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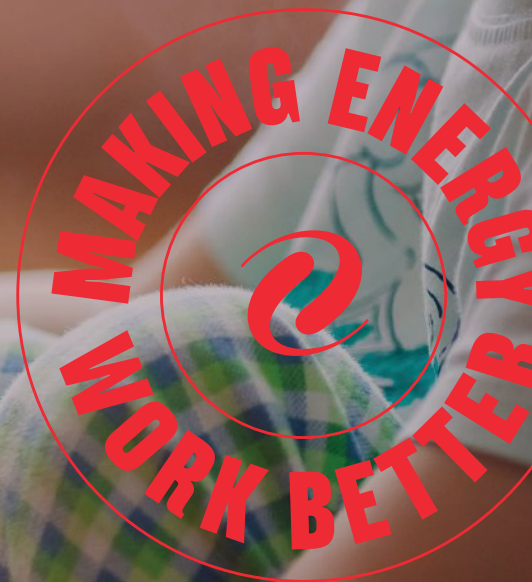
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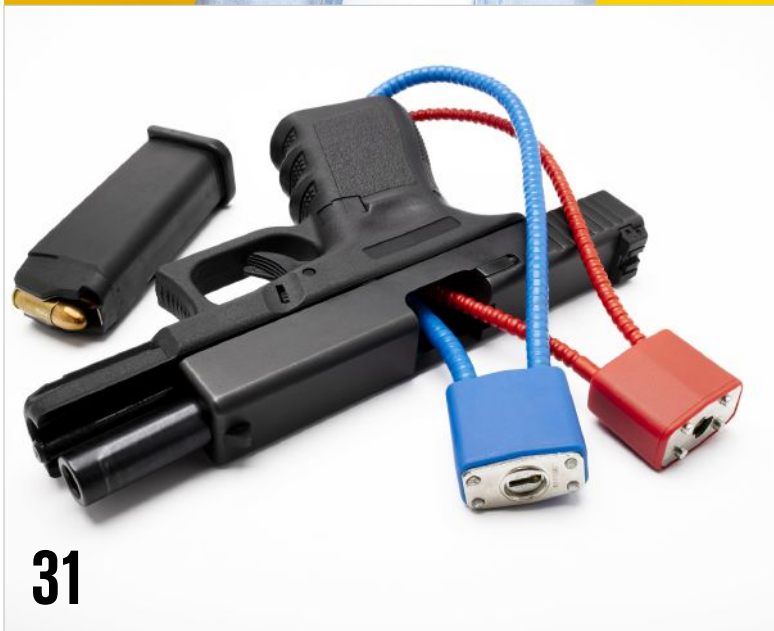
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Rahel Nardos, MD

The universality of suffering and the practice of gratitude

Silence provided the perfect condition for this natural wisdom to emerge. The practice of gratitude to the many gifts we receive every day created a sense of overflowing love and kindness that I can then share. It turns out, there is enough for everyone.

I wanted to share my recent journey inward, a mostly unknown territory for me but one with a potential to heal. I joined 95 other people for a weeklong residential silent meditation with a focus on loving kindness. It was a leap of faith but also a desperate attempt to quiet the noise and reset my nervous system from the impact of what feels like daily chaos with our politics, our struggling healthcare system, and the pressure to constantly do something, be somewhere. I was curious (and scared) to see who I will find in this quiet space. Can I find a “self” I can trust and offer compassion to? Is my heart capable of offering love and kindness to people in my community and the world whose views and actions I find harmful? What would exercising this muscle do to benefit me, my patients, and my community?

The first day was hard. I found myself wanting to connect with the people attending the retreat. I wanted to know their stories and share mine. I was restless with the silence. I noticed my judging mind even in this quite space of gentle humans. That first day, despite my attempt to blend in, I found myself rushing to respond to two retreat attendees who experienced medical emergencies. Being there is a stress test for most people. I made a mental note that as healthcare professionals, our natural inclination is to help and that is a way of being.

Things got hard and blissful the next several days. Hard because working on the muscles of the mind and the heart, especially when they have been overlooked, takes real courage and vulnerability. Blissful, because a beautiful realization emerges from this work, a discovery and friendship with the self, and the potential to accept the world and self as it is and love it anyway.

When I felt resistance in offering love and kindness to those who I perceived to

be difficult in my real life, I found myself leaning into three practices that opened the door. Giving gratitude, recognizing our interconnectedness, and acknowledging the universality of our suffering. The silence provided the perfect condition for this natural wisdom to emerge. The practice of gratitude to the many gifts we receive every day created a sense of overflowing love and kindness that I can then share. It turns out, there is enough for everyone.

Walking through the woods during walking meditation, feeling the supportive ground during sitting meditation, and noticing and tasting the wholesome food on my plate, I found the earth to be a powerful reminder of unconditional generosity. I then started noticing the hard work and ingenious human innovations like the clean water in our faucet, the light and heat that fill our homes, and the medical innovations that have made it possible for us to live our lives with ease. I was overcome with joy when I saw that the coffee we were drinking at the retreat came from a part of Ethiopia where I used to volunteer as a pelvic surgeon. I wondered if it was grown by one of my patients. We should care for each other and all beings because we are interconnected. After all, we are all made of the same stuff—earth, water, air, and fire.

This led me to reflect on the universal nature of suffering and our opportunity to relieve suffering through presence and kindness. Today, I want to send you some loving kindness. I wish you feel safe and protected, I wish you find joy in everyday things, I wish you wellness in the mind, body, and spirit, and I wish you a life of ease and balance, even in chaos. **MM**

Rahel Nardos, MD, MCR, is associate professor, Department of Obstetrics, Gynecology and Women's Health, and director, Global Women's Health, at the University of Minnesota. She is one of two medical editors for *Minnesota Medicine*.



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Minnesota, other states block attempt to stop gender-affirming care

In March, Minnesota Attorney General Keith Ellison and a coalition of 21 states and the District of Columbia secured a federal court ruling blocking an attempt by the Trump Administration to pressure healthcare providers into ending care for youth with gender dysphoria.

The court indicated that it would grant the states' motion for summary judgment and vacate the declaration issued by Health and Human Services Secretary Robert F. Kennedy Jr. last December. Kennedy had hoped to supersede state standards of medical care and



threatened hospitals and clinics that provide gender-affirming care with potential exclusion from Medicare and Medicaid.

“Gender-affirming care is healthcare, and healthcare decisions should be left up to doctors, their patients, and if the patient

is younger, their parents or guardians,” Ellison said. “States are responsible for licensing and regulating the medical profession, and professional associations like the American Medical Association, the Endocrine Society, and others like them establish standards of medical care based on evidence-based research. The federal government should not be part of that equation.”

Joining Minnesota in the lawsuit are the attorneys general of California, Colorado, Connecticut, Delaware, the District of Columbia, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Nevada, New Jersey, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington, Wisconsin, and the governor of Pennsylvania.

U.S. Supreme Court ruling may affect Minnesota

On March 31, the U.S. Supreme Court ruled against a Colorado law banning conversion therapy, treatments that attempt to change individuals' sexual orientation or gender identity, for minors.

The 8-1 decision in *Chiles v. Salazar* ruled in favor of Kaley Chiles, a licensed professional counselor in Colorado, who argued that the law violated her First Amendment right to free speech. In the opinion of the court (Gorsuch), six justices argued that because the sole tool of the practitioner was language, the state was regulating speech itself. In the concurring opinion (Kagan), two justices argued that, while it is appropriate for states to regulate the content of professional services in a viewpoint-neutral way to protect public health, it cannot discriminate based on viewpoint. The Colorado law is viewpoint discriminatory because it prohibits therapists from trying to change their patients' sexual orientation or gender identity, but allows them to affirm LGBTQ individuals seeking acceptance or support.

The decision threatens the enforceability of state-level conversion therapy bans across 23 states, including Minnesota. At least one Minnesota legal scholar suggests



one way around the First Amendment problem would be to ban the harm, rather than banning the viewpoint, as alluded to in Justice Kagan's concurring opinion.

The MMA adopted a policy in support of a state ban on conversion therapy in 2018 and supported the passage of the current state ban in 2023. The MMA's policy is consistent with that of the American Psychological Association and the AMA, both of which cite strong evidence that conversion therapy is ineffective and associated with long-lasting psychological damages.

Women physicians more likely than men to quit medicine

Female physicians in the U.S. are more likely than their male colleagues to leave clinical practice, according to the study of more than 707,000 physicians published in April in the *Journal of General Internal Medicine*. That is true regardless of specialty and geographic location. Female physicians are also younger on average than male physicians when they leave practice.



According to the authors, from Yale School of Medicine, the University of California, San Francisco, and UCLA, “In the context of multiple detractors that drive greater levels of burnout in female physicians, ranging from mistreatment and harassment to worse ratings of work-life integration, lesser perceived appreciation and schedule control, and differential expectations, our findings underscore the need for culture change and targeted resource allocation to enhance the care delivery experiences of female physicians.”

Minnesota's uninsured rate reaches highest point since 2017

New data shows that the state's uninsured rate increased from a historic low of 3.8% in 2023 to 5.8% in 2025, the Minnesota Department of Health (MDH) announced in March. This equates to approximately 116,000 more Minnesotans without health insurance. It is the highest uninsured rate for the state since 2017, reversing years of improvement in this area.

"The sharp increase in uninsured Minnesotans over the past two years is deeply disturbing, as are the long-standing disparities in the uninsured rate by race/ethnicity and income that continue to persist," Minnesota Commissioner of Health Brooke Cunningham, MD, PhD, said in a statement. "For most people, healthcare is unaffordable without insurance. This results in delayed or deferred care and worse health outcomes, more medical debt for families, and increased rates of uncompensated care for health systems."

According to survey data, the increased rate of uninsured Minnesotans appears to be driven by a decrease in public coverage, which dropped from 44.1% to 39.6%. The uninsurance rate among children also increased, rising from 2.7% in 2023 to 4.6% in 2025.

Increases in the rate of uninsurance were seen across the state. Minnesotans living in metropolitan areas saw a significant surge in uninsurance (from 3.4% to 5.7% in 2025), as did Minnesotans living in rural areas (from 4.3% to 6.7% in 2025).

Long-standing disparities in the state's uninsurance rate by race/ethnicity and income are again reflected in the data. Hispanic Minnesotans continue to be the most likely to be without insurance coverage. More than 20% of the state's Hispanic population report being uninsured—greater than three times the state-

wide rate and significantly higher than the 11.4% rate reported just two years ago.



Additionally, Black and American Indian Minnesotans continued to report disproportionately high rates of uninsurance. The uninsurance rate among Black Minnesotans jumped from 6.3% to 10.1%, while American Indians saw uninsurance rates increase from 5.7% to 10.5%. While lower than the statewide rates, the uninsurance rates for white Minnesotans also saw a statistically significant increase (from 2.5% to 3.8%).

According to researchers, people in Minnesota with lower incomes are more than twice as likely to be uninsured, with survey data showing 13% of people with an income below 200% of the Federal Poverty Guidelines being uninsured in 2025.

Concerns over losing health insurance coverage continue to weigh heavily on Minnesotans. More than 12% of insured Minnesotans said they are worried about losing coverage, a statistically significant increase from 7.7% in 2023. The share of these Minnesotans expressing anxiety over rising costs and coverage becoming too expensive jumped more than 10 percentage points in the latest data (28.8% in 2025 compared to 17.5% in 2023).

The Minnesota Health Access Survey is a biennial state-based population survey that collects information on Minnesotans' health insurance coverage and healthcare access. The survey measures how many people in Minnesota have health insurance and how easy it is for them to get healthcare. The survey is conducted as a partnership between MDH and the State Health Access Data Assistance Center, which is part of the Health Policy and Management Division of the School of Public Health at the University of Minnesota. The survey had responses from more than 16,000 Minnesotans across the state and was conducted between September and December 2025.

Youth cannabis use continues to decline, survey says

The Minnesota Department of Health (MDH) reported in April that there continues to be a steady decline in youth cannabis use since 2013, with 96% of students reporting not having used cannabis in the last month.

The 2025 Minnesota Student Survey, Minnesota's first study since adult cannabis use was legalized in 2023, showed healthier trends related to student use and perceptions of harms. Minnesota has seen a 57.7% decrease statewide of self-reported past 12-month cannabis use

from 2013 (14.9%) to 2025 (6.3%) among eighth, ninth, and 11th graders combined. And more students now view using cannabis once or twice a week as moderately to greatly harmful, reversing the trend seen from 2013 to 2022.

The survey, one of the nation's longest-running youth surveys, provides local data to schools about student health, well-being, and a range of topics. Conducted every three years between January and June, the survey anonymously collects information from students in grades five,



eight, nine, and 11. MDH and local public health and community organizations also use the data to strengthen youth substance use prevention strategies and programs.

New residency program aimed at expanding the rural MD pipeline to open in Staples

The University of Minnesota Medical School and Staples-based Lakewood Health System are expanding rural physician training in the state with a new residency program.

The Lakewood Rural Residency Program was recently approved by the Accreditation Council for Graduate Medical Education. Residents will start the three-year program with one year of training with the North Memorial Family Medicine Residency Program in North Minneapolis, followed by two years with Lakewood Health System in Staples. The program will train two new family medicine physicians per year.

Students can start applying to the program in September 2026, with the first cohort set to begin in the summer of 2027.



This new program joins the Willmar Rural Family Medicine Residency Program and the Grand Itasca Rural Family Medicine Residency Program as the only rural family medicine training programs in Minnesota—creating new opportunities for medical students seeking specialized training in rural healthcare.

Mayo Clinic AI helps detect pancreatic cancer up to years before conventional diagnosis

A Mayo Clinic-developed AI model can help specialists detect pancreatic cancer on routine abdominal CT scans up to three years before clinical diagnosis. It identifies subtle signs of disease before tumors are visible, when curative treatment may still be possible. The findings, published in *Gut* early this year, validates a next-generation AI model using data and workflows that mirror clinical practice, including CT scans from multiple institutions, imaging systems and protocols.

Researchers used the AI model to analyze nearly 2,000 CT scans, including scans from patients later diagnosed with pancreatic cancer—all originally interpreted as normal. The system, called the Radiomics-based Early Detection Model (REDMOD), identified 73% of those prediagnostic cancers at a median of about 16 months before diagnosis—nearly double the detection rate of specialists reviewing the same scans without AI assistance.



The advantage was even greater at earlier time points. In scans obtained more than two years before diagnosis, the AI identified nearly three times as many early cancers that would otherwise go undetected.

“The greatest barrier to saving lives from pancreatic cancer has been our inability to see the disease when it is still curable,” says Ajit Goenka, MD, the study’s senior author, and a Mayo Clinic radiologist and nuclear medicine specialist. “This AI can now identify the signature of cancer from a normal-appearing pancreas, and it can do so reliably over time and across diverse clinical settings.”

– Mayo Clinic

Sanford, North Memorial Health announce plans to merge

Sanford Health, based in Sioux Falls, South Dakota, and North Memorial Health announced in early May that they have agreed to merge as a single nonprofit health system.

The partnership is expected to close this year, subject to completion of regulatory processes. Sanford has made attempts to join the Twin Cities market in the past—trying to merge twice before with Fairview Health Services.

On a website created to provide information on the merger, the partnership laid out a series of commitments for the merger, including:

- Strengthening and expanding care through a \$600 million investment across the Twin Cities region to address critical needs at North Memorial Health’s Robbinsdale and Maple Grove hospitals.
- Updating and sustaining Level 1 trauma and emergency services at North Memorial Health—Robbinsdale Hospital.
- Doubling the size of North Memorial Health—Maple Grove Hospital, growing Minnesota’s largest birth center, expanding emergency care and adding inpatient and surgical capacity, while improving access to cardiology and interventional radiology to meet rising demand.

Twin Cities operations will be led by North Memorial Health’s CEO Trevor Sawallish.



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Too much profit in our nonprofit hospitals?

Raises for executives in nonprofit healthcare far outpace pay for other healthcare professionals.

BY THOMAS C. LANE, MSC

From a governance perspective, Minnesota's hospital landscape is surprisingly monotonous. According to the most recent counts from the Department of Health, 100 of Minnesota's 125 hospitals are under private nonprofit ownership, with most of the remainder being publicly owned.¹ Only a single hospital in the entire state has for-profit ownership. In contrast, about one in four hospitals na-

tionwide are for-profit, and in some states, especially in the South and West, around half of hospitals are.²

One might hear this and expect Minnesota's hospital sector to be more closely oriented towards the best interests of the public than in other states, as nonprofit ownership implies a charitable function and public hospitals are quite literally owned by the public. Unfortunately, that is

not necessarily the case. An investigation this spring by the *Star Tribune* and KFF Health News found our state's hospitals to be among the least charitable in the nation, spending far less on average as a percent of their expenditures than their peers nationwide (who aren't exactly the most generous, either).³ Minnesota's health system, just like those across the rest of America, is weighed down by systemic dysfunction

that prevents it from reaching its full potential.

Runaway executive compensation, while representing a relatively small fraction of health system spending by itself, is nonetheless useful as a signal of misaligned priorities within what are supposed to be charitable organizations. If health system leadership is choosing to richly reward themselves at the public's expense, chances are that they are also making other decisions that come at the expense of the public interest. Do the investment choices made by such health systems in acquiring new equipment, building new facilities, setting up new specialty centers, and acquiring other hospitals fill the most pressing unmet needs of Minnesota patients? Or do they merely serve to maximize revenue? Nonprofit leadership teams that view their organizations more

as businesses chasing revenue extraction rather than charities chasing those in need are likely to view their own compensation through the same lens.

By observing trends in executive compensation at Minnesota's nonprofit health systems and comparing them to typical clinician compensation in Minnesota, it is thus possible to gain a uniquely clear view of what health system priorities actually may be. In exchange for nonprofit status, health systems must file various financial disclosures with the IRS, including how much they pay their executives. While health system public relations offices can say more or less anything they want to the press about what their priorities are, their accountants cannot lie to the IRS.

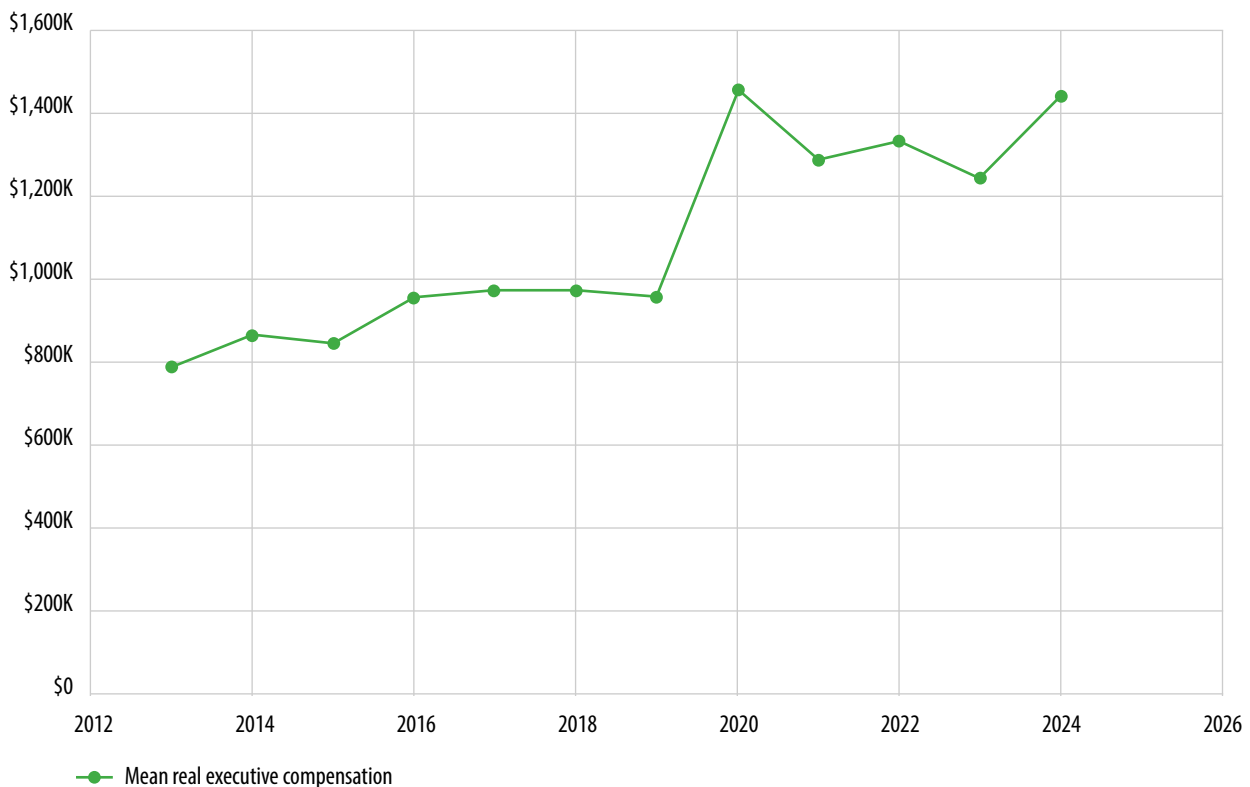
The following graphs come from data extracted from the IRS Form 990 disclosures of each health system operating at

least two hospitals in Minnesota. That includes Allina Health System, Avera Health, CentraCare Health System, CommonSpirit Health (formerly Catholic Health Initiatives), Essentia Health, M Health Fairview, HealthPartners, Inc./Park Nicollet Health Services, Mayo Clinic, North Memorial Health Care, Ridgeview Medical Center, Sanford Health, and St. Luke's Hospital, Duluth. HealthEast Care System, which was acquired by Fairview in 2017, is also included in the data up until its absorption. The individuals included were those classified by the organizations as either officers or key employees according to the IRS's criteria. Data on clinician wages in Minnesota used as a comparison comes from the U.S. Bureau of Labor Statistics.

In nominal terms, salaries for all at nonprofit health systems, whether they

FIGURE 1

Annual mean real executive compensation (inflation-adjusted to 2024)



Average total compensation for executives at nonprofit health systems operating at least two hospitals in Minnesota from 2013 to 2024, as reported on each organization's IRS Form 990 disclosures. All dollar amounts were adjusted to 2024 values using the CPI-U inflation index. Roughly 400 individuals are present in the data each year.

be executives or clinicians or anyone else, are expected to rise over time due to general inflation. Otherwise, in real terms, everyone would be getting a de facto pay cut each year. The point where scrutiny is warranted is when those raises are far in excess of inflation, as that potentially indicates misplaced priorities inside charitable organizations. In Figure 1, the period around the COVID-19 pandemic stands out. Compared with 2019, the average executive received a roughly 52% raise in total pay in 2020 even after taking out the raise inflation would have predicted. The pandemic was hard on everyone, but the health system employees suffering the most were the frontline clinicians, not executives. Nonetheless, in Figure 2, it's clear that clinicians received no "pandemic bonus" similar to that which executives

gave themselves. In real terms, executives received a roughly 82% total increase in compensation beyond what inflation would predict from 2013 to 2024. In contrast, primary care physicians received only about a 16% total raise, and registered nurses not even a 4% raise.

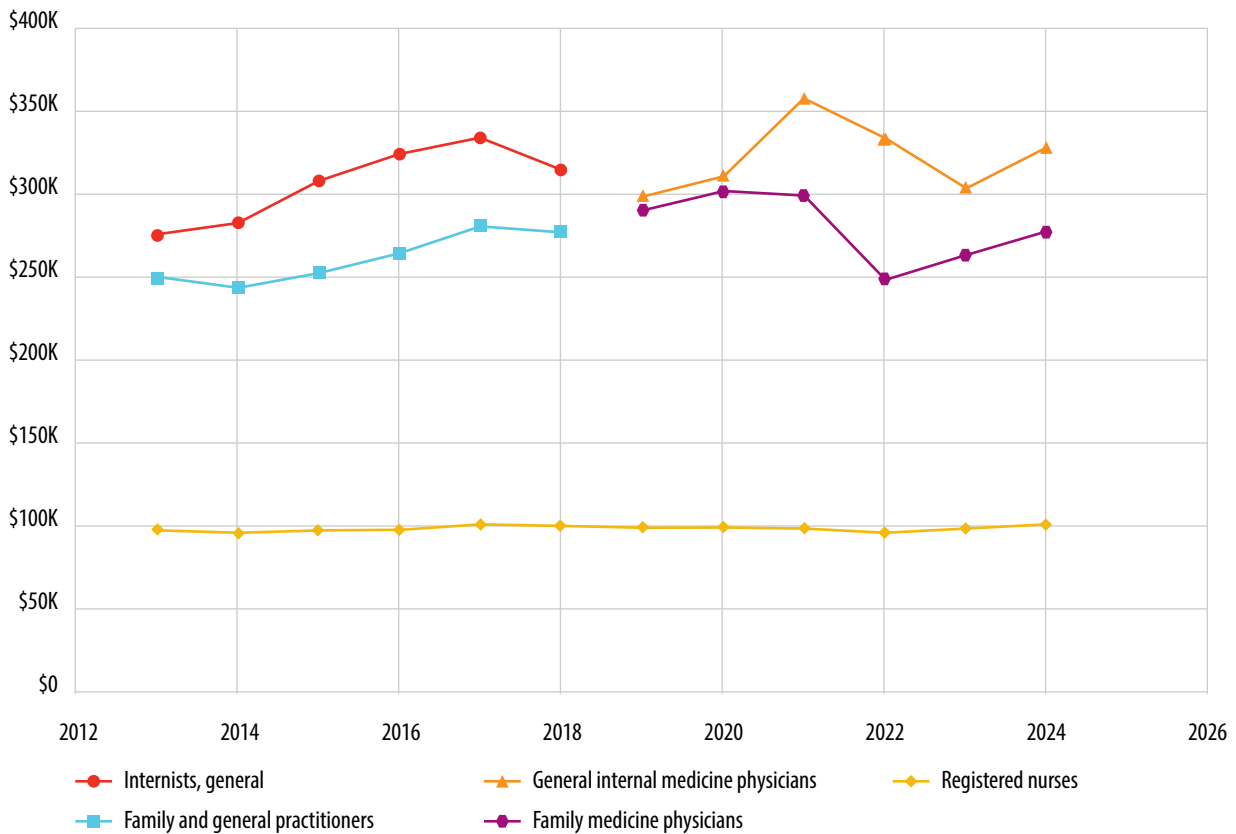
However, this widening income inequality between clinicians and the executives who oversee their workplaces is easier to conceptualize when we compute the ratio between executive and clinician pay in Figures 3 and 4. This ratio tells us how many dollars the average executive earned for each dollar earned by a typical primary care physician or registered nurse. In 2013, the average executive earned about \$3 for each dollar the typical primary care physician earned and a little over \$8 for each dollar the typical registered nurse earned.

In 2024, however, the average executive was earning almost \$5 for each dollar the average primary care physician was paid and over \$14 for each dollar the typical registered nurse was paid. As Minnesota's health systems have grown and consolidated, the executives running them appear to have similarly grown and consolidated their cut of the revenue without sharing that good fortune with anyone else, all while publicly emphasizing a narrative of how difficult it is to keep their health systems in decent financial shape.

This result of growing income inequality between clinicians and executives alongside misplaced health system priorities is not surprising when viewed from a governance perspective. It's exactly what we would predict to occur because of the way we finance healthcare, and especially

FIGURE 2

Annual real wages for Minnesota clinicians by category (inflation-adjusted to 2024 values)



Annual wages of various clinician types in Minnesota from 2013 to 2024. The categories the Bureau of Labor Statistics uses to report physician wages were changed between 2018 and 2019. Due to their data collection methodology, their data is of limited accuracy for most physician specialties beyond primary care, dictating the choice of specialties displayed. All dollar amounts were adjusted to 2024 values using the CPI-U inflation index.

hospitals, in this country. To understand why that is, it's useful to compare how a restaurant and a town fire department are financed.

When we crack open the books at a typical hospital, we find that they are paid more or less the same way a restaurant is, which is based on how many services they provide. Hospitals get paid for each surgery they perform, baby they deliver, X-ray they do, and so on, just as a restaurant is paid for each appetizer, main course, dessert, and drink it serves. This works well for restaurants, as they are financially rewarded for serving good food, something patrons can easily ascertain. Society benefits from this restaurant financing system too. Good restaurants tend to prosper while those that aren't so good tend to close.

In contrast, consider how a fire department is financed. They receive a budget from their community, which they use to pay for things like staff, equipment, and maintenance based on their expected needs. If something extraordinary happens, such as a particularly wide-ranging fire, they may need an extra budget allocation, but for the most part, they are expected to provide a set of essential services to the community while keeping their expenses within a set limit.

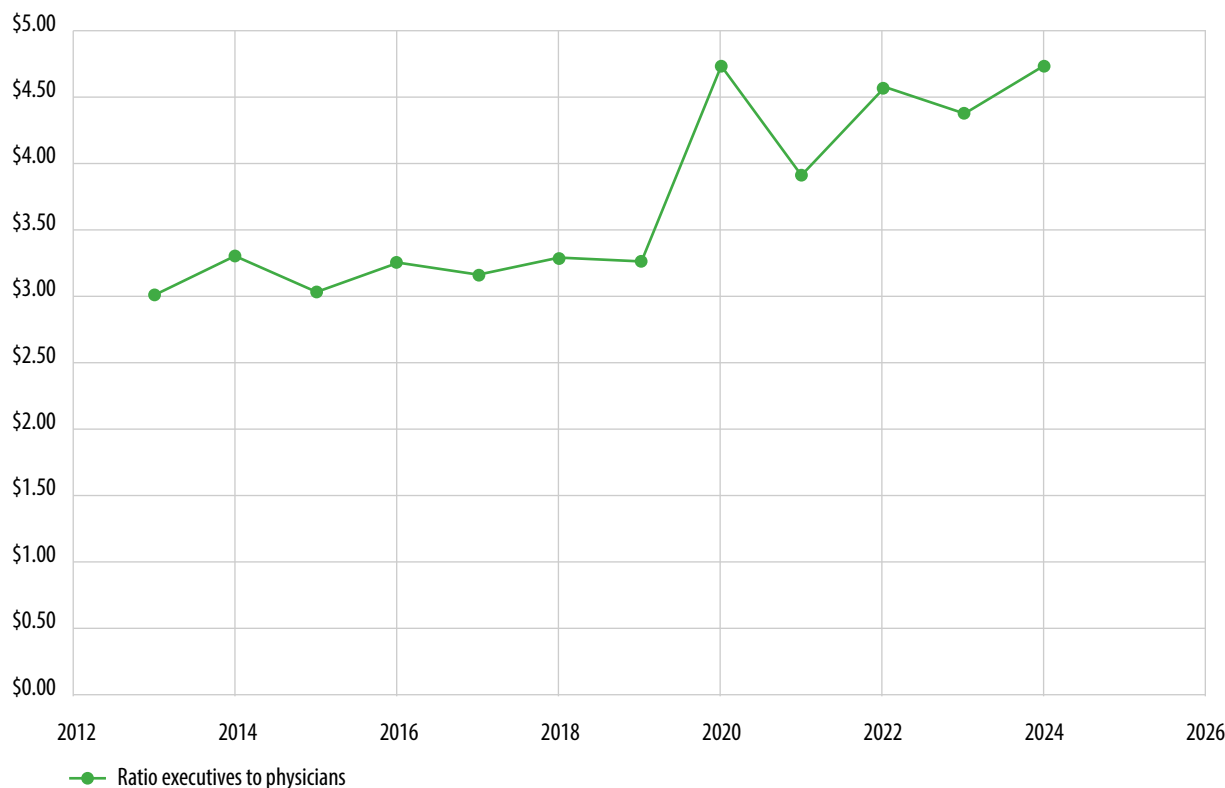
In many ways, the function of a non-profit health system is quite similar to that of a fire department. Of course, fire departments and hospitals both respond to emergencies as their chief public function, but they also do important preventative work, such as verifying building compliance with fire safety regulations in the case of fire departments and providing various

forms of preventative care in the case of health systems. At the same time, they definitely do not function like restaurants. Patrons generally go to restaurants for the pleasure of a special meal, not because their life is on the line if they don't eat soon. Patients go to hospitals and clinics because they need care, not because they think getting surgery or a vaccination is fun. Yet, we finance health systems and their hospitals more like restaurants than fire departments.

When hospitals are financed like restaurants, the system is easily exploited. The patients who can pay the most for care tend to all live nearby one another, leaving the hospitals who serve them financially stable, while those serving less affluent communities often struggle. When a stable hospital and a struggling hospital are both owned by the same health system, services

FIGURE 3

Dollars earned by an average executive for each dollar earned by a physician



A comparison between the total compensation of the average executive at a Minnesota-operating nonprofit health system and a Minnesota physician (defined via the average of the general internist and family and general practitioner BLS-reported mean wages in 2013–2018, and the average of the general and internal medicine physician and family medicine physician BLS-reported mean wages in 2019–2024).

often end up cut at the struggling one so that resources can be diverted towards increasing revenue at the more successful one. The struggling hospital may even end up shuttered. With restaurants, this mode of operation based on profitability makes sense, but for hospitals, it usually leaves society worse off and patients cut off from the care they need. An expecting mother will be OK if the nearest fine dining establishment closes, but she may not be if her nearest hospital closes its obstetrics ward and she is left a dangerously long distance from the next place she could give birth.

As a side effect, this business-first orientation among health systems also frequently leads nonprofit health system executives to see themselves as business managers rather than charity or public service managers, resulting in the executive compensation trends explored previously.

Because health system revenue is determined based on ability to maximize the quantity of profitable services provided, surpluses start getting put towards aims that are expected to further drive profitability, such as expansion of high-margin specialty services, acquiring competitors, and increasing executive compensation to presumably attract more leadership skilled in for-profit business-style operations.

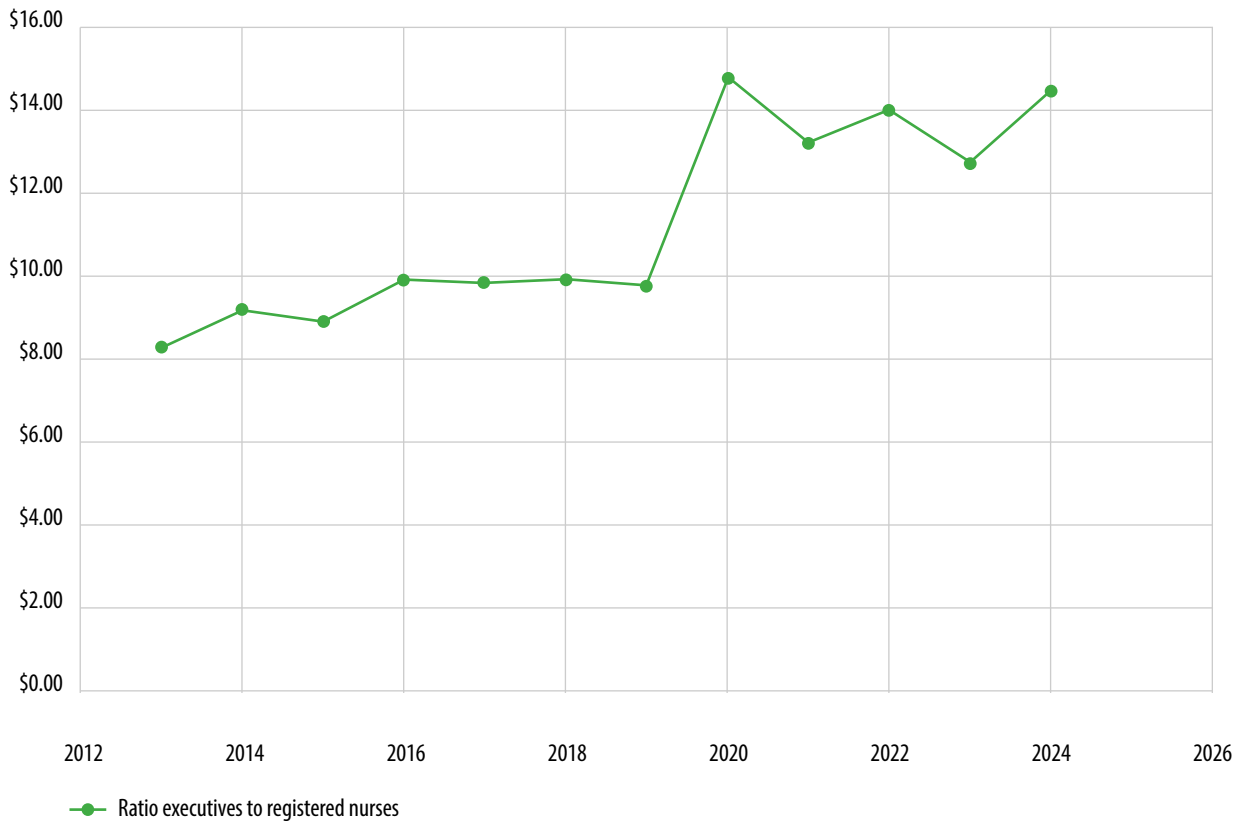
Predictably, as a consequence we get health systems that put business outcomes before charitable functions in just about everything they do. Just as health insurers often seek to delay and deny care to increase their margins, nonprofit health systems have their own vices. Less profitable but essential areas of medicine, such as primary care and obstetrics, tend to be first in line for neglect, budget cuts, and program elimination.⁴ Residents are

often put through shifts of unsafe lengths,⁵ and nurses are often denied safe staffing ratios.⁶ When staff seek to exercise their right to unionize to gain leverage against management choices like these, they are frequently met with hostility and retaliation.⁷ Revenue that could be used to improve quality of care or reduce prices for patients is often instead invested in acquiring other hospitals to increase market power,⁸ and hospitals providing an irreplaceable but unprofitable service in underserved rural and urban areas frequently end up shuttered.⁹

Our nonprofit hospitals go above and beyond just seeking to mimic the goals of for-profit businesses. They also imitate their methods, often hiring expensive management consultants to advise and guide them in their pursuit of business success. A recent study in *JAMA* conser-

FIGURE 4

Dollars earned by an average executive for each dollar earned by a registered nurse



A comparison between the total compensation of the average executive at a Minnesota-operating nonprofit health system and a Minnesota registered nurse (defined via the mean annual wage reported by the BLS).

vatively estimated that nonprofit hospitals spent around \$8 billion in total nationwide from 2009–2023 on such consultants, with the average nonprofit hospital that hired management consultants spending \$15.7 million (or alternatively, the salaries of roughly 46 physicians or 167 RNs for a year).¹⁰ Ironically, no effect of these consultants on financial performance, operational indicators, or quality of care could be detected.¹⁰ The U.S. spends \$1.5 trillion annually on hospitals,¹¹ so as with executive pay, this spending in the big picture is not a large resource drain on its own. But small waste is still waste, and it is a very important signal of what nonprofit hospitals think their problems are and how they think they can be solved, giving us insight into how they approach much more consequential spending choices. Management consultants are trained in maximizing the returns for-profit businesses generate for their shareholders, not maximizing the value nonprofit organizations generate for society, although the study's results on financial outcomes suggest they aren't much good at that, either.

Many countries recognize the inherent contradiction of funding hospitals the same way as restaurants. Instead, they choose to fund them more like fire departments, using what are called global budgets. These global budgets are most commonly found in single-payer systems. The hospital is given one budget for day-to-day operations and another for capital improvement projects, like replacing outdated equipment, renovating aging facilities, and expanding operations to address unmet community needs. They may also have a research budget to advance medicine in ways that the local community could benefit from. Incentives for profit-seeking (and also runaway executive compensation) are absent, as revenue (the global budget) is set based on community needs, and cannot be gamed by management to fund unrelated goals. In the U.S., this method of financing health systems is becoming more and more popular. For example, it was incorporated into the more recent versions of the Medicare for All Act, which would put the U.S. on a

single-payer health financing system.¹² It's also in many state-level single-payer proposals, such as the Minnesota Health Plan legislation led by State Sen. John Marty of Roseville.¹³

In the U.S. we spend more per capita than any other country on Earth.¹⁴ Unfortunately, we still aren't getting the care we need. Somewhere along the way, our money goes missing. As a result, we clearly need to think a bit more carefully about *how* we funnel that money into our health system in order to ensure we get the efficient and reliable care we deserve. **MM**

Thomas C. Lane, MSc, is a health economist from the West Metro. He recently graduated from Sweden's Karolinska Institute (2026) and Dartmouth College (2024). He has worked in a variety of settings generally focused on health system financial sustainability, including with the state of Minnesota and the Swedish government. Opinions expressed in this article are solely his own.

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Protect patient access and medical workforce before it's too late

Sky-high medical liability awards based on noneconomic factors threaten physicians and healthcare generally.

BY KOURTNEY KEMP, MD, FACS

Recently, after the largest medical malpractice award in our state's history at \$16.5 million, Duluth primary care physician David Mast, MD, wrote a letter to the editor of the *Star Tribune* explaining he was retiring early because of the lack of physician protections and fear of escalating litigation pressures. Many of us felt the same—worried.

Minnesota has long been a place where patients have access to high-quality care with timely access for emergencies and specialists. Today patients and physicians are facing many healthcare challenges and

are tasked with repair of systemic issues that are difficult to solve. Medical liability protections have served as a safety net by giving physicians and healthcare systems the stability to take on complex, high-risk care while addressing systemic challenges through the lens of meaningful patient care initiatives.

Unfortunately, there is a troubling shift. Medical liability cases are no longer limited to clear, egregious errors. Instead, physicians are seeing cases involving complex, unavoidable medical outcomes and known complications being argued

in court as through they were preventable errors of negligence. Emotional narratives drive outcomes, and subjective, volatile noneconomic damages for pain and suffering are being pushed to unprecedented levels. Verdicts are becoming increasingly unpredictable and excessive.

Trial practices have evolved. With the addition of private equity financing, there is more money to finance more litigation. In 2017, a prominent national out-of-state plaintiff attorney held an all-day seminar in Minneapolis titled “Trial by Human.” The attorney discussed his tactics in

obtaining \$3 billion in verdicts during his career. These tactics involved using psychology and performance rather than facts. He spoke about creating a story for juries in which the physician was the villain and helping the jurors see themselves as the heroes. He encouraged attorneys to ask for eight figures and avoid settlement prematurely. He advocated normalizing large verdicts and centering the case on noneconomics (pain and suffering). He discussed his strategy of building persuasive client relationships that can withstand the pressures of trial rather than defaulting to settlement, by centering the client on a pursuit of justice against the perceived villain. We have seen planted “anti-health-care” social media to influence public opinion prior to big trials or mediation.

It was heartbreaking when I saw Devon Callahan, MD, a well-respected trauma and critical care surgeon in Minneapolis on the front page of the news as a doctor removing the wrong organ. The reality is that he performed a lifesaving procedure for life-threatening infection involving two organs, and is in active litigation. He has since left Minnesota and we are at a huge loss, and extremely fortunate for the many Minnesota lives he saved through the years.

We have seen a singular verdict bankrupt an entire obstetric practice in Iowa. Years later, the verdict was overturned, and the obstetrician was found not liable. She has since stopped delivering babies and shifted her career elsewhere. The state of Iowa is at a huge loss given her tremendous reputation and safe delivery of thousands of babies through the years.

While most attorneys maintain a moral, ethical compass focused on patients, our current legislation has incentivized this predatory behavior against physicians as well as our vulnerable patients. Patients and communities are not seeking excessive verdicts. They are seeking reasonable compensation, transparency of events, and mediation efforts. The evolution of tactics isn't new, but has been escalating. I have become aware of at least 20 seminars and talks focused on excessive noneconomic damages. This is not about “bad doctors.”

This is not about “bad doctors.” Any physician can be exposed to catastrophic risk regardless of intent or quality of care. As one physician said it, “We are navigating unprecedented times, we are standing in the middle of traffic, hoping not to get hit.”

Any physician can be exposed to catastrophic risk regardless of intent or quality of care. As one physician said it, “We are navigating unprecedented times, we are standing in the middle of traffic, hoping not to get hit.”

These verdicts don't happen in isolation. They ripple through the entire system, creating higher healthcare costs and increased pressure on rural hospitals with razor-thin margins. They reduce access to care and result in growing inequity across communities. Losing physicians to early retirement and career changes puts increasing pressure on those remaining in high-risk specialties. Patients and families are absorbing the cost. A singular excessive verdict can result in rural hospital closure, bankruptcy of independent practices, increase in defensive medicine spending, and erosion of Minnesota's historically strong healthcare system. A singular physician leaving practice or limiting service is estimated to cut access for 1,500 patients annually.

There is a simple path forward that can protect both patients and physicians. Attempts at tort reform in the Minnesota Legislature (such as bill SF3489/HF4274 last session) would restore fairness and reasonableness, reduce volatility and excessive verdict awards, preserve access for patients, support rural hospitals and com-

munities—all while ensuring patients still receive full economic compensation when harmed. This is not about limiting justice. It's about restoring balance, so the system remains sustainable for everyone.

Tort reform is not about choosing doctors over patients. It is about protecting both. Whether in Minnesota or other states, support legislation that does the following:

- Transparent disclosure when errors occur.
- Support fair compensation for injured patients, while avoiding duplicative recoveries.
- Limits on destabilizing, emotionally driven verdicts, caps on pain and suffering awards, while still allowing *full* economic recovery for harm.
- Personal protection for physicians and healthcare professionals acting in good faith without willful or malicious intent (this also protects their families, colleagues and group practices).
- Preservation of healthcare access for communities.
- Pretrial screening panels to help avoid lengthy court processes for nonmeritorious claims.
- Caps on attorney fees, which support fair income while ensuring that compensation reflects fair legal work rather than inflated damages.
- Keeping statute of limitations on filing a claim to a reasonable timeframe.

We cannot continue to pit patients' understandable emotional distress against the altruistic intent of clinicians. That conflict benefits no one except those profiting from litigation itself.

Kourtney Kemp, MD, FACS, is a general surgeon with Specialists in General Surgery serving the West Metro Twin Cities, and physician advocate. Her work at Minnesota Physicians for Reform is grounded in the belief that patients and physicians seek the same goals of understanding, accountability, and resolution. She is a board member of Curi, which offers advisory, insurance, and financial services, primarily for healthcare professionals. The views expressed are solely her own and do not reflect those of her employer or affiliated organizations.

The resurgence of hormone therapy

Physicians and patients are navigating a new landscape for menopause care after the FDA removed black box warnings on hormone treatments

BY SUZY FRISCH



Women have been through the ringer when comes to menopause, and it's not just due to the wide-ranging and often aggravating symptoms affecting their changing bodies. During the past two decades, guidance about how to relieve symptoms like hot flashes, night sweats, sleep disturbances, and brain fog have swung from one extreme to the other, leaving many women suffering.

Hormone therapy, a key component of treatment, went from the darling of menopause medications to a pariah in 2002 after researchers from the Women's Health Initiative reported concerning results from their study. Though several aspects of the research led to risks being overstated, fallout from the study drastically curbed the number of women taking hormones to relieve menopausal symptoms.

In November 2025, the U.S. Food and Drug Administration changed course and removed the black box safety warnings that cautioned clinicians against prescribing hormone therapy. Some OB-GYNs and other clinicians continued to prescribe hormone therapies to women during the no-go era, after careful considerations of patients' risks. Yet many physicians completed training in the past two decades with scant education or experience in counseling women through this decision.

Ekta Kapoor, MBBS, a Mayo Clinic researcher, endocrinologist, and menopause specialist, has seen the shifts in views from one extreme to the other. Either hormone therapy is terribly risky and causes breast cancer and blood clots, or it provides women with a fountain of youth that can improve everything from cardiovascular disease and dementia to osteoporosis.

After researchers terminated the WHI study because of concerns about participants' elevated rates of breast cancer, stroke, and heart attacks, the FDA placed black box warnings on hormone therapy in 2003. These actions "gave the message to the medical community and general public that hormone therapy is bad and risky. People did not want to touch it with a barge pole. So many people went off hormone therapy overnight, and fear lingered

on for decades," Kapoor says. "For a long time, even women who should have been on hormone therapy with bothersome symptoms of menopause or premature loss of estrogen were not using it."

A 2024 *JAMA* paper found that about 27% of women utilized hormone therapy for menopause symptom relief in 1999. After the WHI study was halted, 5% of women took hormones, despite it being a highly effective treatment for symptoms like night sweats, hot flashes, vaginal dryness, and sleep disturbances. In addition, a 2026 *Mayo Clinic Proceedings* study found that hormone therapy use dropped sharply from 4.4% in 2007 to 1.7% in 2023—a decline of 61%. In women ages 50 to 59, who are the most likely to benefit from hormone therapy, just 3.5% were taking hormones in 2023.

These declines left legions of women suffering for years. More recently, women have been speaking publicly about the life-changing effects of menopause and common occurrences like having their symptoms dismissed. Their experiences are not rare. Every woman in the world experiences menopause and the subsequent decline in estrogen levels. In the United States, about 1.3 million women go through this transition each year. Women reach menopause after 12 consecutive months without a period, typically between ages 45 and 56, with an average age of 52.

Many of the common symptoms of menopause begin in perimenopause, anywhere from a few months or a decade before women cross the menopause threshold. Moreover, symptoms can last for two to eight years post-menopause. Vasomotor symptoms like hot flashes, for instance, continue for an average of seven years, according to the federal Study of Women's Health Across the Nation.

Kapoor, lead author of a 2025 *Mayo Clinic Proceedings* study about barriers to menopause care, found that more than 80% of women experience menopause symptoms. In addition, 34% report moderate to very severe symptoms that impact their life and productivity, such as hot flashes, night sweats, disrupted sleep,



"When [hormone therapy] is used for the right person, it can be a very appropriate intervention. But it's not appropriate for everything and for everybody, and it shouldn't be a universal practice. We have to steer away from a black-and-white approach to hormone therapy. It's an individualized decision and it's important to sit with the patient and consider what they might gain from it, what are the potential risks, and understanding their preferences."

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weight gain, sexual problems, and mental and physical exhaustion. Yet nearly 84% did not seek treatment.

There are multiple reasons women are reluctant to seek help with menopause. Some are too embarrassed, while others don't always realize that their multifaceted symptoms stem from menopause. "They were feeling like they had been dismissed or not listened to," says Tenley Klc, MD, MPH, an OB-GYN with Health



“Prescribing hormone therapy can be nuanced and there are different formulations and dosages and considerations. I don’t think we should gatekeep for hormone therapy because we saw the damage it did from the black box warning, but I want people to prescribe it safely. They should be empowered to seek out information or get certified through the Menopause Society to be a safe prescriber,” Klc says. “If not, then know that you can refer patients so that they can get the counseling and treatment they need.”

TENLEY KLC, MD, MPH
OB-GYN
HEALTH PARTNERS

Partners. “They are hungry for someone to explain what they are going through and really talk about managing their bothersome symptoms.”

Christopher Wenner, MD, a family medicine physician in Cold Spring, completed his training when physicians were regularly prescribing hormone therapy for menopause relief. As Wenner began practicing, hormone therapy became severely limited by the black box warnings. Even

now that evidence shows that hormone therapy is generally safe, many patients still associate taking estrogen with a higher risk of cancer and refuse the option.

“Now looking at the data more prudently, we can see that the risks are minimal, and that the benefits of treating menopause symptoms far outweigh the risks for most women,” Wenner says. “It’s a shame that it has taken this long to reexamine the data. Really, a lot of women have suffered needlessly because we weren’t smart enough to reexamine the data and have this treatment available. I’m grateful that the word is getting out now that these treatments are safe and that we should be utilizing them more liberally because they certainly have a foundational impact on quality of life.”

There were real impacts when women lacked access to hormones, either because physicians were reluctant to override the warnings or because patients feared the publicized risks, Klc says. The black box warnings “led to over 1.5 million extra outpatient visits a year and \$30 million in annual healthcare costs—a huge burden to the healthcare system and the economy,” she says, pointing to research from the journal *Menopause*. “It shows how significantly these menopause symptoms can affect women.”

What went wrong

Lisa Mattson, MD, a retired OB-GYN and president of the Minnesota Medical Association, weighed the risks and rewards of hormone therapy for herself and her patients. With a strong family history of breast cancer and genetic risk for ovarian cancer, she had a hysterectomy and oophorectomy at 39, starting hormone therapy shortly before the WHI study was halted. Mattson’s research about the study’s flaws and her conclusions about its evidence guided her to stay on hormones and recommend therapy to patients, when safe and appropriate.

A key flaw of the WHI research involved the composition of the subject pool. Just 10% were women ages 50–54, 20% were 55–59, and 70% were older than 60 when they started hormone therapy, with

63 being participants’ average age. “That’s not reflective of the real world,” Mattson says. “If you get to 63 and you’re not on hormones, we wouldn’t start you on them.”

Though the WHI did uncover safety concerns, they primarily affected women in their late 60s and 70s, who saw an increase in breast cancer, blood clots, and cardiovascular disease, Klc says. Plus, a key driver of breast cancer risk was the study’s hormone formulation of conjugated equine estrogen and synthetic progesterone. Today’s hormone therapies rely on bioidentical estrogens (that is, identical to humans’ own hormones) that are much safer, Mattson says.



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LISA MATTSON, MD
RETIRED OB-GYN
PRESIDENT, MINNESOTA MEDICAL ASSOCIATION

Another criticism of the black box warnings is that they covered both systemic and local vaginal estrogen treatments. Estrogen creams, tablets, and rings are used for genitourinary symptoms like recurring urinary tract infections, vaginal dryness, and pain during sex, says



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CHRISTOPHER WENNER, MD
FAMILY MEDICINE PHYSICIAN
COLD SPRING

Amanda Olson, MD, MPH, a menopause specialist and OB-GYN at M Health Fairview. However, studies have shown no increase in risk for conditions like cardiovascular disease, blood clots, or breast cancer from topical estrogen.

The topical estrogen warning likely dissuaded women from getting safe, effective care for genitourinary syndrome of menopause (GSM), an underrecognized menopause condition, says Elisheva Danan, MD, MPH, an internist and health system researcher at the Minneapolis Veterans Health Care System. She and Susan Diem, MD, MPH, a VA internist and clinical researcher, completed a research review of GSM treatment, published in the *Annals of Internal Medicine*.

GSM affects 13% to 87% of postmenopausal women. The primary treatment is topical estrogen therapy for the vulvovaginal region, in the form of cream, tablets, or rings. The warning on vaginal estrogen “never made a lot of sense,” Danan says. “A very small level reaches the bloodstream, and it’s nothing like taking hormones systemically. But the warning was on all estrogen products. People would look at the tube from the pharmacy or the doctor and see these warnings. It would cause them to feel really stressed about it, and physicians as well, so there was a barrier for using the treatment.”

Other barriers include women’s reluctance to bring up the symptoms they are experiencing, as well as patients and clinicians being unaware that symptoms like UTIs, vulvovaginal atrophy, dryness and irritation, and pain during sex are related to menopause. “A lot of people experience GSM and there can be problems at every step in getting help,” Danan says. “They might not associate it as a part of menopause, or they think they are done with menopause because they haven’t had a hot flash for years.”

Evidence now shows that the ideal group of women to receive hormone therapy are under the age of 60 or within 10 years of reaching menopause, Olson says. A longer gap from menopause to starting hormones raises the risks among the different age groups in the study, with



“Estrogen can help a lot of things, but it doesn’t fix everything. With mood changes, sometimes estrogen will help, but it often needs to be treated with first-line mental health medications. Symptoms can be multifactorial, and people in this age range have a lot of things going on,” including kids leaving the nest, aging parents with health challenges, and heightened work responsibilities. “It’s difficult to isolate the cause.”

AMANDA OLSON, MD, MPH
MENOPAUSE SPECIALIST AND OB-GYN
M HEALTH FAIRVIEW

risks increasing as participants got older because of more underlying health conditions.

A key concern is that starting hormones many years after menopause can turn something beneficial into a negative. For healthy people, hormone therapy can help blood vessels dilate and prevent the formation of plaque, Mattson says. When women already have developed plaque, estrogen can disrupt it, sending it coursing through blood vessels and potentially causing heart attacks and strokes.

Balancing risks and rewards

Women's health specialists and primary care providers have been seeing more women seek hormone therapy in recent years, thanks to more media attention about menopause, women learning about the potential health benefits of hormone therapy, and the removal of most black box warnings. Some of those patients include women in their 60s and 70s who want to start hormone therapy because they have heard about its positive benefits when it comes to preventing heart disease and dementia, Kapoor says.

"Many are seeking hormone therapy whether they need it or not," Kapoor says. "They say, 'I may have missed the boat on hormone therapy when I became menopausal many years ago. Would you start me on it now so that I don't have a heart attack?' This can be a difficult discussion to have with the patient."

Physicians are adjusting to the new hormone therapy landscape and taking a deep dive into the evidence and best ways to counsel patients about their options. There is a learning curve because many OB-GYN training programs do not dedicate much attention to menopause care, Klc says.

A *Menopause* journal study reported that 31.3% of OB-GYN residency programs included a menopause curriculum. Many primary care providers also report that their training is lacking. In addition, up to 80% of primary care physicians had not had any menopause training in the past year, while up to 50% of general practitioners and 30% OB-GYNs believe that they have not had adequate training in menopause care.

One difficulty in treating perimenopause and menopause is that they trigger a host of symptoms, some of which stem from declining estrogen levels and others that are age related. In addition to GSM and vasomotor symptoms, women commonly experience sleep disruption and fatigue, heart palpitations, joint and muscular pain, dry skin and eyes, hair thinning and loss, and mood issues like anxiety, depression, and irritability. Sleep disturbances are actually a very common menopause symptom, with 70% of menopausal

women reporting sleep problems, Kapoor says, citing a 2021 Mayo Clinic study.

"Estrogen can help a lot of things, but it doesn't fix everything," Olson says. "With mood changes, sometimes estrogen will help, but it often needs to be treated with first-line mental health medications. Symptoms can be multifactorial, and people in this age range have a lot of things going on," including kids leaving the nest, aging parents with health challenges, and heightened work responsibilities. "It's difficult to isolate the cause."

Setting expectations for what hormone therapy can do and counseling patients



The warning on vaginal estrogen "never made a lot of sense. A very small level reaches the bloodstream, and it's nothing like taking hormones systemically. But the warning was on all estrogen products. People would look at the tube from the pharmacy or the doctor and see these warnings. It would cause them to feel really stressed about it, and physicians as well, so there was a barrier for using the treatment."

ELISHEVA DANAN, MD, MPH
INTERNIST AND HEALTH SYSTEM RESEARCHER
MINNEAPOLIS VETERANS HEALTH CARE SYSTEM

on when it is appropriate can be a challenge, Kapoor says. Patients might seek hormones after hearing from the FDA that hormones can prevent cognitive decline and heart disease, when the truth is more nuanced.

"When it is used for the right person, it can be a very appropriate intervention. But it's not appropriate for everything and for everybody, and it shouldn't be a universal practice," Kapoor says. "We have to steer away from a black-and-white approach to hormone therapy. It's an individualized decision and it's important to sit with the patient and consider what they might gain from it, what are the potential risks, and understanding their preferences."

When women come to Olson requesting hormone therapy, she first wants to know details about what symptoms are bothering them. Then she can identify the most suitable treatment that also reflects their overall health and family history. Olson runs risk assessments for cardiovascular concerns and breast cancer; if the risk is above 10%, she will recommend nonhormonal medications.

"One of the challenges for the public and for people who don't have a lot of experience with menopause medicine is that it can be tempting to think that because the black box warning is gone that there is no risk," Olson says. "Doctors, nurse practitioners, and physician assistants should make clear that every medication has risks and side effects, even over-the-counter products."

Options on the table

Before the black box warnings were lifted, the general recommendation was the lowest dose for the shortest amount of time. Now the American College of Obstetricians and Gynecologists and the Menopause Society don't set timelines for treatment length. Instead, women should have a check-up annually to make sure no health problems are emerging and to review their individual risks and benefits, Klc says.

"Prescribing hormone therapy can be nuanced and there are different formulations and dosages and considerations. I

don't think we should gatekeep for hormone therapy because we saw the damage it did from the black box warning, but I want people to prescribe it safely. They should be empowered to seek out information or get certified through the Menopause Society to be a safe prescriber," Klc says. "If not, then know that you can refer patients so that they can get the counseling and treatment they need."

It's important for physicians to set expectations about what hormone therapy can and can't do, what symptoms it might improve, and what it won't address. "It won't help and cure everything. It's not a fountain of youth pill," Klc says. "It's not going to lead to substantial weight loss like women hope, and it won't significantly improve libido like a lot of women hope. But it might help them sleep better and have more energy to exercise and have sex, and the brain fog might go away. And it can help with depressive symptoms in perimenopausal women and help with hot flashes and night sweats."

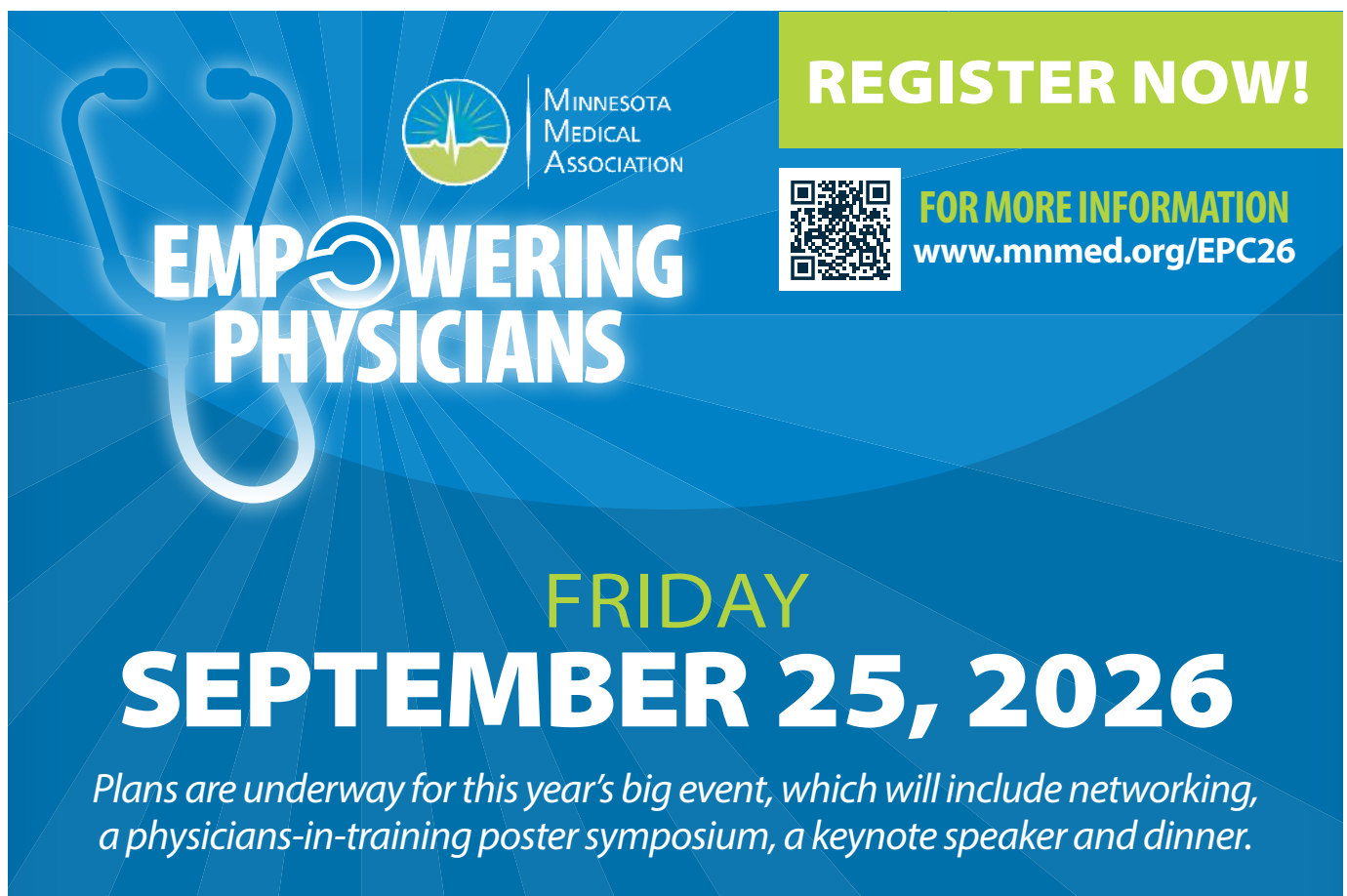
When women were experiencing significant symptoms, Mattson often encouraged them to try hormone therapy for at least two months. If they didn't notice any changes then stop. However, many patients at that point realized that they felt better while on hormone therapy and would resume treatment, she says.

Today, the remaining black box warning covers systemic estrogen-only products, which showed an increased risk for endometrial cancer in women with a uterus. Instead, they should take estrogen combined with progesterone, Olson says.

For women who have too many risks or fear hormone therapy, there are other effective options. For treating hot flashes, women can take fezolinetant, a neurokinin 3 receptor antagonist, or paroxetine, an antidepressant that is FDA-approved for hot flashes, Mattson says. Nonhormonal medications for GSM symptoms like pain during sex, dryness, and vulvovaginal atrophy include ospemifene and prasterone.

Along with having a range of options to help women in menopause, truly listening and believing them when they report bothersome symptoms are best practices, Klc says. "I have learned that women are really great at describing what they are experiencing and recognizing when something has changed from their baseline. As physicians, we need to listen to them. We might not have all the answers and data, but we can get them resources that can help address their symptoms." MM

Suzy Frisch is a Twin Cities freelance writer.



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Plans are underway for this year's big event, which will include networking, a physicians-in-training poster symposium, a keynote speaker and dinner.

What do we make of improvements in well-being?



Surveys suggest physicians are feeling a bit better about their jobs. Are these real improvements or an illusion?

The phenomenon of occupational burnout among physicians has become one of the hottest professional topics since the COVID-19 pandemic, as evidenced by skyrocketing Google searches as well as increases in journal articles on the subject. At the same time, the rate of symptoms of burnout among physicians increased sharply.

More recently, however, rates have shown a slight but apparently significant decline. What's happening? Are we simply moving past the shock of the pandemic? Or are systemic and individual efforts to reduce burnout among physicians actually bearing fruit?

To find out, *Minnesota Medicine* talked to Colin West, MD, PhD, professor of medicine, medical education, and biostatistics, and medical director of employee well-being at Mayo Clinic. West has researched the topic and written about it extensively. The interview has been edited for brevity and clarity.

New data from the American Medical Association show physician burnout continuing to decline nationwide. 41.9% of physicians reported experiencing at least one symptom of burnout—down from 43.2% in 2024 and 48.2% in 2023. These data mirror results that you and

your colleagues reported last year in *Mayo Clinic Proceedings*. Are these improvements real?

I think they are real, but I think that my take on them is to view them with cautious optimism, OK? The reason I say that is twofold. First, even if the numbers look a little bit better, I don't think we should be satisfied with two in five physicians experiencing burnout. Relative to the height of the pandemic, when we saw burnout numbers at all-time highs for medical professionals, it's great to see that things have receded a bit. But I don't think we should lose sight of the bigger picture—that we're not where we need to be. That's the first point.

The second point is, I think there's a very human response when things seem to improve a little bit when we sort of emerge from the worst of a stressful situation, to relax. I think it's really important that healthcare as a whole—practices, organizations—use these results to remain energized about investing in the work environment in healthcare to continue these improvements. And part of that note of caution also has to do with finances in healthcare. As we know, healthcare organizations are really facing challenges. If well-being is viewed as elective, a sort of nice-to-have thing, then when financial strain increases, well-being can be sacrificed, and we may see things go

back in the other direction, as opposed to investing in well-being as something that is foundational to the function of your organization in healthcare. Things that are foundational you don't stop investing in. You actually make sure they're protected.

I think that's a key lesson from some of the improvement for the last few years. Some of it has to do with pressures of the pandemic easing and people kind of getting back more towards normal procedure. But some of it is also because I think there has been an impact of organizations' having greater recognition that when they take care of their healthcare teams, whose teams perform



Colin West, MD, PhD
Mayo Clinic

better, they are better for patients, and they're better, frankly, for the bottom line.

I think that is part of what physicians across the country are experiencing—a little bit more of that positive investment. We need to make sure that we sustain that momentum.

Let's dissect that a little bit. First, the pandemic. It would seem pretty obvious why the pandemic would be really stressful for everyone involved in healthcare. Am I missing anything here? Is it just the obvious thing that people were overwhelmed?

Absolutely people were overwhelmed. And I think beyond just the workload, there was also so much angst and stress across society, a lot of skepticism about science in general, and really some challenges to trust in medicine.

And you know, when we think about dynamics around public health and vaccine conversations, and treatments—not just COVID, but other medical conditions—a lot of really challenging conversations became part of every day for healthcare professionals. We want to engage with patients. We want those to be relationships that are built on trust. A lot of that interpersonal civility was really, really strained during COVID and coming out of COVID. And so I think not just all of the personal and economic and life stress of the pandemic itself, but the things that were traveling with the pandemic also contributed to making physicians' and other members' of the healthcare team jobs harder.

So as the pandemic itself fades into the rearview mirror, we can expect some improvement in sense of physicians' well-being, but we still are carrying a lot of that baggage from the pandemic, the loss of trust, the skepticism towards science, the stress on the system, things like that, right?

Absolutely, yeah. And I think that's going to take time. I'm not going to get the quote or the expression quite right, but there's a

As we know, healthcare organizations are really facing challenges. If well-being is viewed as elective, a sort of nice-to-have thing, then when financial strain increases, well-being can be sacrificed, and we may see things go back in the other direction, as opposed to investing in well-being as something that is foundational to the function of your organization in healthcare.

principle that I've heard from the business world that it takes years to build trust, it takes moments to break it. I think we've lived that. The dynamic between medicine and society is something that really needs some restorative work, in both directions, honestly. That's going to take time.

But of course, patients and physicians alike are in the middle of it now. We can't just hit pause and say we're going to build this for a decade and then come back to it. We're all in the middle of it together, so the stresses residual from the pandemic, we're still living with that.

You had also mentioned that because the whole issue of physician burnout has gotten quite a bit of attention, people have put forth various proposals to provide greater support to physicians. There have been efforts to deal with that on a systemic basis, independent of anything that happened during the pandemic. So this slight but significant decline in burnout rates—does that suggest that

some of these efforts are bearing fruit? It sounds like you think so.

Yeah, I think it does.

And what are some of those efforts that seem to be most promising and fruitful?

One quick comment: The scientist in me always strikes the note of, well, this is complicated, and there are multiple moving parts, and we're not exactly sure what the contribution of each moving part is, which doesn't always make for a crisp headline, but it's part of the challenge in this. When you've got so many moving parts, distilling it down into a simple "if this, then that" gets really tough. And I'm sometimes struck, you know, whether it's in science or just in public discourse, that we seem to have lost our ability to embrace nuance. This is one of those scenarios where there isn't one solution, there isn't one cause. There's an entire ecosystem of medical practice that is involved here.

So with that as a preface, I think there's an increasing recognition that a lot of what physicians have been doing in their work days is, frankly, not value added,

I think there's an increasing recognition that a lot of what physicians have been doing in their work days is, frankly, not value added, and that leads to distress. I think that was highlighted during the pandemic in a way that is maybe paradoxically beneficial.

and that leads to distress. I think that was highlighted during the pandemic in a way that is maybe paradoxically beneficial. Because what we realized in the pandemic, when we were faced with emergencies, we got dispensations to not do certain things. “You don’t need to document this a certain way. You don’t have time. You get focused on the emergency in front of you. So you know what? Temporarily we’re going to waive that. You can evaluate this patient through a video call, maybe even across

from the pandemic. I think that resonates with all of society, because during the pandemic, what was a societal problem? We were isolated. Yes, we were forced by infection to not be as engaged with one another, and that has major human costs.

And then the third one that I’ll mention, which continues to evolve, but it’s really potentially exciting. The role of AI in supporting documentation—notes that we write, orders that we place. Ambient technology where you can be in a room with a

which no physician ever found the most meaningful part of their day.

So I think technology is part of this emerging set of improvements. I’m going to sound a note of caution there as well, because the risk with that is if the technology gets good at taking away some of the administrative burdens, will there be a response to say, “Oh, well, this has eased your workload. Let’s increase your workload in other ways to fill the gap.” That would be sort of human business nature.

And I think we’ve got to be careful about that, because the key that I think is really important about how technology is helping with well-being and maybe contributing to some of the improvement in burnout. And I’m hoping it’s going to continue, by the way, because the technology is getting better and better and better. But the reason it’s helping is not just because it’s reducing time. It’s actually more because it’s allowing us to focus on meaningful things. It’s reducing cognitive load, and if we just pour that cognitive load back on in other ways, I worry that we’re going to erode the benefits and maybe even promote cynicism about the next solution, because, “Well, if I engage in this solution, you’re just going to increase my workload in a different way.” The point is, let’s have physicians doing the work that they are uniquely trained to do that is most meaningful to both them and their patient. The more that we can do that, the better well-being is going to be. Physicians are trained to work hard. It’s not the workload—beyond extremes—that is the issue. We want to do work that matters. And if we can really strip away the noise and give physicians the support to be able to focus on the

There’s really been a deeper understanding, possibly heightened by our pandemic experience, that community and connection are essential. I think individual physicians and practices are doing a better job of recognizing we need to lean on each other.

state lines, where as before that was not allowed.” Things like that. We realized, not only did the sky not fall, it helped things.

And so I think we learned that some of the things we’re doing we don’t really need to be doing. And if they’re not directly benefiting patients, why don’t we maybe get rid of those and let physicians focus on what’s most meaningful to them, which is their direct interactions with patients. And so I think one approach has been trying to streamline the administrative burdens and continue the lessons from COVID rather than slipping back into overregulated administrative burdens. That’s one part.

The second part is there’s really been a deeper understanding, possibly heightened by our pandemic experience, that community and connection are essential. I think individual physicians and practices are doing a better job of recognizing we need to lean on each other. We need to form our own groups as safety nets. And there are interpersonal benefits to that. We know that isolation is strongly associated with burnout, depressive symptoms, a lot of things we rather physicians not experience. And so this idea of trying to build community and be intentional about it is something that I think has emerged

patient, and there is a technology working with you while you’re talking with the patient that is taking down the conversation, and it’s drafting up documentation for you so that you can edit that, as opposed to at the end of the visit having to reconstruct the entire visit, almost relive the visit, in time that you don’t have to generate a note.

There’s evidence that physicians save a small amount of time—not as much time as people originally thought, but they save a small amount of time. But the time that you are at work is more focused on the things that matter, and so you get to spend more time actually engaging with your patient, less time needing to do the documentation and in a way, treating the computer instead of your patient,

Physicians are trained to work hard. It’s not the workload—beyond extremes—that is the issue. We want to do work that matters. And if we can really strip away the noise and give physicians the support to be able to focus on the patient, then we’re going to see well-being continue to improve

If you're trained to be an orthopedic surgeon, you want to do orthopedic surgery. You don't want to fill out a bunch of forms in triplicate. And if you're an organization that has an orthopedic surgeon, you want that orthopedic surgeon operating, because that's what generates revenue. So those stars align.

patient, then we're going to see well-being continue to improve.

Despite the good news in the data overall, slight though significant that it may be, there are great disparities among disciplines. According to the AMA data, for example, you have the highest burnout rates in emergency medicine, urological surgery, hematology oncology, obstetrics and gynecology, and radiology, among others.

Having watched "The Pitt," I can imagine why burnout is high in emergency medicine.

Yes, and it has been the number one specialty in every national survey dating back to the beginning of when we started doing this, more than 15 years ago.

And I imagine disciplines such as radiology might be threatened by AI doing their jobs or some much more poorly paid clinician in a foreign country doing it remotely, or at least some their job. So, why are some disciplines having more trouble than others? Is it because of all these idiosyncratic things, or is there some broader systemic cause?

I think it's a little bit of both. Systemically, some disciplines are better compensated than others. And the issue with well-being is not about the salary so much, but they are better compensated because they generate more revenue for their hospital

systems. And that often leads to more attention and more protection.

And greater status, I would think.

Absolutely. And that doesn't mean that you know someone who's in a very highly compensated surgical discipline has no burnout, but it means that for a lot of those disciplines, or at least to a greater extent than, say, a primary care physician, they will often get more support for the other aspects of their job, the administrative burdens, the pebbles in the shoe. Because what you're paying them to do is generate revenue doing procedures which happens to overlap with what's most meaningful to them. If you're trained to be an orthopedic surgeon, you want to do orthopedic surgery. You don't want to fill out a bunch of forms in triplicate. And if you're an organization that has an orthopedic surgeon, you want that orthopedic surgeon operating, because that's what generates revenue. So those stars align.

Another part of it is, using radiology as an example, yes, there are some professional concerns about reimbursement and security and how much automation is

going to be possible. But the other thing about radiology is that in a lot of radiology practices, the practice may place them at greater risk of being isolated, because they're more interacting with the technology, potentially, rather than other people.

They're sitting in a dark little room looking at a screen.

Stereotypically, yes. Now not all radiology is that. There are people doing radiology-guided procedures directly with patients. There are people who are doing bedside ultrasounds, but there is at least the potential for many radiologists to be on their own in a dark room, away from other people. And how do you really force that sense of community? Some are really good at that, they stay really connected, and they've got great peer groups. But some can recede into isolation, which we know is a problem.

The emergency department is a great illustration of what happens when you really have very little control. You work in an emergency department, it is hectic. You don't know what's going to walk through the door, which can be both exciting and draining.

The other factor with frontline disciplines that are meeting patients at the intersection with their daily lives—primary care, emergency medicine—is you see a lot of patients who are struggling with other aspects of society. These are the vulnerable. These are people with other medical concerns, behavioral, psychological, substance use-type concerns, people who, in many ways, have been sort of cast aside by society. There is a cumulative burden seeing other human beings who are suffering.

If you work in pediatrics and you are seeing families and children who don't have enough food, or they're victims of violence in the home, it can be really hard to not have that over time affect you, especially if your discipline is also one of those that doesn't get a ton of other resources or respect.

And that's not a political statement. That's just an observation: A person is in front of you and they're suffering. You cannot help but feel some of that if you are a physician who is doing what we are supposed to do, which is to be empathetic and actually to try to feel with our patients, at least to an extent. And so I think this concept of moral distress plays into some of this for some specialties, who see this more. If you work in pediatrics and you are seeing families and children who don't have enough food, or they're victims of violence in the home, it can be really hard to not have that over time affect you, especially if your discipline is also one of those that doesn't get a ton of other resources or respect.

The national healthcare system seems to be as ridden with problems as ever. At the beginning of our conversation, you mentioned that there are some warning signs on the horizon, particularly when it comes to finance, funding our hospitals, for example, and adequately paying physicians for treatment of people who are on Medicare, things like that. The financial system simply is not working very well. That has got to have some kind of downstream impact on physicians and their sense of well-being. That's a hard thing to deal with. I mean, talk about systemic—that's about as massive as it comes.

Absolutely. And you know, if I had the golden key to solve that, I guess I'd probably be, you know, ruler of the universe. A really important thing, in my view, stepping back 30,000-foot view, is I think we have to be honest with ourselves, as a country, about what works and what doesn't work in our healthcare system. We're not always willing to do that. I think there's a sort of sense of American exceptionalism, which doesn't allow us to acknowledge that we can do some things brilliantly well, and there are other areas that need to improve. We do incredibly well in the United States with highly technical medical care, using absolutely cutting

There's a moral argument for taking care of our healthcare professionals. There is a financial argument. There's a public health argument. The argument against it is really a matter of will. And I don't personally think that's a very good counter argument. I think we should be committed to taking care of people.

edge technology. We do not do nearly as well with general public health. We need to be able to look in the mirror and say, you know, let's not criticize people who point that out. Let's really think about what we need to do to shore that up.

That gets very challenging, because it very quickly becomes partisan. And I don't think personally that human health should be a partisan concern. I think moving past the partisan nature of ideas into can we focus on what our goal is, which is to optimize the human condition? We need to be more committed to making sure that people have access to the care that they need to meet their fullest potential.

Unfortunately, there are a lot of areas in the United States where, for such a wealthy country, people don't have access to the basic healthcare that they need. And physicians feel that. There is a moral injury that contributes to distress. It contributes to burnout. For a lot of physicians, we can put our heads in the sand and we can sort of ignore it, or we can actually roll up our sleeves and say, "Look, if there's one thing that Americans can do, and have shown this for decades and centuries, is we can solve tough problems, so let's not shy away from this one.

I suppose it bears repeating that burnout is not only a tragedy for individual physicians, but it also worsens patient care and satisfaction and causes physicians to leave the field at a time when we need doctors more than ever.

That's exactly right. It's a vicious cycle. My advocacy for years has been, can we turn

a vicious cycle into a virtuous cycle? Can we actually lean into the meaning that's in medicine? Can we support physicians? Can we support patients and the public? And can we help people thrive? But your point is exactly right. Physicians who experience distress leave the profession earlier. They cut back their clinical hours. Frankly, they engage in self-preservation.

Now, most physicians actually don't want to. They would much rather practice. It's not just a job for most physicians. There's something deeper than that, but it needs to be sustainable. It needs to be meaningful, and the headaches can't be greater than the rewards. So if we don't take care of our physicians, our nurses, our other healthcare professionals, they're going to leave the field earlier, and we need them more than ever.

There's a moral argument for taking care of our healthcare professionals. There is a financial argument. There's a public health argument. The argument against it is really a matter of will. And I don't personally think that's a very good counter-argument. I think we should be committed to taking care of people. **MM**

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

Minnesota Medicine welcomes features, commentaries, and other contributions from members. Pitch ideas to the editor at mm@mnmed.org.

Are Minnesota gun owners thinking safety first?

Most Minnesotans who own guns store their firearms locked and unloaded, but there's room for improvement.

BY RACHEL WEIGERT, MD

Firearm injuries have remained the leading cause of death and injury in children and young adults since 2020. Unlike many other sources of injury, firearms are highly politicized and discussions around firearm injury prevention are often stigmatized, which has unfortunately led to over 5,000 children being injured or killed by firearms annually in the United States.¹⁻⁴ In 2020, the societal upheaval of the COVID-19 pandemic, the civil unrest associated with George Floyd's murder, and more recently Operation Metro Surge have been shown to greatly increase firearm purchasing behaviors, in particular by new firearm owners who are less likely to be familiar with secure storage techniques.^{5,6}

The accompanying report, based on the 2022 and 2024 Minnesota Behavioral Risk Factor Surveillance System (BRFSS) firearm safety module, includes important findings that could aid clinicians seeking additional guidance for counseling at-risk populations on firearm safe handling and secure storage. In this sample, almost 40% of respondents reported a firearm in or around their home, and there was a slight decrease in reports of storing these guns loaded from the 2022 module to the 2024 module. Several factors were noted to be associated with race, including that non-Hispanic white respondents were almost four times as likely to report firearms in the home, while non-Hispanic Black respondents were more likely to report that their firearms were loaded. Higher per-

centages of firearms present in the home were also reported by male respondents and residents of northern Minnesota.

From my perspective as a pediatric emergency medicine physician, I was reassured to see that individuals studied in this sample who had children tended to report firearms as "locked." Though not statistically significant, we did note that in homes with children the percentage reporting unlocked firearms dropped from approximately 40% in 2022 to 30% in 2024. While reassuring, this also means that nearly a third of children living in Minnesota's homes where a firearm is stored loaded are exposed to an unsecured firearm.

It will take years to see significant improvement in this public health crisis. Though it is easy to feel discouraged, these data do demonstrate improving trends from 2022 to 2024, especially in homes with children. We can learn from these injury prevention successes, while continuing to counsel all patients regarding secure storage, plans for firearm bequeathment through end-of-life planning, lethal means counseling, and discussion of extreme risk protection orders with families of patients in crisis.

These results also demonstrate a need for better understanding of interventions that would be best suited to specific populations, such as barriers to secure storage in the non-Hispanic Black population. We must persist in our advocacy at the state level for stronger gun safety laws, which have been demonstrated time and again to



reduce morbidity and mortality.¹ Finally, we must collaborate within our own communities to heal from gun violence and proactively prevent future tragedies. **MM**

Rachel Weigert, MD, is a pediatric emergency medicine physician at Children's Minnesota. She is a strong advocate for firearm safety legislation, and a firearm injury prevention researcher at Children's Minnesota, where she also mentors fellows and residents in similar work.

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Firearm storage practices among Minnesota adults

BY RACHEL WEIGERT, MD; MAGGIY EMERY, BA; MIRIAM GARLAND, SD

Nearly 40% of Minnesota adults report having a firearm in the home, with about one in five reporting storing their firearm loaded. Slightly more than half of those with loaded guns said they were also unlocked.

These are important statistics in a public health context, because ease of access to loaded and unsecured firearms can lead to unintentional injury of self or others by children as young as age two, intentional self-injury by teens and adults, as well as assaults and homicides. Securing a firearm slows the process to access, allowing a moment for cooler heads to prevail prior to acting in an often-lethal manner. Most safety guidance recommends that firearms be stored locked and unloaded—and that ammunition be locked up separately.

The findings below are based on data from the Behavioral Risk Factor Surveil-

lance System (BRFSS), which is an annual telephone survey conducted by the Minnesota Department of Health in partnership with the Centers for Disease Control and Prevention that covers health-related behaviors, health conditions, and use of preventive services. In Minnesota, an optional firearm safety module was used in 2022 and 2024, and contains three questions: (1) Whether any firearms are present in or around the respondent's home, (2) whether any such firearms are loaded, and (3) whether any such loaded firearms are also unlocked. In addition to reporting on the above three objectives, this report specifically addresses veteran status, Minnesota region, and if a child resides in the home, in addition to other demographic factors, and assesses data from both 2022 and 2024.

Key findings

- Nearly four in 10 Minnesota adults reported the presence of a firearm (or firearms) in or around the home; the percentages in 2022 and 2024 were similar (Figure 1, page 33).
- Among respondents reporting the presence of a firearm or firearms in or around the home, one in five reported the presence of any loaded firearms in 2022; that represents a modest decline in this percentage from 2022 to 2024 (Figure 2, page 34).
- In both 2022 and 2024, slightly more than half of those reporting the presence of a loaded firearm or firearms reported that any loaded firearms were also unlocked (Figure 3, page 35).
- Individuals aged 45–64 were the most likely to report the presence of a firearm or firearms in or around the home. But

those aged 25–44 were the most likely to report that any such firearms were loaded. Although those aged 65 and older were the most likely to report that any loaded firearms were also unlocked, this association was weakened in multivariate models.^{a,1}

- Non-Hispanic white individuals were more likely than individuals of other racial or ethnic groups to report the presence of a firearm or firearms in the home; for example, in 2024, non-Hispanic white individuals were nearly four times as likely to report this as were non-Hispanic Black individuals. However, non-Hispanic Black individuals were more likely than non-Hispanic white individuals (e.g., twice as likely in 2024) to report that any such firearms were loaded. (Examination of the third outcome—any such loaded firearms also being unlocked—by race and ethnicity was not possible due to small numbers.)
- Men were more likely than women to report all three outcomes (the presence of a firearm or firearms in or around the home, any such firearms being loaded, and any such loaded firearms also being unlocked).
- Percentages of all three outcomes (firearm ownership, storing firearms loaded, and storing loaded firearms unlocked) varied by Minnesota region; in general, lower percentages were observed in the Twin Cities Metro and higher percentages in rural Minnesota, especially northern Minnesota.
- Individuals with children in the home were as likely to report the presence of a firearm as those without children.^{b,2} However, those with children in the home were about twice as likely to store any firearms in a safe manner compared to those without children when comparing the 2022 and 2024 samples. Additionally, those with children were also less likely to report their firearms were loaded in the 2024 sample.^{c,3}
- Veterans were more likely than nonveterans to report the presence of a firearm or firearms in or around the home and to report that any such firearms were loaded.

- As described in the Minnesota Department of Health report mentioned above, with respect to the composite outcome of any loaded and unlocked firearm in the home, there were no significant differences by disability or LGBTQ+ status; college graduates were at the lowest risk of having loaded and unlocked firearms in the home.

Limitations

One limitation is the lack of data regarding whether unloaded firearms were stored unlocked.

Another limitation is that the data are based on self-reporting. In particular, differences according to age, sex, and veteran status could reflect not only actual storage behaviors, but knowledge of household members' behaviors (if the respondent was not the individual who owned the household firearms or was responsible for their storage).³ However, similar patterns were observed when limiting the analyses to those who were the only adult in the household and who presumably were more likely to have knowledge about household firearm storage.

Discussion and Conclusions

Among adults reporting the presence of one or more firearms in or around the home, the percentages reporting any such firearms being loaded were relatively low compared to rates observed in other states.¹ Initiatives to promote safe and secure firearm storage should incorporate an emphasis on firearms being stored both unloaded and locked.⁴

Individuals with children in the home were more likely than those without children to store firearms safely, especially with respect to storing loaded firearms locked. Future efforts to promote safe and secure firearm storage should build on this foundation by not only continuing to promote firearm safety among households with children, but to reach other groups at risk. Based on these findings, such efforts might include understanding and addressing—in partnership with communities of color—higher risk firearm storage behaviors (e.g., storing guns loaded), as well as

promoting safe and secure firearm storage among other groups at risk (e.g., individuals in northern Minnesota, men, and veterans). **MM**

Acknowledgement

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Maggiy Emery, BA, is the executive director of Protect Minnesota, a nonprofit organization with the mission to prevent gun violence through engagement, advocacy, and community-led solutions. Miriam Garland, SD, is the director of research for Protect Minnesota.

REFERENCES AND NOTES

NOTES

a From multivariate models incorporating sex, individual <18 years in the home, and veteran status (i.e., all variables included in Figure 3 except for region): For 2022, odds ratio for those 65 and older versus 25–44 = 1.61 (95% CI, 0.93–2.79). For 2024, odds ratio for those 65 and older versus 25–44 = 1.13 (95% CI, 0.64–1.99).

b From multivariate models with all variables included in Figure 1: For 2022, odds ratio = 1.34 (95% CI, 1.17–1.53). For 2024, odds ratio = 1.27 (95% CI, 1.11–1.45).

c From multivariate models with all variables included in Figure 2: Odds ratio = 0.69 (95% CI, 0.52–0.92).

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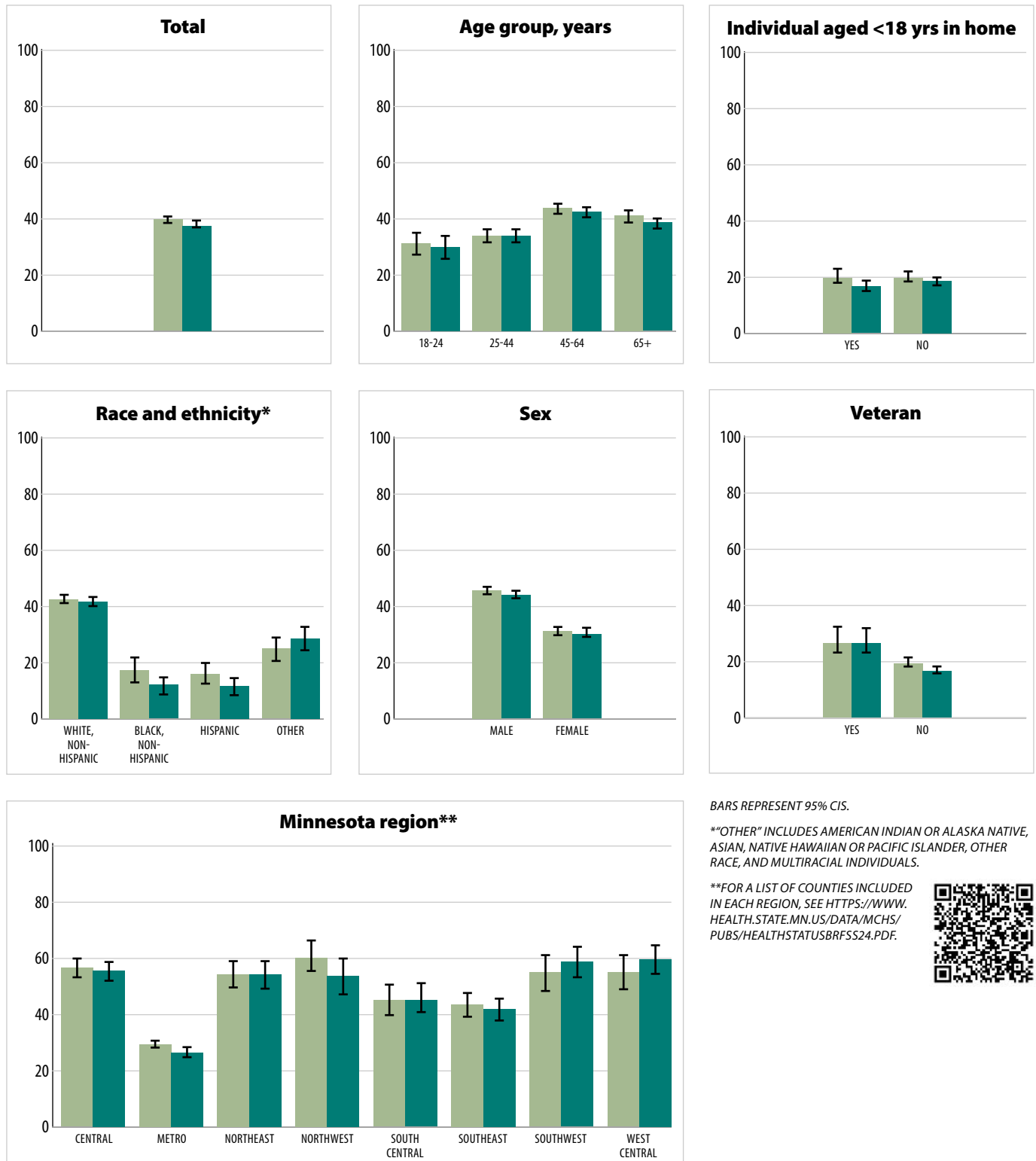
FIGURE 1

Percentage of individuals reporting the presence of any firearms in or around their home, by respondent characteristics

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM, MINNESOTA, 2022 AND 2024

2022 2024

Bars represent 95% CIs.



BARS REPRESENT 95% CIs.

**OTHER* INCLUDES AMERICAN INDIAN OR ALASKA NATIVE, ASIAN, NATIVE HAWAIIAN OR PACIFIC ISLANDER, OTHER RACE, AND MULTIRACIAL INDIVIDUALS.

**FOR A LIST OF COUNTIES INCLUDED IN EACH REGION, SEE [HTTPS://WWW.HEALTH.STATE.MN.US/DATA/MCHS/PUBS/HEALTHSTATUSBRFSS24.PDF](https://www.health.state.mn.us/data/mchs/pubs/healthstatusbrfss24.pdf).



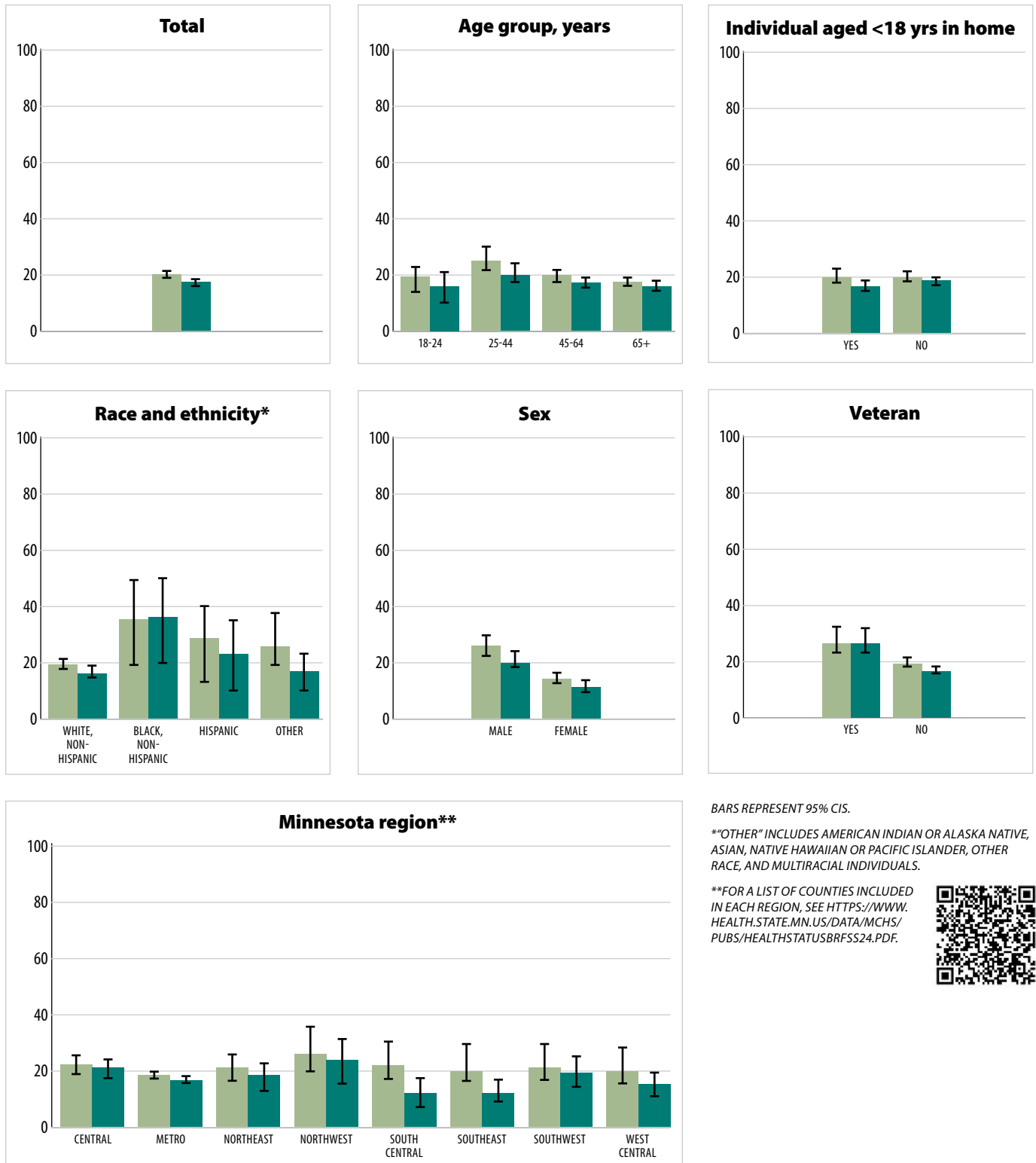
FIGURE 2

Among those reporting the presence of any firearms in or around the home, the percentage of individuals reporting the presence of any loaded firearms, by respondent characteristics

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM, MINNESOTA, 2022 AND 2024

2022 2024

┆ Bars represent 95% CIs.



BARS REPRESENT 95% CIs.

**OTHER* INCLUDES AMERICAN INDIAN OR ALASKA NATIVE, ASIAN, NATIVE HAWAIIAN OR PACIFIC ISLANDER, OTHER RACE, AND MULTIRACIAL INDIVIDUALS.

**FOR A LIST OF COUNTIES INCLUDED IN EACH REGION, SEE [HTTPS://WWW.HEALTH.STATE.MN.US/DATA/MCHS/PUBS/HEALTHSTATUSBRFSS24.PDF](https://www.health.state.mn.us/data/mchs/pubs/healthstatusbrfss24.pdf).

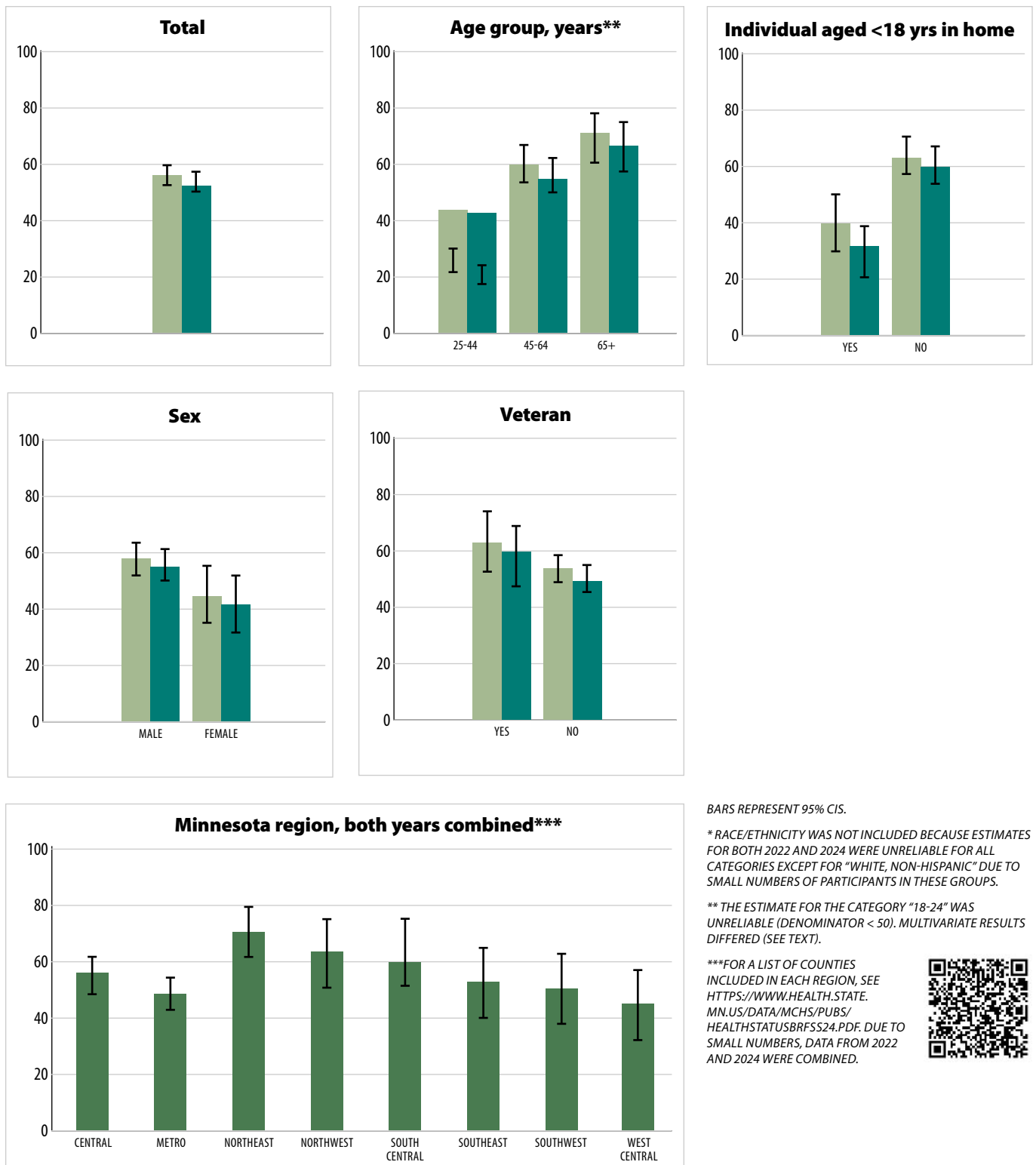


FIGURE 3

Among those reporting the presence of any loaded firearms, the percentage of individuals reporting that any such firearms are also unlocked, by respondent characteristics*

BEHAVIORAL RISK FACTOR SURVEILLANCE SYSTEM, MINNESOTA, 2022 AND 2024

2022 2024 | Bars represent 95% CIs.



BARS REPRESENT 95% CIs.

* RACE/ETHNICITY WAS NOT INCLUDED BECAUSE ESTIMATES FOR BOTH 2022 AND 2024 WERE UNRELIABLE FOR ALL CATEGORIES EXCEPT FOR "WHITE, NON-HISPANIC" DUE TO SMALL NUMBERS OF PARTICIPANTS IN THESE GROUPS.

** THE ESTIMATE FOR THE CATEGORY "18-24" WAS UNRELIABLE (DENOMINATOR < 50). MULTIVARIATE RESULTS DIFFERED (SEE TEXT).

***FOR A LIST OF COUNTIES INCLUDED IN EACH REGION, SEE [HTTPS://WWW.HEALTH.STATE.MN.US/DATA/MCHS/PUBS/HEALTHSTATUSBRFSS24.PDF](https://www.health.state.mn.us/data/mchs/pubs/healthstatusbrfss24.pdf). DUE TO SMALL NUMBERS, DATA FROM 2022 AND 2024 WERE COMBINED.



IMPROVING CARE FOR ALL: TOOLS & RESOURCES



The Minnesota Health Equity Community of Practice (CoP)

The CoP brings together health equity leaders and professionals from Minnesota medical practices to exchange expertise, resources, and ideas. It provides an opportunity for networking, cross-organizational communication, and collaboration. The CoP also guides the work of MMA by providing input on health equity priorities and identifying opportunities for collective action in support of health equity. The CoP meets quarterly and interested physicians may join at any time.

To attend a CoP meeting, contact **Haley Brickner**.

Intercultural Development Inventory

The Intercultural Development Inventory (IDI) is a developmental assessment which provides in-depth insights on individuals' and group's levels of intercultural competence. The IDI process empowers participants to increase their intercultural capability.

The IDI can be used by individuals to receive feedback and recommendations and by organizations for baseline assessments, organizational development, or as a pre-post assessment in program evaluation.

The MMA now offers this valuable resource, including:

- IDI Assessment
- Individual Profile Report
- Group Profile Report
- Customized Intercultural Development Plan
- 1:1 Debrief/Coaching sessions with a qualified IDI Administrator

Learn more at www.idiinventory.com and contact **Haley Brickner** to start your IDI process.

Best Practices for Inclusive Communications – Training and Guide

The words we use can either promote a culture of respect and inclusion or perpetuate harm toward marginalized individuals and communities. As we work to promote an anti-racist culture in medicine, we must also examine the way we speak about people and groups. As language and culture change over time, it is our responsibility to stay up to date on best practices for communicating about health equity. The MMA offers training for organizations on Best Practices for Inclusive Communication, enabling participants to use more inclusive communication by providing suggested language, guidance, and explanatory context, and encouraging them to think critically about the words they use, the meaning conveyed, and the potential impact.

The training accompanies the free **Inclusive Communication Guide**, which can be found at www.mnmed.org/healthequity

Implicit Bias Training (CME available)

Research suggests that implicit biases contribute to health disparities by affecting patient relationships and care decisions.

The MMA offers health care providers several ways to learn about Implicit Bias:

- Public workshops: Our live, virtual 2-hour Understanding and Mitigating Implicit Bias in Healthcare Workshop is offered to the public twice a year.
- Private workshops: Bring workshop to your organization at a time and place that works for you.
- Recorded workshops: Our Implicit Bias Workshop is available on-demand

Explore Implicit Bias resources at www.mnmed.org/IB

Racism in Medicine: Truths from MN Physicians (CME Available)

In this powerful video series, physicians of color share their stories of practicing medicine in Minnesota. Efforts toward making medicine more inclusive require an understanding of the experiences of these physicians. This project is a step toward addressing the harmful effects of racism, microaggressions, and implicit bias within the culture of medicine. Also available is a 90-minute workshop featuring critical reflection on, and discussion, the video series.

View the videos and symposium at www.mnmed.org/racismtruths

Conversations on Race and Equity (CME Available)

The Conversations on Race and Equity (CORE) series is a virtual space for physicians to discuss topics that relate to health equity and inclusion in healthcare.

Each session is 1 hour and includes facilitated dialogue based on curated content. The topics include:

- Session 1: Anti-racism
- Session 2: Cultural Humility
- Session 3: Implicit Bias & Microaggressions
- Session 4: Racism in Medicine
- Session 5: Allyship

There are two ways to bring CORE to your organization:

- MMA Facilitated: With this option, each session will take place via Zoom with an experienced CORE facilitator
- Self-Guided: The MMA has developed a CORE Toolkit for healthcare organizations to host a CORE series on their own.

To bring CORE to your organization, visit www.mnmed.org/CORE

FOR MORE INFORMATION ABOUT ANY OF THESE RESOURCES

CONTACT

Haley Brickner
Health Equity Coordinator
hbrickner@mnmed.org
612-355-9344

VISIT

www.mnmed.org/healthequity



MINNESOTA
MEDICAL
ASSOCIATION



Students explored the components of blood and how it functions in the body through hands-on activities.

PHOTO BY JULIANA MILHOFFER



PHOTO BY LINDSEY SCHNEIDER

A CentraCare staff member demonstrates the X-ray equipment and process.

Rural Youth Medical Careers Discovery Day

Students in Greater Minnesota get an interactive look at the world of healthcare.

Nearly 70 Minnesota children and teenagers ages 9 and up were introduced to occupations in healthcare at the Rural Youth Medical Careers Discovery Day, held April 18 on the campus of the University of Minnesota Medical School CentraCare Regional Campus St. Cloud.

This full-day event provided kids with an opportunity to step into the world of medicine through interactive experiences such as casting and splinting, suturing, administering vaccines, learning about blood and how we test it, and exploring X-ray imaging.

The event was organized to expose young students to healthcare careers before they make critical education and career decisions—as a way to inspire the next generation and open doors to careers that will better prepare Minnesota to meet its future healthcare needs.

Parents and guardians in attendance had a chance to learn more about the important role they can play in supporting their children’s interest in healthcare careers—through a panel discussion titled Growing Your White Coat. The panel showcased the various parts of the physician journey—premed student, medical student, resident, and attending physician.

During the lunch hour, youth and adults had a chance to visit a Career Exploration Fair and connect with representatives from the College of Saint Benedict and Saint John’s University, MMA, Minnesota Rural Health Association, Saint Cloud Technical and Community College, University of Minnesota Pre-Health Student Resource Center, and University of Minnesota Rochester.

The event was a partnership between the MMA and the University of Minnesota Medical School CentraCare Regional Campus St. Cloud, with support from the CentraCare Foundation, the Minnesota Rural Health Association, the University of Minnesota Pre-Health Resource Center, Gillette Children’s, and many other dedicated volunteers and community members.



PHOTO BY JULIANA MILHOFFER

A student and his grandmother learn about casting from a Gillette Children’s staff member.



PHOTO BY JULIANA MILHOFFER

Two students practice their casting skills.

News Briefs



Registration open for 2026–2027 MN Physician Leadership Institute

Registration is open for the 2026–2027 cohort of the MMA’s Minnesota Physician Leadership Institute (MNPLI). Register online at www.mnpli.org.

The MNPLI, created by and for physicians, offers an innovative, best-in-class physician leadership training curriculum to foster professional satisfaction and empower physicians by providing them with the skills, insights, and competencies required to build leadership acumen.

“The MMA has designed this program to support and elevate physicians as leaders,” says Janet Silversmith, MMA CEO. “Given the program’s breadth and depth of content, combined with a diverse cohort of physician colleagues from across the state, it provides unparalleled value. Minnesota healthcare needs more physician leadership; the MMA is committed to helping to realize that goal.”

The nine-month program will meet September 2026 through May 2027.

Early-bird registration is open until July 31, and includes a \$500 savings off the program fee. Participation in the program is limited to MMA members.

The Minnesota Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

This activity has been approved for *AMA PRA Category 1 Credit™*.

Children’s Minnesota to resume gender healthcare

Children’s Minnesota has resumed all services in its Gender Health program that had been temporarily paused in late February.

“Children’s Minnesota is committed to providing evidence-based, high-quality, and essential healthcare to all kids, including our transgender and gender diverse patients,” the hospital said in

a statement. “Our Gender Health program partners with parents and our communities to improve kids’ health now and for the future.”

Children’s had suspended its program under pressure from the Trump Administration, which announced late last year that it would cut Medicare and Medicaid funding to hospitals and clinics that provided gender-affirming care to minors.

In March, a federal judge in Oregon blocked the U.S. Health and Human Services from carrying out the cuts.

In 2024, the MMA adopted the following policy on gender-affirming care:

“Consistent with the prevailing evidence-based standards of care, the MMA recognizes that minors can be diagnosed with gender dysphoria/incongruence and that, under specific clinical guidelines, it is appropriate for these minors to receive certain types of gender-affirming healthcare.

“The MMA affirms that healthcare professionals should encourage and facilitate increased familial understanding and support of minors’ gender identities and gender-affirming healthcare needs unless familial involvement is harmful to the minor or not feasible.

“The MMA understands that, in some cases, parents and guardians will remain steadfast in their disapproval of their child’s gender identity and gender-affirming healthcare needs. The MMA urges professionals who provide gender-affirming healthcare to exercise caution with respect to applicable laws on minor consent. To facilitate this caution, and to empower physicians to care for minor patients to the maximum legal extent, the MMA will educate its members on minor consent laws as it relates to gender-affirming healthcare.” The policy was reaffirmed by MMA’s Board of Trustees in 2026.



MMA bestows teaching award to family physician

In late April, MMA President Lisa Mattson, MD, presented the Exceptional Primary Care Community Faculty Teaching Award to Adrienne Moen, MD, at the eighth-annual Dean’s Tribute to Excellence in Education event at the Bell Museum in St. Paul.

Moen’s nominator wrote: “In every sense of the word, Dr. Moen embodies what academic medicine hopes to cultivate, an extraordinary clinician, a gifted educator, a community leader, and a deeply compassionate and kind human being. Not only does she teach students about primary care, but she inspires them to believe in its profound impact both in the clinic and throughout the community.”



MMA President Lisa Mattson, MD presents the Exceptional Primary Care Community Faculty Teaching Award to Adrienne Moen, MD.

Moen is a family medicine physician at Lakewood Health System in Staples.

The MMA has partnered with the University of Minnesota Medical School since 2015 on what would become the Preceptor Initiative, an effort to develop tools and resources to improve the training and support for preceptors. The partnership serves as a recognition of the important role that community preceptors play in the education of medical students, and their com-

combined commitment to ensuring that there is a sufficient supply of community preceptors across Minnesota.

The teaching award stemmed from this partnership, and it recognizes those who take the time to teach the future primary care physician workforce. The award honors community faculty members and is co-presented by the MMA and the University of Minnesota Medical School.

The need for additional preceptors to educate future primary care physicians is critical. The United States faces a shortage of between 20,200 and 40,400 primary care physicians by 2036, and a projection of about a quarter fewer rural physicians practicing by 2030.

Mattson was joined at the event by Janet Silversmith, MMA CEO, and Juliana Milhofer, JD, MMA's manager of public health policy and community health partnerships.

MMA board approves AI task force recommendations

At its March 16 meeting, the MMA Board of Trustees unanimously approved the policy recommendations from the MMA's Task Force on Artificial Intelligence in Healthcare.

The task force was created by the board in December 2024 in response to the growing concern about AI development and use that was far outpacing regulations, and moves at the federal level to deregulate AI use.

The task force was tasked with considering the complex landscape of AI in healthcare with a focus on four key areas: transparency, the potential for bias, liability considerations, and impact on clinical decision-making. Using these four areas, the task force worked for over a year to develop policy recommendations for the consideration by the board.

The recommendations include:

- Artificial intelligence is a rapidly evolving aspect of medical practice, and physicians need to be prepared to understand and, as appropriate, adapt to the changing landscape.

1. The MMA advocates for the continued evaluation and monitoring through a state-sponsored advisory committee to continually review and improve regulation of AI in healthcare.
 2. The MMA advocates for the inclusion of comprehensive AI education in medical school, postgraduate curricula, and continuing professional development.
 3. The MMA supports the development of a comprehensive regulatory framework for the use of AI in healthcare.
 4. The MMA aims to monitor AI regulations that impact healthcare and educate its members on their impact.
- Individuals have the right to transparent, honest, and timely information pertaining to their healthcare.
 - Physicians have a responsibility to educate themselves on AI-enabled tools utilized in their medical practice.
1. The MMA encourages clinical uses of AI that have the potential to impact patient care, or a physician's clinical decision, be disclosed to a patient.
 2. The MMA advocates for disclosure of the use of AI in clinical decision communications that have not been reviewed and approved by a healthcare professional.
 3. The MMA encourages specialty societies to educate their members on specific AI tools and how to best evaluate and apply them.
 4. The MMA encourages developers of AI to provide detailed information about an AI tool including, the AI's intended uses, training data, data-collection practices, and risk and discrimination mitigation strategies, to deployers of AI in an effort to promote transparency and accountability.
 5. The MMA encourages facilities to make available to their clinicians detailed information about AI tools utilized within the facility.
- All patients have a right to receive unbiased healthcare.
1. The MMA supports equitable access to the benefits of AI by all patient populations.
 2. The MMA acknowledges that the use of AI in healthcare carries a considerable risk of codifying and/or exacerbating existing social inequities.



3. The MMA acknowledges that accounting for bias in AI model design, training, and use is essential in helping to mitigate biases.
 4. The MMA encourages policies requiring rigorous and continuous evaluation of AI models for bias when they are used in the healthcare setting.
 5. The MMA expects that immediate action will be taken to correct or mitigate encountered bias.
- AI should not replace a physician’s recommendation for the provision of healthcare.
 1. The MMA supports efforts to ensure that healthcare professionals always make the final decision regarding the provision of healthcare.
 2. The MMA opposes coverage denial processes that utilize AI to deny coverage for a healthcare service without the meaningful input of a healthcare professional.
 3. The MMA opposes requirements from payers, hospitals, health systems, or governmental entities mandating the use of an AI tool for clinical decision making as a condition of licensure, participation, payment, or coverage.
 - Liability for harm involving AI should be focused on the party that is in the best position to identify and mitigate the harm.
 1. The MMA acknowledges the evolving role of AI in healthcare and therefore, the evolving understanding of liability for the use of AI in healthcare. The MMA supports policies that hold physicians liable only for their own clinical decision-making.
 2. The MMA encourages multidisciplinary governance structures within systems that monitor and evaluate the performance and use of AI tools within their system and provide transparent information to clinicians within the system.

MMA Code of Conduct ensures all are welcome

To create a welcome and inclusive environment for all physicians, trainees, staff, and guests, the MMA established a Code of Conduct. Each year, we remind members of the policy and encourage you to review it and help us create a space of belonging for all. Find it here: www.mnmed.org/application/files/3516/9203/5162/IPPM_Code_of_Conduct.pdf



Physician/Olympian to speak at Empowering Physicians event in September

The first female cross-country skier to represent Mexico in the Olympics will give an inspiring talk on resilience at the Empowering Physicians event on September 25.

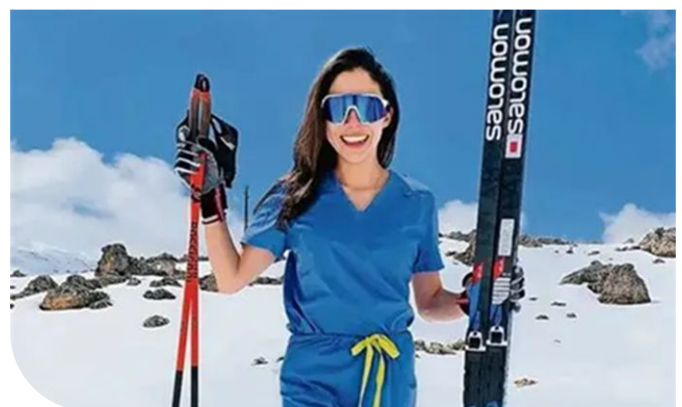
Regina Martinez-Lorenzo, MD, a 2021 graduate of the University of Minne-

sota Medical School, and now an emergency medicine physician in Miami, will detail how she first learned to cross-country ski in Minneapolis’ Theodore Wirth Park and, five years later, competed in the 10K freestyle cross-country ski event at the 2026 Winter Olympics in Milano-Cortina, Italy, this past February.

The Empowering Physicians event will take place Friday, September 25, from 4 to 9 p.m. at the Minneapolis Institute of Art, 2400 3rd Ave. S. The event will also include educational sessions on how the One Big Beautiful Bill Act will affect the practice of medicine in Minnesota, and a deep dive into the state of medical legal affairs in Minnesota.

In addition, the event will feature a poster symposium for physicians-in-training, and an exhibitor section. Copic is the event’s premier sponsor.

For more information on the event, visit www.mnmed.org/EPC26.MM





FROM THE CEO

Playing offense and defense at the Legislature

Another state legislative session has come to an end. As is true every year, the MMA approached the Legislature with an agenda aimed at advancing our mission—to make Minnesota the healthiest state in the nation and the best place to practice medicine. Our five-point agenda reflected both practical and, at least in a political context, aspirational goals.

Overall, it was a fairly successful session, particularly considering that it was a non-budget election year with a tied House and a one-seat margin in the Senate. The MMA's two "practical" goals were enacted—precluding health plan use of AI alone for prior authorization denials, and expanding confidentiality protections

for health professionals utilizing wellness programs. The MMA also worked to support the passage of critical funding for Hennepin Healthcare.

The Legislature failed, however, to make meaningful progress on important public health priorities (politically "aspirational," unfortunately)—preventing firearm death and injury, and increasing childhood vaccination rates.

For the two-year biennium (2025–2026), more than 11,000 (no, that is not a typo) bills were introduced across the Minnesota House and Senate. Although only a very small number of those bills move forward (or are introduced with the intention of moving forward), the MMA government relations team not only advances MMA's agenda, but also must be prepared to respond to other bills—sometimes in support, but many times by playing defense to prevent their advancement.

Among the bills that MMA most often finds itself playing defense on are those that seek to modify the scope of practice of nonphysician healthcare professionals. This year was no exception, and their perennial presence is not all that surprising.

Medicine was the first health profession regulated by the state of Minnesota. In 1883 the state created the Minnesota Board of Medical Examiners (now known as the Board of Medical Practice) to define physician licensure qualifications to ensure consistent professional standards and as a way to protect the public from unqualified and untrained practitioners. As new professions emerged—and continue to do so—the need to define specific roles and authority, often relative to that of physicians, began.

Health professional practice acts set both the qualifications and boundaries for various professionals—nurses, pharmacists, physical therapists, physician assistants, and so on. At the same time, numerous forces—economic, social, political—have prompted changes in the training, demand, and expectations of the healthcare workforce.

This legislative session, two proposals garnered significant MMA concern—one

to change the title of physician assistant to physician "associate," and one to remove the current requirement (adopted in 2014) for a nurse practitioner or clinical nurse specialist, as a condition of licensure eligibility, to complete at least 2,080 hours of postgraduate collaborative practice with a physician or licensed APRN in a hospital or integrated clinical setting. Few legislators are able to objectively evaluate competing narratives. Proponents of expanded scope (or, in this year's case of removing postgraduate collaborative practice) often raise concerns about workforce shortages, particularly in rural communities, and enhancements in educational training. Opponents, including the MMA, cite evidence that expanded scope does not solve workforce maldistribution problems and share examples of patient harm and quality-of-care concerns. At the legislative level, these topics are often deeply emotional and generate considerable constituent feedback.

The MMA negotiated with APRN advocates this year to narrow their proposal. Postgraduate collaborative practice of 2,080 hours is still required for nurse practitioners and clinical nurse specialists, but such practice can now be accomplished outside of a hospital or integrated clinical setting for those providing primary care or mental health services. The physician "associate" title change was not enacted.

The MMA position is clear—patient care is best served by a physician-led team of healthcare professionals working collaboratively. It is also clear that the role of other healthcare professionals will continue to change and evolve. The voice of physicians is critical to ensure that future scope of practice changes continue to protect patients and sustain the medical profession.

Thank you for your continued support. MM

Janet Silversmith
JSilversmith@mnmed.org

Opening the door for tomorrow's physicians

As you know, getting into medical school and then training to become a physician is a difficult, arduous process. Now, imagine yourself in grade school when you were first thinking about what you wanted to be when you grew up. And then imagine that no one in your family had ever attended college, let alone medical school. Would you think becoming a physician was possible? My only exposure to medicine as a child was my pediatrician, but my grandfather told me early on that I was smart and should be a doctor! He lit a spark in me and set me on a path to my future career.

A lot of youth face this situation—ambitious, but with limited resources. We're trying to provide a solution. We need to encourage everyone who has the talent and the drive to become a physician to achieve that dream.

We are all aware that healthcare workforce shortages are straining systems across the country. Here are some sobering numbers:

- According to recent projections published by the Association of American Medical Colleges, the U.S. will face a physician shortage of up to 86,000 physicians by 2036. This is particularly alarming since it is projected that we will see about a quarter fewer rural physicians practicing by 2030.
- In Minnesota, nearly 20% of all physicians, and one in three rural physicians, plan to leave practice in the next five years.
- Overall, 4.4% physicians practice in rural parts of the state and yet 15% of Minnesotans live in rural parts of the state, according to Minnesota Department of Health data.

We need to change this trend. One effective way to strengthen the pipeline is to spark interest early—by exposing youth to healthcare careers before they make critical education and career decisions.

Recognizing the rural healthcare workforce needs of Minnesota, the MMA embarked upon an initiative to expose youth to careers in healthcare—to inspire the next generation and open doors to careers that will better prepare Minnesota to meet its future healthcare needs. (See story on page 37.)

The MMA, in partnership with the University of Minnesota Medical School CentraCare Regional Campus St. Cloud, hosted the Rural Youth Medical Careers Discovery Day on a Saturday this past April.

I'm proud to say that my employer, CentraCare, and its foundation, served a supportive role of the event along with the Minnesota Rural Health Association, the University of Minnesota Pre-Health Resource Center, Gillette Children's, and many other dedicated volunteers and community members.

Gillette Children's in St. Paul has been hosting these types of events for the past several years, with a focus on exposing youth in the metro area to careers in healthcare. The MMA has supported and served as a sponsor for these events at Gillette.

As we began to assess what we could do to support rural health, we decided that replicating this event in rural Minnesota was essential.

Nearly 70 youth, ages 9 to 14, were introduced to the world of healthcare at our St. Cloud event. It provided participants with an opportunity to step into the world of healthcare through interactive experiences like casting and splinting, suturing, administering vaccines, learning about blood and how we test it, and exploring X-ray imaging. The day also included a panel discussion titled, Growing Your White Coat, which gave the parents and guardians in attendance a peek into the various parts of the physician journey, from premed student, to medical student, resident, and attending physician. It was so inspiring to see these youngsters and



Kimberly Tjaden, MD, MPH
MMA board chair

We need to encourage everyone who has the talent and the drive to become a physician to achieve that dream.

their supporting adult caregivers get excited about science and healthcare!

I am honored to have taken part in the day. It was fun and encouraging to see the youth excited to get a glimpse of a career in healthcare and to talk with a variety of healthcare providers outside the clinic walls. It made my heart happy to know that the next generation of healthcare providers (including some future physicians) is already getting the support and resources to help them make the long journey!

One day, perhaps, they will have their own patients and play a role in helping to keep Minnesotans healthy. MM



A Thank You to Our Dedicated Community Preceptors!

Adrienne Moen, MD

is awarded the **2026 Exceptional Primary Care
Community Faculty Teaching Award**



“The role of teacher is one of the most important roles that a physician can take. Thank you, Dr. Moen, for inspiring the next generation of physicians to go into a career in primary care, and for serving as a model of professionalism for so many.”

Lisa Mattson, MD - MMA President



“Community physicians and clinical partners are essential to how we educate the next generation of physicians. Their willingness to teach, mentor, and share their expertise ensures our students learn not only the science of medicine, but also the compassion, judgment, and human connection that define exceptional patient care. We are deeply grateful for their partnership and their commitment to our mission across Minnesota and beyond.”

Carol R. Bradford, MD, MS, FACS - Interim Dean, Medical School & Interim Executive Vice President for Health Affairs, University of Minnesota



Lisa Mattson, MD, presenting the Tribute to Community Preceptors and the 2026 Exceptional Primary Care Community Faculty Teaching Award to Adrienne Moen, MD.



In 2026, the MMA, in partnership with the University of Minnesota Medical School, once again sponsored the “Exceptional Primary Care Community Faculty Teaching Award” at the Dean’s Tribute to Excellence in Education Event.

Community Preceptor Toolbox



The MMA, in partnership with the University of Minnesota Medical School, has created a set of tools and resources to improve the training and support for clinical preceptors. **Visit our Community Preceptor Toolbox to learn more!**



MEDICAL SCHOOL

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Driven to Discover®

Presented by the MMA **Preceptor Initiative**, a partnership between the MMA and the University of Minnesota Medical School.



SCOTT STAYNER, MD, PHD

Scott Stayner, MD, PhD, is an interventional pain physician at Nura Pain Clinic in Edina, where he focuses on multimodal pain management with an emphasis on procedures such as spinal cord stimulation, dorsal root ganglion stimulation, intrathecal pain pump therapy, kyphoplasty, radiofrequency ablation, minimally invasive treatment for spinal stenosis, and sacroiliac joint fusion.

When did you become an MMA member?

I joined MMA when I started medical school at the University of Minnesota in 2003.

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

I completed my undergraduate and graduate work at the University of Utah, earning a BS in materials science and engineering, a BA in Japanese, and a PhD in bioengineering. I then came to Minnesota for medical school and anesthesiology residency at the University of Minnesota, followed by a pain medicine fellowship at UC Davis. My training path was not exactly linear, but it gave me a strong appreciation for engineering, language, research, and clinical medicine.

Tell us about your family.

My wife, Alison, and I live in Eden Prairie with our twin boys, Artie and Leo. At age seven, they keep us busy with school, sports, travel, toy trains, and all the energy that comes with young kids.

Hobbies or side gigs?

I enjoy skiing, volunteering for my church, playing the string bass, studying spoken and written Japanese, and traveling with my family. My newest hobby is creating villages for model trains on our dining room table with my kids. Professionally, I also enjoy teaching and consulting in interventional pain medicine.

Why did you decide to become a physician?

I was drawn to medicine because it combines science, problem-solving, and service. My background in bioengineering shaped the way I think, but medicine added the human element. Pain medicine was especially appealing because of the struggles my grandmother had with chronic pain after multiple back surgeries

in the late 1990s. She was eventually treated with high-dose opioid medication, which caused bowel and other complications. We have much better treatments for chronic pain these days.

What was the greatest lesson of your medical education?

The greatest lesson was humility. Medical training teaches a great deal of science, but patients rarely fit perfectly into textbook categories. Good medicine requires curiosity, patience, and a willingness to keep listening even after you think you understand the problem.

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

When I was doing graduate work in bioengineering, I was surprised by the arduous process involved in bringing innovative medical devices to market. After medical school, I was surprised by how much of medical practice depends on systems outside the exam room: insurance authorization, documentation requirements, scheduling, staffing, reimbursement, and administrative expectations. Medical education prepares you to diagnose and treat disease, but daily practice also requires helping patients navigate a healthcare system that can be difficult even for physicians to understand.

What's the greatest challenge facing medicine today?

One of the greatest challenges is preserving the physician-patient relationship in an environment shaped by administrative burden, payer requirements, productivity pressure, and fragmented care. Physicians want to spend time thinking deeply about patients and helping them make good decisions. The challenge is creating systems that support that work rather than crowd it out.

How do you keep life balanced?

I am not sure I would claim to have mastered balance, but my family helps. Time with my wife and children pulls me back into real life quickly. Skiing, Cub Scouts, music, Japanese study, and travel all give me ways to step outside the clinical world and remember that life is bigger than work.

If you weren't a physician—?

My dream job in high school was to be a bassist in a symphony orchestra. In reality, if I had not gone to medical school after defending my PhD thesis, I probably would have pursued post-doctoral work in academia or industry. One path I saw for myself was as an academic or industry researcher working with Japanese companies. I still enjoy work that combines science, problem-solving, and collaboration across cultures.

What has membership in MMA meant to you?

MMA membership has meant being part of a broader physician community in Minnesota. I first became involved as a medical student, and that early exposure helped me see how physicians can contribute not only through individual patient care, but also through advocacy, education, and organized medicine. *MM*

Life and Hope After Stroke

ADVERTISEMENT

Minnesota woman shares her inspiring story of stroke rehabilitation, recovery

On August 10, 2024, Mindy Tosel-Waddell knew something just wasn't right. She assumed the dizziness and heaviness in her chest was a virus. But when she ended up on the floor from her lack of balance, she decided she needed to go to the hospital.

Mindy remembers fainting while being admitted to the ER and remembers being told she needed to have emergency heart surgery, but she remembers little more after that until she woke up nearly a month later in the hospital.

Mindy experienced a sudden coronary artery dissection, which occurs when an artery wall suddenly tears. During surgery, Mindy experienced several strokes and seizures, which caused severe damage to her brain. Her medical team put her into an induced coma. The situation was grim. So grim that the family was working on pulling together her obituary.

When she finally awoke, Mindy says it was "like a ball of yarn kept unraveling." She learned about her strokes and learned that she would have a long road to recovery before her. She was transferred to an inpatient rehabilitation facility, where she received intensive occupational, physical and speech therapy.

Stroke can happen to anyone, at any age. But there is life – and hope – after stroke. Rehabilitation can build strength, capability and confidence. It can also help someone who



There are more than 7 million stroke survivors living in the U.S. today. But not all strokes – and not all stroke survivors – are the same. Finding the right rehabilitation plan is vital to recovery after stroke. The American Stroke Association has developed standards to help rehabilitation facilities provide consistent, high-quality care for individuals as they recover from stroke.

Facilities that participate in the Association's post-acute stroke standards program agree to follow the Association's treatment guidelines and have made a commitment to providing care that is based on standards aligned with American Stroke Association science and vetted by stroke rehabilitation experts.

Mindy's rehabilitation included inpatient and outpatient care and was customized to her individual needs. The program was very disciplined and included back-to-back sessions throughout the day, with the goal of maximizing her recovery in the first 6 months after her stroke.

"I had to learn how to get dressed, how to eat, how to be mobile and walk," Mindy says.

Mindy says today she is about 85-90% back to being herself. She credits the village behind her, including her family and close friends and the specialists involved in her rehabilitation, for her recovery. She also is an active participant in several stroke support groups that she attends with her husband.

"They helped me so much," she says. "Sometimes when I miss the stroke support group, I feel almost lost. I need that as a little kick – you hear other stories of what other caregivers and survivors have gone through. It's a time of sharing and it boosts you a little bit."



American Heart Association.
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To learn more about
stroke rehabilitation
options.

For more information, contact
Sarah.Donnely@heart.org
Learn more about this initiative at
heart.org/PostAcuteStroke

Congratulations to the following Minnesota facilities who have joined the American Heart Association and American Stroke Association's post-acute stroke care initiative.

These providers have agreed to follow the Association's treatment guidelines and have made a commitment to providing care that is based on standards aligned with American Stroke Association science and vetted by stroke rehabilitation experts:

- Annandale Care Center (Annandale)
- Appleton Area Health (Appleton)
- Aspirus St. Luke's Hospital (Duluth)
- Astera Health (Wadena)
- Birchwood Senior Living (Lake Forest)
- Capitol View Transitional Care Center (St Paul)
- CentraCare-St. Cloud Hospital (St. Cloud)
- Community Memorial Hospital Association (Cloquet)
- Courage Kenny Rehabilitation Associates- Minneapolis (Minneapolis)
- Courage Kenny Rehabilitation Institute- St. Paul (St. Paul)
- Courage Kenny Rehabilitation Institute TRP (Golden Valley)
- Ely Bloomenson Community Hospital (Ely)
- Glacial Ridge Health System (Glenwood)
- Glencoe Regional Health Services (Glencoe)
- Glenfields Living with Care (Glencoe)
- Gundersen St. Elizabeth's Hospital and Clinics (Wabasha)
- Hendricks Community Hospital Association (Hendricks)
- Hennepin County Medical Center, HCMC (Minneapolis)
- Heritage Living Center (Park Rapids)
- Heritage Manor (Chisholm)
- Johnson Memorial Health Services (Dawson)
- Lakewood Health Care Center (Staples)
- Lakewood Health System Hospital (Staples)
- Madelia Health Hospital (Madelia)
- Madison Healthcare Services (Madison)
- Meeker Memorial Hospital (Litchfield)
- MHealth Fairview Acute Rehabilitation Center (Minneapolis)
- Minnesota Masonic Home Care Center (Bloomington)
- Murray County Medical Center (Slayton)
- North Memorial Health Care (Robbinsdale)
- North Shore Health Grand Marais (Grand Marais)
- Pipestone County Medical Center (Pipestone)
- Providence Place (Minneapolis)
- Regions Hospital (St. Paul)
- Riverview Health (Crookston)
- Riverwood Healthcare Center (Aitkin)
- Sanford Bagley Medical Center (Bemidji)
- Sanford Canby Medical Center (Canby)
- Sanford Medical Center Thief River Falls (Thief River Falls)
- Sanford Tracy Medical Center (Tracy)
- Sanford Westbrook Medical Center (Westbrook)
- Sleepy Eye Medical Center (Sleepy Eye)
- United Hospital District (Blue Earth)
- Vitality Living of Aitkin (Aitkin)
- Welia Health (Mora)
- Windom Area Health (Windom)
- Winona Health (Winona)
- Woodbury Senior Living (Woodbury)



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