THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

MINNESOTA MEDICINE

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Aging out

While the number of seniors rises nationwide, the number of geriatricians is falling. Why is that happening? And what can be done?

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Giving **VOICE** PAGE 10

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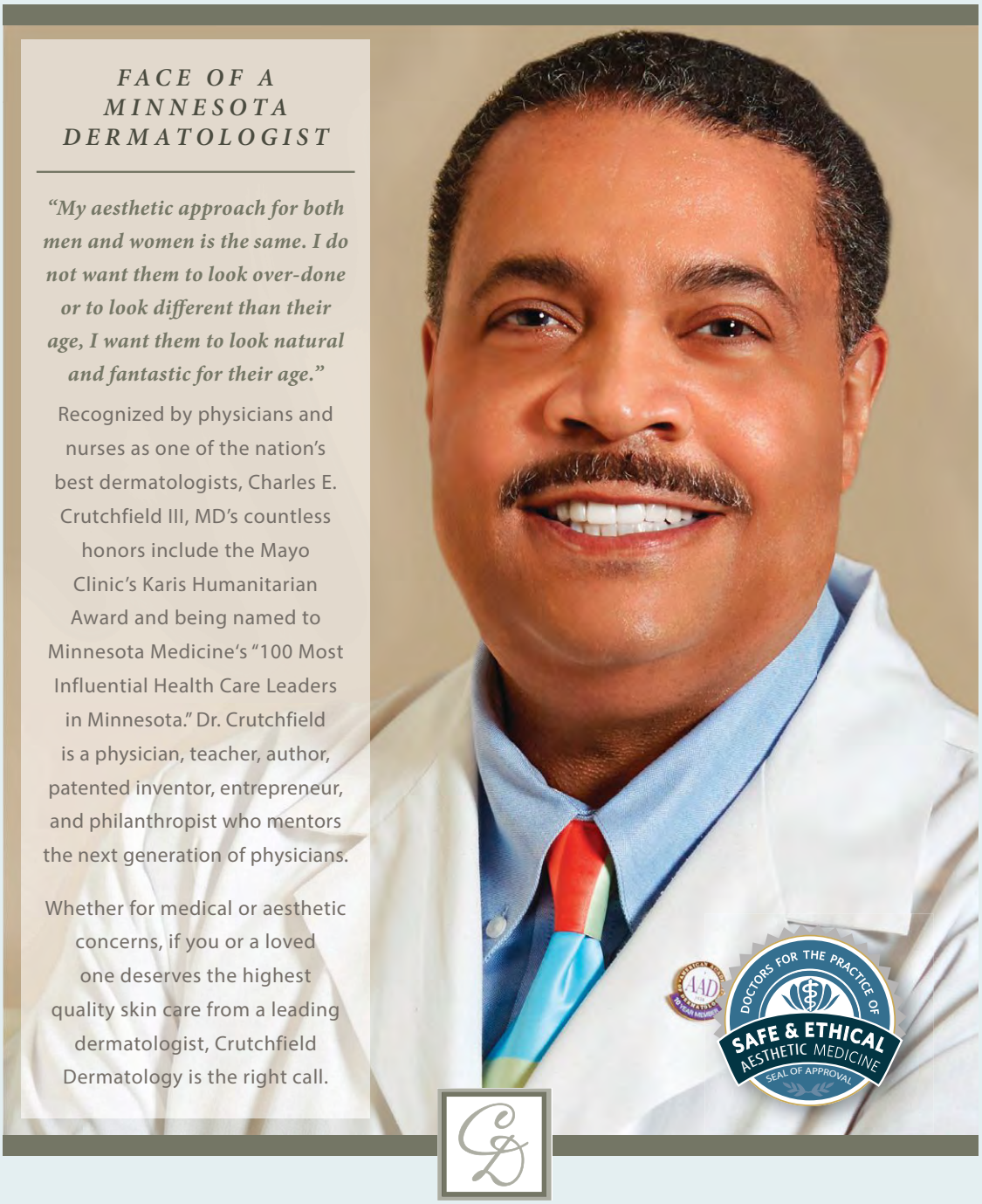

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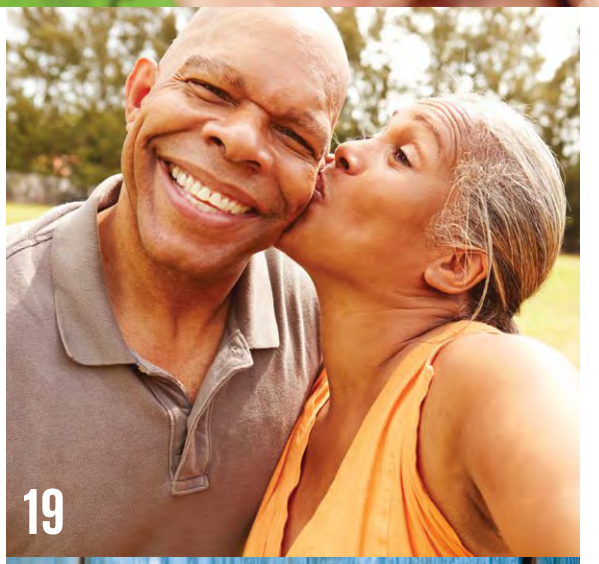

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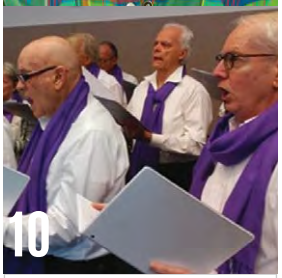
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PHOTO BY SCOTT WALKER

Facing the 'R' word

What will I be, when I'm not a doctor?

I lucked into the right profession, one that meshed with my personality and my skills, a job I could stick with for 41 years.

My father said he would never retire. An MIT-trained engineer, he worked in the "tech" industry of the early 1950s for Stewart Warner and then formed his own business consulting/business broker company. It was a one-man, one-secretary operation that required network building and reputation cultivating. He sometimes needed to travel on short notice, which he did with the help of his private pilot license and his Cessna 310. For most of his working life, he was busy and successful, but gradually the phone stopped ringing. First, he closed his office in downtown Chicago, then he laid off his long-time secretary. He continued to stay active on numerous boards but he basically oozed into retirement.

For most physicians, oozing into retirement is difficult. Indoctrinated into a macho work ethic through medical school and residency, most doctors just keep going at breakneck speed throughout their careers. The bizarre notion that if you're not a busy doctor you're not a good doctor nags at the back of some physicians' minds. Finding a practice arrangement that understands "slowing down" can be problematic, as small physician groups can find it hard to accommodate lighter schedules or part-timers and large patient volumes challenge even the largest groups to have enough providers to meet demand.

And for many docs, just entertaining the idea of leaving their chosen profession promotes a discomfort akin to hives—if not outright terror—accompanied by sleep-depriving thoughts like, "What would I do with myself?" Or, "What's it like not to be a doctor? Or, "I know too many docs who retired and just went downhill or died."

I worried about giving up something I know how to do for many things, like fixing faucets and washing windows, that I'm not good at. And then there's the big question, the late-life identity crisis: "What will I be when I'm not a doctor?"

My journey from not thinking about retirement to thinking about retirement to doing retirement follows. Truthfully, there hasn't been much terror, but it has been an odyssey. For years after it was financially feasible, retirement just wasn't appealing. I enjoyed patient contact and I savored having a body of knowledge and using it daily. On most days, the sometimes-hectic pace of primary care challenged my powers of multitasking and finishing a day of seeing 20 patients, handling twice as many phone calls and reviewing scads of lab results was like getting the marble to the end of the Labrynthspiel I used to play as a kid. An almost empty inbox was a joy to behold. Even during the traumatic dissolution of my small group and the move to Allina, my patient hours were enjoyable.

Still, the practice of internal medicine had changed since I joined my six-doctor group in 1977. Like the body aging, it seemed as if each passing bit of time in practice saw a loss of another facet of internal medicine. With the pressures of time, I stopped doing most procedures. Specialists gradually took over the management of complicated patients in the ICU and coronary care unit. And the closing of our small group meant the end of the hospital part of my day. Each day demanded a smaller and smaller part of my medical knowledge so that articles in medical journals and information in continuing medical education materials became less and less relevant to my daily activities. At times, it felt like a dwindling of expertise and an attrition of responsibility.

While in practice, my nightly review of the day with my wife was usually a discussion of patients with compelling life stories or interesting medical problems. But increasingly, the "R" word popped up. We agreed it would be nice to have more elec-

tive time to travel to cabins and grandkids; for two years I was able to arrange extra vacation time by cutting back to .9 FTE status. Yet the extra time seemed to melt away and we found ourselves avoiding extended trips and trying to squeeze more into long weekends.

When I passed 40 years in practice and the big 70 loomed ahead like an ominous thunderhead, the "R" word began to dominate our beer time conversation. Taking the plunge, I constructed a retirement announcement letter notifying patients that, with a mixture of joy and regret, I would retire in six months.

Those months were a swirling procession of goodbyes. I said goodbye to patients whom I had seen for almost the entire 40 years. I said goodbye to patients who were the fourth generation of a family for whom I had doctored. It seemed as if daily I was saying goodbye to one friend after another. I don't like goodbyes, especially when they feel permanent, so I frequently moderated the farewell with "I'll see you in Byerlys." Many of the goodbyes included hugs, usually from older women I had seen for decades, but some also from apparently dispassionate males who sheepishly requested it just as they were leaving. More than a few tears were shed, again from a mixture of ages and genders.

My own tears flowed with some of the letters and cards I received. All of the cards were supportive, many were touching and a few were comical. With some came gifts ranging from gift cards to nice restaurants or Barnes & Noble to plants or food. One particularly unusual gift was a ticket stub from one of the Chicago Cub's World Series games.

The six months zipped by and, contrary to my expectations, my time was filled to the very last day. Patients were gratifyingly and almost embarrassingly flattering. If you ever are feeling down about yourself, declare your retirement and prepare for a real ego trip.

What about the rest of my life? Following a long post-retirement trip, I awoke at home with the realization that every day was now Saturday. For the first weeks, Medicare, retirement plans and other financial details filled my time. My list of patients to be seen was replaced by to-do lists, the "unsorted pile of details that is life" according to essayist Patricia Hampl in her recent book, *The Art of the Wasted Day*. But the to-dos will get done and then what?

Cabins and grandkids, for sure. More trips—definitely. I'd like to get back into some form of teaching, which I have missed in recent years. I might indulge my secret passion to be a guide or docent and develop an entertaining shtick while educating visitors at a museum or other place of interest. I might follow the example of my daughter's late father-in-law who, after a long career as a general surgeon, started auditing classes in calculus and particle physics. My list of topics could include genomics or Greek or reading the Shakespeare I have ignored in my education.

Perhaps I will cultivate Hampl's *Art*, a life with more reflection, more quiet enjoyment, more non-directed conversation, less accomplishment. I hope to savor people's company without looking at my watch or planning my next activity.

I have been lucky in so many ways—most of all in choosing my wife of 47 years—and I lucked into the right profession, one that meshed with my personality and my skills, a job I could stick with for 41 years, in which I could enjoy mostly unwasted days … and then leave in a non-oozy way with few regrets, ready to start the next journey. **MM**

Change at *Minnesota Medicine*

The January 1994 issue of *Minnesota Medicine* was the first featuring Charles R. Meyer, MD, at the helm as editor in chief. He accepted the role with a bit of trepidation, as he described in his first Editor's Note:

"My keyboard fingers tremble slightly as I assume the editorship of Minnesota Medicine. *For someone who likes to keep a low profile, making noise that can be heard at such a distance is intimidating."*

He wasn't intimidated for long. For 24 years, Meyer has provided counsel, medical expertise and guidance to the magazine and its staff.

With his retirement from clinical practice, Meyer is also retiring from his position at *Minnesota Medicine*. Zeke J. McKinney, MD, MHI, MPH, will be the new chief medical editor of the magazine, beginning with the November/December 2018 issue.

We hope that Meyer will continue to contribute to MMA as he finds time, and we know you'll see him at least occasionally in *Minnesota Medicine*: watch for his book review in the next issue.

Thanks, Chuck!

The first issue with Charles R. Meyer, MD, as editor in chief.

Finding a new way

BY CARMEN PEOTA

Amy Taylor, MD, is spreading the message that you can improve your own health.

Clad in an apron and standing beside a counter spread with jars and bottles, Taylor looks at the camera and begins. "Fish is actually one of my favorite dishes to recommend to my patients because it's heart-healthy, it can help with our cognition and our brain and it can even help with our mood," she says, starting her video lesson on cooking fish.

She tells her audience about growing up in Iowa and family trips to Minnesota in the summer to fish. She explains that the pink piece of trout on the white plate before her contains healthful omega 3 fatty acids. She demonstrates how to test whether the fish is done, scraping it with a fork. With each step, she slips in a health tip. And repeatedly she tells her audience that they don't need special skills, tools or abilities to do what she's doing. "This is not hard, this is not challenging," she says.

The video is a resource offered by Nourishing Minnesota, an initiative to educate Minnesotans about food at the Earl E. Bakken Center for Spirituality and Healing at the University of Minnesota. It's one of the ways Taylor is letting people know there is much they can do to improve their own health.

Wake-up call

Taylor learned as much herself about seven years ago. After completing her emergency medicine residency, she'd taken a job in an ER in Charlottesville, Virginia. "I was doing a lot of stressful shift work. I was not sleeping well. I was not eating well. I found myself not being around friends, family. I didn't feel healthy. I was diagnosed with a stomach ulcer and instructed to reduce stress and make lifestyle adjustments. It was starting to be a wake-up call," she says.

There was another wakeup call: Her father was diagnosed with pancreatic cancer. "It was one of those life-changing moments," she says. "I needed to reevaluate things. I needed to refocus how I was doing things personally and professionally." Her father encouraged her to make a change, telling her, "I really hope you can make the most of your life and career and do what you love."

She realized she was beginning to feel disillusioned with medicine as she was practicing it, as she often saw patients in the last stages of diseases that had lifestyle components. "It started to occur to me that I wanted to be on the other end of that," she says. "I wanted to be helping prevent the problems before they even started."

She recalled her long-standing interest in nutrition. Raised in Waverly, Iowa, she had grown up around people who grew and cooked food. She spent summers helping in the family garden and on her uncle's corn and soybean farm. She'd earned a master's in public health, with a focus on nutrition and exercise, before going to medical school. "In medical school, doctors receive very little education on proper nutrition," she notes.

She was intrigued when a colleague told her about the University of Arizona's integrative medicine fellowship, which offers training in nutritional health, botanicals and dietary supplements, mind-body medicine, complementary and alternative practices, and how and when to integrate these approaches into conventional medicine. The fellowship seemed a way to expand her knowledge about disease prevention through lifestyle management and to provide patient care in a more holistic manner.

PHOTO BY RICH RYAN PHOTOGRAPHY

"Once I started reading about the fellowship, I thought, this is exactly the type of medicine I'd like to practice," she says.

Integrative practice

Taylor began the fellowship as her father was undergoing chemotherapy and radiation. As she was learning things, he would try them: massage for neuropathy that was a side effect of the chemo, ginger for nausea, breath work for pain and anxiety. "He was my first integrative medicine patient," she says. "If you can do anything in that situation to make them feel better, I think it's worth it. After he died, I knew I wanted to take my career in a different path."

> "I respect other physicians who want to practice from a traditional Western basis. That's perfectly fine. I just have a little bit different notion."
>
> – Amy Taylor

That path led to Minnesota, where she set out to bring integrative medicine to both emergency and urgent care. As she saw things, the ER, especially, presented teachable moments. Many patients with chest pain, for example, were open to a conversation about eating well. "I'd take that moment—and it would just take a couple of minutes—and say, 'Let's talk about your diet. What's the one thing that you could do better?'" If the answer was to eat more broccoli, she'd jot down a recipe for roasting it. "That's all I'd have time for," she says. "But it's a stepping stone toward getting someone to start thinking about changing their diet or lifestyle. And then it snowballs from there."

She's now practicing only in urgent care clinics (at Allina clinics in Woodbury, Burnsville and Inver Grove Heights). "I never press anything integrative or natural or botanical if the patient doesn't want it," she says, noting she always starts by offering conventional medicines and treatments. "If a patient inquires about natural options or seems open to the idea, I'll offer to discuss what integrative approaches might be useful. For example, if a patient wants to treat a cough naturally, I'll go through some of the plant-based medicines that might help or even simple home remedies like thyme-honey cough syrup." An equally important part of her practice is helping patients learn when using botanicals or supplements is not appropriate or could potentially be dangerous. "Just because a product is labeled as 'natural' does not mean it's safe."

Having studied the research on botanicals and supplements, she knows not only which are effective but also how they work. She explains to her patients, for example, that cranberry prevents urinary tract infections because it prevents bacteria from adhering to the urinary tract lining. The marshmallow plant is effective for sore throats and reflux because it forms a protective coating on the throat and esophagus; she takes it herself when she has problems.

She points to Consumerlabs.com, which independently tests supplements for quality and contaminants. "That's a big problem with botanicals and supplements that are sold in stores," she says. "You don't entirely know what you're going to get." She encourages her patients to buy directly from manufacturers or even to make their own preparations.

The joy of teaching

Working in urgent care allows Taylor time for other activities. She's on the steering committee for Nourish Minnesota, which includes chefs, another physician and a nutritionist. And she's teaching an online course on botanical medicine for health professionals at the University of Minnesota.

In the online course, Taylor shares an overview of integrative medicine in the United States and discusses how botanicals are regulated, "which isn't much," she notes. She goes through body systems and discusses which botanicals are appropriate for which indications. "I'm kind of a stickler on making sure they're as evidence-based as possible," she says. She also shows the future doctors, nurses and therapists how to make their own botanical preparations at home.

"She's really concerned about medicine," says Mary Jo Kreitzer, director of the Bakken Center. "She knows it's really important to educate the next generation of health professionals."

The course is highly rated by students. "As a teacher, she's very gifted," Kreitzer says, noting that Taylor is relaxed and comfortable in the role. "She's definitely an expert, but she's very relatable to people. When she talks about things—whether with students or patients—she can put things in simple ways that they understand." She says Taylor shares her perspective as a trained physician, which adds context to her teaching.

Taylor's confidence, passion, skill, clinical experience and training is on display in the Nourish Minnesota video, where Taylor looks as relaxed as Julia Child in front of the camera. "I'd never done anything like that before, so I didn't really know how it would go," Taylor says. "But I absolutely love teaching."

"It's something that I think I got from my mother," she says, explaining that she taught third grade for years. "Teaching is something I really enjoy and get a lot of meaning from. I feel like those videos are another way to teach to a wider audience."

A better fit

Taylor understands that many of her peers don't share her interest in integrative medicine. "I respect other physicians who want to practice from a traditional Western basis. That's perfectly fine. I just have a little bit different notion. I think that's fine, too," she says, gently. "I know it's an interesting path."

For Taylor, integrative medicine is a good fit. The fellowship opened up a new approach to medicine that aligns with who she is. She's been able to use her talents, particularly for teaching, and to offer patients new tools and information. "While a cure may not always be possible, there is always the opportunity to heal," she says, she says summing up her philosophy.

PHOTO BY RICH RYAN PHOTOGRAPHY

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Giving Voice

BY BARBARA GREENE, MPH

A Twin Cities metro chorus has shown that music can make a difference for Alzheimer's patients.

"He has no idea what he did for a living, where he is living now, or what he did ten minutes ago. Almost every memory is gone. Except for the music. (Yet) he opened for the Radio City Music Hall Rockettes in Detroit this past November … The evening he performed, he had no idea how to tie a tie … he got lost on the way to the stage—but the performance? Perfect … He performed beautifully and remembered all the parts and words."

This patient story, shared by internationally renowned neurologist Oliver Sacks, MD, in his 2007 publication of *Musicophila: Tales of Music and the Brain,* is not an isolated case. Sacks also described a meeting with his patient several weeks after the Radio City Music Hall performance. When asked how he was feeling, his patient responded, "I think I am in good health."

How can you be in good health after an Alzheimer's diagnosis? We are learning as a society that one way is through music and other arts. We are becoming increasingly aware that for persons living with Alzheimer's, music occupies a special realm. Music can move us to great emotional heights or depths. It can lift us out of depression and move us to dance. Music actually occupies more areas of our brain than language. And we are learning that for persons living with Alzheimer's disease, music is a salve like none other.

In 2017, researchers from the University of Victoria, British Columbia, noticed that patients with Alzheimer's who were engaged in singing in a community-based chorus experienced a greater sense of enjoyment, sense of purpose and personal empowerment. For caregivers singing in the chorus, a greater recognition of support and respite occurred, as well as an increased community awareness of dementia outside the chorus. This 2017 study and others like it suggest that participatory choral programs for persons living with Alzheimer's and their caregivers can result in better quality of life for both groups.

A 2016 Finnish study described the positive impact of an unusual music intervention where caregivers of persons with dementia were coached to use singing or listening to music as a regular part of their everyday care. Additional international pilot studies between 2008 and 2016 employing non-pharmacological interventions such as choral singing also resulted in promising patient findings. In a variety of these studies, the introduction and continued involvement with new relationships, ongoing personal communications and regular group support in a quiet, reflective space under the direction of a chorus director and supportive program administrator was noted to have highly valued social benefit for both singers and their families.

A Twin Cities metro chorus called Giving Voice, launched in 2014 to enrich the lives of persons living with dementia and their caregivers, is discovering similar results. Giving Voice founders Mary Lenard and Marge Ostroushko recognized the potential of music's healing power and music memory to improve well being, increase mental ability and decrease depression and isolation. In an initial pilot with the MacPhail Center for Music, the first chorus of 30 singers grew to 65 singers and staged two public concerts. Since then, interest and impact has exploded.

Today, three distinct Twin Cities' choruses of more than 170 singers bring a broad range of music abilities to weekly rehearsals and public concerts. Most recently, the national organization, American Composers Forum, funded a world premiere of new music based on the personal stories of and performed by singers in Giving Voice Chorus. This sell-out performance at the Ordway Center for Performing Arts Concert Hall in St. Paul affirmed the power of stories by those living with dementia and the transformative joy of singing together in community.

In 2018, with a generous grant from the Mt. Sinai Community Foundation, Giv-

Singing in a group is not simply a hobby or an activity for those with Alzheimer's disease, it is a way to improve their mental and physical health.

ing Voice Chorus also broke new ground by expanding its reach to metro-area and statewide healthcare professionals. Three carefully designed continuing education healthcare seminars brought together audiences of physicians, faith-community-based nurses and baccalaureate nursing students. In addition to standing ovations in all three distinct performances, overwhelmingly positive healthcare evaluations were received based on the weaving together of Alzheimer's disease education, intimate singer stories and the celebration of music.

After delivering a moving education session and singer performance for more than 250 physicians at this year's Minnesota Academy of Family Physicians conference in St. Paul, several physicians described their experiences with the chorus.

Michael Rosenbloom, MD, behavioral neurologist and clinical director, HealthPartners Center for Memory and Aging

Individuals can be quite devastated from their compromise in memory. Memory factors into one component for many people: self. Individuals with this diagnosis suffer from an identity crisis. They feel they cannot contribute to society. They are also burdened about feeling dependent on their family members.

Music and singing provide us with a profound way to preserve value in living—even through advanced stages of this disease. Music is a form of talent and a way for us to express our creative intelligence. I am pleased that many of my patients are part of the Giving Voice Chorus. When I ask them what they are doing, their stories about the chorus are positive and fulfilling. They are not intimidated by the music or music direction. They are proud of cultivating new music skills.

As HealthPartners Center for Memory and Aging continues its research study with Giving Voice singers, we look forward to seeing some important quality of life changes. I hope the study will demonstrate positive changes in socialization and reduced isolation among these patients. This research may also have a strong impact on how the medical field views the role of music in the lives of persons with Alzheimer's.

Victor Sandler, MD, medical director, Fairview Homecare, and associate medical director, Fairview Hospice; adjunct professor, University of Minnesota Medical School, Department of Family Medicine & Community Health

Music is a powerful way of reawakening the mind. Anything we can do to catalyze and greater open and rekindle the mind is a positive step. I've seen the power of music in my father and uncle who both suffered from Alzheimer's. I've also seen the impact with my own patients. On a regular basis, I hear about patients who are mute from the effects of Alzheimer's and how they become verbal again when singing. I have no doubt that this is a modality we wish to promote.

I heard a world-renowned medical specialist on Alzheimer's some years ago. I had the chance to ask him the question, "If we could take all the dollars spent on pharmaceuticals used to treat Alzheimer's and use it instead for music therapy for Alzheimer's, which would you choose?"

He answered, "Without a doubt, music therapy would be more beneficial. We are a very long way from understanding and remedying the inner cause of this disease. There is no question that music would have a greater impact as a therapy than all the drugs being used for patients right now."

I strongly believe that we need to reshape the culture of medicine as to how we approach the treatment and palliation of many chronic diseases. We should be actively investigating the powerful impact of modalities such as music. What will really help patients is when nurses, physicians, social workers, and other health care team members think much earlier about music as an effective therapy. These interventions are far from "fluff"—they are terribly consequential. We should be thinking about music "front and center"—as a top priority for individuals living with Alzheimer's.

Jon Hallberg, MD, associate professor, Department of Family Medicine and Community Health, University of Minnesota Medical School

I was struck by how the Giving Voice Chorus so deeply resonated with the assembled family physicians at a recent statewide MAFP conference. This audience of doctors from across the state is at the front lines of dealing with the overwhelming task of taking care of patients at various stages of memory loss. Given that they—that we—have so few tools to combat this disease, it was a complete revelation that art, that

singing collectively, could come along and offer hope and dignity and joy the way the chorus does. The standing ovation that the presentation received was, of course, well deserved. But it also represented something more than just an acknowledgment of a job well done. I think it also represented an acknowledgment that here was a form of healing that they could, relatively easily, turn to wherever they live and practice.

Jane West, MD, retired ophthalmologist and Giving Voice choral volunteer

I witnessed the impact of Giving Voice Chorus when a volunteer chorus friend and her husband living with Alzheimer's invited me to a public performance. I was incredibly moved by the experience that everyone in the chorus was having. The sound of the chorus was terrific and for the most part, I couldn't tell who had the disease and who were family members or volunteers. They were all in this moving artistic experience together—on a level playing field.

Both my parents had Alzheimer's and they both loved music. My mother accompanied herself on the piano while singing and my father was a pianist. They would have loved this chorus experience under the guidance of a professional music director. As a weekly activity throughout the year, the chorus has created a solid community of persons who feel a special bond toward each other. Rehearsals are an amazing shared weekly highlight for the person living with Alzheimer's as well as the family member and volunteer. People feel a unique solidarity as they experience their capacity to sing under professional music guidance, learn new parts, and learn new music. As a physician, I believe this experience helps to maintain cognitive functions and stimulates the brain and well-being at the same time. **MM**

Barbara Greene, MPH is a health care consultant on issues of aging and community engagement. She is an officer of the board of directors for the Giving Voice Initiative.

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EDITOR'S NOTE

GOOD PRACTICE is a regular feature in *Minnesota Medicine*. If your practice—large or small—is doing something innovative, unusual or particularly effective, please share it with our readers. Contact Linda Picone, editor of *Minnesota Medicine*, at 612-362-3758 or lpicone@mnmed.org with your ideas.

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Minnesota Medical Association

Aging out

While the number of seniors rises nationwide, the number of geriatricians is falling. Why is that happening? And what can be done?

BY ANDY STEINER

It's best to lay it out at the beginning. There's no way to discuss the state of geriatric medicine without talking about the numbers.

The numbers are stark—and the best way to give a sense of the problem that lies ahead. All the experts agree: As millions of Baby Boomers reach retirement age, the number of physicians trained to address their unique medical concerns is shrinking; Minnesota—along with the rest of the United States—faces a looming healthcare crisis.

Talk to James Pacala, MD, MS, professor and head of the Department of Family Medicine and Community Health at the University of Minnesota and author of *Geriatrics At Your Fingertips*, for instance, and listen as the numbers spill out of his mouth.

"Right now, there are somewhere between 40 to 45 million Americans over the age of 65," he says. "In 30 years, that number will double. By 2050, there will be over 80 million Americans over age 65."

The numbers in Minnesota are similar to the rest of the nation, Pacala says. Right now, about 14 percent of the population, or some 700,000 Minnesotans, are over 65. Demographers think that number will almost double to 1.3 million, or 21 percent of the population, by 2035.

As they age, that large population of seniors will increasingly need medical care geared toward their complex medical needs. But the numbers just don't add up.

"In the state of Minnesota, there are 15,000 physicians. As of a couple of years ago, only 153 of those physicians were certified in geriatrics," Pacala says. "There are about 75,000 nurses in the state. About 3,700 are nurse practitioners. Out of those, just 9 percent are certified in geriatrics. That's the kind of numbers we're looking at today."

The workforce numbers aren't any better nationwide, Pacala adds: "Nationally there are about 7,000 geriatricians in a workforce of 830,000 doctors." Despite the looming senior population that the nation has known about for decades, he says, "In my lifetime, the numbers of geriatricians has remained flat."

Even more concerning is the fact that the numbers of practicing geriatricians are actually shrinking.

George Schoephoerster, MD, a geriatrician at CentraCare Clinic in St. Cloud, explains it this way:

"Every year, more geriatricians retire than graduate from fellowship programs," he says. "You can't get around this reality."

The problem is way too big for an obvious or quick fix. Edward Ratner, MD, associate professor of medicine at the University of Minnesota Medical School and associate director for educational evaluation and geriatric research and education at the Minneapolis VA Hospital, says that it is impossible to train enough physicians to care for the elderly living in America now, never mind the millions to come.

"There are just way too many already," Ratner says. "Even if you started training people now you could never catch up. The problem we're facing is at that level already. We don't really have a pipeline to create the faculty needed to train the doctors. There are so few people going into advanced geriatrics training that we aren't going to have enough people teach other people."

Aging isn't sexy

So why are there so few geriatric physicians in the United States?

The reasons for this shortage are varied, Pacala says, but can be summed up in three basic points.

Money. "The pay for geriatricians is toward the bottom of the pay scale," he says.

Glamour—or lack of it. Unlike cardiology or surgery, geriatrics is not viewed as a glamour position: "There aren't TV shows out there about geriatricians. It doesn't sound very romantic."

Attitudes about aging. "There is an erosion of attitudes toward older people the further along students get in their medical training," Pacala says. "Some role models and teachers in med school even say things to students like, 'You are too smart to go into geriatrics. Who wants to go into a profession where everybody dies and no one gets better?'"

It doesn't help that most medical schools offer their students very little time to interact with elderly patients, Pacala adds, and that the opportunities they are given are often overshadowed by acute illness and death.

"These patients are sicker, more complex than most. They take longer to care for. They are harder to care for, and so physicians in training get the impression that's all there is in geriatric care." It would help if medical students were given a chance to see older patients in a variety of settings, and in a variety of conditions.

"You have to look at the curriculum and what it does to students and residents," Pacala says. "It's important for students and residents to see old people who are doing just fine. Right now, the only ones they see are the ones who are sick."

The reason for this limited exposure to geriatric medicine may have to do with the fact that many medical schools still operate with a curriculum based on 1940s and '50s models, where today's demographics were flipped on their heads—with more babies being born, thus dwarfing the elderly population. "We haven't adapted since then," Ratner says

Today, he explains, medical students in their pre-clinical years usually are required to complete four afternoons focused on geriatrics and long-term care. "That's a total in terms of homework and clinical experience of 24 hours. To put that in context, obstetrics has 160 hours of rotation in the third year and pediatrics has six weeks or 240 hours."

Less is more:

*All fields of medicine are complex, but, when practiced right, **geriatric medicine may be the field that involves the most complex thinking and problem-solving.***

As a person ages, the number of medical concerns usually grows, and each of those concerns involves some kind of intervention.

While the media has plenty of accounts of 100-year-olds who play tennis and take nothing but Tylenol for their aches and pains, the reality is that most older adults live with multiple chronic conditions, says Schoephoerster.

"I might have a patient with 20 different problems on their list," he says. "That might mean they are on a number of medicines. Sometimes I have patients who take as many as 30 different medicines. Each individual I see is complicated and complex."

Older patients are harder to care for, says Pacala, and this makes their care more complex. Physicians who specialize in geriatric medicine need to take a particularly careful approach with their patient population, who tend to metabolize medicine differently than younger patients and take longer to bounce back from illness. The best geriatricians are skilled multitaskers who are carefully observe their patients for symptoms and interactions.

"You can't make mistakes in frail older people," he says. "You can make all kinds of mistakes in kids and they'll get better. Middle-aged people usually have a single problem, so a physician only has to focus on one thing at a time. It's never that easy with older adults."

To make sure that the care they provide to their older patients will be effective, geriatricians need to slow down, ask questions, and patiently listen for answers.

"Geriatric medicine is very person-centered," Leppin says. "It takes into consideration all of the social and psychological determinates that contribute to aging. A geriatric medicine physician has to provide whole-person care, which should be

The right stuff

Caring for old people may not be glamorous, but it's also not for the faint of heart. Pacala, who has focused his career on geriatric care, admits decades later that his decision to enter the field felt at first like a kind of personal dare.

"I got into it as a challenge to myself," he says. "When I was young, old people freaked me out. I was scared of them. I was frightened of nursing homes. They made me uncomfortable."

Instead of running away from his fear, Pacala decided to face it: "I thought, 'I'm going to turn this around and I'm going to go toward it and embrace it and take it on and overcome it."

He's happy now that he took the challenge, because it turned out that he is well suited to geriatric care. "My career has been extremely rewarding," he says. "When I see a complex old person, I am 100 percent comfortable with what's going on and I enjoy it and enjoy the challenge. I enjoy working with old people and with their families."

Geriatric medicine requires patience, complex thinking and problem-solving. That approach takes time, and the physicians best suited to this specialty are willing to slow down and listen to patients, addressing their sometimes-complex concerns sequentially, Schoephoerster cautions.

"I think that is one of the things my patients notice is I'm never trying to get them out the door. I've always enjoyed my time with them, and I'm willing to take the time required to solve their problems."

Some people like to divide medical specialties into two categories: caring and curing, Schoephoerster says. "With curing specialties like surgery and anesthesia, you get to help your patients and then you get to leave. With caring specialties, you have to stick around. Geriatrics is most definitely a caring specialty."

Treating older patients, especially the most vulnerable, also often requires intense interaction with their family members. Though many assume that it may be easier to work with younger family members than it is with the elderly patients themselves, geriatricians often have a special bond with their patients and a

What physicians need to know about older patients

standard at all ages of life, but is especially important with older adults."

It's also important when working with elderly patients for physicians to shift their attitudes about what constitutes quality medical care. It's not always about looking for miracle cures or medical breakthroughs: It's often about understanding each patient's goals and helping them live a comfortable life.

This can feel like a major perspective switch for healthcare professionals trained to save lives at all costs.

"In this work I often have to have to ask myself, 'What are you really trying to accomplish here?'" Schoephoerster said. "I do full-time nursing-home work, where the average lifespan of my patients is two and half years. If my patients have two-and-a-half years left of their lives, how does that change what I am doing with my treatments?"

In many ways, that reality check frees physicians like Schoephoerster to focus on what truly matters in a person's life. Many of the old rules can get tossed out the window in favor of a focus on finding joy in life.

"When a patient gets dementia, I usually say, 'Forget about the low-salt, low-calorie, low-cholesterol diet.' The problem suddenly becomes getting enough calories and finding enough happiness. I almost always put my elderly patients on an 'eat all you can eat' or an 'eat what you love' diet. For many older people, it's a welcome change."

This approach to care doesn't have to feel like giving up, Chebli adds. It could actually feel like a radically loving approach to care.

"We are in an era where we think everybody should live forever," he says. "I'm all for living a long life, but in the end, what kind of life, what quality of life do you actually want? That may include not treating certain conditions because it does not benefit the patient. It may be doing less."

Maybe doing less is a misnomer, because taking this approach to medicine requires a different kind of work, at a level that is no less intense but actually much more involved.

"Geriatrics involves working with families and patients at a highly vulnerable stage of their lives," Pacala says. When care is handled correctly, and the complex pieces that make up an older person's health are aligned, he adds, "You are truly helping them improve their quality of life, affording them more time, maximizing their functioning and paying attention to their overall goals."

unique understanding of their needs that their own family members may lack.

"When you get into nursing home care like I have, you sometimes spend more time with the family than with the person," Schoephoerster says. "Sometimes I don't like the family all that much, but I always like my geriatric patients. The last 10 years that I've spent treating them have been the best 10 years of my medical career."

Not every physician has an innate gift for working with elderly patients, says Yasser Chebli, MD, a geriatrician with Fairview Health Systems who and serves on the board of the Minnesota Association of Geriatrics Inspired Clinicians (MAGIC).

"I really enjoy being around older adults and being able to help them," says Chebli. "I'm from Lebanon—It's part of my culture to respect the elderly. I have a passion to do this job well, and I find the work highly rewarding."

Makeover needed

A public relations professional might say that geriatric medicine has an image problem. If we live in a society that glamorizes youth and makes admitting aging seem like a failure rather than a natural part of life, it should come as no surprise that there is a shortage of medical students interested in focusing on the treatment of the elderly.

Pacala says that that disinterest—or, more honestly, avoidance—of the inevitable reality of age is reflected in the number of unfilled geriatric medicine fellowships nationwide. "There are currently about 350 fellowship positions available in geriatric medicine," he says. "Only about 235 of those are filled. There are simply not enough med students applying for these positions."

What can be done to make geriatrics more appealing to medical students? There are a number of options, Pacala says: "First of all, you could try paying us more. That always helps. Some states have looked at loan forgiveness or some other type of incentive for people who have chosen those careers."

Another, decidedly more complicated, strategy involves a makeover of sorts, he adds. "We need to rethink the values our society glorifies when we talk about medicine: In good old *Mpls/St. Paul* magazine, for instance, a recent cover said, 'The Doctor Will Save You Now.' In the article, they featured doctors doing exotic, lifesaving procedures that are miraculous—but only impact a small percentage of the population. In the meantime, we have a lot of seniors out there with multiple chronic conditions and not all that many physicians interested in caring for them."

In some ways this shortage feels curious to Joseph E. Gaugler, PhD, the Robert L. Kane-endowed chair in Long-Term Care and Aging and professor in the Division of Health Policy and Management at the University Of Minnesota School of Public Health.

In the United States, people over 65 represent a powerful block of influence, he says. As a group, they have been able to use their sheer numbers and combined to advocate for renewed focus on important issues that directly impact their lives, including a recent increase in research on Alzheimer's disease and dementia.

"I would say much of that change is due to the effective advocacy of families of people with memory loss across the U.S.," Gaugler says. "With so many people behind that effort, the issue has gained bipartisan support in Washington. Unfortunately, we haven't yet seen anything similar in geriatrics and long-term care."

How can that change? Aaron Leppin, MD, assistant professor of health services research at the Mayo Clinic and a Health and Aging Policy fellow with the Minnesota Board on Aging, says that geriatric medicine needs to organize itself around a strong voice that can clarify the needs of a generation and advocate for its long-term care.

"Somebody needs to be the leader," Leppin says. "Geriatricians can speak to the medical community in an important way about the realities of what it is like to be an older person in the country. They can talk about what's lacking and, hopefully ,rally the supports that we need."

Maybe this new army of older people should take its cues from other distinct communities that have made noise and demanded change.

"In order for this movement to be successful, older people and their family members are going to need to demand better geriatric care," Gaugler says. If this group stays silent, even though it is large, it will be easier to ignore. Society does that at its own peril: "Look at what we've seen in the disability community, where people who were silent for generations rose up and demanded better care." Change happened there, largely in the form of the powerful Americans with Disabilities Act. Something similarly powerful could happen for seniors. **MM**

Andy Steiner is a Twin Cities freelance writer.

NO EXPIRATION DATE

AGING DOESN'T HAVE TO MEAN A LOSS OF SEXUAL INTEREST OR ABILITY

BY JUNE LA VALLEUR, MD

Several years ago, I was delivering a lecture on "Sexuality and Aging" to first-year medical students at the University of Minnesota. At the beginning of the lecture, I said, "I am not going to ask you to think about your parents being sexual human beings." I could sense a collective sigh of relief. "Instead, I want you to think about your *grandparents* being sexual human beings." A young woman in the second or third row said, with a look of incredulity, "I don't want to go there!"

I told them that if they couldn't bear to think about their grandparents' sexuality, to think about their grandparents' friends instead. No matter what specialty they choose, with the exception of pediatrics and pathology, they would be seeing aging and elderly people who are sexually active.

Human sexuality is not taught in many medical schools and if it is, it is addressed in as few as three to 10 hours over four years of medical school training. We are fortunate here in Minnesota; the University of Minnesota Medical School offers an entire course on Sexual Health (although the hours have been cut in the past few years).

Because physicians are not trained in this vital human function, they often do not address the topic with their patients. Physicians may not ask questions about sexual health because, they say, it takes too much time, there's little or no reimbursement, they and/or the patient is uncomfortable with the topic, sexual health and activity is not a high

priority and there are limited available therapies. Lawrence Siegel of the Sage Institute for Family Development in Florida says a doctor's silence about sexuality can send older adults the message that it is not something they want to discuss. I call this phenomenon "implicit ageism."

We have known for decades that many people continue to be sexually active throughout their lifespan. The National Commission on Aging has reported that the majority of people over 70 found that their sex lives were more physically and emotionally satisfying than in the past. In this year's National Poll on Healthy Aging, which included both men and women ages 65 to 80, 54 percent said they still "do it," 61 percent said that healthy sex matters for quality of life and 73 percent stated they were satisfied with their sexual lives. Not surprisingly, those in good health were more apt to be sexually active and satisfied.

Sexual health concerns

Data suggests that a significant number of women seen in their family physicians' offices have sexual health concerns. A survey in 2000 showed that 99 percent have more than one sexual concern, 87 percent have decreased interest, 83 percent have difficulty attaining orgasm, 72 percent have dyspareunia (pain during sex), 67 percent have unmet sexual needs and 63 percent need information about sexual issues.

A more recent survey in 2016 of 746 women ages 50-89 showed that sexual dysfunction was highly prevalent. Eighty-seven percent had low libido, 92 percent had difficulty with arousal, 89 percent had difficulty with lubrication, 87 percent had difficulty achieving orgasm, 80 percent had poor satisfaction and 90 percent had pain with sex.

In the United States, 1.4 to 3.8 million GLBTQ people over 65 years of age have an even more difficult time. They have had a lifetime of stressors as a sexual minority. Services and Advocates for LGBT Elders (SAGE) reports that 22 percent of LGBT people are reluctant to reveal their sexual identity. Forty-three to 82 percent report mistreatment at some point in their lives. The National Resource Center on LGBT Aging reported in 2013 that 75 percent of LGBT people live alone, as compared to 33 percent of the heterosexual population, and 90 percent have no children, as compared to 20 percent of heterosexual people, thereby experiencing more isolation. They suggest a relevant question would be, "Who are the important people in your life?"

As compassionate, caring physicians, we need to learn—and practice—techniques for discussing issues of sexuality and sexual function with older patients and we need to know the appropriate therapies for managing sexual dysfunctions that may occur with aging.

Asking the patient, "Are you sexually active?" is not particularly effective. I actually had a patient pause for a moment and say, "No, I just lie there." A more appropriate question would be, "Are you in a sexual relationship?" If the answer is yes, you might say "Many women/men your age can start to have sexual difficulties. Has this happened to you?" Or, "Do you or your partner have any sexual health concerns?" and if so, "Tell me about them." These questions can be included in your "review of systems" (ROS) and follow the general gyn/urology ROS questions. Use the same tone of voice expressing the same concern as you would for any other area. If it becomes clear that more time is needed, suggest to the patient you can see how important this is to them and ask them to schedule another appointment. How can we call ourselves holistic physicians if we ignore this important area of human health?

The PLISSIT model may be helpful:

Permission. Bringing up the topic of sexuality gives patients permission to ask about any sexual questions they may have.

Limited Information. Offering information—but not too much—about support groups, useful websites, other readings, etc. is helpful. I strongly recommend online articles from the North American Menopause Society (NAMS).

Specific Suggestions: Specific suggestions may include the management of vulvar and vaginal atrophy (VVA), a component of genitourinary syndrome of menopause (GSM).

Intensive Therapy. You can refer patients for therapy for any issue with which you aren't comfortable or don't have the time or expertise to handle yourself.

Normal aging

There are normal changes in the body that occur with aging, and that can affect sexual interest and sexual activity.

Women may experience symptoms of menopause, which can include hot flashes, night sweats, VVA/GSM. Premenopausal women have a moist, pink, healthy appearing vagina that has three layers of cells: superficial, intermediate and basal, with a pH from 3.5 to 4.5. As they age and in the absence of therapy, women lose the superficial and intermediate cells and the pH rises significantly, to 4.5-7.5. A simple (and billable) test can give good information about vaginal health. Other changes of menopause can include a small weight gain, loss of skin turgor, hair loss on the scalp, legs, axillae and vulva, with increased facial hair. Orgasms may be less intense. These body changes can alter a woman's sexual self-image.

Another issue for women can be loss of libido—although some women experience an increase. There can be many etiologies for this problem. Stress, relationship issues or changes in hormones. Although some women seek testosterone to improve their libido, testosterone is very loosely associated with libido in women. I have had patients with high circulating total and free testosterone and no libido and vice-versa. There is currently no available systemic testosterone approved by the FDA for women, with the exception of prasterone (Intrarosa), a vaginal insert, for postmenopausal sexual pain.

Similar body changes may occur in men: weight gain, loss of scalp hair, decreased turgor of skin and enlargement of the prostate, with or without cancer. The force of ejaculation diminishes. Common changes in sexual function may include difficulty attaining or maintaining an erection (erectile dysfunction or ED), which

IN A 2017 ARTICLE, *HARVARD HEALTH* OUTLINED

A FEW MYTHS ABOUT SEXUALITY AND AGING

MYTH 1: *Only the young are sexually attractive.*

REALITY: *Being older can be quite sexual.* We often discover the largest sex organ in the body, the skin. While it may be wrinkled, it is still very sensual.

MYTH 2: *Sex later in life is undignified* (we tend to desexualize older adults).

REALITY: *It is healthy for older adults to express their sexuality.* Some of the health benefits can be decreased risk for prostate cancer, lower blood pressure, improved bladder control for women, decreased pain, increased sleep—and it's great exercise.

MYTH 3: *Men and women lose their ability to perform sexually after a certain age.*

REALITY: *Older folks can have satisfying sexual lives and experience sexual activity in new rich styles.* Although it may take longer, that can be a good thing. Maturity can bring the ability to refocus—not giving up on orgasm but enjoying the process more.

MYTH 4: *Sex is boring when one is older.*

REALITY: *Sex is as good as you make it!*

may lead to loss of interest/desire, which can lead to significant relationship issues. More foreplay, including more genital touching, is often necessary for a man to get and keep an erection. There may be a change in how an orgasm is experienced and there is an increased refractory period (time between orgasm/ejaculation until another erection can occur). Today, there are a number of PDE-5 inhibitors available to manage ED. Other modalities include a vacuum pump, injections directly into the penis, a penile suppository or surgery to insert an inflatable pump. For primary care physicians, it is important to determine the cause of the ED and be able to refer the patient to a urologist for management as well as to a sexual health counselor or therapist.

As we age, the incidence of many diseases increases, including any cancer, diabetes, heart disease, incontinence, arthritis, dementia, depression, Parkinson's and other conditions that can add to sexual dysfunction. In addition, many of the treatments and medications we use to manage these conditions also may affect sexual function.

When these kind of normal or disease-related changes occur, in the absence of the Big C—communication, not climax—an intimate relationship often suffers.

Desire discrepancy, defined as the difference between desired frequency of sexual intercourse or activity and the frequency that actually occurs in the relationship, causes problems in many relationships, regardless of age. This discrepancy actually diminishes with aging. It may be caused by relationship difficulties, pain, illness, medications, surgery etc. and can often be difficult to treat. Couples in which one or both partners are dissatisfied with the frequency of sexual activity may benefit from counseling.

Our aging patients want, need and deserve the right to be thought of as sexual human beings. Some may choose not to be sexual—as is their right. But as physicians, we need to be able to bring up the topic, ask appropriate questions, educate the patient to the best of our ability, manage what we can and refer the patient to trusted colleagues for appropriate management of any sexual dysfunction they may have.

Sexual health is more than the absence of disease; it's having joy and fulfillment. **MM**

June La Valleur, MD, is an OB/GYN and AASECT-certified sexual health counselor. She retired from the faculty of the University of Minnesota Medical School and is now in practice at Minnesota Personalized Medicine in Minneapolis.

Generation gaps

Why patients may want different things from life—and their physicians

BY KEVYN BURGER

Jennifer Krzmarzick, MD, understands the nuances of the health care expectations of young adults. As director of primary care at Boynton Health at the University of Minnesota, most of the 58-year-old physician's practice is devoted to patients in their late teens through their mid-20s.

So Krzmarzick is no longer surprised when an undergraduate she's seeing in clinic calls their mother in the middle of the appointment. "They pass the phone to me to explain what we're doing," Krzmarzick says. "It adds time to the visit to include another person, but they have such close relationships with their parents, they like them involved in their care. Generationally, that's very different than I was when I was in college."

Technology enables the phone connection, but there's another theory to explain the close ties between today's young adults and their parents—the characteristics common to an age cohort.

"Few doctors learn about this, but if they understood what drives these generational differences, it could make their job so much easier," says Ann Fishman, president of Generational Targeted Marketing, who has researched age cohorts for two decades and advised the American College of Cardiology on her findings.

Demographers note that millennials (born between 1980 and 1995) and their younger siblings known as Gen Z (birth years 1996-2010) came of age in the post 9/11 era, when the threat of global terrorism and school violence engendered a protective approach in

Generations cheat sheet

Generational consultants are doing brisk business around the country, slicing the demographic to offer insight and advice on consumers from different age cohorts and helping businesses integrate five generations into a dynamic workforce.

Minnesota Medicine asked four top generational consultants for their suggestions for physicians to help them improve interactions with each group, from youngest to oldest. Their suggestions may help explain why some patients will likely challenge whatever the physician says, while others simply accept their advice without question.

THE EXPERTS:

ANN FISHMAN, president and founder, Generation Targeted Marketing, author of *Marketing to the Millennial Woman*.

HILLARY PLANK, senior health and wellness strategist for global consumer advisory firm Gartner.

AUSTYN RASK, research analyst and consultant, Bridgeworks.

JOHN ZOGBY, national pollster, demographic analyst and author of *First Globals: Understanding, Managing, and Unleashing the Potential of Our Millennial Generation*.

NEXT PAGE

GENERATIONS CHEAT SHEET

GEN Z

Born between 1996 and 2010, the oldest of the 61 million Gen Zs are entering adulthood and the workforce. They grew up in the most recent Great Recession and experienced their first school lockdown drills in kindergarten. Obama is the first president they remember. Social media savants, they don't recall a time before they could do everything on a mobile device.

HILLARY PLANK: There are rising rates of depression and anxiety among Gen Z. As young people, they carry a heavier financial burden and they are well aware that their stress levels take a toll; for them, it's just as important to maintain their mental health as their physical health. They love using technology, wearables and apps to track what's going on in their bodies.

ANN FISHMAN: They're a generation of worriers. They seek peace and quiet, they don't like chaos. They're not as volatile as millennials; they want to be good citizens. They are visual communicators and learn with videos and infographics. They have close relationships with their grandparents as well as their parents and may want them involved in their health care

JOHN ZOGBY: This generation is not hierarchical; they don't automatically trust someone with a title. You have to show them. They have a short attention span but are knowledgeable, empowered and curious. They will reference a YouTube video on an experimental treatment or ask about new medical technology in Korea.

TIP: *GenZs use their phones for everything—except talking. They only chat with a small circle of intimates and won't pick up for anyone else. Many don't care to or know how to retrieve voicemail messages, so don't count on them hearing voicemail messages from your office. Texting is the coin of the Gen Z realm.*

their moms and dads that in its most extreme form became known as helicopter parenting.

"They grew up with close relationships with teachers and coaches, too," says Austyn Rask, analyst at Wayzata-based Bridgeworks, a generational consulting firm that has worked with health insurance companies and professional associations representing dentists, nurses and anesthesiologists. "In the self-esteem movement, adults told them to speak their mind, state their opinion. So they expect a two-way conversation; they don't see authority or power as a barrier."

Today's physicians treat five generations of patients, each arriving with a distinct blend of attitudes, values, habits and behaviors.

The theory of generational difference posits that influential current events and cultural forces present in childhood shape each group of young people as they come of age. That gives them a shared generational framework for viewing the world.

"They carry these values for the rest of their life and that creates genuine, radical differences that we can document," says national pollster John Zogby, who has surveyed young adults for decades. "Each age cohort makes decisions in their own way. Look at how Pearl Harbor turned teenagers into the Greatest Generation; with so many in the military, they came of age with deep respect for hierarchy and titles, 'the doctor knows best.' Their kids, the baby boomers, challenged authority and were the first empowered generation."

As they're aging, the baby boomers (now between the ages of 54 and 72) are taking up an ever-greater share of the health care system's resources. Researchers who analyze the behavior of this gigantic demographic say those in this generation don't like to acknowledge that they are aging, which can be a drawback for physicians who are trying to level with them.

"Boomers maintain an aspirational mindset; they see themselves as relevant, engaged, still full of possibilities," says Hillary Plank, a consumer strategist at Gartner who advises Fortune 500 companies on health and wellness trends. "Even after a new diagnosis, they want to leave the clinic saying, 'I can make changes and still be me, still live a wonderful life.'"

Because those in this generation don't see themselves as old, Plank advises hospitals and insurance companies that are targeting Boomers to steer clear of pictures of people with canes and white hair in their brochures, websites or marketing materials.

St. Paul colon and rectal surgeon Judith Trudel, MD, has found a way to curate her language to encourage Boomer patients to schedule their next procedure. "People in their 60s ask me if they need to come back for another colonos-

copy and I say, 'Yes, you're still so young.' They like that," says Trudel, who is 61. "I remind them that at this age, they are significantly healthier than their parents and grandparents were, that they have so much more ahead of them as current life expectancy is close to 80 years old."

Hospitals market directly to young adults in hopes that a positive experience when they deliver a baby or visit an emergency room will convert them into loyal patients for a lifetime.

St. Francis Regional Medical Center in Shakopee draws from the state's two fastest growing counties, Scott and Carver, and identifies 33 as the median age of its patients.

The hospital has stepped up its efforts to serve millennials by studying their habits and responding to their preferences. According to Michael Morris, director of business development, last year St. Francis became Minnesota's first hospital to facilitate advanced online check-in for its emergency room and urgent care locations. ER wait times are also listed in real time on its website to better cater to these digitally-savvy patients.

"Today, we can go online and get what we want at our door in an hour. That's the expectation for healthcare as well; that it's simple, predictable and convenient," Morris says. "Our patients want a smooth, customized care experience and it's important that we evolve to meet that expectation. The reality is that there are new and innovative solutions and care models being introduced to the healthcare market all the time, and we need to keep pace."

"Millennials do not follow the traditional patient-physician relationship as we've always seen it," he says. "They make use of online reviews and do more research. When they come in they may have self-diagnosed and talk to the physicians in an informed way. That can create a fine line for physicians: they respect the fact that patients have done the research but *they* are the voice of experience."

Over the past four years, Joshua Jauregui, MD, assistant professor and associate director of the medical education research fellowship in the department of Emergency Medicine at the University of Washington, has been invited to deliver a faculty development seminar on generational theories at several academic health centers. His focus is not on millennial patients, but rather on the youngest generation of physicians.

"I come at it from medical education perspective," Jauregui says. "I wanted to use the generational lens to provide some actionable things for educators to better reach these learners."

Jauregui, who is 35, urges mid-career physicians to adopt what he calls "generational humility" when approaching their millennial colleagues, remembering the stereotypes they faced when they entered the profession.

GENERATIONS CHEAT SHEET

MILLENNIALS

Born between 1980 and 1995, there are 82 million millennials, making them the largest living generation. Columbine, 9/11 and child kidnappings made their parents overprotective. Coming of age with technology, they expect constant feedback and connectivity and are adept at multi-tasking and collaborating.

HILLARY PLANK: They expect more diversity and are accustomed to seeing women in jobs of authority. As consumers, taking care of their health means mindfulness, meditation, cleanses and supplements, as well as diet and exercise. They look at a doctor as just one input on their health map. They turn to the internet first and crowd-source every symptom.

ANN FISHMAN: They have an almost compulsive need to share with their social media circle. From your waiting room, they'll tweet, pin or post if they're kept waiting. One interaction with a millennial could mean many more impressions; they can be your PR person or they can trash you.

Millennial women are first generation to truly get all the benefits of Title IX. They've played sports all their lives and are strong and athletic, participants not spectators. Doctors who don't understand that miss a clue to half of their millennial patients.

JOHN ZOGBY: Millenials are not as frightened by scary sounding diseases. When I was growing up, cancer was a death message but they don't regard it that way. They've grown up seeing recovery, new treatments, cures.

TIP: *Make sure your practice has a clean, easy-to-navigate website; millennials will check you out online. Review and streamline paperwork required before an appointment; with their short attention spans, long forms look like time-wasters. And ask about insurance information at the end. They want to know you care before you ask about payment.*

GENERATIONS CHEAT SHEET

GEN X

Born between 1965 and 1979, this generation of 50 million came of age in the 24-hour news cycle, so they watched institutions fall apart—political scandals, the Challenger explosion, the dot-com bust. They were the first latchkey kids; the divorce rate doubled in their youth and more moms went to work. Their entry into the workplace was slowed by the sheer numbers of baby boomers; while Gen Xers wait for Boomers to retire so they can move up, millennials are arriving to crowd them from below.

ANN FISHMAN: They raised themselves and they're tough and cynical, a generation of survivors. No one has ever been there for them and they don't expect Social Security or Medicare to be around after the baby boomers, so they take great care of themselves. They're practical—they will go to physical therapy, learn the exercises and then do them at home.

AUSTYN RASK: Gen Xers want to get straight to the point, no sugar coating. They've moved into being the decision-makers for aging parents and grandparents and they're raising kids too, so they're juggling a lot. They want to get in and get out of the doctor's office. They appreciate efficiency and the use of technology to save time.

HILLARY PLANK: Crossing into their 40s and 50s, their bodies are changing. They are busy with caregiving and don't have enough time, energy or money to devote to themselves. They entered middle age as there were breakthroughs about keeping the brain sharp and they're very interested in preserving their minds as well as their bodies.

TIP: *Gen Xers will deeply appreciate it if you take an extra moment at the end of an appointment to ask if there's anything else they care to discuss. Millennials and Boomers have always operated with a sense of entitlement and expect you to be interested in them. After a lifetime of being overlooked, Gen Xers will welcome and value the attention.*

"We grew up in an environment that taught us that a well-balanced life is important and we will be better physicians as a result," he says. "Don't assume these learners are lazy because they value time off and want paternity leave."

He adds: "As we grew up, communication became more fluid. People are accessible to us. I can email a department chair and there's no secretary to intercept me. I hear colleagues complain that young physicians are so casual, but it's not intended to be disrespectful, it's the way we learned to communicate."

At the University of Minnesota Medical School, students do not get specific training on generational differences. But Brian Muthyala, MD, MPH, assistant professor of medicine at the University of Minnesota, spots classic millennial traits and values in his 20-something students.

"The cost of medical school is very high and they want bang for their buck," Muthyala says. "They push faculty and expect excellence. I have to prove myself; having an MD behind my name isn't enough."

GENERATIONS CHEAT SHEET

BABY BOOMERS

Born between 1946 and 1964, the 80 million Boomers once comprised 40 percent of the U.S. population, giving them the demographic power to rewrite the norms of every life stage they've passed through. The children of the booming post-war era became change agents in the '70s and hard-charging yuppies in the '80s and they're still listening to rock 'n' roll as they fire up post-retirement encore careers

AUSTYN RASK: Baby Boomers had to be competitive and ambitious because there were so many of them. They value a strong work ethic and they want to see a doctor who is working hard and who is devoted to them.

They are optimistic by nature and will always want to know the bright side of any diagnosis.

ANN FISHMAN: They've always questioned authority, and that's meant questioning Western medicine. They're the Me Generation and they want everything tailored to them. It's part of their DNA that they want to be as young as they can; they want to live a long time but they don't want to be old. They're not going to like you if you talk too much about aging. Instead, tell them what they need to do to stay vital.

HILLARY PLANK: We conducted research that asked consumers how they felt about medical intervention that would prolong life but diminish its quality. We were surprised that so many Boomers would not go to great lengths to live longer if it meant diminished capacity. They want to maintain their independence;

"I'm teaching a course to first-year residents on how to conduct physical exams, and they let me know they want to work with a more diverse population," he says. "Their criticisms are valid. They don't want to hear, 'This is the way we've always done it.'"

Many health care providers seek to be more sensitive to racial, cultural and gender differences to better zero in on the needs of patients, but few have developed a working knowledge of generational differences.

Analysts who study patient engagement warn they're missing an opportunity.

"Providers are not communicators or marketers but if they understand their patients better, it will drive satisfaction," says Hillary Plank. "Amazon and CVS Health are getting into this world; they know a lot about consumers and they are going to use that data and insight." **MM**

Kevyn Burger is a Twin Cities freelance writer.

they don't want to be stuck in a chair for their final years. So many have been caregivers to long illnesses with their parents and they don't want to do that to their kids.

TIP: *Baby Boomers will respond well to health issues being framed around vitality. They want to live a long time but they don't want to be old; they still see themselves as young psychologically. They will be motivated to follow recommendations about what will help them remain vital or increase their vitality.*

GENERATIONS CHEAT SHEET

MATURES

(Also called the Silent Generation, Traditionalists)

Born 1900–1945. The oldest of this group, the Greatest Generation, are few in number now. They survived the Great Depression to win World War II. This generation has the highest percentage of men who served in the military. As a result, they and the younger part of the age cohort, who were children during the war, value a top-down leadership structure and think it's important to follow the rules. Growing up before safety nets were established, they're frugal and self-sufficient.

AUSTYN RASK: This generation maintains strong respect for authority and tradition; they seldom ask about alternative medicine treatments. They demonstrate great loyalty. They want to stick with the same doctor to the end.

JOHN ZOGBY: They grew up with the expectation that doctors know best. They listen to the doctor. To this generation, doctors are like priests or rabbis. If they don't have the answers, then nobody does.

ANN FISHMAN: They're formal and they understand and appreciate good manners. They want a doctor with credentials—what school did he go to, let's see that diploma. Physicians who are team doctors for a pro or college team or on faculty at the medical school would gain a certain amount of clout that these patients would appreciate.

TIP: *Generations don't live in a vacuum. When treating the oldest generation, you will also interact with their children, who will be directly involved in decision-making and may challenge you in ways their parent will not. This can require a generational balancing act; a Mature patient is unlikely to ask you what you think about Reiki, but their Baby Boomer caregiver might.*

Physician conflict

Managing emotions and expectations when you can't avoid a clash

BY UMESH SHARMA, MD, MBA, AND AMIT GHOSH, MD, FACP, FRCP

Background

The health care environment is an interesting field where many stakeholders, including physicians, nurses and non-clinical staff, interact on a continual basis to provide patient care. This environment is evolving as a result of challenges that include an increased demand for services, accompanied by pressure to increase value and reduce costs, and newer accountabilities. The complex interplay of these factors can create different priorities among stakeholders and may create an environment ripe for potential conflict.

Conflict is defined as a disagreement within oneself or between people that causes harm or has a potential to cause harm. The precursor to a conflict is a disagreement that causes an emotional impact on an individual, which then results in a reaction. This kind of disagreement typically starts when one person thinks that another person has or is about to have a negative influence on an issue the first person cares about deeply. Differences in ideas, perspectives, priorities, preferences, beliefs, values, goals and organizational structure can all contribute and accelerate the conflict.

Differences of opinion and the potential for resulting conflicts tend to appear on a regular basis in the typical workday of a physician, when providing quality health care has to be balanced with a focus on quantity and costs, or when a physician has to adapt to an evolving healthcare environment while managing his or her existing workload. There may be a difference of opinion with another clinician about management of patient care. These conflicts can have a tremendous impact on the individuals involved, those surrounding them and the existing work culture.

Typical course of a conflict

Conflict can start with a potential opposition or incompatibility, in which one or both parties realize they have a difference of opinion. This incompatibility can lead to frustration and, if unmanaged, conflict will occur. Conflict typically passes through three phases:

Thoughts and emotions. Unmanaged frustration progresses to cognition and conceptualization, where negative emotions, rationalization and assumptions about the other person's intentions are made. Emotions, especially negative emotions, can play a major role in creating stories and oversimplifying a situation.

Behavior or expression. This phase includes the range of actions taken in response to the conflict, including statements, actions and reactions.

The outcome. What happens as a result of the actions taken in response to the perceived conflict.

Depending on the nature of the disagreement and its outcome, a conflict can be categorized as functional (constructive) or dysfunctional (destructive). Functional conflicts are those in which a group is unified, a problem is solved and growth and productivity increase with an optimal, con-

Conflict-management styles

STYLE	SELF-INTEREST	OTHER PARTY'S INTEREST	USE
Competition	+ + +	- - -	Defending your rights or position that you believe is right
Collaboration	+ + +	+ + +	When issue is equally important for both parties
Compromise	+/-	+/-	To resolve an issue quickly
Accomodation	- - -	+ + +	When maintaining a long-term relationship with other party is important
Avoidance	- - -	- - -	Manage issues that are of minor consequence

structive outcome. A dysfunctional conflict results in a group being divided, problems remaining unsolved or increased and growth and productivity reduced, leading to suboptimal and unsatisfactory outcomes.

Most conflicts arise as a result of systems issues but, as people and emotions get involved, the nature and complexity of the conflict rapidly evolves. Timely diagnosis and root cause analysis is crucial in highlighting where and what kind of intervention is appropriate, as well as management of emotional conflicts at every level.

Managing conflict

There are five approaches to managing conflict: competition, collaboration, compromise, accommodation and avoidance.

Competition occurs when one person chooses to satisfy his or her own interest regardless of the impact or position of the other person. Very little cooperation is required. Competition is useful when resources are limited, outcomes are very important and a quick decision is needed, as in emergencies, or when the decision could be unpleasant. Competition may protect you against those who want to take advantage of a non-competitive behavior, but to be competitive, you usually have to be quite assertive, which may adversely affect short-term and long-term relationships with others.

Collaboration means that those involved work to find solutions to a high-value issue that fully satisfy the concerns of both. Successful collaboration is based on understanding each other's positions and interests, working together to gain insights, consensus and commitment. A creative solution found through collaboration may be better than what either party could come up with individually. Collaboration helps parties work through hard feelings that may have been negatively affecting their interpersonal relationship. But it can be very time-consuming and just may not work when both parties have limited capacity to communicate or have a history of not trusting each other.

Compromise occurs when both parties decide to find a quick, mutually acceptable solution that at least partly satisfies the interests of each. This can be useful when the issue needs to be resolved quickly or is not worth an extended effort. If those involved have mutually exclusive goals, compromise can leave them exchanging concessions and splitting the difference, creating suboptimal outcomes or only a temporary settlement of complex issues.

Accommodation is when one party to the conflict lets the other control any decisions for settlement of the conflict. You may accommodate another when you realize that you are wrong, when maintaining a long-term relationship with the opposite party is more important than your own short-term interest, when you want to build up social credit and demonstrate reasonableness and preserve harmony or when competition could damage your position.

Avoidance is choosing to not get engaged in the conflict. Avoidance does not resolve a conflict. Avoidance strategies include diplomatically sidestepping the issue, delaying involvement until a suitable time is identified or even denying the existence of conflict. This typically works if the issue is of very minor importance, expected to resolve by itself with time or has minimal chance to satisfy your concerns, or when the risks outweigh the benefits of resolving the conflict or it is better managed by someone else.

The first step in conflict management is managing your emotions. The second step is to make a genuine effort to reframe the conflict as an opportunity and then determine what kind of result you are looking for and what relationship you want to have with the other party. You need to exercise emotional intelligence to recognize, adapt and manage your own emotions and to recognize those of others involved in the conflict. Label—and then manage—your emotions before you address the conflict with others. For example: anger, although it can help the person in a more powerful situation, tends to hurt anyone in a less-powerful position. Anxious negotiators have lower expectations from negotiations and tend to exit the process sooner.

(continued on next page)

Examples of conflict management styles and situations

STYLE	EXAMPLE	APPROACH	STRATEGY ACHIEVED
Competition	A colleague refuses to follow a pre-established practice expectation, which is affecting other colleagues.	You confront the colleague and ask him or her to stop the sub-optimal behavior.	Achieve your interest at the cost of the interest of the colleague.
Collaboration	Determining how to manage patient flow when ED and hospitalists are busy.	Put together a workgroup made of ED and hospital medicine representatives to problem-solve.	Collaboration should achieve outcomes better than what each group might come up with on its own.
Compromise	Hospitalist staff requests locums to help manage open shifts.	You ask those in the group to pick up as many shifts as they can and hire locums to cover the rest.	Compromise and agree to the extra locums to help maintain the morale of the group and prevent staff burnout
Accommodation	Nurses want the hospitalist to use the telephone instead of pagers for communication.	You agree to do so without any negotiations.	Accommodating this request helps maintain the long-term working relationship.
Avoidance	The local management group wants you to work beyond your scope of practice.	You refer the group to the specialty council for discussion.	Avoid dealing with an issue that can be better handled by someone else.

Personality factors like agreeableness and extraversion are directly related to accommodation and indirectly related to competition. Men are more likely to be competitive; women are more likely to accommodate or even to avoid conflicts.

Psychologist Laura Rizkalla found that an effort to see other parties' perspective and emotional management, with a focus on empathy and forgiveness, was associated with greater conflict resolution. A cross-sectional study by T. Hendel *et al* of 75 physicians and 54 head nurses in five hospitals found that although compromise was used most often to solve conflicts, head nurses chose to collaborate significantly more than did physicians.

Types of bargaining

In his book, *The 7 Habits of Highly Effective People*, the author Stephen Covey posited that a window of opportunity exists between the cognition and behavioral response to a conflict. While in this "window," you can try to understand the other party's position and engage in empathic or active listening. It is crucial to focus on the problem and create a safe zone for the other party to express their position. Listing specific facts and the impact of the conflict helps create a platform for the other party to provide their perspective.

There are two approaches to negotiations: distributive and collaborative or integrative bargaining. Distributive bargaining assumes that the "pie" is fixed and each party involved has to compete for the better half of the pie. For example: How are holiday shifts shared among a group of hospitalists, if every member of the team wants the same holiday off each year? Some are going to "win" and get the holiday off; others will "lose" and have to work on the holiday. Each hospitalist will have to think about his or her resistance point and what the worst possible outcome might be. To find a solution, those involved are likely to compete (maybe those with seniority get the choice of holidays) or compromise (those who work the holiday this year won't have to next year).

Integrative bargaining assumes a win-win solution for both parties and encourages working collaboratively to create possible outcomes. Integrative bargaining requires both parties to be trusting, flexible, engaged and committed. For example: representatives from the emergency department and the hospital medicine department may work together to find the root cause of a conflict and come up with mutually acceptable tactics to manage those conflicts. Particularly within teams, integrative bargaining promotes better collaboration, idea-sharing, and understanding of the root cause of conflict.

Conclusion

Successful conflict-management is necessary for maintaining morale and long-term retention of employees—and it's a measure of a leader's success. It can lead to better understanding, collaboration and improvement of long-term relationships among stakeholders.

Collaboration and integrative negotiation may be the best approach for critical conflict. The ability to forgive, manage negative emotions, get perspective, collaborate and communicate are crucial to not only managing conflicts, but to avoiding them in the first place.

We recommend that communication skills, with emphasis on building emotional intelligence and conflict resolution, should be an essential part of medical school and residency curriculum or onboarding of new physicians to prepare physicians to manage the challenges of an evolving healthcare environment. **MM**

Umesh Sharma, MD, MBA, is chair of the Division of Community Hospital Medicine for the Mayo Clinic Health System; Amit Ghosh, MD, FACP, FRCP, is an internist at the Mayo Clinic and part of the Mayo Clinic Executive Health Program.

Factors that can cause conflict

Personal factors	• Age • Sex • Hierarchy • Self-esteem • Locus of control • Current emotional status • Personal ethics, values, bias
Psychological asset factors	• Hope, optimism • Resource depletion like exhaustion, stress, burnout • Perceived trust and integrity of other party • Competing priorities
Interpersonal factors	• Communication breakdown • Cohesion, trust and collaboration amongst members • Power differential and social distance • Incivility, use of aggressive tactics
Systems/ organization factors	• Multiple and unclear lines of authority • Unclear risk-reward incentive structure • Competing priorities, changes happening in organization • Constraints of resources like time, money, knowledge, skills • Existing organizational culture

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Minnesota Medical Association

Annual Conference Schedule

Thursday, September 20

6 – 8pm	Pre-Conference Reception

Friday, September 21

7 – 8am	Breakfast
7 – 7pm	Onsite conference check-in
7 – 7	Exhibit hall open
8 – 10	Welcome and opening session: Diagnosing Minnesota
10 – 10:30	Break time with exhibitors
10:30 – 11:45	Who Will Deliver the Next Generation? The Rural Maternity Care Dilemma
11:45 – 1pm	Lunch and networking with exhibitors
1 – 2:15	Lightning Learning: Community Health Explored
2:15 – 2:45	Break time with exhibitors
2:45 – 4:00	Small Towns, Big Problem: How Minnesota is Tackling the Opioid Crisis
4 – 4:30	Break time with exhibitors
4:30 – 5:30	It's a Wrap! Day 1 Summary
5:30 – 7	Student/Resident Poster Symposium/ Inaugural Reception
7 – 8:30	Dinners Around the Town

Saturday, September 22

7:30 – 8:30am	Breakfast
8:30 – 9:45	Open Issues Forum
10 – 11	Who Heals the Healer?
11 – 12pm	Transforming Patient Lives: The Art of Person-Centered Care
12pm	Adjourn
12:30	House of Delegates

Sessions

Diagnosing Minnesota

Speaker: Jan Malcolm

Where we live largely determines our options and influences our ability to stay healthy. Decades of study on the social determinants of health demonstrate the limitations of clinical care in creating health. Instead, a much larger set of economic, social and environmental forces and policies shape individual and community health. Join Health Commissioner Malcolm to examine the current state of Minnesota's health and explore how we can work together for change.

Who Will Deliver the Next Generation? The Rural Maternity Care Dilemma

Speaker: Katy Kozhimannil, PhD

How people give birth and are born is fundamentally important to health and well-being; however, the issue of maternity care access for families in rural Minnesota has grown in urgency and importance. This session will start with an overview of access to care challenges in Minnesota and move into discussions of potential policy changes that could improve maternity care for Minnesota women.

Lightning Learning: Community Health Explored

Health care organizations increasingly are recognizing the value of identifying and acting on social determinants of health, such as access to housing, transportation, healthy foods and employment support. In this fast-paced session, we'll feature several examples of innovative community partnerships that are working to deliver better health.

Small Towns, Big Problem: How Minnesota is Tackling the Opioid Crisis

Speakers: Heather Bell, MD; Kurt DeVine, MD; and Arti Prasad, MD, FACP

As part of the University of New Mexico's Project ECHO, CHI St. Gabriel's Health and Hennepin Healthcare are working to reduce opioid use and abuse through virtual clinics with community providers. Learn how the program began, the initial outcomes and how democratizing medical knowledge can help expand access to specialty care for patients throughout the state.

Sessions *(continued)*

It's a Wrap! Day 1 Summary

Facilitator: Douglas Wood, MD

Facilitated by MMA's new president, Douglas Wood, MD, this session will review what we've heard throughout the conference from the overall health of the state to partnerships and innovations at a local community level. Share your take-aways, hear how others plan to implement changes and discuss what we all can do differently to enhance the health of Minnesota.

Who Heals the Healer?

Speaker: Christine Sinsky, MD

The practice of medicine is getting tougher. The burdens of administrative rules, regulations and paperwork are decreasing job satisfaction, interfering with patient care and leading to the highest rate of burnout among U.S. physicians in history. These challenges affect not only the physician, but also the patient experience and quality of care. In this session, Sinsky will outline strategies you can pursue in your practice to reduce stress and improve satisfaction. Learn how to thrive in this continuously evolving environment by working smarter, not harder.

Transforming Patient Lives: The Art of Person-Centered Care

Speaker: Allison Massari

With her perceptive view inside the "patient experience," Massari's riveting and insightful keynote illuminates the immense value that physicians have upon a patient who is suffering. This dynamic and poignant program offers real solutions to the struggle of how to keep the patient first despite limited time and other practical constraints. By weaving her remarkable journey with potent life-lessons, Massari highlights the integral nature of patient-centered care and fortifies audience members, reigniting your passion for why you went into health care in the first place. She explains: "The power of what you do goes far beyond the technical part of your job. You are healing the places medicine cannot touch. In fact, you are the medicine." Massari's keynote offers a sincere and direct approach to navigating adversity, transcending life's difficulties and always finding a way to be the healer in the room. Massari's deeply moving story offers tools for managing change, adversity and the everyday challenges of being human.

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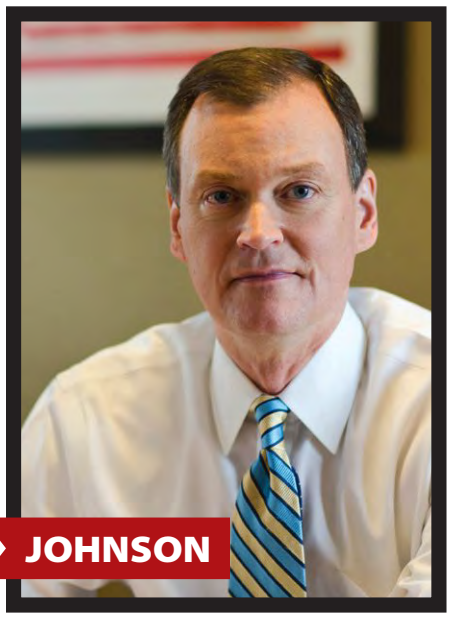
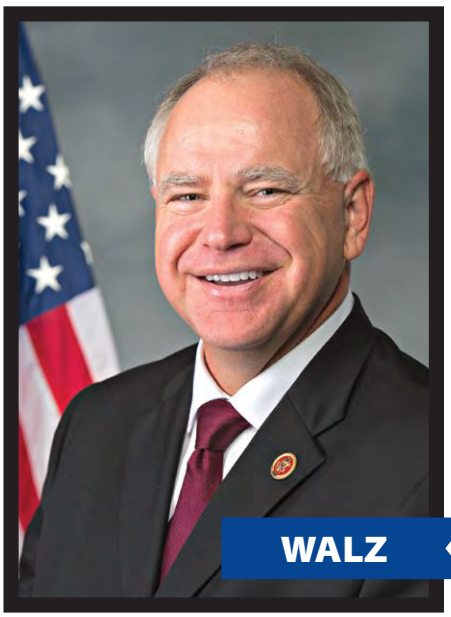




Health Care Q&A

Jeff Johnson and Tim Walz

Minnesota Medicine asked the state's two major gubernatorial candidates (Jeff Johnson-R, Tim Walz-DFL) to provide their views on three questions, so our readers could have a better sense of where they stand on important health care questions. Following are their written responses.

Q *Access to high-quality, affordable health care is one of the single biggest challenges facing both consumers and policy makers across the state. What do you see as the biggest challenges in ensuring all Minnesotans have access to affordable, high-quality health care? How would you propose to lower the cost of care while preserving quality and access for patients?*

Johnson The biggest challenge is a lack of competition. Insurers have managed health care delivery for 40 years and that approach has failed to contain cost. We will promote private-driven plans to finance care as an alternative to the traditional insurance model. We will also eliminate some coverage mandates to allow individuals limited coverage policy options if they believe that is best for them. We will make it easier for private groups to band together and create their own pool and work with neighboring states toward an Upper Midwest compact allowing our citizens to buy across state lines. We will also seek to reinstate Minnesota's high-risk pool to stabilize the individual market and provide for those with preexisting conditions.

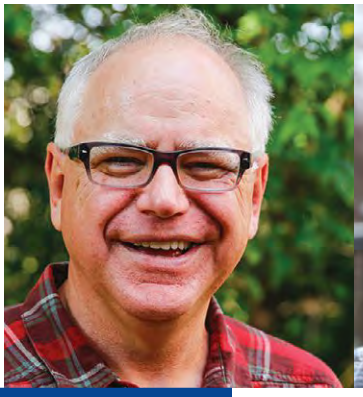
Walz Every Minnesotan has the right to high-quality, affordable health care, yet we face challenges in making this a reality. Too many Minnesotans struggle to afford coverage with increasing monthly costs on the individual market and in employer-based coverage—and still many lack coverage entirely with that need increasing. We see drug prices increase exponentially, provider and workforce shortages, and overall rising costs of care. All of these issues need to be a priority. The first stop will be for me to listen to you and other health care experts across Minnesota to craft new strategies and examine what's been tried here and across the country. To ensure coverage, we need to make sure that in regions where the private market is not providing meaningful products or affordable choices for families, that we have an affordable option. MinnesotaCare is a health care program that was created with bipartisan support back in 1992 and I support a buy-in as an opportunity to provide comprehensive benefits at a lower cost. Reimbursement for providers will be central to making this work and I hope to work with physicians to develop solutions to expand coverage. In expanding access, we also need a strong commitment to primary care. We must also take on the rising cost of care directly. Taking on the rapid increases in drug prices must be a top priority. Prescription drug costs have spiraled and essential medications are out of reach for many Minnesotans. As governor, I will look for ways to use the buying power of the state to negotiate better prices and bring those costs down. The Integrated Health Partnerships, a program working with health care providers to improve care, while lowering cost for Medicaid populations, is an example of success Minnesota has already had in this area.

Q *Minnesota has long been known as one of the healthiest states in the nation, though we've slipped in recent years. As governor, what will you do to return Minnesota to the top spot as the nation's healthiest state?*

Walz There are a number of reasons for why Minnesota has a long history of being one of the healthiest states in the na-

tion. Number one, our health care system has been rated as the best in the country; we have a wealth of talent, a world-class medical school and some of the best hospitals and systems in the world. As we look for ways to improve our health care system, we must protect these successes. Health care is only one of many factors that influence health. Social and economic determinants of health such as housing, job opportunity, transportation and environmental factors like clean air and water can have an even greater impact on creating and sustaining people's health. If we are going to improve our overall health, we must address those factors in all our policies. We see how these social factors affect health in the staggering racial and ethnic disparities in the health outcomes of our communities of color and indigenous communities. We need to do more to address the social factors that contribute to higher rates of infant mortality, asthma, diabetes, smoking, opioid addiction, and substance use disorder. Our investments in health must include an emphasis on prevention and a robust public health system. It will be a priority of my administration to make progress in addressing these disparities across state government. My administration will also invest in infrastructure that promotes health like investing in parks and space for exercise, promoting improved nutrition and addressing mental and behavioral health issues. I will also work to make sure that residents living in greater Minnesota have access to health care and ensure that we maintain and expand the health care infrastructure throughout Minnesota. We are only healthy as a state when all Minnesotans have the opportunity for optimal health.

Johnson There should be rewards for making healthy choices. Under the ACA (Affordable Care Act) and any law requiring community rating, there is a limit on any variance in rates dependent on lifestyle or health history. In addition, the insurance companies have to rate according to the highest risk meaning the healthy individual pays substantially more than necessary. We ought to let actuaries do their job and rate according to the actual risk of each individual.



WALZ

JOHNSON

Q A key strategic goal of the MMA is to make Minnesota the best state in the nation in which to practice medicine. Unfortunately, many hurdles stand between physicians and patients and all too often the patient's care can be compromised. From burdensome prior authorization requirements imposed by health plans and pharmacy benefit managers (PBMs) to state-mandated quality measures, physicians' time is routinely diverted from patient care. As governor, what will you do to make Minnesota the best state in the nation to practice medicine?

Johnson As governor, I will get out of the way. We need to give control of medical care back to patients and their doctors. I often hear from medical professionals that they spend a substantial amount of time on compliance paperwork rather than seeing patients. We need to re-evaluate regulations in health care to see what's absolutely necessary and what is not.

Walz: The doctor-patient relationship is at the core of effective, high-quality health care delivery. Providers are on the front line of health care delivery and they need to have decision-making authority to deliver medically appropriate, high-quality care. While doctors operate in a larger system of quality, cost and other goals, we must also recognize and value their expertise. Doctors need more time with patients and less time on the computer. Allowing providers to focus on care rather than "bottom-line" issues will allow providers to do what brought them into medicine in the first place and will improve health outcomes. Minnesota-sponsored health care programs, including Medical Assistance and MinnesotaCare, should provide reimbursement rates that reflect the value of the care received at a level that will sufficiently cover the cost of delivery of care. The pace of change and federal regulation in health care is rapid and it is leading to physician burnout. While regulation can create positive protections, it can also be an added burden to providers focusing on that patient relationship. We need alignment between state and federal regulations so that measures are meaningful and not overly burdensome. As governor, I will listen to providers to understand regulatory burdens—like prior authorization reforms sought by MMA—and look for ways to ensure all our work is focused on improved health and not unnecessary hurdles. The Walz-Flanagan administration will be committed to working together to find common sense solutions. In health care, this includes working with you—physicians—to improve our health care system and ensure world-class health care delivery where physicians are valued, the system operates efficiently and patients have the opportunity to achieve their optimal health.

News Briefs

MMA video provides update on state's medical cannabis program

In late August, the MMA premiered an educational video called "Cannabliss or Cannabust: Three Years of Medical Cannabis in Minnesota." The video provides an update on the implementation and use of the state's medical cannabis program with data

from the Minnesota Department of Health's Office of Medical Cannabis (OMC). The video includes Tom Arneson, MD, MMA member and OMC research director, answering questions from members about the program, discussing emerging medical cannabis research and sharing Minnesota patient experiences. The video is only available to MMA members. To view it, visit www.mnmed.org/advocacy/Key-Issues/Medical-Cannabis.

Provider tax: the risks and rewards of MMA leadership

Although the 2019 Legislature won't convene for another four months, Minnesota physicians and other health care providers should be paying attention now. Why? Because at the end of 2019, the 2 percent provider tax is scheduled to go away. That's the good news. But what will happen to the public programs it helps fund? The MMA believes that now is the time for Minnesota to update its approach to health care financing and move beyond the flawed provider tax—a tax that has generated passionate opposition and has splintered support for health care coverage for thousands of Minnesotans. CEO Janet Silversmith examines the issue in the latest edition of Insights (www.mnmed.org/news-and-publications/Insights-(1)/July-2018-(1)/A-New-Approach-to-the-Provider-Tax).

MMA celebrates 165 years

On July 23, the MMA turned 165. It was on that date in 1853 that John H. Murphy and 10 young physicians gathered at the new St. Paul courthouse for the first-ever statewide convention for the medical profession. This convention was the formation of the Minnesota Medical Society, now known as the MMA.

"As a physician, I'm incredibly proud to be part of an organization—one that is five years older than Minnesota statehood—that was founded to improve patient care, public health, and medical standards—goals that continue to drive our work," says George Schoephoerster, MD, the MMA's current president.

At more than 10,000 members today, the MMA is still going strong. The association will celebrate its 165th birthday at its Annual Conference on Sept. 21 and 22 at the Saint Paul RiverCentre.

The MMA's bi-monthly journal, *Minnesota Medicine*, is also celebrating a major milestone this year. The award-winning publication has been published for 100 years, sending out its first issue in 1918.

MMA's Policy Council turns 5 in 2018

2018 marks the fifth anniversary of the forming of the MMA's Policy Council, which provides a representative mechanism and simplified process for obtaining broad member input, feedback and ideas on critical health policy issues facing Minnesota physicians throughout the year.

At the 2013 Annual Meeting, the House of Delegates voted to form the Council, which is made up of 40 members from across the state, representing all specialties and practice styles. Members are appointed from their component medical societies, the Medical Student Section, the Resident/Fellow Section and the Board of Trustees.

So far, the Council has recommended more than four dozen policies to the Board, and helped create eight policy forums on such issues as telemedicine, end-of-life care and value-based payment.

MMA files amicus brief on "curbside consultations" lawsuit

The MMA filed an amicus, or "friend of the court," brief in June with the Minnesota Supreme Court in a case that deals with preventing meritless malpractice actions against physicians and protecting the ability of physicians and allied professionals to collaborate to enhance patient care.

The MMA filed the brief on behalf of its members and in partnership with the Minnesota Hospital Association (MHA) and the AMA Litigation Center.

In the case, a hospitalist, who is an MMA member, received a call from a nurse practitioner (NP) at an unaffiliated hospital regarding the condition of the NP's patient. At the time, NPs did

not yet have independent practice and the NP had a collaborative relationship with another physician. Nonetheless, the NP called the hospitalist to discuss hospital admission.

During this conversation, which lasted approximately 10 minutes, the NP provided some lab results but did not provide medical records, nor did the hospitalist examine or talk to the patient. Relying on the information provided to him by the NP, the hospitalist suggested that the patient's symptoms were nonemergent

and could be managed through outpatient care. Following that conversation and despite her own reservations, the NP sent the patient home. The patient passed away; the family sued both the NP and the hospitalist.

The family reached a settlement agreement with the NP in which the NP admitted to providing negligent care to the patient and breaching the standard of care by failing to order certain tests and procedures. Despite this settlement and the NP's admission, the family pursued a wrongful death claim against the hospitalist. After both the District Court and Appeals Court found that the hospitalist could not be held liable for the patient's death, the family appealed to the Minnesota Supreme Court.

The Court is now tasked with determining whether a physician can be liable for providing an uncompensated, informal consultation to an allied professional with whom the physician has no collaborative or supervisory relationship. The MMA, joined by the AMA and MHA, filed the amicus brief to support the existing legal standard that requires a physician-patient relationship to exist before a physician can be held liable for malpractice or wrongful death. In doing so, the MMA emphasized the importance of collaboration among physicians and allied professionals, and argued that policy permitting malpractice actions against physicians providing informal consulting services would discourage behavior that is in the patients' best interest. The MMA additionally noted that allied professionals, like physicians, have their own obligations to their patients and physicians should not be liable for independent actions taken by care-team partners.

The MMA advocates for Minnesota physicians through the courts as a member of the American Medical Association Litigation Center and by filing amicus briefs in cases with the potential to impact how physicians practice and provide care to their patients. For questions regarding the MMA's current and future legal advocacy, contact MMA Policy Counsel Becca Branum at bbranum@mnmed.org.

On the calendar

Event	Date	Location
Annual Conference	Sept. 21-22	St. Paul
Duluth Doctors' Lounge	Oct. 16	Duluth
MMA Day at the Capitol	Feb. 13, 2019	St. Paul

MMA to examine MMA/CMS Structure

The MMA Board of Trustees has authorized formation of a new work group to examine the organizational structure of the MMA and its component medical societies (CMS).

The group, which is made up of representatives from the MMA board and from CMSs and/or trustee districts, is scheduled to begin meeting in August and will work through the end of the year. The group will develop recommendations for consideration by the MMA board and the boards of CMSs. If any recommendations require changes to MMA bylaws, such changes would need to be approved by MMA membership.

The purpose of the work group is to: examine the current organizational structure of the MMA and component medical societies; evaluate options to improve the organizational structure that will best meet the needs of Minnesota physicians; and clarify organizational roles and relationships. As part of its process, the work group will solicit input from physicians across the state to help understand experiences, needs and ideas.

The work group will include:

- Ryan Greiner, MD—Twin Cities Medical Society (TCMS) appointee
- Kathryn Lombardo, MD—Zumbro Valley Medical Society (ZVMS) appointee
- Patrick Zook, MD—Stearns Benton Medical Society (SBMS) appointee
- Paul Sanford, MD—Northeast Trustee District
- Cindy Firkins Smith, MD—Prairie Medical Society/Southwest Trustee District
- Marilyn Peitso, MD—MMA Board member from SBMS
- Edwin Bogonko, MD—MMA Board member from TCMS
- Doug Wood, MD—MMA Board member from ZVMS
- Abigail Ring, MD—MMA Board member from the Northwest Trustee District

Over the past several years, there have been significant changes in the number and composition of CMSs. Several have merged, closed or significantly reduced or changed their amount and scope of activity. With more than 30 component medical societies at its zenith, today the MMA has 20 component societies. There are no MMA-chartered CMSs in 16 of Minnesota's 87 counties.

Coalition sends step therapy letter to Congress

The MN Step Therapy Coalition, which comprises 26 health organizations including the MMA, sent a letter to the Minnesota Congressional delegation in June in support of legislation that reforms health plans' use of step therapy.

"We write to express our support for House Resolution 2077, the Restoring the Patient's Voice Act of 2017, which would ensure that patients with serious diseases, such as cancer, epilepsy, and diabetes, are able to access the medications they need without having to try another medicine and be forced to 'fail first,'" says the letter.

This past session, the Minnesota Legislature passed, and Gov. Mark Dayton signed into law, a measure that aims to reform and limit the practice of step therapy by health insurers. The MMA has long supported legislation to help patients get the right medicines faster and reduce administrative burdens associated with prior authorization, step therapy and other ways in which health plans and PBMs interfere with the physician-patient relationship.

More than a dozen other states have passed similar laws to limit or reform step therapy practices by health insurers, and many more are considering related legislation.

"We ask for your support of H.R. 2077 as a fair and balanced way to put health care providers and patients back in charge of their health care," the letter says. "It is a common-sense solution that establishes reasonable reforms and limits on step therapy practices and ensures that a health care provider's professional judgment and a thorough review of a patient's history are part of a successful health care equation."

George Schoephoerster, MD

Juliana Milhofer

Scott Wilson

Dave Renner

Eric Dick

MMA in Action

MMA President **George Schoephoerster**, MD, represented the MMA at the Health Care Inequities Roundtable at the University of Minnesota McNamara Alumni Center. It was part of a two-day listening tour in the state by United States of Care, a new nonpartisan, non-profit organization co-located in Minneapolis and Washington, DC, with the mission of ensuring that every single American has access to quality, affordable health care.

Juliana Milhofer, MMA policy analyst, and **Scott Wilson**, MMA manager of member outreach, attended orientation at the University of Minnesota Medical School in August.

Dave Renner, MMA director of state and federal legislation, attended the AMA State Legislative Roundtable in Park City, Utah in late July. The meeting includes government relations staff from state and specialty societies discussing upcoming legislative issues impacting medical societies. While there, Renner also participated in the Advocacy Resource Center's Executive Committee meeting, of which he is a member. This is a committee of 19 state medical society lobbyists or EVPs.

Renner and **Eric Dick**, MMA's manager of state legislative affairs, attended a provider coalition meeting at the Minnesota Dental Association in mid-July to discuss the scheduled repeal of the provider tax. Their message was that the provider tax must be replaced to ensure needed funds to maintain our safety net programs.

VIEWPOINT

Vote and get engaged

Randy Rice, MD
MMA Board Chair

So, did you vote in the August 14 primary?

I know for some of you, this is not a topic you like to discuss. It used to be common practice that when groups gathered there were three topics you would never discuss—money, religion and politics. Given the political climate in the United States these days, I can see why many of my peers still adhere to this maxim. Many people are simply put off by politics.

But, we live in a society with a representative government, and we need to make sure that the government represents all of us. As physicians, we have an even larger responsibility to be involved. In survey after survey, physicians land in the top three most admired professions in the world. We are looked to as the kind of people who make a difference. And making a difference in people's lives is what elections and the political process, when done properly, are all about.

In the last national election, only 56 percent of eligible voters voted. More than 100 hundred million eligible voters did not participate and took a pass on choosing our country's leaders. Minnesotans can take some pride in the fact that we continually lead the nation in the percentage of eligible voters who vote. But even with a voting rate of 63 percent for this state, there are too many voters skipping the process.

Our country continually ranks low compared to other democratic countries when it comes to the percentage of eligible voters who vote. In fact, the United States finished 26 out of 32 developed countries when it comes to voting turnout.

When so much is at stake, why aren't more people voting?

On November 6, be sure to do your part. Get out and vote. And before that date, encourage friends, families and coworkers to register and then get out to the polls.

Then, after you have cast your ballot, engage with your elected officials. We have so many challenges before us in the world of health care—fighting the opioid epidemic, reforming health care so that all have access and it's more affordable, reforming prior authorization and other administrative burdens, figuring out an alternative to the provider tax so we can continue supporting public programs, strengthening immunization laws, reducing gun violence and aligning Minnesota with HIPAA standards, to name a few.

Yes, it is easy to get frustrated with politics and politicians, and it takes a little time to know where the candidates stand on key issues, but our patients need us to advocate for them and to help Minnesota be the best place to practice. You have a voice that must be heard.

Please vote in November so that we truly have a representative government that works for all Minnesotans.

We are looked to as the kind of people who make a difference. And making a difference in people's lives is what elections and the political process, when done properly, are all about.

Is the care of rheumatoid arthritis in Somali patients associated with implicit bias?

BY PAUL H. WAYTZ, MD; ANDREW FORSBERG, BA; ABDI MAHAMED, MBA

Rheumatoid arthritis is a chronic inflammatory disease that can affect people of all ethnicities. There are no published studies that attempt to elaborate disease-specific characteristics of Somali immigrants. In this paper, we attempt to better categorize various aspects of rheumatoid arthritis for this population, including modes of presentation, laboratory findings, responses to treatment, medication tolerance, and outcomes. A database of 40 Somali patients with rheumatoid arthritis was compiled via chart review, with a goal of examining and analyzing these and other variables. Several cultural differences and other potential barriers emerged, including the possibility of implicit bias. Using the insights from our database, we outline several areas of concern that potentially could be useful to other caregivers in evaluating illnesses in the Somali population, as well as in other ethnic groups.

Introduction

Rheumatoid arthritis (RA) remains a serious, chronic inflammatory disease with the potential for significant joint damage, as well as systemic morbidity. RA can affect any ethnic group; its prevalence approaches 1% of the population worldwide.[1] It is not known if there are variations in clinical presentations and outcomes among various ethnic minorities and in locations where limitations accessing components of medical care may exist. Diagnosis of RA relies primarily on the history of symptoms, as well as a detailed physical examination of joints and attention to other organ systems.

Minnesota is home to the largest Somali population in the world outside of Somalia or refugee camps, with a population now approaching 40,000 residents by conservative estimates,[2] the majority of whom live in the Twin Cities. The percentage of Somali who are Muslim is nearly 100%. Most immigrants left Somalia around the time of the country's civil war in 1991 and over the following 10 years. The current Minnesota population now also reflects a substantial number of second-generation Somali. At first glance, our cohort of RA patients would appear to be a small sample. However, accepting the 1% prevalence, our group of 40 represents 10% of patients in the state, a not insubstantial number for a private medical group. Although sweeping generalizations cannot be made, we feel our observations are worthy of consideration and discussion.

TABLE 1

Baseline Patient Characteristics (n=40)

Sex	1% male
Age at Diagnosis	54.6
Undressed	0
Smoking, asked	40, 100%
Smokers	1
Alcohol, asked	7, 18%
Illegal Drug, asked	0, 100%
Employment	6, 16%

Arthritis and Rheumatology Consultants is a 13-person private practice group located in Edina and Maple Grove, Minn. Records of Somali patients were reviewed for demographic and medical data in hopes of discerning a unique cohort that would identify physician and patient variables that might affect both decision-making and outcomes. During this review, it quickly became apparent that socio-cultural factors played an important role in the evaluation and management process, a role that might well be associated with implicit bias. The purpose of this initial study looking into RA in Somali is to examine socio-cultural issues and how various barriers might affect the delivery of care. By extension, we raise the question of how similar barriers might affect medical care of other illnesses in Somali or other ethnic minorities.

Methods

Patients were identified based on the needs for a paid interpreter from Jan. 1, 2016 through Dec. 31, 2016. Records of Somali-speaking patients were reviewed for a diagnosis of any rheumatologic complaint based on ICD-9 and/or ICD-10 criteria. A computational spreadsheet was created for data compilation, visual use, and reference. Although patients were identified during the year 2016, charts were mined for dates of first appointments, follow-up appointments, cancelled appointments, and failed appointments ("no-show"). Patients with a diagnosis of RA, either seropositive or seronegative, are those included in this study. Patients with RA met 2010 American College of Rheumatology/European League Against Rheumatism Classification Criteria for RA.[3] A number of patients originally diagnosed with inflammatory arthritis at the time of their first appointment were subsequently changed to a diagnosis of RA by their individual clinic

TABLE 2

Age of Diagnosis (n=40)

	SEROPOSITIVE (21)	SERONEGATIVE (19)	TOTAL
20-29	3	0	3
30-39	5	0	5
40-49	3	0	3
50-59	2	10	12
60-69	5	7	12
70-79	2	1	3
>80	1 (95)	1 (82)	2

provider based on clinical follow-up and supported by laboratory data.

Various social parameters were identified by a standardized printed office questionnaire and clarified by medical assistant personnel via interpreters. In some circumstances, family members were present during appointments along with paid interpreters.

A number of diagnostic tests and therapeutic interventions were obtained during data mining. Results of ESR, CRP, and the autoantibodies rheumatoid factor (RF) and anti-citrullinated peptide (anti-CCP) are reported here to address comparability in our population with previous expectations for RA.

Statistical analysis was performed using the two-tailed T test.

Results

As previously established, all patients were accompanied by a paid interpreter. Sixty-one patients were Somali and, of those, 40 (66%) were identified as having rheumatoid arthritis and form the basis of this study. Other rheumatologic diagnoses included arthralgia (4), Sjogren's syndrome (3), connective tissue disease (3), polymyalgia rheumatic (3), musculoskeletal pain (3), systemic lupus erythematosus (2), psoriatic arthritis (1), ankylosing spondylitis (1), and giant cell arteritis (1).

Table 1 demonstrates various demographic features of our study group. Our population of Somali with RA is 98% female, distinctly different from the standard reported percentages of nearly 3:1, female to male. [4]

Patients' initial visits involved the typical history, physical examination, and laboratory work-up to best establish a specific diagnosis, exclude other diseases, and determine potential ancillary complicating issues. Our average age of diagnosis was 54.6, perhaps slightly older compared with previously established reports.[4] Of note, Table 2 shows that the average age of seropositive patients was 12 years younger than those of seronegative patients, 48.9 versus 60.8 (paired T test, $P < .05$). A majority of seropositive but no seronegative patients were under the age of 50 when diagnosed. All but two seronegative patients fell between the ages of 50 and 69 (Table 3).

No patients, including the male subject, undressed during the initial appointment. All patients were asked about smoking habits, likely a reflection of the Centers of Medicare and Medicaid Services Meaningful Use mandate of 2011 and implemented in our office in 2012. Only seven patients were asked about alcohol intake; none were asked about recreational drug use. None had sexual activity histories obtained. Six patients (five women, one man) worked outside of their homes.

TABLE 3

Abnormal Laboratory Studies (n=40)

ESR	32
CRP	35
ESR+CRP	31
RF Positive	20
anti-CCP Positive	10
RF Positive + anti-CCP Positive	9

Table 3 demonstrates results of markers of inflammation, RF, and anti-CCP antibodies in our Somali population. ESR and CRP results are consistent with previously reported percentages in RA. Both RF and anti-CCP results are somewhat lower than might be expected.[5]

Table 4 reports follow-up information in our cohort. This data was pursued based on a previous report from Hennepin County Medical Center (HCMC) that suggested a high rate of failed appointments for follow-up visits. In contrast, our results indicate follow-up to be acceptable and appropriate.

Discussion

Early diagnosis and treatment of RA are keys to better outcomes, as there appears to be an individual window of opportunity for optimal long-term positive results. The most complete understanding of successful rheumatoid arthritis treatment also involves both sides of the medical partnership and is essential to optimizing decisions and eventual achievement of control. Any impediment to the patient-physician relationship can create confusion, delays, and misunderstandings of otherwise appropriate choices.

Implicit bias refers to unintentional notions and belief patterns that affect our perceptions, behaviors, and decision-making. Implicit as opposed to explicit bias is an unconscious phenomenon that might be uncomfortable to confront and may contradict and conflict with conscious attitudes and values. Furthermore, implicit bias may be just as unacceptable and harm just as much if not more than explicit bias. Recognizing and acknowledging implicit bias when evaluating a Somali patient must be an essential component, as it underlies the essence of caregiving at every step of the process.

Our cohort fit with typical expectations regarding abnormal markers of inflammation and seropositivity. However, the average age of diagnosis of our patients was slightly older than expected for reasons that may merit further explanation.

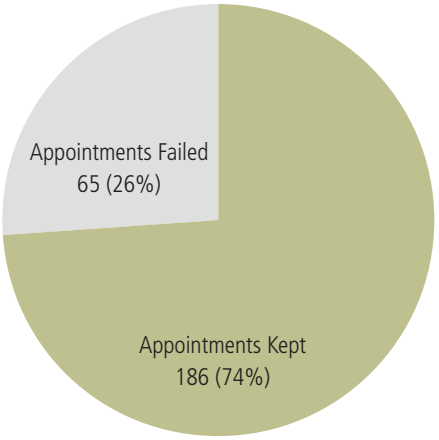
Of greater interest was that seropositive patients were significantly younger than seronegative patients, an issue that raises several questions—especially if this is unique to Somalis. Though our cohort may be too small to generalize, we regard this as an interesting feature and wonder if this pertains to other ethnic groups with RA.

From the initial moments of an encounter, the presence of an interpreter, even if the interpreter is a family member, creates a barrier. Interpreters are well-educated and trained but may still not know or understand specific rheumatologic terms and questions. Caregivers may have concerns that their explanation of a disease or planned course of treatment—with all of the intricacies—might not be effectively and accurately communicated. An issue with any foreign language is the possibility there is an absence of a word or words, commonplace in English, for symptoms or findings. In Somali, there is a word for "swelling," *barar,* but not "joint swelling." There is no word for "stiffness," but a direct translation would be *dhaqaaq xumo* (lack of movement). In northern Somalia, a translation might be *sidii ay bir iku taagantahay* ("as if there is a metal in my body").[6]

Other aspects of appointments with Somali patients, be it the initial encounter or subsequent follow-up, are affected by not having the patient undress, respecting religious modesty. Though a reasonably thorough joint examination can be performed with a clothed individual, one might miss organomegaly or lymphadenopathy associated with some other illness, including neoplasm masquerading as inflammatory arthritis. Furthermore, one might miss finding an important underlying or associated illness by not obtaining optimal auscultation of the heart or lungs. By not asking about alcohol intake, does the physician assume the patient doesn't drink because he or she is Muslim and does not want to offend? Perhaps the only reason that smoking is asked about is because of Meaningful Use requirements. Notably, smoking is an important risk factor for the development of RA, making it an essential question for the history.[7,8]

TABLE 4

Appointments (total appointments: 251)



Based on statistical expectations of RA, one would expect approximately 15 men to be a part of our database, yet there was only one. Again, the size of our group precludes making only speculative the observation that this reflects a stark difference in gender prevalence. Unique social expectations could suggest that Somali men may not raise concerns as much as women. One of the authors (Mahamed) suggests that this is not the case. Perhaps men are not inclined to take time from work, something difficult to compare in our study given that only five women worked outside of their home. One might also wonder if deeper reasons—financial issues, image, self-esteem, or social expression of masculinity—associated with the stress and mental health status of immigrants contributes to the observed disparity.[9]

It has previously been reported[10] that follow-up in the Somali population is suboptimal, however, that report dealt with 100 patients initially presenting to an HCMC clinic, rather than a cohort with a specific diagnosis. We did not find kept appointments to be an issue with a low rate of cancellations or no-shows, in spite of our suburban location and challenges of transportation, especially in winter months. This could relate to the establishment of a specific and serious diagnosis and subsequent treatment with medications requiring regular monitoring. We do not have statistics for a comparable Caucasian population. We would like to believe that patients, their families, and their support networks understood the necessity and importance of discussions and responded accordingly, and that potential barriers were being recognized and addressed.

Physicians should initiate a necessary dialogue and not be afraid to ask difficult questions. Physicians also need to understand and appreciate cultural beliefs about disease[11, 12, 13] and factor them into caregiving. Community education about RA as well as other diseases can provide earlier access to appropriate medical attention. Physician education, perception, and self-reflection are essential to solving serious problems with healthcare delivery and a step toward negating implicit bias.[14] Different patients have different needs, a notion that must not be forgotten with any ethnic minority, or even the majority population, and that is a standard for solidifying important interpersonal relationships.

This is not a rigorously controlled medical study, but it is real life. Respect for the Somali culture and Islam appears to be at the heart of observations in our study. Social factors have the potential to play a dominant role in both the evaluation and decision-making process for physicians. Whether implicit bias or other simple, uncovered obstacles affect outcomes remains to be determined. By extension, we raise the question of how barriers might affect medical care of other illnesses in Somali or in other unique minorities.

Questions raised

Our results and observations raise many questions and, perhaps, provide the start of a pathway for providing improved care for any ethnic group.

- With Somali patients, are we guilty of implicit bias and hampered in our diagnoses by the consequences of not having a patient undress or by not asking about alcohol or illegal drugs?
- How do we integrate essentials of the health history as they might apply to different cultures? Is pain the same for

(continued on page 48)

Uncovering hidden health disparities

Breastfeeding trends in Minnesota among non-Hispanic black and white infants

BY MARCIA B. MCCOY, MPH, IBCLC

Despite progress in achieving the Healthy People 2020 objective for breastfeeding initiation, racial and economic disparities persist. Significant health disparities are masked when health indicators such as breastfeeding are reported using standard race/ethnicity categories and without considering income status. In Minnesota, the "black" racial category includes multiple culturally diverse communities with widely differing breastfeeding practices. Strategies for addressing health disparities require a deeper look into the data.

To determine rates of breastfeeding initiation within cultural groups in Minnesota, we conducted an analysis of birth records for non-Hispanic black and white infants born in Minnesota from 2012 to 2016. Birth certificates were linked with WIC programmatic data to identify WIC participation, maternal nativity, and cultural identity (CID), and rates were calculated for subpopulations defined by these factors.

When black infants were considered as a whole, the disparities in breastfeeding initiation between WIC participants and non-participants were much larger than the disparities between black and white infants. Breaking the data out by CID and maternal nativity revealed wide disparities within the black category. In 2016, black infants with no specified CID had the lowest rate of breastfeeding initiation (78.3%). Those with East African CIDs had the highest rates (92.7%). For infants of U.S.-born mothers, the disparities between black and white infants were 4.8 percentage points (89.4 vs 94.2) among those not participating in WIC, and 7.2 percentage points (75.6 vs 82.9) among WIC participants.

In Minnesota, reporting on breastfeeding by WIC participation, cultural identity, and maternal nativity uncovers disparities hidden in the aggregated data. Uncovering disparities is the first step to effectively addressing them.

Introduction

While breastfeeding initiation has significantly increased among infants in Minnesota in recent years, rates are lower among participants in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). The program serves families at or below 185% of the U.S. poverty income guidelines or who are adjunctively eligible through another program such as Medical Assistance.[1] Although participation in WIC during pregnancy is associated with better breastfeeding outcomes among those eligible for the program, disparities persist between those who participate in WIC and those who do not.[2]

A recent CDC analysis of infants born between 2010 and 2013 found persistent disparities in breastfeeding between black and white infants.[3] Minnesota had the highest initiation rate reported for black infants at 90.8%, and was one of only three states where a higher proportion of black infants than white infants initiated breastfeeding. However, a closer look at the data reveals that, when it comes to breastfeeding, some Minnesota infants are not faring as well as others. This is due to disparities in the supports available to women wishing to breastfeed. WIC participants and U.S.-born black mothers face greater structural, economic, medical, cultural, and psychosocial barriers to breastfeeding.[4]

Minnesota's rates of breastfeeding initiation in 2016 ranged from 75.6% for U.S.-born black WIC participants to 94.2% for U.S.-born white non-WIC participants. Evidence-based strategies exist which are effective in communities experiencing the greatest disparities and could reduce these disparities significantly.

FIGURE 1

Breastfeeding initiation for black and white infants born in Minnesota by participation in WIC - Minnesota birth certificate and WIC program data, 2012-2016

MINNESOTA BIRTHS TO BLACK AND WHITE MOTHERS, 2012 - 2016	YEAR				
CATEGORY OF WIC PARTICIPATION AND RACE	PERCENTAGE OF INFANTS WHO INITIATED BREASTFEEDING				
	2012	2013	2014	2015	2016
non-WIC white n=155,149	92.2	92.4	93.4	93.9	94.2
WIC white n=65,229	79.6	80.5	82.4	82.3	83.3
non-WIC black n=6,654	88.6	89.2	90.2	89.8	91.7
WIC black n=38,194	78.2	79.3	80.7	83.1	84.6

* "Black" includes single-race black, black/white, black/American Indian, and black/white/American Indian

Breastfeeding is important for the physical and emotional health of both mother and infant. When communities cannot successfully sustain breastfeeding, families, employers, and society shoulder the burden of increased health care costs for mother and child, higher absenteeism from work or school, poorer school achievement, and reduced adult earning potential.[5] Lack of breastfeeding is associated with higher risk in children of lower respiratory tract infections requiring hospitalization, acute otitis media, acute lymphoblastic leukemia (ALL), necrotizing enterocolitis (NEC), gastrointestinal infection, and death and with higher risk in mothers of breast cancer, type 2 diabetes, hypertension, and myocardial infarction.[6,7,8]

Disparities in breastfeeding among racial groups are of special concern because suboptimal breastfeeding is associated with a disproportionately greater burden of disease among black infant-mother dyads compared to white dyads. These health disparities include excess cases of otitis media, gastrointestinal infection, NEC, sudden infant death syndrome (SIDS), and child deaths, in part related to higher prevalence of preterm birth among black mothers.[7,9] In Minnesota, although the overall infant mortality rate is below the national average, black infants of U.S.-born mothers are three times as likely as white infants to die before their first birthday (12.4 vs 4.1 deaths per thousand births, 2008-2012).[10]

The designation of "black" encompasses many diverse communities. According to birth certificate data, half (50.2%) of black infants born in Minnesota in 2016 had mothers born outside the United States. Several communities in Minnesota have a black population made up mostly of Somali and/or Ethiopian immigrants, while others are largely Liberian or multigenerational American. These groups differ markedly in their breastfeeding traditions, practices, and supports.

Breastfeeding rates are lower among WIC participants, a population that faces more barriers to breastfeeding initiation than those of higher socioeconomic status. In 2015, the Minnesota WIC Program began collecting data on cultural identity for black program participants. The following year, Minnesota WIC staff linked Minnesota birth certificate data with WIC Program data. The birth certificate data contain information on mother's country of origin and cultural identity, as well as on breastfeeding initiation. The enhanced data enabled disaggregation of the black race category by cultural identity.

FIGURE 2

Breastfeeding initiation among black and white infants born in Minnesota by race and cultural identity - Minnesota birth certificate and WIC program data, 2012-2016*† §¶**

MINNESOTA BIRTHS TO BLACK AND WHITE MOTHERS, 2012 - 2016	YEAR				
RACE AND CULTURAL IDENTITY	PERCENTAGE OF INFANTS WHO INITIATED BREASTFEEDING				
	2012	2013	2014	2015	2016
Black/American Indian n=1,110†	79.9	79.4	79.1	79.5	79.7
Black or black/ white n=20,882§	69.9	71.4	73.2	75.4	78.3
East African n=16,155¶	90.4	90.5	91.3	93.1	92.7
Liberian n=2,158	80.9	82.8	79.6	83.2	87.1
Other black n=4,543**	90.1	91.9	92.2	91.4	93.4
White n=220,378	87.9	88.6	90.2	90.7	91.4

* Race, ethnicity and cultural identity were obtained from self-report to WIC or from self-report and mother's country of origin on the birth certificate.
† "Black/American Indian" includes black/American Indian and black/white/American Indian who specified a black cultural identity of "multi-generational black American" or who did not specify a black cultural identity.
§ "Black or black/white" includes single-race black and biracial black/white who specified a black cultural identity of "multi-generational black American" or who did not specify a black cultural identity.
¶ "East African" includes those who specified a cultural identity of "Somali," "Sudanese," "Ethiopian," "Kenyan," or "Oromo."
** "Other black" includes those who specified a black cultural identity of "Ghanian," "other African," or "other black"; category not shown on graph
†† Breastfeeding initiation rates for "East African" and "White" categories previously published in:
Minnesota WIC Program, Minnesota Department of Health. Breastfeeding Initiation for Infants born in Minnesota by Race/Ethnicity and Selected Cultural Identities by Calendar Year of Birth. 2017. Available from: http://www.health.state.mn.us/divs/fh/wic/localagency/reports/bf/healthequity/allmn.pdf

Methods

Birth records for all non-Hispanic infants born in Minnesota 2012–2016 were identified (n=302,095) for this analysis. From this number, infants identified as either black alone or in combination with white and/or American Indian (n=44,848) or white (n=220,378) were selected for inclusion. Asian and Native Hawaiian/Pacific Islander infants (n=24,406) and non-black American Indian infants (n=6,116) were excluded. Birth records with incomplete breastfeeding data (n=1,118) and infants with unknown race (n=8,660) were excluded. Infants born in Minnesota but residing in another state were excluded (n=5,059) because WIC participation among those infants is undeterminable.

Cultural identity was determined from information on the birth certificate and from WIC program data. Black subcategories on the birth certificate include Somali, Ethiopian, Liberian, Ghanian, Kenyan, Sudanese, Nigerian, and other African. Race, ethnicity, country of origin, and cultural identity are self-identified on the birth record.

Race, ethnicity, and cultural identity are also self-reported by participants during WIC appointments. Cultural identity categories collected by WIC include black multigenerational American, Somali or Somali American, Liberian or Liberian American, Sudanese or Sudanese American, Ethiopian or Ethiopian American, Kenyan or Kenyan American, Oromo or Oromo American, and other black.

The initial sample was divided into subcategories based on WIC participation, cultural identity, and maternal nativity (U.S.-born or foreign-born). Rates of initiation

were calculated in SAS version 9.4 for the entire sample and for subcategories of WIC participation, race and cultural identity.

Results

When black infants were considered as a whole, the disparities in breastfeeding initiation between WIC participants and non-participants were much larger than the disparities between races (Figure 1). In 2016 the gap between WIC and non-WIC initiation rates was 10.9 percentage points for white infants and 7.1 percentage points for black infants. Among non-WIC participants, the gap between white and black initiation was 2.5 percentage points. Among WIC participants, the gap was even smaller (Table 1). The proportion who initiated breastfeeding was similar for both races, with the gap changing from 1.4 percentage points higher for white infants in 2012 to 1.3 percentage points higher for black infants by 2016. The black initiation rate surpassed the white rate in 2015. For all groups, breastfeeding initiation rates steadily increased across the five-year period, similar to national trends.

Initiation rates by cultural identities (CIDs) varied dramatically (Figure 2), calling into question the practice of aggregating all black infants into one category. Black infants whose mothers did not specify a CID had the lowest rates of initiation (78.3% in 2016). Those with East African CIDs (Somali, Oromo, Kenyan, Sudanese and Ethiopian) had the highest rates (92.7% in 2016), a difference of 14.4 percentage points. Over the five years, rates increased 8.4 percentage points (from 69.9 to 78.3) among black (multigenerational American) infants, 3.5 percentage points (from 87.9 to 91.4) among white infants, and 2.3 percentage points (from 90.4 to 92.7) among infants of East African mothers. Rates among infants identified as black and American Indian declined slightly over the same time period, from 79.9% to 79.7%.

When breastfeeding initiation was assessed for infants of U.S.-born mothers only, the disparities between black and white infants became evident in the WIC and non-WIC populations (Figure 3), with a gap in 2016 of 4.8 percentage points among those not participating in WIC, and a larger gap of 7.3 percentage points among WIC participants (Table 1). Although the gap is large among WIC participants, it has improved from 11.6 percentage points in 2012.

FIGURE 3

Breastfeeding initiation for black and white infants born in Minnesota to U.S.-born mothers by participation in WIC - Minnesota birth certificate and WIC program data, 2012-2016*

MINNESOTA BIRTHS TO BLACK AND WHITE MOTHERS, 2012 - 2016	YEAR				
CATEGORY OF WIC PARTICIPATION AND RACE	PERCENTAGE OF INFANTS WHO INITIATED BREASTFEEDING				
	2012	2013	2014	2015	2016
non-WIC black n=3,347	84.3	87.3	87.8	85.0	89.4
non-WIC white n=150,718	92.1	92.3	93.4	93.8	94.2
WIC black n=17,535	67.6	68.6	70.5	73.4	75.6
WIC white n=62,990	79.2	80.1	82.1	81.9	82.9

* "Black" includes single-race black, black/white, black/American Indian, and black/white/American Indian

Discussion

When considered as a whole, Minnesota's population is doing well compared to other states in breastfeeding initiation, reaching 89.0% in 2016 and exceeding the Healthy People 2020 goal of 81.9%. There remain, however, communities and populations that fall far short of recommended rates. Rates vary markedly for WIC participants in comparison to non-participants. Traditional race/ethnicity categories are inadequate to describe the disparate communities that co-exist in Minnesota. High breastfeeding rates among infants of immigrant mothers mask ongoing disparities experienced by infants of U.S.-born black mothers. Although progress is being made, significant disparities continue to negatively impact the health of black mothers and infants in Minnesota. These disparities are greater among WIC participants, a population at higher risk of both suboptimal breastfeeding and other negative health outcomes.

Lower breastfeeding rates among low-income and U.S.-born black women arise from the greater number of barriers to breastfeeding these women face, including geographic, structural, economic, medical, cultural, and psychosocial factors.[11,12] There are proven strategies that can address these barriers and reduce disparities.

Consistent, high-quality breastfeeding education and support across the health care system can improve outcomes. Prenatal education on breastfeeding that includes both the mother and her support system can improve rates.[13] Earlier prenatal enrollment in WIC can provide additional education. Prenatal health care provider endorsement of exclusive breastfeeding has a strong influnce on a mother's intention to breastfeed and on breastfeeding duration.[14] The Minnesota Breastfeeding Coalition has developed a prenatal toolkit for prenatal care providers.[15]

Maternity care practices that support breastfeeding are less prevalent in areas with a larger percentage of black residents.[16] Implementation of Breastfeeding Friendly Hospital Initiative (BFHI) practices could address this disparity and is positively associated with breastfeeding outcomes, especially among low-income women and WIC participants.[17,18] The Minnesota Department of Health recognizes maternity centers that have taken steps toward implementing Breastfeeding Friendly policies and procedures with Five-Star Designation and the Minnesota Mother-Baby Ten STEPS Award.[19]

Ongoing postpartum support is crucial. Availability of peer support (such as La Leche League or Baby Café) and of skilled postpartum care (such as lactation consultant visits) varies widely. Rural and low-income women and women of color have less access to such postpartum assis-

tance. WIC breastfeeding peer counseling provides culturally specific support and is associated with increased breastfeeding initiation.[20] Since 84% of black infants of U.S.-born mothers in Minnesota participate in WIC, the peer program is ideally suited to reach this population.[21]

Workplace support is essential for sustaining breastfeeding. Low-income workers have less access to paid maternity leave and fewer workplace accommodations, such as space and time for pumping. Childcare that is supportive of breastfeeding is also critical to enabling mothers to meet their breastfeeding goals.[17] Lastly, social support for breastfeeding wherever and whenever necessary is crucial. Minnesota has strong legislation in support of breastfeeding, but bottle-feeding remains the cultural norm in some communities.[22,23]

The linkage between birth certificate data and WIC program data is incomplete. About 12.5% of Minnesota WIC participants were not matched to a Minnesota birth record and were excluded from this analysis. The majority of those infants were born in neighboring states.

The use of WIC participation as a proxy for socioeconomic status is an imprecise approximation. Participation in WIC among WIC-eligible families is lower among white families than families of color. For this analysis, infants born in Minnesota who participated in WIC outside of Minnesota were included in the non-WIC-participant group. This may cause the observed differences between WIC- and non-WIC-participant breastfeeding rates to be smaller than they would be if these recipients of WIC services were properly identified.

Significant health disparities are masked when health indicators such as breastfeeding are reported using standard race/ethnicity categories and without considering income status. In Minnesota, reporting on breastfeeding by WIC participation and cultural identity as well as by race uncovers disparities hidden in the collective data. The ability to determine accurate rates of breastfeeding and other health measures in distinct cultural groups is key to understanding the health of local communities and to guiding efforts to reduce health disparities through culturally appropriate interventions.

TABLE 1

Disparities in rates of breastfeeding initiation by race, cultural identity, mother's nativity, and WIC participation, Minnesota births 2016

	SERVED BY WIC	NOT ON WIC	% POINT DIFFERENCE NOT WIC VS WIC
White infants	83.3	94.2	10.9
Black infants	84.6	91.7	7.1
% point difference White vs. Black	-1.3	2.5	
White infants of U.S.-Born Mothers	82.9	94.2	11.3
Black infants of U.S.-Born Mothers	75.6	89.4	13.8
% point difference White vs. Black	7.3	4.8	
	BLACK (AFRICAN-AMERICAN)	LIBERIAN	% POINT DIFFERENCE
Black infants	78.3	87.1	8.8
	BLACK (AFRICAN-AMERICAN)	EAST AFRICAN*	% POINT DIFFERENCE
Black infants	78.3	92.7	14.4

**Somali, Ethhiopian, Kenyan, Sudanese, or Oromo.*

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Is the care of rheumatoid arthritis in Somali patients associated with implicit bias?

(continued from page 43)

a Somali woman as it is for a Caucasian man? What does loss of appetite mean to a Somali, someone who may have gone days without eating at various times during migration to the United States?

- Does the presence of an interpreter foster implicit bias in addition to creating a barrier to communication? How do we better educate interpreters and family members as to the words we us in questions and explanations?
- How do we better educate caregivers in terms of delivery of medical care to unique populations, as well as obtain better insights into the life of a refugee and the transformation that occurs after relocation?
- How do we involve communities to raise awareness of various diseases and better facilitate access to care?
- As scientists, how do we best assess characteristics of unique cohorts? Is the lack of smoking in our group or the younger diagnosis of our seropositive patients germane and deserving of further investigation?
- How do we, as caregivers, reconcile implicit bias with our concern for showing respect? If not being respectful, are we guilty of explicit bias? **MM**

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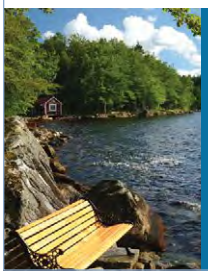

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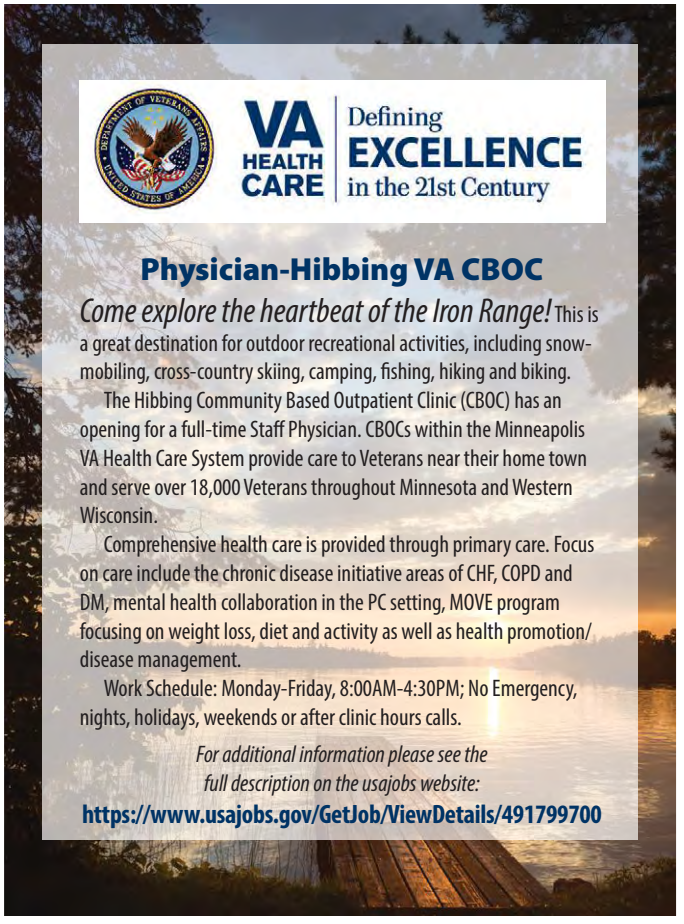

VA HEALTH CARE | Defining EXCELLENCE in the 21st Century

Physician-Hibbing VA CBOC

Come explore the heartbeat of the Iron Range! This is a great destination for outdoor recreational activities, including snow-mobiling, cross-country skiing, camping, fishing, hiking and biking.

The Hibbing Community Based Outpatient Clinic (CBOC) has an opening for a full-time Staff Physician. CBOCs within the Minneapolis VA Health Care System provide care to Veterans near their home town and serve over 18,000 Veterans throughout Minnesota and Western Wisconsin.

Comprehensive health care is provided through primary care. Focus on care include the chronic disease initiative areas of CHF, COPD and DM, mental health collaboration in the PC setting, MOVE program focusing on weight loss, diet and activity as well as health promotion/ disease management.

Work Schedule: Monday-Friday, 8:00AM-4:30PM; No Emergency, nights, holidays, weekends or after clinic hours calls.

For additional information please see the full description on the usajobs website:

https://www.usajobs.gov/GetJob/ViewDetails/491799700

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56+ primary care clinics and 55+ specialty care clinics

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- Cardiology (Non-invasive)
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- Emergency Medicine
- Endocrinology
- Family Medicine
- Family Medicine w/OB
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- Hospitalist
- Infectious Disease
- Internal Medicine
- Medical Director
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VA HEALTH CARE Defining EXCELLENCE in the 21st Century

Minneapolis VA Health Care System

Opportunities are available in the following specialties:

- Chief of GIM
- Chief of Nephrology
- Cardiologist - Interventional
- Gastroenterologist
- Internal Medicine/Family Practice
- Psychiatrist - inpatient/outpatient/consult-liaison
- Tele ICU - Las Vegas, NV
- CBOC providers, MD
  - Hibbing, MN
  - Ely, MN
  - Hayward, WI
  - Rochester, MN

Minneapolis VA Health Care System (MVAHCS) is a teaching hospital providing a ***full range*** of patient care services with ***state-of-the-art technology***, as well as ***education*** and ***research***. Comprehensive health care is provided through ***primary care, tertiary care*** and ***long-term care*** in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, and most other specialty areas inpatient and outpatient care.

US citizenship or proper work authorization required. Candidates should be BE/BC. Must have a valid medical license anywhere in US. Background check required. EEO Employer

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For more information on current opportunities, contact:

Yolanda Young • Yolanda.Young2@va.gov • 612-467-4964

One Veterans Drive, Minneapolis, MN 55417 www.minneapolis.va.gov

Sioux Falls VA Health Care System

"A Hospital for Heroes"

Working with and for America's Veterans is a privilege and we pride ourselves on the quality of care we provide. In return for your commitment to quality health care for our nation's Veterans, the VA offers an incomparable benefits package.

The Sioux Falls VAHCS is currently recruiting for the following healthcare positions.

- Cardiologist
- Emergency Medicine (part-time)
- Endocrinologist
- ENT (part-time)
- Gastroenterologist (part-time)
- Geriatrician
- Neurologist
- PACT
- Physiatrist
- Psychiatrist
- Psychologist
- Pulmonologist
- Urologist (part-time)

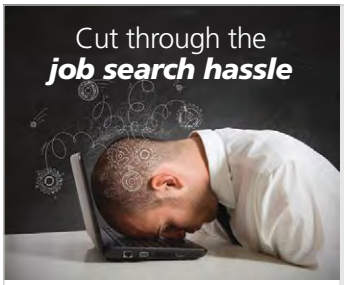
Applicants can apply online at www.USAJOBS.gov

They all come together at the Sioux Falls VA Health Care System. To be a part of our proud tradition, contact:

Human Resources Mgmt. Service
2501 W. 22nd Street | Sioux Falls, SD 57105 | (605) 333-6852

VA | U.S. Department of Veterans Affairs

★ ★ ★ **www.siouxfalls.va.gov** ★ ★ ★



MMA Online Physician Career Center

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Minnesota Medical Association

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For more information, go to **www.mnmed.org/careercenter**

GREGORY A. PLOTNIKOFF, MD, MTS, FACP

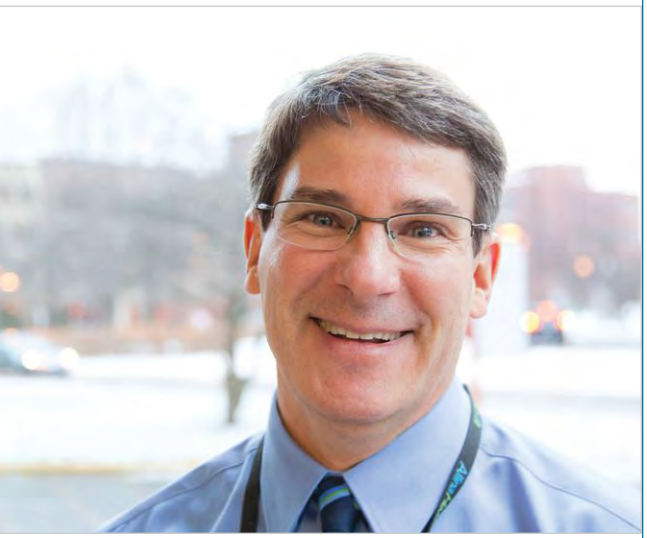
- Medical director and senior consultant.
- Minnesota Personalized Medicine, Minneapolis.
- MMA member since 1985.
- From Lake Forest, Ill. Graduated from Carleton College, Harvard Divinity School and University of Minnesota Medical School. Residency in internal medicine/pediatrics at University of Minnesota. Previously has been associate professor at University of Minnesota Medical School, associate professor at Keio University Medical School in Tokyo and senior consultant to the Penny George Institute in Minneapolis.
- Married to Shawn Monaghan; shares "furry four-legged child" Pélé with her.

Became a physician because …

I wanted to relieve the suffering of persons like my neighbor growing up, Mrs. Heaney.

Greatest challenge facing medicine today …

We need organized physician leadership to upgrade the medicine we practice. I see three parallel challenges. The first is to navigate better the tension between population health and personalized medicine. One size does not fit all. Exclusively utilitarian reasoning ("the greatest good for the greatest number") results in unnecessary suffering by large numbers of patients. The second is to bridge the gap between an organ-system orientation and a systems biology approach. Disciplined focus, by definition, restricts what we see. Too many patients suffer from our disciplinary blind spots. The third parallel challenge is to foster meaningful medical innovation that incorporates the first two concerns. I am not optimistic however. In my opinion, the combination of mandated consistency and excessive time efficiency drives systemic stagnation.



Favorite fictional physician …

Dr. Kyojō Niide, a wizened physician in 1820s rural Japan. He is the title character in the 1965 film "Akahige" (Red Beard) directed by Akira Kurosawa. My medical students in the professionalism class I taught at Keio Medical School (Tokyo) introduced me to him. Dr. Niide is far from perfect but he exemplifies the best attributes of a physician committed to fostering the healing of those who suffer—including the film's protagonist, the ambitious and resentful intern, Dr. Noboru Yasumoto.

JULIE BENSON, MD, FAAFP

- Family medicine and medical director, hospice and palliative care.
- Lakewood Health System, Staples.
- MMA member since 2017.
- From St. Paul. Graduated from the College of St. Benedict and University of Minnesota Medical School-Duluth. Riverside Family Medicine residence in Minneapolis. Has worked at Lakewood Health System since 1997.
- Husband, Steve, and two children: Katie, 19, and Jack, 17. At home has chickens, guineas, peacocks, a dog, cats … and bees.

Became a physician because …

I saw my dad cared for by a family physician when he was ill and in the hospital for three months. The physician coordinated everything. He was intelligent and never forgot to take care of the family. I am forever grateful.

Greatest challenge facing medicine today …

Besides the obvious, that we can't afford to keep going as we are, it's talking about the end of life, the tough choices and what not to do to our patients. Just because we can, doesn't mean we should.

Favorite fictional physician …

Hawkeye Pierce—I loved "M*A*S*H"—he did cutting-edge medicine, taking risks and saving lives (forget the womanizing part of him). He cared deeply and did what was right first. What would he have done in this world of prior authorizations, data collection, quality measures? And Quincy; you've gotta love the original forensic murder mysteries. Does Dr. Ross Geller from "Friends" count? And Dr. Bricker from the "Love Boat" did have a sweet job!

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