage for all.
- Ensure access to appropriate care for all Minnesotans.
- Improve affordability of care.
- Invest in public health and prevention.
- Advance health equity.
- Support innovation in care delivery and payment.
- Ensure broad-based, stable and adequate financing.

## Other health care-related legislative issues

### Abortion reporting *PASSED*

This provision, included in the final HHS budget bill, amends the current state abortion reporting law to add reporting related to abortions performed via telemedicine. The report must include the facility code for where the patient is seen and the facility code for where the physician is located.

**MMA position:** Oppose

### Advance care planning *PASSED*

To promote advance care planning, this establishes grant funds of \$250,000 each year for two years to provide services to individuals, families, caregivers and providers statewide. Funds will go to Honoring Choices Minnesota, the advance care planning initiative led by the Twin Cities Medical Society.

**MMA position:** Support

### Biomedicine innovation grants *PASSED*

This allocates \$2.5 million to a University of Minnesota and Mayo Foundation partnership for grants to entities conducting biomedical and bioethical research.

**MMA position:** Support

### Children's mental health report *PASSED*

Funding for a comprehensive analysis of Minnesota's continuum of intensive mental health services. Under the study, the Department of Human Services (DHS) is to analyze the state of children's mental health services and develop recommendations for a sustainable and community-driven continuum of care for children with serious mental health needs, including children currently being served in residential treatment.

**MMA position:** Support

### Pediatric mental health beds *PASSED*

Twenty-one new pediatric mental health beds were approved for PrairieCare. These beds are an important addition to ensure access.

**MMA position:** Support

### For-profit HMOs *PASSED*

Minnesota will now allow for-profit HMOs to operate in the state. This provision was passed early in the session and then modified in the HHS budget bill to include a two-year moratorium on existing nonprofit HMOs seeking to convert to for-profit status.

**MMA position:** Neutral

### Immunization *STALLED*

Despite the publicity generated by a large measles outbreak, the Legislature failed to act to improve Minnesota's weak vaccination law. Proposals to tighten restrictions on how parents can seek to exempt children from vaccine requirements were introduced but not considered, as was funding for culturally appropriate outreach to communities directly impacted by the measles outbreak.

Another proposal to allow minors to consent to HPV vaccination without parental consent was introduced. Current law allows minors to consent to Hepatitis B vaccination and to health care services related to drug and alcohol abuse, pregnancy, and sexually transmitted diseases.

**MMA position:** Support

### Interstate Medical Licensure Compact *PASSED*

Minnesota is now in federal compliance with its Interstate Medical Licensure Compact law. The bill was a technical fix to provide the BMP authority to request criminal background checks on physicians who choose to seek licensure through the Compact.

**MMA position:** Support

**Managed care oversight** *PASSED*

The bill includes compliance with new federal managed care rules related to Medical Assistance (MA). It requires managed care plans to provide to MA enrollees up-to-date provider directories, drug formularies (including differing medication tiers), and any physician incentive plans. The DHS commissioner is required to establish a monitoring system to ensure the managed care plans are complying with these requirements and meeting network adequacy standards. The bill also requires that at least 85 percent of the capitation payment the health plan receives is spent on providing medical services. The bill authorizes the Office of the Legislative Auditor to audit each participating managed care organization to determine if they are using the public money in compliance with federal and state law.

**MMA position:** Support

**MNSure** *FAILED*

Legislators recommended moving Minnesota to the federal insurance exchange, arguing that MNSure is still not working properly.

**MMA position:** Oppose

**Narrow networks** *PASSED*

For 2017 and 2018 networks, a provision was added to give physicians and other providers the ability to appeal a waiver of network adequacy requirements granted to a health plan by the Minnesota Department of Health (MDH). Under current law, MDH may grant waivers of network requirements—including access within 30 minutes/30 miles to primary care physicians, a general hospital and mental health services—if the health plan demonstrates with specific data that the network requirements are not feasible in a particular area. Appeals will take place before an administrative law judge.

**MMA position:** Support

**Palliative Care Advisory Council** *PASSED*

This 18-member council will advise the health commissioner on the establishment, operations and outcomes of palliative care initiatives in the state.

**MMA position:** Support

**Premium relief** *PASSED*

The state will provide \$326 million in premium relief to Minnesotans who bought coverage on the individual market for 2017. It will come in the form of subsidies to health plans that will retroactively reduce enrollee premiums by approximately 25 percent.

**MMA position:** Neutral

**Public health response fund** *PASSED*

This allocates \$5 million to a new public health response contingency account, to be used by MDH in the case of a pandemic influenza or an outbreak of a communicable or infectious disease. This is in response to the recent measles outbreak.

**MMA position:** Support

**Public option** *STALLED*

Gov. Dayton proposed a MinnesotaCare buy-in option for those who buy their health coverage on the individual market. This option would have allowed any Minnesotan, regardless of income, the option to purchase coverage through MinnesotaCare. (The program currently provides coverage to Minnesotans not eligible for MA and earning below 200 percent of the federal poverty level.)

Enrollees would have paid the full premium cost. Physician services provided under the buy-in option would have been reimbursed at the unsustainably low MinnesotaCare and MA rates.

**MMA position:** Oppose

**Reinsurance** *PASSED*

Insurers offering coverage in the individual market will split with the state the costs of an enrollee's care that fall between \$50,000 and \$250,000 in one year. The state will cover 80 percent of those costs; the insurer will cover the other 20 percent. As a result, it's estimated that premiums in the individual market will be reduced by 20 percent next year.

To ensure that this program does not result in Minnesota losing federal money, it is contingent on the state receiving a waiver from the federal government. This new Premium Security Plan account is funded by a combination of \$71 million each year from the General Fund and \$200 million each year from the Health Care Access Fund. This funding is for 2018 and 2019 only.

**MMA position:** Neutral

**SHIP funding/quitline** *FAILED*

Legislators proposed using a portion of Statewide Health Improvement Program (SHIP) money to fund a tobacco quitline. The MMA had concerns that it would take away from the focus of SHIP in funding local public health programs. The MMA did support funding for quitline services from non-SHIP sources.

**MMA position:** Oppose

**Title protection** *PASSED*

The BMP sought legislation to clarify its authority to prohibit non-physician health

care practitioners from using words such as "physician" and "surgeon" in their title and in advertising.

**MMA position:** Support

**Tobacco 21** *INTRODUCED*

Following the lead of other states, as well as communities in Minnesota, a bill was introduced to raise the minimum age at which a person can purchase tobacco from 18 to 21. The bill was introduced this year in anticipation of building momentum for passage in future legislative sessions.

**MMA position:** Support

**Tobacco tax cuts** *PASSED*

Included in a compromise tax proposal: The automatic tax "inflator" that increases the tobacco tax to keep pace with inflation was repealed, costing the state \$10.5 million in lost revenue in the next biennium. The inflator was included in the 2014 tobacco tax increase when the tax was increased \$1.60 per pack. Also included in the tax bill is a provision that caps the tax on "premium" cigars from \$3.50 to 50 cents—an 85 percent cut. The governor is requesting another special session to reinstate these taxes.

**MMA position:** Oppose

**Unexpected billing** *PASSED*

For care provided at an in-network facility, patients will not have to pay out-of-network rates when they receive care from a non-network physician or other provider without having advance understanding or ability to choose. This is expected to affect specialties like anesthesia, pathology and radiology if they are not part of a patient's insurance network and are practicing at an in-network hospital or surgery center.

The MMA was concerned that this would hurt out-of-network physicians' ability to get fairly compensated for their work, so the association lobbied lawmakers to revise the original language. As passed, the bill directs physicians and health plans to negotiate the out-of-network rate. If the parties can't reach an agreement, either side can seek review by an independent arbitrator. Arbitrators will reference a number of sources, including a national database gathered by an independent nonprofit that tracks all payers to determine a usual, customary and reasonable payment for physicians.

A disclosure provision applies to services in ambulatory settings in which specimens are collected by a physician and referred to an external lab, pathologist or other testing facility.

**MMA position:** Neutral

## News Briefs

### MMA's 2017 Annual Conference is September 23

Plans are underway for the 2017 Annual Conference scheduled for Saturday, Sept. 23, at the Mayo Civic Center in Rochester. Attendees will discover operational and clinical approaches to optimizing patient care while they network and collaborate with hundreds of peers.

Session topics will include "Combatting the Opioid Epidemic," prescription drug prices and spending, improving access to mental health services, and much more. The conference will also include an open issues forum, a medical student and resident poster session, dozens of vendors, and a closing session with The Theater for Public Policy.

To register, visit [www.mnmed.org/AC2017](http://www.mnmed.org/AC2017).



### Physicians' socials celebrate practice of medicine

Dozens of physicians, residents and medical students gathered at socials in the Twin Cities, Rochester, St. Cloud and Duluth in May and June. A great time was had by all! The socials—which included free food, wine, beer and other beverages—were a celebration of medicine, a thank you to members, and a welcome to new and prospective members.

### On the calendar

Event	Date	Location
Annual Conference	Sept. 23	Rochester – Mayo Civic Center

### Opioids series reaching health care workers around the globe

Since it launched in late 2014, the MMA's *Pain, Opioids, and Addiction Lecture Series* has continued to grow; it now includes 18 free online course offerings and has served approximately 1,000 health care professional customers around the world, including participants in 43 U.S. states, Europe, Asia, Australia and New Zealand.

The series is a result of the MMA teaming with the Steve Rummeler Hope Network (SRHN) and the University of Minnesota Medical School to bring medical education on the topic of opioids to medical students, residents and practicing physicians. The lectures are recorded live at the University of Minnesota Medical School and are made available for CME and MOC on the MMA website in partnership with the SRHN.

The series was created to provide a medical curriculum on pain, opioids and addiction as it should be in a medical school setting: balanced, practical, evidence-based information free of commercial bias. Through the series, physicians and other providers learn how to 1) assess a patient's pain and function; 2) make informed treatment decisions; and 3) recognize and manage addiction.

### Forum with national speakers addresses ever-changing health care landscape

Nearly 60 physicians, residents and medical students gathered in person and online in late April to contemplate the future of health care reform in Minnesota.

The event, which took place on the University of Minnesota's St. Paul campus, featured Jean M. Abraham, Wegmiller professor and director of the Master of Healthcare Administration program at the U of M; Emily Johnson Piper, Department of Human Services commissioner; and Richard Deem, AMA senior vice president of advocacy.

The speakers described key policy proposals under consideration by Congress and the Trump administration for replacing or changing the Affordable Care Act (ACA). They also assessed the implications of potential ACA changes for Minnesota patients and physicians, and they examined the political paths and barriers to change.

For those who missed the forum, the MMA has made the entire event available online. Visit [mnmed.org/hcforum17](http://mnmed.org/hcforum17) to access the recording.



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### Search is on to find new MMA leader

After nearly 15 years at the helm of the MMA, Robert Meiches, MD, MBA, resigned in late April as CEO to pursue other professional opportunities.

“The MMA has benefited greatly from Dr. Meiches’ leadership over the last 14 years, and it has been my personal privilege to work with him directly over the last three years,” said MMA board chair Douglas Wood, MD.

A search committee made up of MMA board members and a national search firm has been formed to conduct a search for Meiches’ replacement.

Meiches has a long history of service to the MMA, including tenures as a trustee and board chair in the 1990s. Prior to becoming the MMA’s CEO, Meiches worked as a medical executive for Fairview Health Services. Meiches is an internist and geriatrician who continues to see patients and has an active voice in the long-term care community. He currently sits on the boards of MN Community Measurement, Minnesota Alliance for Patient Safety and the MMA Foundation.

### MMA physicians honored for preceptor work

Two primary care physicians who are active preceptors for medical students in the Twin Cities were honored in early May at the University of Minnesota Medical School’s *Dean’s Tribute to Excellence in Education* event held at the Weisman Art Museum.



## A Thank You to RPAP Preceptors FOR TEACHING OUR FUTURE PHYSICIANS!

The MMA, in partnership with the University of Minnesota Medical School, sponsored the Exceptional Primary Care Community Faculty Teaching Award, which was established to honor and encourage the kind of preceptor teaching in a primary care setting that medical students hold in high esteem. MMA President David Agerter, MD, presented the awards to Tod J. Worner, MD, and Gregory Young, MD.

The event was a part of the partnership that the MMA and the medical school have built regarding preceptors. The partnership, known as the Preceptor Initiative, is an effort to develop tools and resources to improve training and support for clinical preceptors.

Help the MMA  
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## MMA revises position on physician aid-in-dying

At its May 20 meeting, the MMA Board of Trustees revised its 25-year-old position on physician aid-in-dying. The MMA will oppose any bill unless it includes specific protections detailed in the new policy.

The decision came after extended discussion among board members, as well as a variety of engagement activities with membership.

The MMA took a deliberate approach to this topic, as it's quite sensitive with members. The association held a policy forum with members, convened a task force and conducted a member poll. The poll went out in April, garnering more than 700 responses. Seventy percent of poll respondents endorsed the recommendation to modify existing policy by withdrawing opposition and moving toward conditional opposition.

The MMA is not alone in reconsidering its position on this topic. A number of other state medical societies, including organizations in California, Colorado, Maine, Maryland, Nevada and Oregon, have revised their positions on physician aid-in-dying.

The revised MMA policy is:

*Physician aid-in-dying raises significant clinical, ethical, and legal issues. A diversity of opinion exists in society, in medicine, and among members of the Minnesota Medical Association. The MMA acknowledges that principled, ethical physicians hold a broad range of positions on this issue.*

*The physician-patient relationship is a sacred trust. This relationship must be protected through all stages of life including the dying process. The trust and honesty central to this relationship applies to the difficult decisions made at end-of-life, and encompasses any decision to engage in aid-in-dying.*

*The MMA will oppose any aid-in-dying legislation that fails to adequately safeguard the interests of patients or physicians. Such safeguards include but are not limited to the following:*

- *Must not compel physicians or patients to participate in aid-in-dying against their will.*
- *Must require patient self-administration.*
- *Must not permit patients lacking decisional capacity to utilize aid-in-dying.*
- *Must require mental health referral of patients with a suspected psychological or psychiatric condition.*
- *Must provide sufficient legal protection for physicians who choose to participate.*

*All physicians who provide care to dying patients have a duty to make certain their patients are fully aware of hospice and palliative care services and benefits.*

The MMA remains opposed to euthanasia, which is generally defined to mean physician- or other provider-administered direct actions.



Robert Meiches, MD



Janet Silversmith



Elizabeth Anderson



Scott Wilson

## MMA in Action

In mid-May, the MMA hosted a listening session with National Government Services (NGS) representatives. NGS is Minnesota's Medicare Administrative Contractor. Hospital and clinic representatives participated and shared input on ways NGS could improve communication and service.

MMA CEO **Robert Meiches, MD**, and **Janet Silversmith**, director of health policy, met with Julie Sonier, the new MN Community Measurement president, in May.

Silversmith, **Elizabeth Anderson**, membership manager, and **Scott Wilson**, sponsorship manager, met with representatives of Hazelden Betty Ford to present and discuss MMA advocacy priorities.

MMA member **Kirby Clark, MD**, has been named the new director of the Rural Physician Associate Program (RPAP) and Metropolitan Physician Associate Program (MetroPAP).

Former MMA President **Cindy Firkins Smith, MD**, the president and CEO of Affiliated Community Medical Centers in Willmar, served as a panelist at a League of Women Voters, Dakota County-hosted health care forum on June 1.

MMA member **Dionne Hart, MD**, a psychiatrist in Rochester, received a 2017 National Alliance on Mental Illness (NAMI) Exemplary Psychiatrist Award at the American Psychiatric Association Conference in San Diego, which took place in May. Award winners are recognized for their advocacy for access to care and research funding, community education programs, or other NAMI priorities.

## VIEWPOINT

# What lies ahead?

In the debate over the repeal of the Affordable Care Act (ACA), blame has been cast in many directions: at insurers, politicians, market regulators, businesses, drug companies and health care providers. Solutions proposed in the American Health Care Act (AHCA) aren't making discussions any easier.

The ACA certainly has problems: Fewer plans are available in many parts of Minnesota, and for many people, the costs of the plans (including premiums, copays and deductibles) add up to more than 10 percent of their income. For people who buy consumer-directed plans, either through an employer or individually, their insurance benefit may turn out to be too expensive for them to use. Consequently, access to health care may be quite illusory. That is, even for people who have insurance, it may be too expensive for them to seek care.

The current iteration of the AHCA has its problems as well, including roll-backs of consumer protections (especially for people who have pre-existing conditions), reduced federal payments to states for Medicaid, and reduced payments to physicians.

In late May, the MMA Board of Trustees, along with guests from the Minnesota Hospital Association and several medical specialties and component medical societies, gathered in St. Paul to consider the implications for physicians and other health care providers posed by possible outcomes of the debate surrounding ACA repeal. We considered two options: 1) that the ACA would not be repealed and 2) that the ACA would be repealed but with a less extreme solution than the AHCA.

We asked participants to consider challenges for the MMA and implications for future policy development. Some thought that incremental changes could address

the challenges of access to care, affordability and disparities (age-based, geographic and disease-based), while softening impacts resulting from consolidation of providers and financing. Others argued that a truly transformative approach is needed.

Incremental changes might mean retaining the provider tax, either to help extend benefits to people who may not currently qualify for subsidies or to increase payments to providers. Other financing options discussed included a public option (but not with provider payments at Medicaid rates), single-payer financing, global budgets for hospitals (the Maryland model), payment reductions for providers (the Vermont all-payer model), new taxes for drug and device companies, and more broad-based tax revenue sources (income taxes or dedicated health taxes).

The transformative approach calls for financing and delivery system changes, with an emphasis on creating health, transforming the care process with team-based care, and eliminating waste in all forms (clinical, drug and device use, administrative).

The MMA will not be able to do all the work that is needed to improve health care in Minnesota on its own. We will need to partner with others. But it is important for the MMA to take a leadership role by creating a clear and convincing vision of a new system for health and health care. Striving for health implies that we focus on the ability of people to do the things they need to do, and that we seek ways to ensure communities are also healthy.

The delivery system should consider coordination and integration of care to produce better health, including improved public health and social services. Necessary components include universal coverage, an adequate benefit set, afford-



Douglas Wood, MD  
MMA Board Chair

We need an honest discussion of how much money it would cost us to achieve health for our citizens.

able premiums and copays, income-based subsidies, strengthened physician-patient relationships, adequate payment rates for providers, and strengthened community health. The financing system should be stable, broad-based and transparent.

Lastly, as a society, we need an honest discussion of how much money it would cost us to achieve health for our citizens. The MMA board will discuss options in more detail, but there will be work for many people to do in a coordinated effort.

We are also interested in your ideas about how we describe and achieve this concept of health. Please send us your thoughts at [mma@mnmed.org](mailto:mma@mnmed.org).

# Allergic contact cheilitis: four cases

BY MOLLY C. GOODIER, KELLY A. ASCHENBECK, AND ERIN M. WARSHAW, MD, MS

## Case 1

A 17-year-old female presented with a 5-year history of a pruritic, papular rash involving her lips (Figure 1A) that was recalcitrant to topical and oral diphenhydramine, topical antibiotics, and oral corticosteroids. Due to the duration of her persistent symptoms, she was referred to dermatology for possible allergic contact dermatitis (ACD). Patch testing to several allergen series revealed a strong positive reaction to benzophenone-3 (Figure 1B), a sunscreen, which was identified in the patient's Carmex lip balm. She also had a strong positive reaction to the lip balm itself (Figure 1C). Other pertinent reactions are described in Table 1.

## Case 2

A 65-year-old female presented with a 1.5-year history of dermatitis primarily involving her lips (Figure 2A). Her symptoms had not improved with over-the-counter topical hydrocortisone or a topical anesthetic. Patch testing showed a strong reaction to menthol and a mild reaction to propolis, or bee glue (Figures 2B and C), both of which were identified in the patient's Carmex lip balm, to which she also reacted (Figure 2D). Additionally, the patient had a mild reaction to lidocaine, which was present in the Medi Quattro First Aid Cream she was applying to the area. This patient also reacted to a number of flavoring agents that can be found in oral hygiene products, drinks, and food. Other pertinent reactions are described in Table 1.

## Case 3

A 42-year-old woman presented with an approximate 1-year history of lip dermati-

tis and intermittent episodes of periorbital dermatitis (Figure 3A). Prior patch testing had revealed positive reactions to lanolin and bacitracin. Despite avoiding these al-

lergens, the patient's dermatitis persisted. She was tested to a screening series and to other pertinent allergens. Testing revealed a strong reaction to the patient's Dr. Dan's

TABLE 1

### Relevant Patch Test Reactions

ALLERGEN	CASE 1	CASE 2	CASE 3	CASE 4
<b>Sunscreens</b>				
Benzophenone-3	++			++
<b>Fragrances/Flavors</b>				
Balsam of Tolu		++		
Cinnamic alcohol		++		
Cinnamic aldehyde		++		
Fragrance Mix I		++		
Fragrance Mix II		?		
Limonene		+		
Menthol		++		
Peppermint		+		
<b>Anesthetics</b>				
Lidocaine		+		
<b>Dyes</b>				
Carmine			+	
<b>Emollients</b>				
Lanolin			+	
Propolis			+	
<b>Personal Products</b>				
Carmex lip balm	++	++		
Medi Quattro First Aid Cream		+		
Sensodyne Fresh Mint toothpaste		+		
Dr. Dan's CortiBalm lip balm			++	
Revlon ColorBurst Lip Butter			?	
L'Oreal Paris Caramel Comfort lip balm			?	
Neosporin Lip Health Daily Hydration				+

### LEGEND

++ = strong (edematous or vesicular)

+ = mild (erythema and infiltration, possible papules)

? = doubtful (macular erythema)

CortiBalm lip balm (Figure 3B). Mild reactions were noted to propolis and to carmine (Figures 3C-E), a red dye frequently found in cosmetics such as lipsticks. Propolis was identified in her Dr. Dan's lip balm. Other pertinent reactions are listed in Table 1.

### Case 4

A 62-year-old woman with a 10-year history of perioral dermatitis (Figure 4A) accompanied by occasional irritation of the buccal mucosa presented for patch testing. Desonide and tacrolimus had been applied in the past without significant improvement. Patch testing showed a strong reaction to benzophenone-3 (Figure 4B) with a mild reaction to her Neosporin Lip Health Daily Hydration Therapy personal product (Figures 4C and D), which was confirmed to contain benzophenone-3. Additional pertinent reactions are listed in Table 1.

### Discussion

Allergic contact cheilitis (ACC) is a delayed-type cutaneous hypersensitivity reaction affecting the lips. Typically, patients present with lips that are dry, scaly, and fissured, a condition that often spreads beyond the vermillion border to involve the perioral area. Vesicles and edema may also be present.<sup>1</sup> Females are more likely than males to be affected,<sup>2</sup> which may be due to allergens in cosmetics.<sup>3</sup>

Common allergens implicated in ACC include fragrances and flavorings, nickel, and cosmetic ingredients.<sup>3</sup> Fragrances and flavors can be found in cosmetics and personal hygiene products such as toothpastes and mouthwashes. Nickel, the most common allergen identified in skin patch testing,<sup>4</sup> may cause ACC through direct contact of the lips with metal items such as musical instruments, dental appliances,<sup>5</sup> and metal-rimmed drinking bottles.

Other cosmetic ingredients, including lanolin and propylene glycol, may also be responsible for ACC. The dual allergenic and moisturizing properties of

FIGURE 1

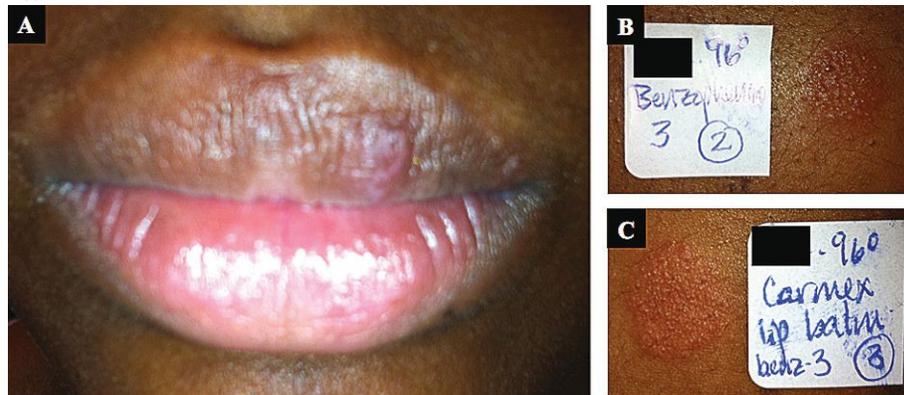


FIGURE 2

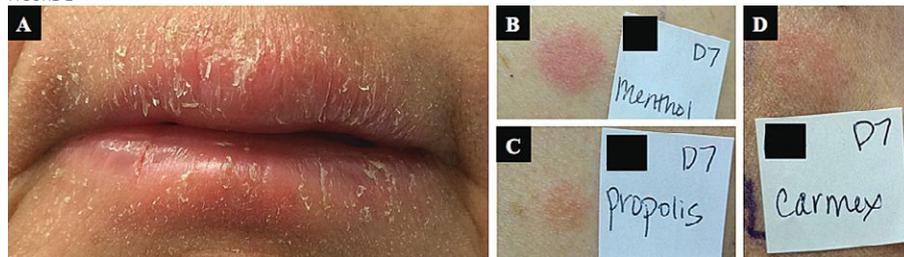


FIGURE 3

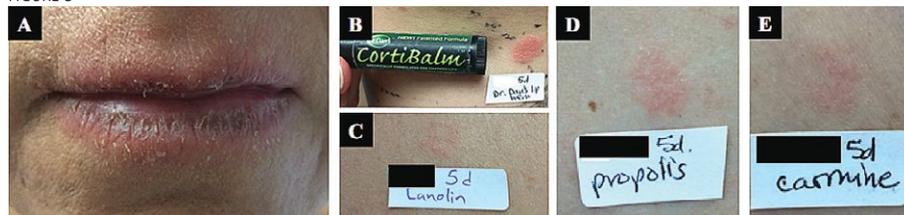
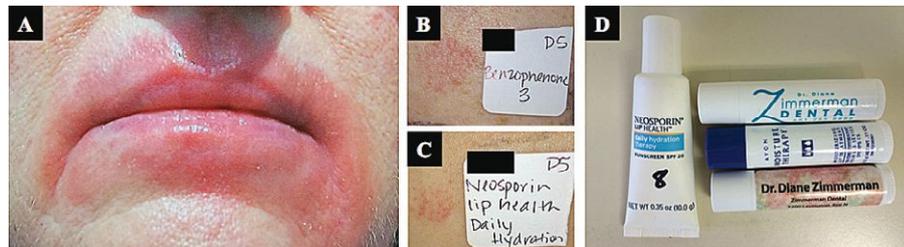


FIGURE 4



**FIGURE 1** Case 1 clinical photographs. (A) Minimal diffuse erythema predominantly involving patient's lower lip. (B) Strong patch test reaction to benzophenone-3. (C) Strong patch test reaction to Carmex personal product containing benzophenone-3.

**FIGURE 2** Case 2 clinical photographs. (A) Bright pink erythema of the lips with prominent xerosis and scale extending beyond the vermillion border. (B) Strong reaction to menthol. (C) Mild reaction to propolis. (D) Strong reaction to Carmex personal product containing menthol and beeswax.

**FIGURE 3** Case 3 clinical photographs. (A) Circumferential erythema and scale extending beyond the vermillion border. (B) Strong reaction to Dr. Dan's CortiBalm lip balm. (C) Mild reaction to lanolin. (D) Mild reaction to propolis. (E) Mild reaction to carmine.

**FIGURE 4** Case 4 clinical photographs. (A) Circumferential erythema extending down the bilateral marionette lines, left greater than right. (B) Strong reaction to benzophenone-3. (C) Mild reaction to Neosporin Lip Health Daily Hydration Therapy. (D) Patient's personal lip products.

these emulsifiers help perpetuate a vicious cycle, wherein the dryness from ACC is subsequently treated with the offending agent leading to continuation of symptoms. Propylene glycol is frequently found in personal care products and topical corticosteroids, while lanolin is a common ingredient in lip balms and lipsticks.<sup>6,7</sup>

In addition to the aforementioned compounds, sunscreens may serve as another source of ACC. Sunscreen agents such as benzophenone-3 (also known as oxybenzone) are becoming increasingly more common in cosmetic products, as

consumers become more conscientious about preventing exposure to UV rays.<sup>8</sup> Benzophenone-3 is a broad-spectrum chemical blocker that absorbs both UVA and UVB radiation. It is the most common sunscreen agent to cause allergic contact sensitization<sup>9</sup>; among 219 patients with contact allergy to sunscreen agents, benzophenone-3 was the culprit allergen in the majority of cases.<sup>8</sup> Benzophenone-3 can induce both ACD and photoallergic dermatitis.<sup>9</sup> Sunscreen agents like benzophenone-3 can also “hide” in products not advertised to have sun protection properties (eg, nail polish, shampoo, and perfumes), where it is used to prevent photodegradation and discoloration. As a result, benzophenones were named Contact Allergen of the Year for 2104 by the American Contact Dermatitis Society to raise awareness of these ubiquitous and potentially unexpected allergens.<sup>10</sup>

Carmine, a dark red pigment derived from an aluminum salt harvested from the cochineal insect,<sup>11</sup> is often used for its colorant properties. It can be found in red cosmetics (eg, blush, lipstick, and eye shadow), medicines, textiles, and foods (eg, yogurt, ice cream, and shrimp). There have been few reports of ACD from carmine, and most have involved lip products.<sup>11,12</sup> The specific inclusion of carmine in products that contact the lips (such as lipsticks and food) makes it an important allergen to consider when ACC is suspected.

The differential diagnosis of ACC is broad. Angular cheilitis, which can also be associated with ACC, can develop alone from mechanical injury, infection (eg, *Candida*), or a systemic process. Other infectious etiologies include herpes labialis, which presents with clusters of vesicles on an erythematous base. Additionally, lip licker's eczema (especially common in children) and irritant contact dermatitis may have similar presentations to ACC. Cheilitis granulomatosa involves idiopathic, episodic swelling of the lips that eventually becomes persistent. Cheilitis exfoliativa presents with thick scaling of the mucosal lips, and the cause is unknown.

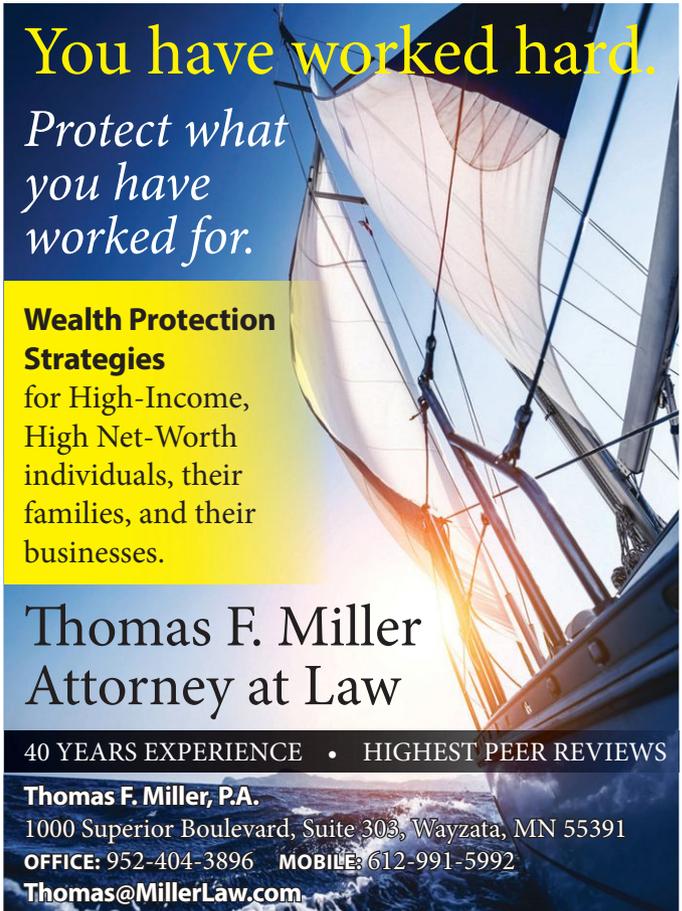
As evidenced by these cases, a wide range of allergens may cause ACC. Based on a patient's presentation and history, providers may elect to initially treat the patient with a topical corticosteroid. Referral to a skin patch testing clinic for further work-up and testing should be considered in refractory cases. **MM**

Molly C. Goodier and Kelly A. Aschenbeck are medical students at the University of Minnesota. Erin M. Warshaw is a professor in the university's Department of Dermatology. All three authors work at the Minneapolis Veterans Affairs Medical Center's Department of Dermatology and at the HCMC Parkside Occupational and Contact Dermatitis Clinic in Minneapolis.

This material is based on work supported in part by the Minneapolis Department of Veterans Affairs Medical Center. The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the U.S. Department of Veterans Affairs or the U.S. government.

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## About this section

### *The future looks bright.*

At least that's how we see it, based on the quality of responses we received to this year's call for abstracts highlighting research and clinical work by Minnesota medical students, residents and fellows.

Members of our review panel were impressed with the work they saw. They assessed each manuscript with several questions in mind: Was the research or case description clear and complete? Was the methodology sound? Was the scientific literature review sufficient? And did the findings have implications for medical practice or further research?

We thank our reviewers: Angela Buffington, PhD; Peter Kernahan, MD, PhD; Zeke McKinney, MD, MHI, MPH; and Barbara Yawn, MD. Based on their thorough evaluation, we've selected six submissions—three from residents and three from medical students—for publication in this issue. We thank all the medical trainees who submitted their work.

# Food for thought: pediatric residents' perspectives on screening for food insecurity

BY RACHEL CAFFERTY, MD, DIANA CUTTS, MD, AND AMANDA GILLETT, MD

## Background

More than 13 million children in the U.S. live in homes in which access to adequate and nutritious food is limited or unreliable.<sup>1</sup> Food insecurity affects 20% of families with children under age 6 in Minnesota.<sup>2</sup> Food insecurity is a known social determinant of health for children. It results in higher rates of illness, more dysregulated behavior, and poorer academic outcomes.<sup>3</sup> The American Academy of Pediatrics (AAP) now recommends universal screening for food insecurity at health maintenance visits and early referral to food resources.<sup>4</sup>

## Objective

The aim of this study was to evaluate current screening practices among pediatric residents and to design a tool for use in clinic that would increase access to resources for food-insecure children and families.

## Design/methods

We surveyed pediatric residents at the University of Minnesota to evaluate knowledge of the AAP policy, screening rates, interventions for positive screens, and resident comfort with screening. Local food pantries, free meal services, and reduced-cost food distribution sites were identified and compiled in easy-to-read pamphlets, which residents could provide to patients screening positive for food insecurity.

## Results

Of 101 residents surveyed, 54 responded (a 53% response rate), representing 16 of the 19 resident continuity clinic locations. Most respondents (61%) were unaware of the AAP policy on food insecurity.

Forty-four percent of residents screen for food insecurity; two-thirds of those work at one hospital, which recently incorporated a 2-question screen into the EMR template for routine health maintenance visits. Just 21% of residents at the other 15 represented clinic sites screen for food insecurity. When screening, 48% of providers feel either somewhat uncomfortable or very uncomfortable. Only 2 of the 54 residents (3.7%) feel very comfortable screening for food insecurity. Most residents (72%) are unaware of resources to utilize if a child is identified as living in a food-insecure home.

## Conclusion

The majority of pediatric residents at the University of Minnesota are unaware of the AAP policy and do not currently screen patients for food insecurity. Very few residents feel comfortable with the screening process, and most are not knowledgeable about resources to refer families to if food insecurity is identified. The created brochures provide a simple and readily available list of local food resources. After reviewing the AAP policy with current residents, sharing the results of our study, and distributing brochures throughout clinics in the Twin Cities, we hope to raise awareness of food insecurity as a social determinant of health for children, improve resident comfort level with screening, and, ultimately, increase rates of screening and utilization of resources in Minnesota. **MM**

Rachel Cafferty and Amanda Gillett are pediatric residents at the University of Minnesota. Diana Cutts is a pediatrician at Hennepin County Medical Center.



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# Drug-induced liver injury after *garcinia cambogia* supplement use

BY DOROTHY CURRAN, MD, JAMES P. CAMPBELL, MD, DALE SNOVER, MD, AND JONATHAN KIRSCH, MD

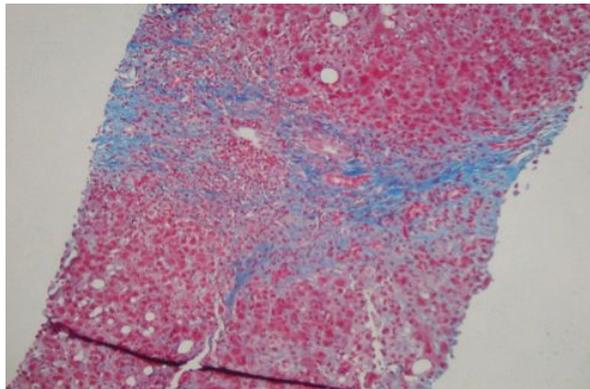
## Introduction

**G***arcinia cambogia* (*G. cambogia*) was an ingredient in several Hydroxycut weight-loss supplement formulations and is also marketed as a stand-alone weight-loss supplement.<sup>1</sup> It has been postulated to be involved in the pathogenesis of Hydroxycut-induced liver injury.<sup>1,2</sup> However, few cases have been reported with pure *G. cambogia* supplements causing liver injury.<sup>1,3</sup> Here, we present a case of acute liver injury secondary to *G. cambogia* use.

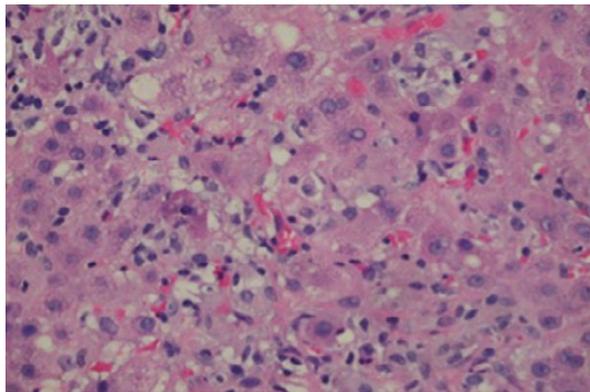
## Case description

A 56 year-old Caucasian woman presented with 1 week of jaundice and fatigue. She denied taking any prescription or over-the-counter medications. Social history was negative for any infectious exposures. She had a 20-pack-per-year smoking history and drank 1 to 2 alcoholic beverages per day.

On exam, vital signs were normal, and scleral icterus and diffuse jaundice were noted. Total bilirubin was 22, alkaline phosphatase was 290, alanine aminotransferase (ALT) was 1276, aspartate aminotransferase (AST) was 886, and international normalized ratio (INR) was 1.05. Hepatitis C virus (HCV) IgG was positive with an HCV RNA level of 196815 IU/mL. Additional labs were negative for other infectious autoimmune conditions and for genetic causes of hepatitis, including hemochromatosis, alpha-1-antitrypsin deficiency, and Wilson's disease. Magnetic



**Figure 1.** H&E liver biopsy. Active acute cholestatic hepatitis with plasma cells with possible chronicity, consistent with autoimmune hepatitis or Hydroxycut toxicity. No evidence of active alcoholic hepatitis or steatohepatitis.



**Figure 2.** Trichrome stain, liver biopsy shows widening of portal tracts with focal relatively well-formed fibrosis with no evidence of bridging-fibrosis.

resonance imaging (MRI) revealed no hepatic lesions or biliary tract abnormalities.

On further questioning, the patient endorsed taking *G. cambogia* weight-loss supplements twice daily for 3 months prior to symptom onset. N-acetylcysteine (NAC) treatment was empirically started. Liver biopsy demonstrated evidence of cholestatic hepatitis consistent with autoimmune or drug-related etiologies, which were most likely drug-related given the clinical history and negative autoim-

mune serologies. The patient was discharged on hospital day 4 and advised to discontinue *G. cambogia* and to avoid alcohol. Liver enzymes and bilirubin slowly improved with supplement discontinuation. Seven weeks after discharge, liver enzymes had normalized. At 3- and 6-month follow-up, HCV RNA was also undetectable.

## Discussion

*G. cambogia* supplements are derived from a fruit native to Southeast Asia.<sup>1</sup> The main ingredient implicated in weight loss is hydroxycitric acid, an inhibitor of a citrate cleavage enzyme, which blocks de novo synthesis of fatty acids.<sup>1</sup> Cases of idiosyncratic drug-induced liver injury (DILI) attributed to herbal and dietary supplements have increased in the past decade.<sup>4,5</sup> *G. cambogia* was one of the main implicated hepatotoxic ingredients in previous Hydroxycut weight-loss supplement formulations.<sup>4</sup> More recently, *G. cambogia* has been mar-

keted as a stand-alone weight-loss supplement, and there have been case reports of DILI associated with *G. cambogia*.<sup>2</sup>

In this case, given the patient's acute presentation, labs, and pathology, *G. cambogia* was implicated as the cause of the patient's acute liver injury. Interestingly, the positive HCV RNA with rapid clearance at follow-up visits suggested a potential concurrent acute or chronic HCV infection that achieved spontaneous clearance. However, based on the biopsy, it was thought unlikely

that the HCV contributed to the acute liver injury, as the pathologic findings on H&E and trichrome stain were more consistent with DILI secondary to *G. cambogia* as opposed to a viral hepatitis. (Plasma cells were consistent with autoimmune hepatitis or DILI, and there were no signs of bridging fibrosis found in chronic HCV.) It is not known if a secondary hepatic inflammatory process, such as DILI in this case, contributes to spontaneous HCV clearance. This case illustrates the importance of asking patients about nonprescription drugs and supplements, particularly herbal and dietary weight-loss supplements not regulated by the Food and Drug Administration, which are increasingly recognized as an etiology for DILI.<sup>4,5</sup> MM

Dorothy Curran is a 2017 graduate and pediatric resident, James P. Campbell is an internal medicine resident, Dale Snover is an adjunct professor in the Department of Lab Medicine and Pathology, and Jonathan Kirsch is an assistant professor in the Department of Internal Medicine at the University of Minnesota Medical School.

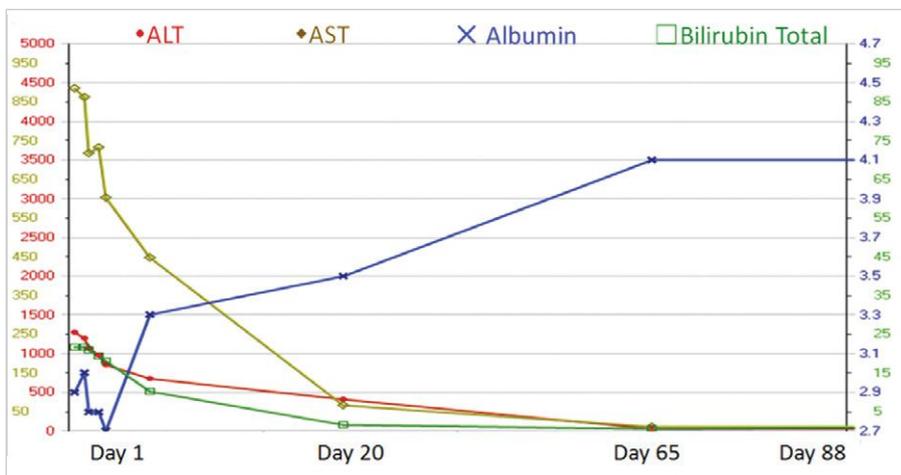


Figure 3. ALT, AST, total bilirubin and albumin trending from admission to 3 months.

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# Radical resection and reconstruction in a child with craniofacial fibrous dysplasia and Marfan syndrome

BY VICTORIA JORDAN, MD, MEGAN DISHOP, MD, JILL MELICHER, MD, JOSEPH PETRONIO, MD, AND ROBERT TIBESAR, MD

## Case Description

An 8-year-old male with Marfan syndrome and expansile frontal mass presented with frequent headaches and progressive left frontal and eyelid swelling.

A multidisciplinary surgical team including a pediatric neurosurgeon, an otolaryngologist, and an oculoplastic surgeon evaluated this patient for resection and reconstruction. Examination showed firm left frontal bossing and ptosis. Ophthalmologic examination did not demonstrate optic nerve compression or ophthalmoplegia. CT scan showed ground-glass opacity and expansion of the left lateral and superior fronto-orbital region (Figure 1), consistent with fibrous dysplasia.

Radical resection and reconstruction was performed using patient-specific polyether ether ketone (PEEK) implant (Figure 2).

After obtaining exposure of the lesion via coronal approach, a preformed template based on the radiographic extent of disease was used to mark the area of resection. The involved left frontal bone, orbit (extending from superior orbital fissure to inferior orbital fissure), and lateral orbital wall to



Figure 1. Ground-glass lesion of the left lateral and superior fronto-orbital region.

zygoma were resected with careful preservation of the underlying periorbita, dura, and cranial nerves (Figure 3). The frontal sinus was cranialized to avoid intracranial-to-sinus communication, and the PEEK implant was placed.

Surgical pathology showed a benign fibro-osseous lesion with extensive osteosclerosis consistent with fibrous dysplasia (Figure 4).

## Discussion

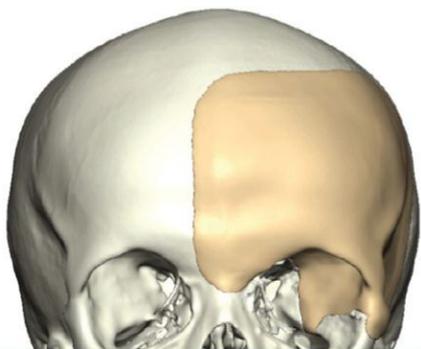
Fibrous dysplasia is a rare, benign bone lesion characterized by replacement of normal bone with fibro-osseous connective tissue. Lesions may be single (monostotic) or multiple (polyostotic). Craniofacial involvement is present in approximately one-fourth of the cases of monostotic disease and in half of the cases of polyostotic disease. Polyostotic disease may be part

of a syndrome such as McCune-Albright syndrome, which may cause the patient to have skin pigmentation and endocrine abnormalities.

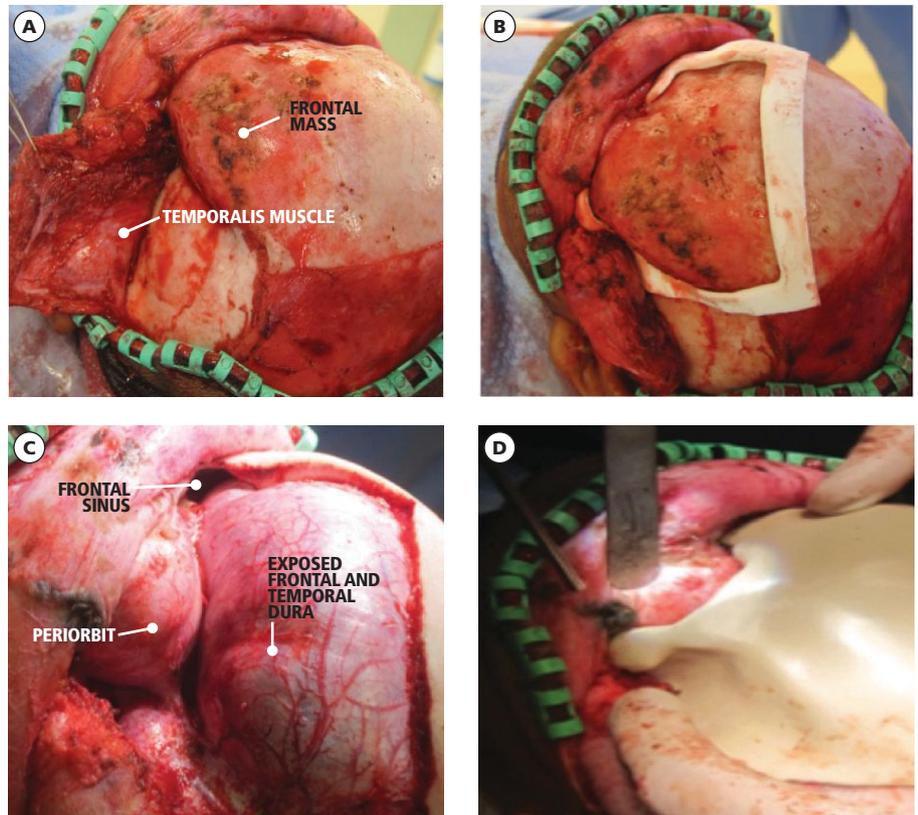
Fibrous dysplasia is a nonhereditary disease of growing bone that occurs when a mutation leads to increased cell proliferation and overproduction of disorganized immature fibrous bone. It typically presents in the first 2 decades of life. Lesions are progressive but typically not painful. Radiographically, lesions are classically described as “ground glass” due to the mixture of fibrous and osseous elements. Microscopically, normal bone is replaced with a cellular fibroblastic stroma containing variable amounts of irregular, thin bone trabeculae that resemble Chinese letters.<sup>1</sup>

The association between Marfan syndrome and fibrous dysplasia is limited to a single case report of a patient with Marfan syndrome who had mandibular fibrous dysplasia.<sup>2</sup> Marfan syndrome is an autosomal dominant disorder caused by mutations on the fibrillin-1 gene affecting connective tissue and craniofacial skeletal growth. Manifestations are long, narrow skull, high-arched palate, recessed mandible, and malar hypoplasia.<sup>3</sup> It is not known if the pathophysiology of Marfan syndrome predisposes to developing the spontaneous mutation causing fibrous dysplasia.

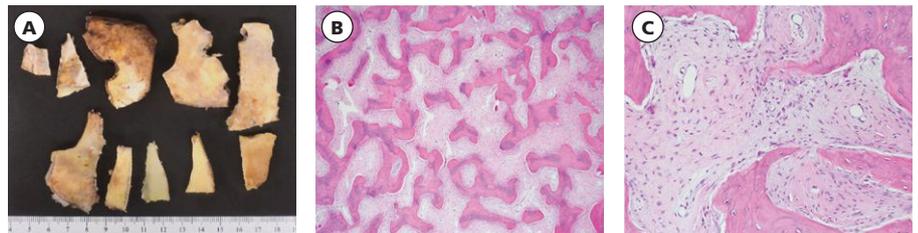
Our patient has polyostotic craniofacial fibrous dysplasia affecting the fronto-orbital region. Principles of craniofacial fibrous dysplasia management have previously been described based on craniofacial zones of involvement.<sup>4</sup> Favored treatment of the cosmetic facial area is radical excision and reconstruction, whereas the cranial base is



**Figure 2.** 3D reconstruction of patient-specific PEEK implant used for surgical planning.



**Figure 3.** Intraoperative photos. (A) Exposed frontal bone mass. (B) Personalized template generated from patient's CT to outline area of fibrous dysplasia. (C) After resection of fibrous dysplasia lesion with view of intact periorbital, dura, and right frontal sinus. (D) Placement of PEEK implant.



**Figure 4.** Pathologic findings. (A) The resected calvarium was thickened with a dense tan-white lesion expanding the bone, best seen in the 3 cross-sections at the lower center of this image. (B) The lesion is composed of curvilinear trabecular bone embedded within a fibrous stroma, typical of fibrous dysplasia (H&E). (C) Unlike many examples of fibrous dysplasia, this lesion had more prominent osteosclerosis and focal osteoblastic activity (H&E).

generally limited to symptomatic relief due to the difficult resection.<sup>5</sup>

Typically, radical resection is the cure for benign fibrous dysplasia. However, due to this patient's underlying Marfan syndrome and potential for skull growth, he will continue to require close monitoring in craniofacial clinic. **MM**

Victoria Jordan is a fourth-year resident at the University of Minnesota in the Department of Otolaryngology-Head and Neck Surgery. Megan Dishop is a pathologist at Children's Minnesota. Jill Melicher is an ophthalmologist at Abbott Northwestern Hospital and Children's Minnesota. Joseph Petronio is a pediatric neurosurgeon and Robert Tibesar is a craniofacial surgeon at Children's Minnesota.

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# Assessing Vietnam veterans' awareness of benefits for Agent Orange-related diabetes mellitus type 2

BY KIRSTEN LARSON, KAYLA SCHENHEIT AND LINDA OLSON BERGUM, MD

## Background

Since the passing of the Agent Orange Act of 1991, the Institute of Medicine (IOM) has found that exposure to Agent Orange is linked to a number of medical conditions. Diabetes mellitus type 2 (T2D) is one of these conditions.<sup>1</sup> The United States Department of Veterans Affairs (VA) has therefore designated T2D as a “presumptive disease,” meaning that the VA assumes this disease is related to veterans’ qualifying military service. This means that Vietnam veterans who served in Vietnam between January 9, 1962, and May 7, 1975, are eligible for a VA benefit that covers disability and medical care associated with managing their T2D. Discussions with patients led us to hypothesize that many Vietnam veterans are unaware of their eligibility for this benefit. We developed this study to investigate Vietnam veterans’ awareness of this benefit. We will use the results of our study to educate physicians about Agent Orange T2D causality and Vietnam veteran benefits.

## Methods

An 18-question interview was developed for interviewing Vietnam veterans. Institutional review board approval was granted for this study. Contact information for veterans was provided to research staff by a past commander of the Disabled American Veterans of Minnesota and by other contacts known to research staff. Each interview took 20-90 minutes to complete. Study data were collected and managed using REDCap electronic data capture tools hosted at the University of Minnesota.<sup>2</sup>

## Results

Twenty-five Vietnam veterans were contacted, and 22 completed interviews. The age distribution, branch of service, and diabetes status of participants are shown in Figures 1A, 1B, and 1C, respectively. Twenty-one of the 22 interviewees served during the time frame of January 9, 1962-May 7, 1975. Of the 22 interviewees, 18 (81.8%) were unaware of the Agent Orange-related T2D benefit (Figure 2A). Of the 22 interviewees, 13 had a T2D diagnosis and 2 had a prediabetes diagnosis. Of the 15 who had a T2D or prediabetes

FIGURE 1A. Age of Participants

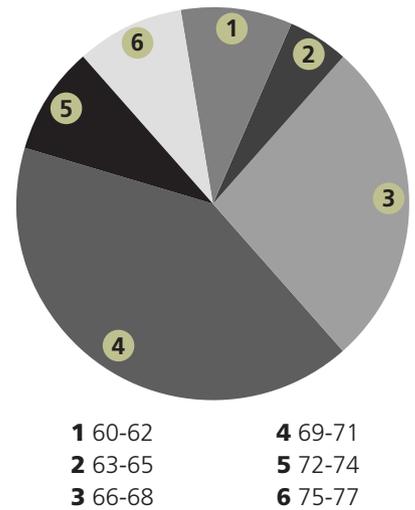


FIGURE 1B. Branch of Service

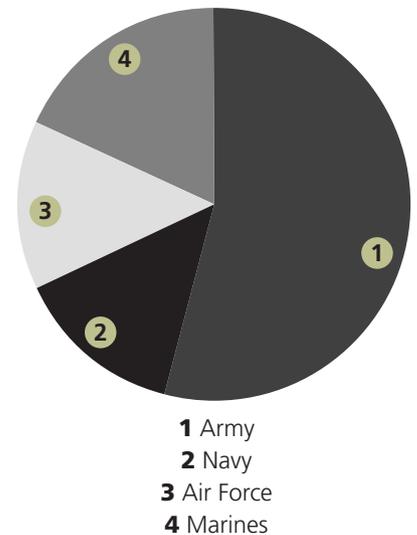


FIGURE 1C. Diabetes Status

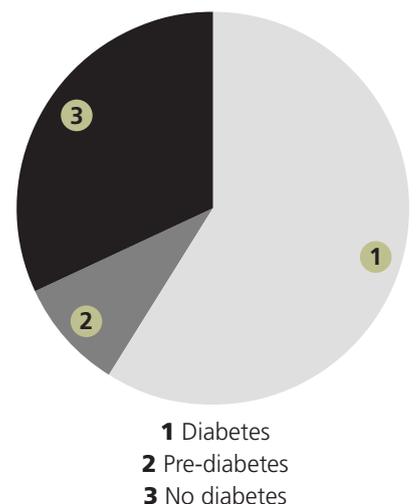


FIGURE 2A. Percentage of all respondents aware of Agent Orange-related T2D benefit



FIGURE 2B. Percentage of respondents with T2D aware of Agent Orange-related T2D benefit



diagnosis, 12 (80%) were unaware of their eligibility for this benefit (Figure 2B).

## Discussion

The goal of this study was to investigate whether Vietnam veterans were aware of their eligibility for a VA benefit that would cover the costs of their T2D care if they served in Vietnam between January 9, 1962, and May 7, 1975. Our study found that the majority (81.8%) of all Vietnam veterans we interviewed were not aware of this benefit. Furthermore, of those Vietnam veterans with diabetes, 80% were unaware of the VA benefit and, remarkably, none were receiving the Agent Orange-related T2D VA benefit. These results correlate with those from the 2010 National Survey of Veterans, which found that only 41% of veterans felt they understood their general benefits.<sup>3</sup> From these combined results, we can conclude that additional outreach to veterans and physicians regarding this benefit is warranted and should be a priority. Primary care physicians are uniquely positioned to leverage their access to veterans and efficiently raise awareness of this important VA benefit among this patient population. **MM**

Kirsten Larson and Kayla Schenheit are fourth-year medical students at the University of Minnesota Medical School. Linda Olson Bergum is an adjunct assistant professor in the university's Department of Family Medicine and Community Health.

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# Discoid lupus presenting within red tattoo pigment

BY SANNA D. RONKAINEN, MD, AND SARA A. HYLWA, MD

**A** healthy 33-year-old female presented to our dermatology clinic with a 7-month history of a progressively pruritic and indurated papule appearing within the red portion of a tattoo located behind her right ear. Three years prior to presentation, she had 5 stars tattooed in this area, each in a different color: orange, teal, red, yellow, and blue, and each with a black outline. No other areas of color were similarly affected with the rash. She reported no past medical history, was on no medications, and had no family history of rheumatologic or other dermatologic conditions.

Physical exam revealed a nonscaly, indurated, and slightly painful papule isolated solely within the red tattoo, with no involvement of the other colors or black outline. Dermatologic examination was otherwise unremarkable.

A biopsy of the affected skin revealed interface dermatitis with follicular plugging and concomitant perivascular and periadnexal lymphohistiocytic infiltrate with underlying mucin deposition, diagnostically consistent with discoid lupus. In subsequent laboratory evaluation, tests for antinuclear antibodies (ANA), anti-dsDNA, and anti-Smith antibodies were negative, and C3/C4 complement levels were within normal limits. Of note: Systemic findings, including serologic markers of lupus, are often negative in the setting of discoid lupus.

Tattoo reactions are common in up to 6% of patients, according to one New York-based survey,<sup>1</sup> with many of these reactions (44%) occurring specifically within red tattoo pigment.<sup>1</sup> Historically, red tattoo color was created from mercuric sulfide (cinnabar), a known photosensitizer. Given its tendency towards causing reactions, red tattoo pigments are now infrequently cinnabar-based and instead made from other pigments, such as cadmium red, ferric sulfate, and other organic dyes. However, de-



**Figure 1.** Cutaneous examination of the right postauricular skin revealed an indurated papule isolated within the red tattoo pigment.

spite the trend away from using cinnabar as a red coloring, the association between red pigment and chronic tattoo reactions has persisted.<sup>2</sup> These red tattoo reactions are most commonly granulomatous, pseudo-lymphomatous, morphea-like, or leukocytoclastic-vasculitic. While delayed reactions within tattoos have been described,<sup>2</sup> discoid lupus occurring predominantly within a tattoo has only been reported in the literature 4 times.<sup>3-6</sup> Interestingly, as in this case, all of the previously reported cases of discoid lupus within a tattoo have occurred within red pigment.

Treatment of discoid lupus consists of diligent photo-protection, topical calcineurin inhibitors, topical or intralesional steroids, and, often, antimalarial medications. **MM**

Sanna D. Ronkainen is a fourth-year internal medicine/dermatology resident and Sara A. Hylwa is an assistant professor in the Department of Dermatology at the University of Minnesota.

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# Psychosis and epileptiform encephalopathy in a patient with a novel gene mutation

BY KEVIN KAY, LORA WICHSER, MD, AND KATHARINE J. NELSON, MD

## Case Report

A 64-year-old woman with hereditary spastic paraplegia and a history of major depressive disorder—recurrent, severe, and without psychotic features—was brought to the emergency department by her husband for abnormal behavior. Her husband described worsening mood and decreased self-care for the last year. She had been describing visual and auditory hallucinations for 2 days, despite no prior history of psychosis.

Family history included hereditary spastic paraplegia and a seizure disorder. Further genetic history showed that her family was a carrier of a novel mutation in the KCNA2 gene, where other mutations have been known to cause channelopathies. The mutation had been identified in other family members, but the patient had not been tested.

At the time of admission, she demonstrated persecutory delusions with visual hallucinations; she believed people she knew were spying on her, even within the hospital. A full medical work-up was unrevealing. A full neurologic evaluation led to an EEG that showed atypical generalized spike and wave activity. A brain MRI showed nonfocal age-related changes.

Valproic acid 500 mg twice daily was started to target seizures, and risperidone 0.5 mg twice daily was started to target epileptic encephalopathy. Hallucinations and delusions decreased within the subsequent 48 hours but did not fully resolve. Even with her improvement, her Montreal Cognitive Assessment score of 5/30 reflected severe cognitive impairment. She was eventually discharged home with her husband assuming 24-hour care for her. Four months after discharge, she continued to report persecutory delusions and visual hallucinations despite the above pharmacologic therapy.

## Discussion

This patient's case is remarkable for the discovery, during an admission for psychosis, of epilepsy in a patient with a novel gene

mutation. The KCNA family of genes encodes voltage-gated potassium channels preferentially expressed in the central nervous system (CNS). Mutations in these genes have been reported to cause epilepsy and epileptic encephalitis.<sup>1,2</sup> This patient's EEG suggested symptomatic generalized epilepsy, but we did not witness any acute epileptic events. This is unusual, as the other identified KCNA2 mutations presented with visible seizure.

We account for our patient's presentation by noting years of unrecognized subclinical epileptiform insults gradually culminating in overt psychosis. Recent studies suggest forms of epilepsy can predispose a patient to a chronic schizophrenia-like illness often called schizophrenic-like psychosis of epilepsy (SLPE) or chronic interictal psychosis.<sup>3</sup> A 2014 systematic review and meta-analysis found the rate of psychosis in epileptic patients to be 5.4%, 7.8 times higher than psychosis in the nonepileptic population.<sup>4</sup> While

the association has been known for many years, precise etiology of psychosis in patients with epilepsy is still controversial.

This case stresses the importance of considering gradual, potentially cumulative insults to the brain over long periods of time in the development of a psychiatric illness. It also highlights the importance of considering organic causes of psychosis, particularly in older patients and in those with a history suggestive of neurologic decline. **MM**

Kevin Kay is a 2017 graduate of the University of Minnesota Medical School. Lora Wichser is a fourth-year resident and Katharine J. Nelson is an assistant professor in the university's Department of Psychiatry.

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# The Veteran

BY LISA FRIEDMAN, MD

From out in the hall  
 In walked Thoreau's machine  
 Against which my life  
 I had pledged to be the weight.  
 Killer of Gooks  
 Hurler of Napalm  
 A vision of a naked child  
 Burning  
 Screaming  
 Running for a life, a future  
 Streamed through my head  
 As the old man sauntered in.  
 The personification of evil  
 Imperialism  
 Jingoism  
 Pessimism.  
 But I had made an oath.

I entered the room  
 The fetor of tobacco  
 Burnt my eyes  
 Clenched my throat in spasm.  
 The veteran sat  
 Jeans stained with white paint  
 Of projects long ago  
 Cowboy boots yearning for use  
 Beyond the three-legged hobble  
 From chair to examining table  
 A thick, grey beard  
 Hid a face of pock marks and wrinkles  
 Aging him twenty years.  
 His hair matted beneath a cap worn proudly  
 Boasting of his community, his family, his identity.

As he talked  
 His hand punched the air  
 Like a Western sheriff shooting into the sky  
 Begging someone, anyone to listen  
 Except the gun was now missing.  
 Da Nang and Saigon slipped simply off the tongue  
 From a man who spent his life working the land  
 In the same small town  
 On the same small farm.  
 He spoke of the young daughter he had raised alone  
 To be tough  
 Like him.  
 Not like the texting, rapping, impertinent youths  
 We have these days.  
 When he was a boy  
 Nobody received a trophy.

He told stories of men  
 Good men  
 Brothers  
 Who were lost.  
 I could see the propellers flickering in his eyes  
 The sound of gunfire echoing in his ears  
 His face stuck in an earnest plea  
 To travel back  
 And move six inches to the right  
 To have foreseen the threats that now seem so clear  
 To have it be him instead.  
 He blinked, but the tears would not come  
 There were none left.

Up on the light box  
 I showed him his insides  
 The black abutting the white  
 In startling contrast  
 Bone crunching against bone  
 Like soaked boots snapping branches  
 On a march over a wet jungle floor.  
 He assured me he was just fine  
 He was getting along  
 I apologized that I couldn't fix it.  
 There was nothing to cut out  
 Nothing to repair.  
 The pain would be chronic, I said.  
 He nodded, already knowing.

He thanked me as he stood to leave.  
 Shook my hand  
 Told me I was a good doctor  
 A good person  
 But I didn't believe it  
 In war  
 Even in a just war  
 We are all losers.  
 As he tottered away down the long hallway  
 And turned to disappear  
 I looked onto a crowded waiting room  
 Survivors of a world gone mad  
 Heroes and villains all.  
 I whispered a promise, a pledge  
 As the last soldier wheeled himself slowly  
 Down the hall  
 Into my room.

I can ease your pain  
 But I cannot cure what ails you.



*Resident, Second Place*  
 Lisa Friedman, MD, is an orthopedic resident at the University of Minnesota. Her column, "Residency Diary," appears in the journal *Clinical Orthopaedics and Related Research*.

ABOUT THIS POEM

"I wrote it during my first rotation at the Minneapolis Veterans Affairs (VA) Medical Center. I come from a fairly liberal family that can be somewhat critical of the actions of our military, particularly during the Vietnam War, so I was originally nervous about working at the VA. This poem is about a patient I saw there. His life and the views he espoused could not have been more different from my own. Yet I learned from him that all my patients, at their heart, hold in common a simple desire to live a good life consistent with their values."



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