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†**Victoza® is not indicated for the management of obesity, and weight change was a secondary end point in clinical trials.**

VICTOZA®
liraglutide (rDNA origin) injection

Indications and Usage

Victoza® (liraglutide [rDNA origin] injection) is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus.

Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza® only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza® is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise.

Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza®. Victoza® has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for pancreatitis while using Victoza®. Other antidiabetic therapies should be considered in patients with a history of pancreatitis.

Victoza® is not a substitute for insulin. Victoza® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings.

Victoza® has not been studied in combination with prandial insulin.

Important Safety Information

Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be ruled out by clinical or nonclinical studies. Victoza® is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Based on the findings in rodents, monitoring with serum calcitonin or thyroid ultrasound was performed during clinical trials, but this may have increased the number of unnecessary thyroid surgeries. It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate human risk of thyroid C-cell tumors. Patients should be counseled regarding the risk and symptoms of thyroid tumors.

Do not use in patients with a prior serious hypersensitivity reaction to Victoza® (liraglutide [rDNA origin] injection) or to any of the product components.

Postmarketing reports, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis. Discontinue promptly if pancreatitis is suspected. Do not restart if pancreatitis is confirmed. Consider other antidiabetic therapies in patients with a history of pancreatitis.

When Victoza® is used with an insulin secretagogue (e.g. a sulfonylurea) or insulin serious hypoglycemia can occur. Consider lowering the dose of the insulin secretagogue or insulin to reduce the risk of hypoglycemia.

Renal impairment has been reported postmarketing, usually in association with nausea, vomiting, diarrhea, or dehydration which may sometimes require hemodialysis. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment.

Serious hypersensitivity reactions (e.g. anaphylaxis and angioedema) have been reported during postmarketing use of Victoza®. If symptoms of hypersensitivity reactions occur, patients must stop taking Victoza® and seek medical advice promptly.

There have been no studies establishing conclusive evidence of macrovascular risk reduction with Victoza® or any other antidiabetic drug.

The most common adverse reactions, reported in ≥5% of patients treated with Victoza® and more commonly than in patients treated with placebo, are headache, nausea, diarrhea, dyspepsia, constipation and anti-liraglutide antibody formation. Immunogenicity-related events, including urticaria, were more common among Victoza®-treated patients (0.8%) than among comparator-treated patients (0.4%) in clinical trials.

Victoza® has not been studied in type 2 diabetes patients below 18 years of age and is not recommended for use in pediatric patients.

There is limited data in patients with renal or hepatic impairment.

Please see brief summary of Prescribing Information on adjacent page.

0513-00015590-1 June 2013

Victoza® (liraglutide [rDNA origin] injection)
Rx Only
BRIEF SUMMARY. Please consult package insert for full prescribing information.

WARNING: RISK OF THYROID C-CELL TUMORS: Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether Victoza® causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as human relevance could not be ruled out by clinical or nonclinical studies. Victoza® is contraindicated in patients with a personal or family history of MTC and in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Based on the findings in rodents, monitoring with serum calcitonin or thyroid ultrasound was performed during clinical trials, but this may have increased the number of unnecessary thyroid surgeries. It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate human risk of thyroid C-cell tumors. Patients should be counseled regarding the risk and symptoms of thyroid tumors *[see Contraindications and Warnings and Precautions]*.

INDICATIONS AND USAGE: Victoza® is indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. **Important Limitations of Use:** Because of the uncertain relevance of the rodent thyroid C-cell tumor findings to humans, prescribe Victoza® only to patients for whom the potential benefits are considered to outweigh the potential risk. Victoza® is not recommended as first-line therapy for patients who have inadequate glycemic control on diet and exercise. Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis has been observed in patients treated with Victoza®. Victoza® has not been studied in patients with a history of pancreatitis. It is unknown whether patients with a history of pancreatitis are at increased risk for pancreatitis while using Victoza®. Other antidiabetic therapies should be considered in patients with a history of pancreatitis. Victoza® is not a substitute for insulin. Victoza® should not be used in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings. The concurrent use of Victoza® and prandial insulin has not been studied.

CONTRAINDICATIONS: Do not use in patients with a personal or family history of medullary thyroid carcinoma (MTC) or in patients with Multiple Endocrine Neoplasia syndrome type 2 (MEN 2). Do not use in patients with a prior serious hypersensitivity reaction to Victoza® or to any of the product components.

WARNINGS AND PRECAUTIONS: Risk of Thyroid C-cell Tumors: Liraglutide causes dose-dependent and treatment-duration-dependent thyroid C-cell tumors (adenomas and/or carcinomas) at clinically relevant exposures in both genders of rats and mice. Malignant thyroid C-cell carcinomas were detected in rats and mice. A statistically significant increase in cancer was observed in rats receiving liraglutide at 8-times clinical exposure compared to controls. It is unknown whether Victoza® will cause thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, as the human relevance of liraglutide-induced rodent thyroid C-cell tumors could not be determined by clinical or nonclinical studies. In the clinical trials, there have been 6 reported cases of thyroid C-cell hyperplasia among Victoza®-treated patients and 2 cases in comparator-treated patients (1.3 vs. 1.0 cases per 1000 patient-years). One comparator-treated patient with MTC had pre-treatment serum calcitonin concentrations >1000 ng/L suggesting pre-existing disease. All of these cases were diagnosed after thyroidectomy, which was prompted by abnormal results on routine, protocol-specified measurements of serum calcitonin. Five of the six Victoza®-treated patients had elevated calcitonin concentrations at baseline and throughout the trial. One Victoza® and one non-Victoza®-treated patient developed elevated calcitonin concentrations while on treatment. Calcitonin, a biological marker of MTC, was measured throughout the clinical development program. The serum calcitonin assay used in the Victoza® clinical trials had a lower limit of quantification (LLOQ) of 0.7 ng/L and the upper limit of the reference range was 5.0 ng/L for women and 8.4 ng/L for men. At Weeks 26 and 52 in the clinical trials, adjusted mean serum calcitonin concentrations were higher in Victoza®-treated patients compared to placebo-treated patients but not compared to patients receiving active comparator. At these timepoints, the adjusted mean serum calcitonin values (~1.0 ng/L) were just above the LLOQ with between-group differences in adjusted mean serum calcitonin values of approximately 0.1 ng/L or less. Among patients with pre-treatment serum calcitonin below the upper limit of the reference range, shifts to above the upper limit of the reference range which persisted in subsequent measurements occurred most frequently among patients treated with Victoza® 1.8 mg/day. In trials with on-treatment serum calcitonin measurements out to 5-6 months, 1.9% of patients treated with Victoza® 1.8 mg/day developed new and persistent calcitonin elevations above the upper limit of the reference range compared to 0.8-1.1% of patients treated with control medication or the 0.6 and 1.2 mg doses of Victoza®. In trials with on-treatment serum calcitonin measurements out to 12 months, 1.3% of patients treated with Victoza® 1.8 mg/day had new and persistent elevations of calcitonin from below or within the reference range to above the upper limit of the reference range, compared to 0.6%, 0% and 1.0% of patients treated with Victoza® 1.2 mg, placebo and active control, respectively. Otherwise, Victoza® did not produce consistent dose-dependent or time-dependent increases in serum calcitonin. Patients with MTC usually have calcitonin values >50 ng/L. In Victoza® clinical trials, among patients with pre-treatment serum calcitonin <50 ng/L, one Victoza®-treated patient and no comparator-treated patients developed serum calcitonin >50 ng/L. The Victoza®-treated patient who developed serum calcitonin >50 ng/L had an elevated pre-treatment serum calcitonin of 10.7 ng/L that increased to 30.7 ng/L at Week 12 and 53.5 ng/L at the end of the 6-month trial. Follow-up serum calcitonin was 22.3 ng/L more than 2.5 years after the last dose of Victoza®. The largest increase in serum calcitonin in a comparator-treated patient was seen with glimepiride in a patient whose serum calcitonin increased from 19.3 ng/L at baseline to 44.8 ng/L at Week 65 and 38.1 ng/L at Week 104. Among patients who began with serum calcitonin <20 ng/L, calcitonin elevations to >20 ng/L occurred in 0.7% of Victoza®-treated patients, 0.3% of placebo-treated patients, and 0.5% of active-comparator-treated patients, with an incidence of 1.1% among patients treated with 1.8 mg/day of Victoza®. The clinical significance of these findings is unknown. Counsel patients regarding the risk for MTC and the symptoms of thyroid tumors (e.g. a mass in the neck, dysphagia, dyspnea or persistent hoarseness). It is unknown whether monitoring with serum calcitonin or thyroid ultrasound will mitigate the potential risk of MTC, and such monitoring may increase the risk of unnecessary procedures, due to low test specificity for serum calcitonin and a high background incidence of thyroid disease. Patients with thyroid nodules noted on physical examination or neck imaging obtained for other reasons should be referred to an endocrinologist for further evaluation. Although routine monitoring of serum calcitonin is of uncertain value in patients treated with Victoza®, if serum calcitonin is measured and found to be elevated, the patient should be referred to an endocrinologist for further evaluation. **Pancreatitis: Based on spontaneous postmarketing reports, acute pancreatitis, including fatal and non-fatal hemorrhagic or necrotizing pancreatitis, has been observed in patients treated with Victoza®. After initiation of Victoza®, observe patients carefully for signs and symptoms of pancreatitis (including persistent severe abdominal pain, sometimes radiating to the back and which may or may not be accompanied by vomiting). If pancreatitis is suspected, Victoza® should promptly be discontinued and appropriate management should be initiated. If pancreatitis is confirmed, Victoza® should not be restarted. Consider antidiabetic therapies other than Victoza® in patients with a history of pancreatitis.** In clinical trials of Victoza®, there have been 13 cases of pancreatitis among Victoza®-treated patients and 1 case in a comparator (glimepiride) treated patient (2.7 vs. 0.5 cases per 1000 patient-years). Nine of the 13 cases with Victoza® were reported as acute pancreatitis and four were reported as chronic pancreatitis. In one case in a Victoza®-treated patient, pancreatitis, with necrosis, was observed and led to death; however clinical causality could not be established. Some patients had other risk factors for pancreatitis, such as a history of cholelithiasis or alcohol abuse. **Use with Medications Known to Cause Hypoglycemia:** Patients receiving Victoza® in combination with an insulin secretagogue (e.g., sulfonylurea) or insulin may have an increased risk of hypoglycemia. The risk of hypoglycemia may be lowered by a reduction in the dose of sulfonylurea (or other concomitantly administered insulin secretagogues) or insulin **Renal Impairment:** Victoza® has not been found to be directly nephrotoxic in animal studies or clinical trials. There have been postmarketing reports of acute renal failure and worsening of chronic renal failure, which may sometimes require hemodialysis in Victoza®-treated patients. Some of these events were reported in patients without known underlying renal disease. A majority of the reported events occurred in patients who had experienced nausea, vomiting, diarrhea, or dehydration. Some of the reported events occurred in patients receiving one or more medications known to affect renal function or hydration status. Altered renal function has been reversed in many of the reported cases with supportive treatment and discontinuation of potentially causative agents, including Victoza®. Use caution when initiating or escalating doses of Victoza® in patients with renal impairment. **Hypersensitivity Reactions:** There have been postmarketing reports of serious hypersensitivity reactions (e.g., anaphylactic reactions and angioedema) in patients treated with Victoza®. If a hypersensitivity reaction occurs, the patient should discontinue Victoza® and other suspect medications and promptly seek medical advice. Angioedema has also been reported with other GLP-1 receptor agonists. Use caution in a patient with a history of angioedema with another GLP-1 receptor agonist because it is unknown whether such patients will be predisposed to angioedema with Victoza®. **Macrovascular Outcomes:** There have been no clinical studies establishing conclusive evidence of macrovascular risk reduction with Victoza® or any other antidiabetic drug.

ADVERSE REACTIONS: Clinical Trials Experience: Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. The safety of Victoza® has been evaluated in 8 clinical trials: A double-blind 52-week monotherapy trial compared Victoza® 1.2 mg daily, Victoza® 1.8 mg daily, and glimepiride 8 mg daily; A double-blind 26 week add-on to metformin trial compared Victoza® 0.6 mg once-daily, Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, placebo, and glimepiride 4 mg once-daily; A double-blind 26 week add-on to glimepiride trial compared Victoza® 0.6 mg daily, Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, placebo, and rosiglitazone 4 mg once-daily; A 26 week add-on to metformin + glimepiride trial, compared double-blind Victoza® 1.8 mg once-daily, double-blind placebo, and open-label insulin glargine once-daily; A double-blind 26-week add-on to metformin + rosiglitazone trial compared Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily and placebo; An open-label 26-week add-on to metformin and/or sulfonylurea trial compared Victoza® 1.8 mg once-daily and exenatide 10 mcg twice-daily; An open-label 26-week add-on to metformin trial compared Victoza® 1.2 mg once-daily, Victoza® 1.8 mg once-daily, and sitagliptin 100 mg once-daily; An open-label 26-week trial compared insulin detemir as add-on to Victoza® 1.8 mg + metformin to continued treatment with Victoza® + metformin alone. *Withdrawals:* The incidence of withdrawal due to adverse events was 7.8% for Victoza®-treated patients and 3.4% for comparator-treated patients in the five double-blind controlled trials of 26 weeks duration or longer. This difference was driven by withdrawals due to gastrointestinal adverse reactions, which occurred in 5.0% of Victoza®-treated patients and 0.5% of comparator-treated patients. In these five trials, the most common adverse reactions leading to withdrawal for Victoza®-treated patients were nausea (2.8% versus 0% for comparator) and vomiting (1.5% versus 0.1% for comparator). Withdrawal due to gastrointestinal adverse events mainly occurred during the first 2-3 months of the trials. *Common adverse reactions:* Tables 1, 2, 3 and 4 summarize common adverse reactions (hypoglycemia is discussed separately) reported in seven of the eight controlled trials of 26 weeks duration or longer. Most of these adverse reactions were gastrointestinal in nature. In the five double-blind clinical trials of 26 weeks duration or longer, gastrointestinal adverse reactions were reported in 41% of Victoza®-treated patients and were dose-related. Gastrointestinal adverse reactions occurred in 17% of comparator-treated patients. Common adverse reactions that occurred at a higher incidence among Victoza®-treated patients included nausea, vomiting, diarrhea, dyspepsia and constipation. In the five double-blind and three open-label clinical trials of 26 weeks duration or longer, the percentage of patients who reported nausea declined over time. In the five double-blind trials approximately 13% of Victoza®-treated patients and 2% of comparator-treated patients reported nausea during the first 2 weeks of treatment. In the 26-week open-label trial comparing Victoza® to exenatide, both in combination with metformin and/or sulfonylurea, gastrointestinal adverse reactions were reported at a similar incidence in the Victoza® and exenatide treatment groups (Table 3). In the 26-week open-label trial comparing Victoza® 1.2 mg, Victoza® 1.8 mg and sitagliptin 100 mg, all in combination with metformin, gastrointestinal adverse reactions were reported at a higher incidence with Victoza® than sitagliptin (Table 4). In the remaining 26-week trial, all patients received Victoza® 1.8 mg + metformin during a 12-week run-in period. During the run-in period, 167 patients (17% of enrolled total) withdrew from the trial: 76 (46% of withdrawals) of these patients doing so because of gastrointestinal adverse reactions and 15 (9% of withdrawals) doing so due to other adverse events. Only those patients who completed the run-in period with inadequate glycemic control were randomized to 26 weeks of add-on therapy with insulin detemir or continued, unchanged treatment with Victoza® 1.8 mg + metformin. During this randomized 26-week period, diarrhea was the only adverse reaction reported in ≥5% of patients treated with Victoza® 1.8 mg + metformin + insulin detemir (11.7%) and greater than in patients treated with Victoza® 1.8 mg and metformin alone (6.9%).

Table 1: Adverse reactions reported in ≥5% of Victoza®-treated patients in a 52-week monotherapy trial

	All Victoza® N = 497	Glimepiride N = 248
Adverse Reaction	(%)	(%)
Nausea	28.4	8.5
Diarrhea	17.1	8.9
Vomiting	10.9	3.6
Constipation	9.9	4.8
Headache	9.1	9.3

Table 2: Adverse reactions reported in ≥5% of Victoza®-treated patients and occurring more frequently with Victoza® compared to placebo: 26-week combination therapy trials

Add-on to Metformin Trial			
	All Victoza® + Metformin N = 724	Placebo + Metformin N = 121	Glimepiride + Metformin N = 242
Adverse Reaction	(%)	(%)	(%)
Nausea	15.2	4.1	3.3
Diarrhea	10.9	4.1	3.7
Headache	9.0	6.6	9.5
Vomiting	6.5	0.8	0.4
Add-on to Glimepiride Trial			
	All Victoza® + Glimepiride N = 695	Placebo + Glimepiride N = 114	Rosiglitazone + Glimepiride N = 231
Adverse Reaction	(%)	(%)	(%)
Nausea	7.5	1.8	2.6
Diarrhea	7.2	1.8	2.2

Constipation	5.3	0.9	1.7
Dyspepsia	5.2	0.9	2.6
Add-on to Metformin + Glimepiride			
	Victoza® 1.8 + Metformin + Glimepiride N = 230	Placebo + Metformin + Glimepiride N = 114	Glargine + Metformin + Glimepiride N = 232
Adverse Reaction	(%)	(%)	(%)
Nausea	13.9	3.5	1.3
Diarrhea	10.0	5.3	1.3
Headache	9.6	7.9	5.6
Dyspepsia	6.5	0.9	1.7
Vomiting	6.5	3.5	0.4
Add-on to Metformin + Rosiglitazone			
	All Victoza® + Metformin + Rosiglitazone N = 355	Placebo + Metformin + Rosiglitazone N = 175	
Adverse Reaction	(%)	(%)	
Nausea	34.6	8.6	
Diarrhea	14.1	6.3	
Vomiting	12.4	2.9	
Headache	8.2	4.6	
Constipation	5.1	1.1	

Table 3: Adverse Reactions reported in ≥5% of Victoza®-treated patients in a 26-Week Open-Label Trial versus Exenatide

	Victoza® 1.8 mg once daily + metformin and/or sulfonylurea N = 235	**Exenatide 10 mcg twice daily + metformin and/or sulfonylurea** N = 232
Adverse Reaction	(%)	(%)
Nausea	25.5	28.0
Diarrhea	12.3	12.1
Headache	8.9	10.3
Dyspepsia	8.9	4.7
Vomiting	6.0	9.9
Constipation	5.1	2.6

Table 4: Adverse Reactions in ≥5% of Victoza®-treated patients in a 26-Week Open-Label Trial versus Sitagliptin

	All Victoza® + metformin N = 439	**Sitagliptin 100 mg/day + metformin** N = 219
Adverse Reaction	(%)	(%)
Nausea	23.9	4.6
Headache	10.3	10.0
Diarrhea	9.3	4.6
Vomiting	8.7	4.1

Immunogenicity: Consistent with the potentially immunogenic properties of protein and peptide pharmaceuticals, patients treated with Victoza® may develop anti-liraglutide antibodies. Approximately 50-70% of Victoza®-treated patients in the five double-blind clinical trials of 26 weeks duration or longer were tested for the presence of anti-liraglutide antibodies at the end of treatment. Low titers (concentrations not requiring dilution of serum) of anti-liraglutide antibodies were detected in 8.6% of these Victoza®-treated patients. Sampling was not performed uniformly across all patients in the clinical trials, and this may have resulted in an underestimate of the actual percentage of patients who developed antibodies. Cross-reacting anti-liraglutide antibodies to native glucagon-like peptide-1 (GLP-1) occurred in 6.9% of the Victoza®-treated patients in the double-blind 52-week monotherapy trial and in 4.8% of the Victoza®-treated patients in the double-blind 26-week add-on combination therapy trials. These cross-reacting antibodies were not tested for neutralizing effect against native GLP-1, and thus the potential for clinically significant neutralization of native GLP-1 was not assessed. Antibodies that had a neutralizing effect on liraglutide in an *in vitro* assay occurred in 2.3% of the Victoza®-treated patients in the double-blind 52-week monotherapy trial and in 1.0% of the Victoza®-treated patients in the double-blind 26-week add-on combination therapy trials. Among Victoza®-treated patients who developed anti-liraglutide antibodies, the most common category of adverse events was that of infections, which occurred among 40% of these patients compared to 36%, 34% and 35% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. The specific infections which occurred with greater frequency among Victoza®-treated antibody-positive patients were primarily nonserious upper respiratory tract infections, which occurred among 11% of Victoza®-treated antibody-positive patients; and among 7%, 7% and 5% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. Among Victoza®-treated antibody-negative patients, the most common category of adverse events was that of gastrointestinal events, which occurred in 43%, 18% and 19% of antibody-negative Victoza®-treated, placebo-treated and active-control-treated patients, respectively. Antibody formation was not associated with reduced efficacy of Victoza® when comparing mean HbA_{1c} of all antibody-positive and all antibody-negative patients. However, the 3 patients with the highest titers of anti-liraglutide antibodies had no reduction in HbA_{1c} with Victoza® treatment. In the five double-blind clinical trials of Victoza®, events from a composite of adverse events potentially related to immunogenicity (e.g. urticaria, angioedema) occurred among 0.8% of Victoza®-treated patients and among 0.4% of comparator-treated patients. Urticaria accounted for approximately one-half of the events in this composite for Victoza®-treated patients. Patients who developed anti-liraglutide antibodies were not more likely to develop events from the immunogenicity events composite than were patients who did not develop anti-liraglutide antibodies. *Injection site reactions:* Injection site reactions (e.g., injection site rash, erythema) were reported in approximately 2% of Victoza®-treated patients in the five double-blind clinical trials of at least 26 weeks duration. Less than 0.2% of Victoza®-treated patients discontinued due to injection site reactions. *Papillary thyroid carcinoma:* In clinical trials of Victoza®, there were 7 reported cases of papillary thyroid carcinoma in patients treated with Victoza® and 1 case in a comparator-treated patient (1.5 vs. 0.5 cases per 1000 patient-years). Most of these papillary thyroid carcinomas were <1 cm in greatest diameter and were diagnosed in surgical pathology specimens after thyroidectomy prompted by findings on protocol-specified screening with serum calcitonin or thyroid ultrasound. *Hypoglycemia:* In the eight clinical trials of at least 26 weeks duration, hypoglycemia requiring the assistance of another person for treatment occurred in 11 Victoza®-treated patients (2.3 cases per 1000 patient-years) and in two exenatide-treated patients. Of these 11 Victoza®-treated patients, six patients were concomitantly using metformin and a sulfonylurea, one was concomitantly using a sulfonylurea, two were concomitantly using metformin (blood glucose values were 65 and 94 mg/dL) and two were using Victoza® as monotherapy (one of these patients was undergoing an intravenous glucose tolerance test and the other was receiving insulin as treatment during a hospital stay). For these two patients on Victoza® monotherapy, the insulin treatment was the likely explanation for the hypoglycemia. In the 26-week open-label trial comparing Victoza® to sitagliptin, the incidence of hypoglycemic events defined as symptoms accompanied by a fingerstick glucose <56 mg/dL was comparable among the treatment groups (approximately 5%).

Table 5: Incidence (%) and Rate (episodes/patient year) of Hypoglycemia in the 52-Week Monotherapy Trial and in the 26-Week Combination Therapy Trials

	Victoza® Treatment	**Active Comparator**	**Placebo Comparator**
Monotherapy	**Victoza®** (N = 497)	**Glimepiride** (N = 248)	**None**
Patient not able to self–treat	0	0	—
Patient able to self–treat	9.7 (0.24)	25.0 (1.66)	—
Not classified	1.2 (0.03)	2.4 (0.04)	—
Add-on to Metformin	**Victoza® + Metformin** (N = 724)	**Glimepiride + Metformin** (N = 242)	**Placebo + Metformin** (N = 121)
Patient not able to self–treat	0.1 (0.001)	0	0
Patient able to self–treat	3.6 (0.05)	22.3 (0.87)	2.5 (0.06)
Add-on to Victoza® + Metformin	**Insulin detemir + Victoza® + Metformin** (N = 163)	**Continued Victoza® + Metformin alone** (N = 158*)	**None**
Patient not able to self–treat	0	0	—
Patient able to self–treat	9.2 (0.29)	1.3 (0.03)	—
Add-on to Glimepiride	**Victoza® + Glimepiride** (N = 695)	**Rosiglitazone + Glimepiride** (N = 231)	**Placebo + Glimepiride** (N = 114)
Patient not able to self–treat	0.1 (0.003)	0	0
Patient able to self–treat	7.5 (0.38)	4.3 (0.12)	2.6 (0.17)
Not classified	0.9 (0.05)	0.9 (0.02)	0
Add-on to Metformin + Rosiglitazone	**Victoza® + Metformin + Rosiglitazone** (N = 355)	**None**	**Placebo + Metformin + Rosiglitazone** (N = 175)
Patient not able to self–treat	0	—	0
Patient able to self–treat	7.9 (0.49)	—	4.6 (0.15)
Not classified	0.6 (0.01)	—	1.1 (0.03)
Add-on to Metformin + Glimepiride	**Victoza® + Metformin + Glimepiride** (N = 230)	**Insulin glargine + Metformin + Glimepiride** (N = 232)	**Placebo + Metformin + Glimepiride** (N = 114)
Patient not able to self–treat	2.2 (0.06)	0	0
Patient able to self–treat	27.4 (1.16)	28.9 (1.29)	16.7 (0.95)
Not classified	0	1.7 (0.04)	0

*One patient is an outlier and was excluded due to 25 hypoglycemic episodes that the patient was able to self-treat. This patient had a history of frequent hypoglycemia prior to the study.

In a pooled analysis of clinical trials, the incidence rate (per 1,000 patient-years) for malignant neoplasms (based on investigator-reported events, medical history, pathology reports, and surgical reports from both blinded and open-label study periods) was 10.9 for Victoza®, 6.3 for placebo, and 7.2 for active comparator. After excluding papillary thyroid carcinoma events *[see Adverse Reactions]*, no particular cancer cell type predominated. Seven malignant neoplasm events were reported beyond 1 year of exposure to study medication, six events among Victoza®-treated patients (4 colon, 1 prostate and 1 nasopharyngeal), no events with placebo and one event with active comparator (colon). Causality has not been established. **Laboratory Tests:** In the five clinical trials of at least 26 weeks duration, mildly elevated serum bilirubin concentrations (elevations to no more than twice the upper limit of the reference range) occurred in 4.0% of Victoza®-treated patients, 2.1% of placebo-treated patients and 3.5% of active-comparator-treated patients. This finding was not accompanied by abnormalities in other liver tests. The significance of this isolated finding is unknown. **Vital signs:** Victoza® did not have adverse effects on blood pressure. Mean increases from baseline in heart rate of 2 to 3 beats per minute have been observed with Victoza® compared to placebo. The long-term clinical effects of the increase in pulse rate have not been established. **Post-Marketing Experience:** The following additional adverse reactions have been reported during post-approval use of Victoza®. Because these events are reported voluntarily from a population of uncertain size, it is generally not possible to reliably estimate their frequency or establish a causal relationship to drug exposure: Dehydration resulting from nausea, vomiting and diarrhea; Increased serum creatinine, acute renal failure or worsening of chronic renal failure, sometimes requiring hemodialysis; Angioedema and anaphylactic reactions; Allergic reactions: rash and pruritus; Acute pancreatitis, hemorrhagic and necrotizing pancreatitis sometimes resulting in death.

OVERDOSAGE: Overdoses have been reported in clinical trials and post-marketing use of Victoza®. Effects have included severe nausea and severe vomiting. In the event of overdosage, appropriate supportive treatment should be initiated according to the patient's clinical signs and symptoms.

More detailed information is available upon request.

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PHOTO BY SCOTT WALKER

Charles R. Meyer, M.D., Editor in Chief

What do you do with an M.D.?

An M.D. can be a ticket to more than pushing pills or removing appendices.

My high school friend and first-year college roommate headed to law school after graduating from Princeton. Following law school, he tossed his diploma in a drawer and became an agent for professional athletes. He subsequently served as CEO of a sporting goods company and now is the headmaster at an East Coast private school. He never practiced law and, as far as I know, never even dressed up as a lawyer on Halloween. Although he might say his law degree taught him skills of analysis and logical thought, his professional journey does provoke the question, "What do you do with a law degree?"

For that matter, what do you do with an M.D.? As I contemplated going to medical school, my template for a doctor was our family internist, Dr. Kirkland. Short, affable, a windsurfer with what seemed like boundless energy, he would breeze through the review of systems with the intensity of a gale-force wind. His physical exams were thorough, ending in a succinct summary of his findings. During my trek through medical training and beyond, I saw other uses for a medical degree in operating rooms, emergency rooms and rural clinics, with physicians performing tasks far different than what Dr. Kirkland did. But like my model internist, they all tended to the clinical needs of patients.

My first revelation that M.D.s could use their skills away from the clinical world came when one of my partners left our group in the early 1980s to become medical director of the Burlington Northern Railroad. Trading his stethoscope for a corporate title, he figuratively rode the rails, applying his medical knowledge to injuries and worker's compensation cases. I learned that an M.D. can be a ticket to more than pushing pills or removing appendices.

As the business of medicine became big business, many of the medically trained were not content to labor in the clinic. Increasingly, I saw fellow physicians traipsing off to night school to earn an M.B.A. with an eye toward doing something "administrative" or "in the leadership arena." Soon, a raft of health care CEOs emerged, sporting M.D.s and M.B.A.s after their names.

Although it did expose you to the larger issues of medical practice, full-time administrative work even in the rarefied air of the corporate boardroom seemed to me to be an unsatisfactory substitute for diagnosing and treating patients. Instead, I found that I could keep my clinical cake and nibble at the edges of organizational medicine through medical staff leadership, where I could tackle problems of quality monitoring and hospital operations while still seeing patients every day.

This issue of *Minnesota Medicine* documents that a career in medicine is not a simple, preset path. There are a multiplicity of journeys into, through and out of medicine. Many seem light-years removed from the anatomy lab or the clinic. But, like law, medicine can teach its students not just a body of knowledge but hopefully a perspective about the larger system of medical delivery.

I'm still basically doing Dr. Kirkland work, seeing a cast of patients every day. But my few administrative diversions have broadened my view of the wider medical world. **MM**

Charles Meyer can be reached at meyer073@umn.edu.

Susan Alpert, Ph.D., M.D., Peter Dehnel, M.D., and Joshua Riff, M.D., M.B.A., have all had somewhat unconventional medical careers.

Paths less chosen

Physicians show students nontraditional options in medicine.

BY KIM KISER

Despite the diversity in medicine today, physicians in most settings and specialties typically care for patients. But not all. Three Minnesota physicians who don't work in clinics or hospitals recently shared with University of Minnesota medical students how they make a living.

In November, Joshua Riff, M.D., M.B.A., Susan Alpert, Ph.D., M.D., and Peter Dehnel, M.D., spoke to about 30 students on the Twin Cities campus about their nontraditional careers; the session was sponsored by the MMA and Twin Cities Medical Society. Riff, an emergency medicine physician, is chief medical officer at Target Corporation. Alpert, a pediatrician, works with medical device start-ups. Dehnel, also a pediatrician, is medical director of utilization management for Blue Cross and Blue Shield of Minnesota.

Each described the trajectory their careers took after medical school and encouraged students to keep their options open.

Riff, who went through a joint M.D./M.B.A. program at Tufts University in suburban Boston, always saw himself as an entrepreneur. "By my second year in medical school, I knew I wasn't going to practice," he said.

As a student, he formed a consulting group and began working with hospitals on issues such as staffing levels and reducing wait times. But after seeing the effect 9/11 had on the U.S. economy, he decided he needed a back-up plan and did a residency in emergency medicine—a field that offered a flexible schedule. He joined Target in 2006, when the company was planning its retail clinics, and has been there ever since.

He currently oversees those clinics and promotes health and wellness among Target's employees. He also practices emergency medicine on the side at United Hospital in St. Paul. "As an ER doc, I help one patient at a time, and usually they have problems that are 100 percent preventable and I'm helping them at the last minute," he told the students. "[At Target], I really have a public health role. I get to manage a couple hundred thousand lives."

Alpert says she came to medicine late. She started her career as a bench researcher at Boston City Hospital and decided to go to medical school after working on several clinical projects. After doing a pediatrics residency at Montefiore Hospital in New York, she was looking for an infectious disease fellowship and found a joint program with Children's National Medical Center in Washington, D.C., and the Food and Drug Administration. "Rather than doing research, I became an FDA reviewer," she said. "I got hooked."

Alpert stayed with the FDA after the fellowship, helping evaluate drugs for approval in the United States. She later directed the Office of Device Evaluation at FDA's Center for Devices and Radiological Health. That work eventually led her to a job at Medtronic, where she was responsible for their global regulatory efforts. She now advises start-up companies. "I could never have done what I did had I not had the medical education and clinical training," she said.

Dehnel also did a residency in pediatrics and practiced in the metro area, eventually serving as medical director of Children's Physician Network. A colleague who was involved in the insurance industry got him interested in the field. "It was interesting to see how it had an effect on medicine," he said. He became medical director for utilization management at Blue Cross in 2011.

In that role, he brings the physician's perspective to the review of complex cases: "It's not hard to see how much of an influence insurance has on the health of your patients. To have a physician engaged is very important," he said.

Dehnel still sees patients on a limited basis. "It grounds me for what's important," he explained.

All three physicians encouraged the students to be creative when it comes to their careers. "The opportunities that are out there, if you're willing to think outside the box, are unlimited," Dehnel said. "But you need to figure out what's important to you."

Joel Greenwald, M.D., was recently named a top financial planner for physicians by *Medical Economics* magazine.

PHOTO COURTESY JOEL GREENWALD, M.D.

Specialized in finance

Physician-turned-financial planner Joel Greenwald on career and money

BY CARMEN PEOTA

In a bad moment, many physicians might think about veering from their career path. And a number of them do eschew practice for administrative positions. But few take as sharp a vocational turn as Joel Greenwald, M.D., did in the late 1990s after practicing internal medicine for 11 years.

Greenwald, who was working for HealthPartners in the Twin Cities at the time, found himself taking a hard look at his life. He and his wife, Carol Grabowski, M.D., a radiation oncologist, were both working long hours, and he was beginning to question whether it made sense for their family. "We had two kids, and then three. So there were the issues of raising the kids. Then there was concern about where medicine was headed, whether it made sense to have both of us in medicine," he recalls.

Those questions prompted Greenwald to explore his other interests, one of which was personal finance. So while he was still practicing, Greenwald began studying to become a certified financial planner. By the late 1990s, he had cut back his clinic work to three days a week. And by 2000, he cut it altogether. "The more I did it, the more I enjoyed it," he says of caring for his clients' financial health.

Professional advice

Although he acknowledges that financial planning is decidedly different than practicing medicine, Greenwald says there are parallels—namely, dealing with people and solving problems. "In medicine, people come to you with health problems. You figure out what's wrong and try to help them. In financial planning, people come to you with their money problems," he says. "They say, I haven't been doing this, I've been doing a bad job, take care of this for me. Fix this."

In Greenwald's case, the people coming to him are often physicians. More than half of his clients are docs, and another 25 percent are dentists. That's by design—he's targeted those professionals, offering them what other financial planners can't: "I can relate to them," he says. "I know what they do and how hard they work. I work hard now, but it's not the same as when you have people's lives entrusted into your care. I respect them."

Greenwald says he thinks physicians at all stages of their careers can use help when it comes to managing their money. But there are two periods when it's especially important: just after residency and a few years before retirement. "I absolutely love talking to physicians when they're just finishing residency and going into their first job," he says. "There are a few basic things they can do to get on a good trajectory."

One is to live within their means. Often, he says, young physicians have delayed gratification for so long, they feel they deserve a reward. "They buy a house that's too big and too expensive. They don't realize that when the roof needs fixing or the driveway needs paving on that million-dollar house, that it will cost a lot more than on a half-million-dollar house."

Another is to be realistic about how long they want to practice. "They think, 'If I just keep doing this thing I do that generates all this money, I'll be fine.' But maybe they'll want to slow down. If you have to make $700,000, you're trapped," he says.

> "I don't think being a physician was central to who I was."
>
> —Joel Greenwald, M.D.

On call—as dad

Greenwald says he doesn't consider going back to medicine, although he retains his license. He likes the flexibility financial planning affords. For example, nearly every day, he drives his youngest son, a swimmer, to practices or meets. "I'm the one who can reliably do that. I'm the schlepper."

Greenwald knows other physicians may not understand his decision to leave the profession. Even within his marriage, he knew if someone was to make a change, he was the one. "Being a physician is central to who she is," he says of his wife, adding, "I don't think being a physician was central to who I was."

Why they stay

Why do physicians stay in a practice? According to researchers at the Minnesota Department of Health's Office of Rural Health and Primary Care and their counterparts in Indiana and Wisconsin, salary is only part of the answer. Here are the top 10 factors that influence a physician's decision:

- Availability of relief coverage when taking time off
- Quality of public schools
- Compatibility with others in health care community
- Availability of quality housing
- Availability of practice partners and specialists
- Income potential
- Employment opportunities for spouse/partner
- Help with retiring education loans
- Availability of continuing education opportunities
- Opportunity to be a preceptor

Source: Midwest Retention Toolkit 2012 (www.in.gov/isdh/files/Midwest_Retention_Toolkit_Final_9_13_12.pdf)

Who's up, who's down?

In 2012, most specialties reported modest-to-significant increases in average annual income over the previous year, according to Medscape's 2013 physician compensation report. Here's a look at the big winners and losers.

The winners

- Orthopedics +27% ($405,000*)
- Nephrology +20% ($263,000*)
- Neurology +18% ($217,000*)

The losers

- Oncology -4% ($278,000*)
- Endocrinology/diabetes -3% ($178,000*)

*average annual income in 2012

Source: Medscape's Physician Compensation Report: 2013 (www.medscape.com/features/slideshow/compensation/2013/public)

WHAT IF... you weren't a doctor?

Compiled by the editors

All of us occasionally catch ourselves playing the "what if" game. What if I hadn't gone to medical school and become a doctor? What would I be?

We asked physicians to dream a little and tell us what career they would choose if they were to do it over. More than a dozen responded to our question.

Several saw themselves as educators, teaching elementary or middle school or college anatomy. One would have pursued wildlife biology. Another would have become a chef or baker because "it fills the need to use my hands and work creatively."

A few elaborated on their choices. Here's what they had to say.

Daniel R. Baker, M.D., a Twin Cities surgeon, would be a sculptor or architect. "These careers rated highest on my aptitude tests; plus, over the years I have been drawn to study both," he says. He currently does wood sculpture in his spare time.

Kevin Manzel, D.O., would have become a tennis instructor. "I've played tennis all my life and worked as an instructor for many summers while in school. I enjoy the way the sport challenges both the body's and the mind's endurance," he says. Manzel, a family medicine resident at Methodist Hospital, still plays as often as he can.

Fred Hall, M.D., a pathologist in Brainerd, would have followed family tradition and become a pharmacist. "I started in pharmacy since my grandfather was a pharmacist, my sister and her husband were pharmacists, and other relatives were pharmacists," he writes, adding that he went to the same pharmacy school as his grandfather and sister. After four years of college, he had an opportunity to go to medical school and chose that path instead. "I was interested in science and microscopy, so I became a pathologist," he says.

Aaron Crosby, a fourth-year medical student at the University of Minnesota, would be a ranger in one of the national parks. "I think rangers embody many of the same core values as physicians—they are public servants, educators and professionals," he says. Crosby worked as a docent at a Minnesota park and felt it was "a privilege to teach the public about a place that our society valued enough to set aside." He hopes that in his retirement he can one day work for or volunteer with the National Park Service. "Until then, I will work on my goal of visiting every U.S. National Park."

Neal Holtan, M.D., M.P.H., Ph.D., a preventive medicine physician and adjunct faculty in the University of Minnesota's School of Public Health, would be a historian—something he's been working toward for a number of years. Holtan earned a doctorate in the history of medicine in 2011. Although he considers his study of history a side activity at the moment, he says he plans to dedicate more time to it in retirement.

Neel Shah, M.B. B.Ch., a hospitalist and medical geneticist at Mayo Clinic, admits he still thinks about this question from time to time. "Not because I am unhappy or unfulfilled in clinical practice, quite the opposite. But now that I have children, it's interesting to consider how

young people decide what they want out of life," he says. Shah initially considered a career in law, but didn't go that route. "I shadowed several lawyers to no avail. I had read too much Jeremy Bentham to convince myself about the culture of that profession," he explains. He ultimately chose medicine, as he found biology and discoveries in genetics far too interesting. "I also felt medicine was the way that I could make a difference," he says. Had he not gone into medicine, he would have become a journalist. "The past few months have been a distinct reminder about what I admire about the Fourth Estate, its ethical ideals and role in a civilized society. People at outlets like *The Guardian* who, at enormous risk to themselves, have publicized the lengths to which Power can extend in order to remain unchecked."

Keith Swetz, M.D., says his family and friends tell him that if he weren't a physician, he would be a customer service agent for an airline or a travel agent. "I wasn't on an airplane until I was 21, and now I tend to be the go-to guy for finding discounted tickets or thinking about alternate travel plans during delays," he says.

Dean R. Myers, M.D., a family physician in Princeton, says realistically he may have been a mortician. "As a mortician, there are great opportunities to work with people, but the overnights and call would have been more limited." But watching the show "American Restoration" gave him another idea: "If I knew people would pay for restoration of old mechanical items, I might have done that. It appeals to my mechanical, inquisitive mind," he says.

Jon Hallberg, M.D., a family physician at Mill City Clinic, would have been a high school teacher. "I loved school—all levels, elementary through college," he says. "My wife is a teacher and I see the impact she's having on her students." Although he teaches medical students at the University of Minnesota and considers every patient encounter … "an opportunity to teach," he says he doesn't think of himself as a "true teacher." That's because most of his time is spent in the clinic providing patient care and doing administrative work.

Dale Anderson, M.D., would have been an actor/speaker—vocations he has been pursuing in retirement. He now considers himself an "aged sage of the vintage stage" and uses his talents to promote wellness among physicians and the public. **MM**

PHOTO COURTESY OF CENTRACARE

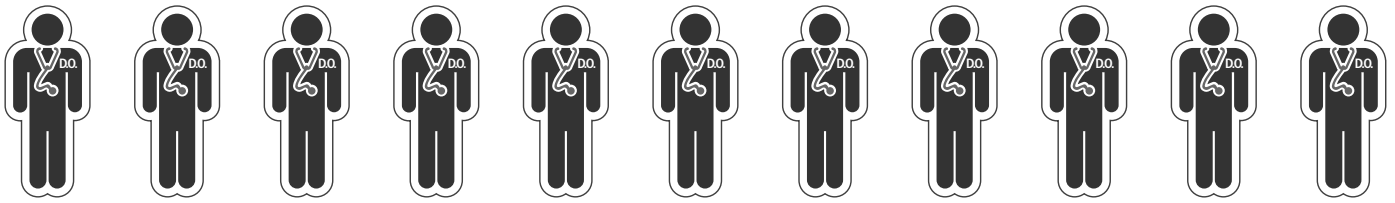
Barbi Kaplan-Frenkel, D.O., serves as medical director for radiation oncology at CentraCare in St. Cloud.

Growth spurt

One of every five new physicians is a D.O.—and their ranks are growing.

BY HOWARD BELL

Minneapolis neurologist Mary Chiasson, D.O., remembers the time she went to the hospital to see a patient who asked, "What's the eye doctor doing here? There's nothing wrong with my eyes." She had to explain that a D.O. is a fully licensed physician trained just like any other doctor. "That was 20 years ago and that rarely happens anymore," she says.



Today, doctors of osteopathic medicine are so commonly found working alongside their M.D. colleagues that to most patients the only difference between them is the letters after their name. D.O.s specialize in all fields of medicine, they hold leadership positions throughout Minnesota and their ranks are growing quickly.

Mary Chiasson, D.O.

More than 20 percent of all medical students now attend one of the nation's 30 colleges of osteopathic medicine, according to the American Association of Colleges of Osteopathic Medicine (AACOM). Those schools have seen a 96 percent increase in enrollment since 2002, compared with an 18 percent increase at allopathic medical schools. With three new colleges opening in 2013 and several more in the planning stages, enrollment at osteopathic medical schools is expected to grow another 125 percent by 2017. At that pace, by 2019, one of every four newly minted physicians will be a D.O.

For now, the American Osteopathic Association (AOA) estimates D.O.s make up 6.5 percent of the U.S. physician population. Six hundred are licensed to practice in Minnesota, compared with 20,754 M.D.s. Two-thirds practice primary care, and the percentage of D.O.s working in rural or underserved areas is greater than that of M.D.s.

Similar-but-different training

Students at osteopathic medical schools complete four years of academic study at an institution accredited by the AOA's Commission on Osteopathic College Accreditation. (The closest one to Minnesota is the Des Moines University College of Osteopathic Medicine.)

Before they can be licensed, D.O.s must pass a three-step exam called the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA), which is similar to the United States Medical Licensing Examination (USMLE). Minnesota's Board of Medical Practice licenses D.O.s.

Like allopathic medical students, first- and second-year osteopathic medical students are served large helpings of anatomy, physiology, biochemistry and other core science subjects. Third- and fourth-year students complete clinical rotations at local hospitals, usually in family medicine, internal medicine, general surgery, pediatrics, obstetrics/gynecology, psychiatry and sometimes emergency medicine.

One of the biggest differences is that D.O. students receive instruction in osteopathic manipulative treatment (OMT). OMT is used to treat musculoskeletal problems and relieve pain such as that caused by carpal tunnel syndrome, men-

struation, migraines and sinus disorders (see p. 14).

The other big difference is that D.O.s are taught to take a whole-person approach to treating patients. "From the first day of medical school, we are trained to understand the musculoskeletal system's importance to health and the power of the body to heal itself," says Jennifer Johnson, D.O., president of the Minnesota Osteopathic Medical Society and a family physician at Mayo Clinic Health System Mankato-Northridge. "We are taught to look at the whole patient—body, mind and spirit, including lifestyle, in order to treat not only specific symptoms but the underlying cause of those symptoms."

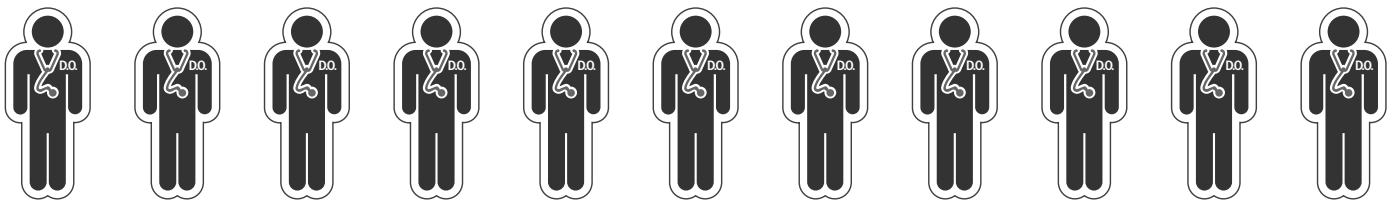
D.O.s will evaluate patients with back pain, for example, by looking for the root cause, just as M.D.s do. But they also might evaluate a patient for depression or social stressors that can cause symptoms to worsen or prevent that patient from getting better. D.O.s might use OMT if they feel it will help, but they also might refer the patient to a dietitian for weight-loss counseling to prevent future back pain. Or they might arrange for instruction in back-strengthening exercises. Of course, M.D.s might take a similar approach. But D.O.s say prevention is their focus.

Although they prescribe pain medications as indicated in the same way M.D.s do, D.O.s might be more willing to embrace alternative treatments such as acupuncture or massage. "D.O.s are generally not so quick to reach for the prescription pad," says St. Cloud radiation oncologist Barbi Kaplan-Frenkel, D.O.

Choice of residencies

D.O.s can either do a residency at an AOA-accredited program or an allopathic program accredited by the Accreditation Council for Graduate Medical Education (ACGME). Afterward, they can apply to take the AOA board certification exam (if they completed an osteopathic residency) or an allopathic board certification exam (if they completed an allopathic residency). D.O.s who complete an allopathic residency can still take the osteopathic exam, if they want, and some do sit for both.

Since 1985, allopathic residency programs have had the option of being dually accredited by the AOA and ACGME. To be dually accredited, a program must have a formal relationship with an osteopathic medical school. The University of Minnesota's family medicine residency programs in St. Cloud and Mankato are the only dually accredited residencies in Minnesota. Mankato is affiliated with Des Moines University College of Osteopathic Medicine; St. Cloud with Kansas City University of Medicine and Biosciences' College of Osteopathic Medicine.



Growing pains

Osteopathic medical schools are expanding. Three new colleges opened in 2013, with several more in the planning stages, according to the American Association of Colleges of Osteopathic Medicine (AACOM). Others are increasing their class size.

The big wave of newly minted D.O.s could help reduce the projected shortage of primary care doctors, especially in rural and underserved areas, provided there are enough residency positions for them.

AOA-accredited residencies are expanding the number of slots they offer. But half of D.O.s complete ACGME-accredited residencies. Because allopathic medical schools are also ramping up enrollments, there's going to be far more competition for those slots.

An article in the July 25, 2013, *New England Journal of Medicine* noted it may soon be impossible for all graduates of U.S. medical and osteopathic colleges to secure slots. "For D.O.s who already have to jump a higher bar to get into allopathic residencies, it's going to get even tougher," says Robert Miner, M.D., director of Abbott Northwestern Hospital's internal medicine residency program. That program has accepted one or two D.O.s in recent years and has seen an uptick of D.O. applicants.–H.B.

D.O.s "are taught to look at the whole patient—body, mind and spirit, including lifestyle, in order to treat not only specific symptoms but the underlying cause of those symptoms."

–JENNIFER JOHNSON, D.O.

About half of D.O.s complete allopathic residencies, according to the AACOM. Although all allopathic residencies are technically open to D.O.s, AOA figures show the D.O. match rate for many specialty programs is much lower than that for M.D.s. Match rates for primary care residencies, however, are 98 percent for both D.O.s and M.D.s.

"In general, D.O.s have little or no difficulty getting M.D. primary care residency slots," says Leonid Skorin Jr., D.O., an ophthalmologist with Mayo Clinic Health System in Albert Lea and past president of the Minnesota Osteopathic Medical Society. "Slots in surgery, ENT, dermatology and ophthalmology can be difficult to get because these programs are especially coveted by M.D. candidates."

"Slots in surgery, ENT, dermatology and ophthalmology can be difficult to get because these programs are especially coveted by M.D. candidates."

–LEONID SKORIN JR., D.O.

At Duluth's family medicine residency program, one or two of the 10 residents in each class are D.O.s. "It's more the result of the mix of D.O.s/M.D.s applying than any preference for one or the other," says Katherine Dean, M.B.A., director of health science and medical education for Essentia's Institute of Rural Health in Duluth.

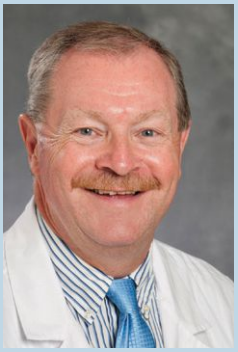
In 2013, Abbott Northwestern's internal medicine residency program received 50 applications from D.O.s for its 10 residency slots—a 25 percent increase over 2012. "We've had a D.O. or two in each class for the last several years," says program director Robert Miner, M.D. "That wasn't happening 10 years ago."

Miner admits that most allopathic residencies would rather fill with M.D.s. "If two applicants are equally qualified in every way, but one is a D.O., I'm sure most allopathic programs would take the M.D. candidate."

After getting her D.O. degree at the New York Institute of Technology College of Osteopathic Medicine, Kaplan-Frenkel completed an allopathic residency at Montefiore Medical Center at the Albert Einstein College of Medicine and a fellowship in radiation implants at New York University Booth Memorial Medical Center. She's double-boarded in radiation oncology by the American Board of Radiology and the American Osteopathic Board of Radiology. Although she says she did not have difficulty getting a slot in an M.D. program in 1991, she knows that isn't always the case. "I've heard from some of my D.O. colleagues that as D.O.s they had to work harder to be recognized. Perhaps there is some truth in that."

Osteopathic manipulative treatment

Osteopathic manipulative treatment (OMT) was developed in 1874 by the founder of osteopathic medicine, surgeon Andrew Taylor Still, M.D., D.O. Today many D.O.s use OMT for musculoskeletal pain, carpal tunnel syndrome, sinus disorders, breathing problems and menstrual pain. It is used as a complement to, not a substitute for, medications or other medical treatments. All D.O.s receive at least 200 hours of OMT training.



Keith Olson, D.O., M.H.A.

Although chiropractic manipulations target similar areas of the body, OMT uses a completely different set of techniques with names such as "muscle energy techniques," "counterstrain," "high velocity/low amplitude," "myofascial release" and "lymphatic pump."

Leonid Skorin Jr., D.O., who works for Mayo Clinic Health System in Albert Lea, doesn't have much need for OMT because he's an ophthalmologist, but he does use it to treat headaches caused by muscle tension in some of his patients. "I don't think D.O.s are moving away from OMT," he says. "Many use it in addition to other therapies when it's indicated."

Family physician Keith Olson, D.O., M.H.A., who practices at Allina Health in Farmington, uses OMT on about 10 percent of his patients. Recently, he used it on a 34-year-old patient with rib lesion pain and on a 12-year-old with torticollis.

St. Cloud radiation oncologist Barbi Kaplan-Frenkel, D.O., recently saw a breast cancer patient who had shoulder, arm and neck pain following lymph node surgery and radiation treatments. "After ruling out metastatic disease," she says, "I referred her to a D.O. colleague who used OMT to significantly reduce her pain and her need for pain medication."

Jennifer Johnson, D.O., a family physician at Mayo Clinic Health System Mankato-Northridge, uses OMT to treat muscle pain and on patients with upper respiratory infections or asthma to help ears drain, reduce secretions and improve breathing.

Minneapolis neurologist Mary Chiasson, D.O., uses OMT on certain patients with pain. "It doesn't cure migraines," she says. "But it relieves the back and muscle pain that migraines often cause." For patients with back, arm or neck pain not caused by disc herniation, Chiasson says, OMT can increase range of motion and decrease pain and tenderness. "It's better than drugs," she says. "There are no side effects, and people are happier because we've corrected a mechanical problem instead of just masking it."– H.B.

Prejudice fading

As the lines between D.O.s and M.D.s continue to blur, D.O.s are becoming more accepted by both patients and their M.D. colleagues. Up until a few years ago, the "Best Doctors" awards in a popular Minnesota magazine rejected all D.O. nominees. But now D.O.s are included each year. Kaplan-Frenkel says what little prejudice against D.O.s she's encountered over her 21-year career "is pretty subtle." "Mostly what I've encountered is more ignorance than prejudice that simply required education, and that has certainly decreased over time."

Chiasson, who works at Noran Neurological Clinic and is one of four D.O.s among 28 M.D.s, says the comments she hears from colleagues are generally positive. "They want to know if I can use OMT on their sore neck," she says.

Any lingering prejudice may have more to do with the relative value placed on the two degrees, says Abbott Northwestern's Miner. "I'm not saying most D.O. students would rather be M.D.s, but I know the reverse isn't true, because right or wrong, a medical degree is viewed as more prestigious, not because it better prepares you to be a doctor."

That hasn't stopped Minnesotans with D.O. credentials from becoming leaders. Ruth Westra, D.O., M.P.H., chairs the family medicine and community health department at the University of Minnesota Medical School, Duluth. Kaplan-Frenkel is medical director for radiation oncology for CentraCare Clinics in St. Cloud. Family physician Keith Olson, D.O., M.H.A., is Allina Health's southeast region medical director.

Merger unlikely

Neither D.O.s nor M.D.s appear to be interested in merging the two professions, says Boyd Buser, D.O., an AOA Trustee and spokesperson. In October 2012, the AOA and ACGME began discussions about unifying their graduate medical education accreditation systems. "But for now no agreement has been reached," he says. "While D.O.s and M.D.s have much in common, osteopathic medicine is a parallel branch of American medicine with a distinct philosophy and approach to patient care."

Kaplan-Frenkel agrees that the two arms of medicine need to keep their separate identities. "Our guiding principles and philosophy are so different, and we would lose that if the two professions merged," she says.

Chiasson says it's valuable to have both views. "If we merged, we would lose that preventive treat-the-whole-patient-not-just-their-symptoms bias that I really believe in and that attracted many of us to osteopathic medicine in the first place," she says. "Each profession brings strengths to the table. Osteopathic medical schools do a great job of primary care training and allopathic medicine does specialty training very well. If we work together as separate professions, we get the best that both offers. That's good for us, and it's good for our patients." **MM**

Howard Bell is a medical writer and frequent contributor to *Minnesota Medicine*.

Osteopathic medicine timeline

1874 – Surgeon Andrew Taylor Still, M.D., D.O., introduces the medical community to OMT and encourages all physicians to incorporate it into their practices. Still's philosophy is that medicine must do more than repair, relieve or remove the effects of disease. It must prevent it and find the underlying cause of it.

1892 – Still opens the first osteopathic medical school in Kirksville, Missouri.

1896 – The nation's third osteopathic medical school, The Northern College of Osteopathy, opens in Minneapolis.

1897 – The American Osteopathic Association (AOA) is established to enforce common standards for osteopathic education.

1898 – Still's two sons open an osteopathic clinic in Red Wing, Minnesota.

1899 – The Minnesota Osteopathic Medical Society is founded.

1902 – The Northern College of Osteopathy in Minneapolis closes when it merges with the Des Moines University College of Osteopathic Medicine.

1903 – The AOA begins accrediting osteopathic medical schools.

1916 – Osteopathic medical schools begin requiring a four-year curriculum.

1929 – D.O. training begins including pharmacology and the use of vaccines and other drugs.

Last half of 20th century – Osteopathic and allopathic medicine see a growing similarity in their training and standardized tests.

1960 – The AOA has established 11 osteopathic specialty boards that certify D.O.s in fields including radiology, surgery, pediatrics, internal medicine and anesthesiology.

Mid-1960s – The AMA opens its membership to D.O.s. D.O.s are encouraged to apply to allopathic residency programs.

1995 to present – Fifty percent of D.O.s complete allopathic residencies.

2013 – One in five medical students attends an osteopathic medical school.

2019 – One of every four physicians will be a D.O., according to projections published in a 2009 issue of *Academic Medicine*.

Sources: Iglehart J, The residency mismatch, *New England Journal of Medicine*, October 15, 2013, 297-299; *Osteopathic Medicine: An American Reformation*, AOA, 1987; Goblirsch E, *The History of Osteopathy in Minnesota*, Minnesota Osteopathic Medical Society, 1982; Grevitz N. The transformation of osteopathic medical education. *Acad Med*. 2009:701-6.

A family tradition

Sons and daughters who followed their parents into medicine

BY KATE LEDGER

PHOTO COURTESY OF MAYO CLINIC

Andrea Wahner-Hendrickson, M.D., and her mother Dietland Wahner-Roedler, M.D., are the first mother-daughter physician duo to work at Mayo Clinic.

Andrea Wahner-Hendrickson knew from the time she was a child that she wanted to be a doctor. It helped that she lived with two role models: Her mother, Dietlind Wahner-Roedler, M.D., is an internist and her father, Heinz Wahner, M.D., is the former head of nuclear medicine, both at Mayo Clinic. Even as she spent long evenings waiting around doing homework in a parent's office, what she felt keenly was the significance of her parents' jobs. In particular, her mother's career in primary care made an impression. "We would happen to be out places and would meet patients, and they would just give her big hugs. We'd hear stories about how she'd helped them," Andrea says. "I always knew I wanted a career where I could have an impact on someone's life."

Since landing her first job two years ago as an oncologist at Mayo Clinic, Andrea now occasionally sees her mother in the hall or meets her for a quick lunch during the work day (her father retired in 1994). Because they share an interest in women's cancers—Andrea specializes in ovarian and Dietlind sees patients in Mayo's Breast Clinic—they occasionally talk over the details of a complicated case. "That's been amazing, to share that with a parent," Andrea says.

Medicine has a long history of children following their parents into the trade. Hippocrates learned medicine from his father and grandfather. His two sons and son-in-law also treated patients. Medicine in Minnesota is synonymous with the Mayo family. During the Civil War, surgeon William Worrall Mayo moved to southern Minnesota to examine recruits for the Union Army. After the war, he stayed in the area to practice medicine. His two sons, William J. and Charles H. Mayo, would accompany him on patient visits and help with autopsies. According to William, the younger son, "We came along in medicine like farm boys do on a farm," learning by doing. After graduating from medical schools in the Midwest, both sons returned to Rochester, joined their father's practice and helped found Mayo Clinic.

Data about the extent to which medicine runs in families are sparse. When asked, the research team at the American Medical Association (AMA) said it was "not aware of any tracking of generational family affiliations among physicians." Earlier this year, it seemed the habit of physicians' encouraging their children to pursue the profession might be in jeopardy. A Physicians' Foundation survey found a "high degree of disillusionment" in the field and reported that 58 percent of doctors said they would not encourage their children to go into medicine. (Another survey, sponsored by *Physicians Practice* magazine, put the figure at only 17 percent.)

But children still follow their parents into the field, and those who do understand the realities. They know what it's like to grow up with a parent who gets called to the hospital during the middle of dinner or who misses the school play because it's flu season and clinic is running late. Many have also heard stories about how their parents made a difference in patients' lives. We talked with some multigeneration physician families to find out what ultimately inspired the younger generation also to pursue medicine and how working in the profession has changed over the years.

A different environment

When Andrea Wahner-Hendrickson started working at Mayo Clinic, she and her mother, Dietlind, were pleased and also surprised to learn they were the first mother-daughter physician duo in Mayo Clinic's history. Neither had ever considered it remarkable to be a woman in medicine.

Dietlind, who entered medical school at Freie Univesität Berlin in 1960, had known several other girls from her high school class who were interested in becoming doctors. "I didn't think about it much at all," she says. After two years of internships, one in Germany and one at Somerset Hospital in New Jersey, she interviewed at Mayo Clinic, where she completed her residency. Although she felt wholly supported by colleagues in internal medicine, she would occasionally encounter signs of women's limited presence. "There was no overnight on-call room

for women at Methodist Hospital, so they assigned me a patient room," she remembers.

The early years of juggling career and family were particularly hard. During her residency, she met her husband, then a staff physician at Mayo. When their first child was born in 1973 during her hematology fellowship, she had no maternity leave and used her vacation days to spend time at home. Her next three children were born after she joined the staff, and by then she was able to take six weeks of maternity leave with each child. (With the youngest, she decided to take six weeks paid and six unpaid.) "There was no flexibility," she says. "I remember asking to work 50 percent (mornings only) for six months rather than get three full months off, but this was declined." She remembers relying on live-in babysitters, *au pairs* and occasional lengthy stays by grandparents visiting from Germany to care for the children while she and her husband were at work. "You did what you had to do, and I was glad to do it," she says.

The idea of working long hours while raising children didn't faze Andrea because she had seen her mother do it. "I think my mother made it look easy," she says. When Andrea got to medical school at the University of Minnesota, she realized she was interested in patient care like her mother, but she was also compelled by research, particularly tumor biology. She established a rigorous career plan during residency and fellowship that involved both treating patients and developing new drugs for ovarian cancer.

She says the work environment is significantly different from that which her mother stepped into decades ago. Her department recently hired several women with young families, and they have established an informal network. "We try to get together for dinner every month or so, and it is a wonderful support system. It helps to know that there are others who understand the challenges of juggling medicine, research and family," she says.

As she and her husband, a commercial insurance agent who's also entered his family's business, have navigated their careers and the care of their three children, she says Mayo has been very supportive. With her most recent baby, who is now eight months old, she was able to take 12 weeks of maternity leave. Moreover, the pushback to spend time with family is no longer exclusively a women's issue. "Many people, men and women, want to be able to make it to their kids' activities after work."

On difficult days, Andrea still holds onto the encouraging words her mother offered when she was in residency with young children: "My mother said, 'You're tired now, but you'll pull through it.' And it meant a lot because she's been there, too. She's the one who showed me it's all possible."

Not about the money

One reason *not* to go into medicine, family physician Paul Bergstrand, M.D., told his kids, is money. "They've heard me say it a hundred times," he says. For the hours and effort he put into his education and training, he figures he could have made considerably more doing something else. "I worked a hundred hours a week through medical school and residency and came out with huge, huge debt. It's nice that you get compensated [in medicine] for the effort, but that's not why you do it."

PHOTO COURTESY OF MARILYN PEITSO

Medical student Robyn Hegland with her mother, St. Cloud pediatrician Marilyn Peitso, M.D.

As the son of a Lutheran minister, Bergstrand was drawn to a career in which he could help people. He became the first in his family to go to medical school, studying at State University of New York in Buffalo and returning to Minnesota for residency at Methodist Hospital. He discovered family medicine enabled him to not only help people address a wide range of health issues but also establish long-term relationships with them.

For the last 26 years, Bergstrand has worked at Alexandria Clinic, a group with 50 physicians and other providers in Alexandria, Minnesota. He often sees more than 30 patients a day—"babies, the elderly and then everything in between—diabetics, hypertensives, heart issues, [doing] small procedures, removal of moles, skin biopsies, joint injections," he says. Once a week, he visits patients at a nursing home in nearby Osakis. Often, appointments keep him at the clinic until 7 p.m., and during the months he was learning to use the clinic's electronic medical record, he sometimes stayed until midnight to enter patient records.

"It was really tough, but I wasn't willing to compromise on the quality of reporting, and I wouldn't sit and look at the computer instead of looking at my patients," he says. Over the years, he's been deliberate about spending quality time with his family, for example, scheduling afternoons to attend his children's tennis matches. Each year, he and his wife planned several brief family vacations, but last year when he had a knee replacement was the first time since high school he had taken two weeks off in a row.

When Bergstrand's son Mark and daughter Ann, now both in their twenties, each decided a few years ago to apply to medical school, he didn't have to warn them about the long hours. "They'd lived it," he says. He acknowledges his arduous schedule

is a matter of how he wants to practice medicine; he's noticed that younger partners tend to request more restricted hours. (That's the trend, according to the AMA. In recent years, primary care physicians ages 35 to 49 years have been working fewer hours on average than those who are 50 to 64 years of age.)

But his energy and enthusiasm for his work have made an impression. "I hope I'm able to have the kind of strength he has," says Ann, now a second-year medical student at the University of Minnesota-Duluth, where the focus is training primary care physicians to practice in rural areas. "I'm a hard worker, but he's of a different level."

Although fascinated by science, she didn't consider becoming a doctor until she was a junior in college. At the time, her brother was in his second year of medical school at the University of Minnesota. "I think I was trying to forge my own path, denying it would be a good fit," she says. "Science was great for me, but I also wanted the personal connection I saw my dad enjoy." She admires her father's ability to give wholeheartedly to both career and home, and she hopes that one day she will be able to do the same. "I don't know how my dad balances it all. He's busy and he's passionate about his work, but he's always been very intentional about being with us."

Next year, Mark will be heading into emergency medicine. Ann is interested in working in an area of need like her father, maybe going abroad and doing mission work. Thus far, she has found herself enthralled by everything she's been exposed to in medical school. "I'm still interested in rural family practice, and that's what drew me, but I'm keeping my eyes open."

Families first

At one point in her career, pediatrician Marilyn Peitso, M.D., realized she had to make major changes if she was to manage both work and life. For eight years after finishing residency at the University of Iowa, she was the sole pediatrician in a rural community. After she and her husband, an artist, had two children, she realized a 24/7 on-call schedule "wasn't compatible with family life." She and her family moved to St. Cloud, and she joined Women's and Children's, an independent group, where she could share call duty with a larger team of doctors. Her husband's schedule was flexible, so he could be available to the children. When her group merged with CentraCare Health in 1998, she saw patients at its St. Cloud site.

For the last 10 years, Peitso has focused on her passion: health care homes, which she believes are critical to developing meaningful partnerships between patients and health providers. "I came from rural medicine, where the local doctor worked with families and there was a personal connection," she says. "Medicine today has gotten more corporate. It's bigger business, and certainly within large health care systems, it's easy for it to be very depersonalized, and that's frustrating for families. They can't get access or the kind of attention they need." In addition to helping her clinic set up health care homes, she co-chaired a work group that helped other pediatric clinics do the same and has served on state steering committees charged with setting standards and payment rates for health care homes. She also has led local medical organizations, served as president of the Minnesota chapter of the American Academy of Pediatrics and is currently a member of the Minnesota Medical Association's board of trustees.

Her daughter, Robyn Hegland, now 25, was in high school when she started to take note of her mother's commitment to attending meetings, on top of her patient responsibilities. "I realized it was something she really cared about," Robyn says. "Who chooses extra meetings?" During college, as she began to consider her own career options, she spent time in her mother's clinic. "It was easy to see people saw her as a leader, and patients were grateful for what she'd done for them." But most compelling was her mother's love of her work. "She never complains about the work or sees it as a chore."

Now in her second year at the University of Minnesota Medical School, Robyn is also considering a career in primary care. Although her mother never encouraged or discouraged her children from entering medicine, she did offer them advice: to never be satisfied with the status quo, whether it's a matter of health care delivery or personal accomplishments. "I hope she feels free to pursue dreams throughout her career, to develop her own professional leadership abilities, and look to develop programs and projects," Peitso says of her daughter.

Although Robyn has yet to choose a specialty, she wants to one day have the same kind of job satisfaction her mother does.

PHOTO COURTESY OF GEORGE NEMANICH

Joseph, George and Mike Nemanich in 2007—the year Joseph started practice.

"That's the kind of career I want," she says, "to do this very demanding job seeing patients and also be involved in professional organizations that help shape the direction of communities. I think that will be very fulfilling."

A calling, not a job

When Joseph Nemanich was considering medical school, his brother Michael, an orthopedic surgery resident, took him aside and warned him about the hard years of training involved. As Joseph recalls, "He said, 'Don't just follow this lock step. If you're doing it just because Dad and I did it, you're going to get really disheartened.'"

Instead of dissuading him from medicine, the advice prompted Joseph to think about his father, general surgeon George Nemanich, M.D.,—how he found joy in what he did every day. "He's always worked hard at what he does, but it's not toiling," Joseph says. It made him realize he wanted to go into medicine, too.

Unlike his sons, George Nemanich's decision to go into medicine didn't grow out of family tradition, although his mother had been the only nurse anesthetist in Soudan, Minnesota, where he grew up. In 1965, he had finished medical school at the University of Minnesota and begun his internship year at St. Mary's Hospital, just as the Vietnam War was escalating. Knowing he would be serving, he was pressed to choose a specialty and decided on surgery because it was "action-oriented," he says. "We're diagnosticians as well, but we're doers. I thought that fit my personality." After leading a surgical unit in Vietnam, he spent 35 years practicing in the western suburbs of the Twin Cities. (He began his career as one of three surgeons in a group that merged with another and later became Surgical Consultants.)

Over the years, he served as chief of surgery at Fairview Southdale Hospital and chief of staff at North Memorial Medical Center. Even though he retired from the operating room a few years ago, he continues to see patients with chronic wounds one half-day a week at the Fairview Southdale Wound Healing Institute in Edina. "That's been great," he says, "to continue having contact with patients."

Although George often shared stories with his family about patients he was seeing and the challenges at work, he insists he never intended to influence his children. Yet Michael and Joseph say they were swayed by their father's enthusiasm and his generous approach to his career—being available to his patients, the hospitals where he worked and sometimes even the neighbors who came by the house with medical questions. They, too, wanted to practice an action-oriented specialty and gravitated toward orthopedic surgery "because it's more fun," Joseph says with a laugh.

Today, both brothers practice at Twin Cities Orthopedics. Like their father, they work long hours and love what they do. (Their two other siblings are both educators.) "We're somewhat similar in that we both look at it as not just a job. It's a calling. The way my dad practiced, and the way Mike and I do, is we never really come home and take the hat off. We're relaxed, but we still have a responsibility to our patients and the community."

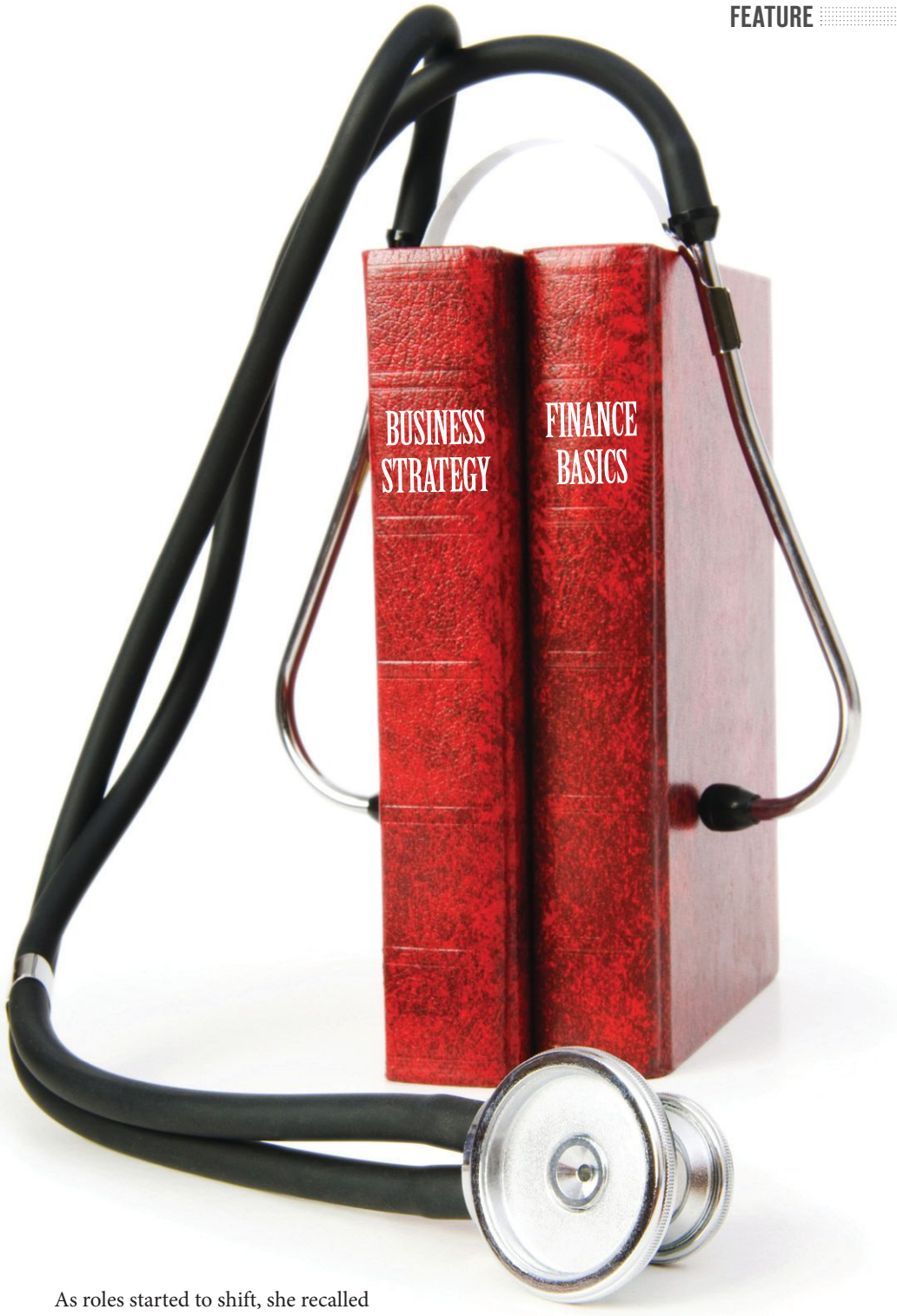
Like their father, they have been involved in the administration at hospitals. Both have served as chief of surgery at Fairview Ridges in Burnsville, and Michael was chief of orthopedics at Fairview Southdale. That involvement in the management of hospitals is rare these days, as Joseph notes: "We see the same 12 to 20 people on every committee."

Joseph imagines his later years may look different from those of his father's generation. He and his siblings had worried about what their father would do with himself after retiring. "When we retire, we'll actually retire and enjoy it. We don't want to work until we basically keel over in the OR ourselves," Joseph says. One person he views as a role model for retirement is his mother's brother, John Banovetz, M.D., an ear, nose and throat surgeon, who died several years ago but cultivated multiple interests at the end of his career, including bee keeping, wine making and attending culinary school.

When the time comes, will Joseph Nemanich encourage his own son (now age 3) to keep with the family tradition? "If that's what he wants to do," Joseph says. "It's a helluva lot of work, but a really rewarding career. I think he'll probably get the same positive reinforcement Mike and I did." **MM**

Kate Ledger is a St. Paul writer.

From exam room to board room



Physicians are finding they need to learn about business and leadership in order to adapt to changing roles.

BY KIM KISER

Three years ago, Lorene Rutherford, M.D., newly elected chief of staff of Ridgeview Medical Center in Waconia, realized that an increasing number of her colleagues were taking on leadership duties at the hospital. The 109-bed facility was undergoing a major change in the way it operated, and physicians were being asked to work with administrators to manage a "service line" such as women and children's care, oncology or emergency services. One of Rutherford's duties was to help physicians make the transition.

As roles started to shift, she recalled her own experience with organizational politics and challenging personalities and realized her colleagues needed new skills if they were to be successful leaders in the changing environment.

Rutherford had met Warren Hoffman, chair of an organization that runs the Minnesota Physician Leadership Program, which educates physicians in the economics of health care and teaches skills related to problem-solving, dealing with difficult people, communicating effectively and leading teams. Hoffman offered to design a 15-month program specifically for Ridgeview. "Our goal was to have it on site with a group that we knew would be working together and that we could develop," Rutherford says.

In 2011, 12 physicians, including Rutherford, and three administrators took part in the training. Today, a third cohort is going through the program.

Skills not taught in medical school

Rutherford isn't unique in recognizing that when physicians suddenly find themselves having to understand the language of business, motivate others and get administrators to buy into their ideas, they can flounder and become frustrated. "Being a physician does not automatically mean we have leadership skills," says Randy Card, M.D., a family physician from Cuyuna Regional Medical Center in Crosby, who completed the University of St. Thomas's (UST) Physician Leadership College last spring.

"Being a physician does not automatically mean we have leadership skills."

– RANDY CARD, M.D.

The fact that more physicians are being asked to take on roles outside of patient care has driven demand for leadership and business education. Three Twin Cities programs that use an educational model in which a cohort of students work through a curriculum together have seen growth in recent years. Hoffman's organization, the AWL group, which has been working with hospitals and health systems, recently teamed with Bethel University to offer a new nine-month on-campus program that will start in September. Participants will meet one evening and one day per month. The UST Physician Leadership College, a 15-month program, just enrolled its largest cohort ever—22 physicians. The Health Care M.B.A. program at UST, which enrolls physicians as well as other health care professionals, added a second cohort of 30 students in 2011.

"To make sure we were being the best possible stewards and using those resources to advance the care of cancer patients, I felt like I had to have a much deeper understanding of business."

– TIM SIELAFF, M.D.

Physicians seek out such programs for a number of reasons, according to Jack Militello, Ph.D., director of the Health Care M.B.A. program at UST. He says the physicians who enroll in that program (about 10 to 15 percent of each cohort) want to be able to better understand the business of health care, move into a chief medical officer position, start their own practice or leave medicine for something completely different. (One graduate left medicine to become a bank CEO.) "With the ACA and ACOs and the turbulence over policy, a lot of people are looking for depth, not just in understanding health care issues but in problem-solving and sorting out complexity," he says.

The 27-month M.B.A. program includes courses on finance, marketing, business strategy, ethics, human resources and operations as well as health law, health care policy and quality improvement. Leadership is also part of the curriculum. But where the M.B.A. program focuses on broader business knowledge, the emphasis of UST's Physician Leadership College is on relationships and working with others, Militello says. He explains that some physicians start the M.B.A. program and move into the Leadership College and vice versa.

Liver and pancreas surgeon Tim Sielaff, M.D., M.B.A., had just been named president of the Virginia Piper Cancer Institute at Abbott Northwestern Hospital in Minneapolis when he decided to enroll in the UST M.B.A. program in 2005. "Until I moved to Abbott Northwestern in 2004, I had spent my career working in research, trying to get grants and doing translational research," he says. When he became president of the Institute, he found himself involved in program development and creating new care models. "To do that, I had to interact with administrators in a more detailed and complex way," he says.

Sielaff also found himself managing gifts from philanthropists. "To make sure we were being the best possible stewards and using those resources to advance the care of cancer patients, I felt like I had to have a much deeper understanding of business," he says.

Having done stints as a director of quality, hospital chief of staff and clinic medical director, Cuyuna's Card felt he wasn't as effective a leader as he could be. "I was finding myself less successful than I wanted to be in managing people and instrumenting change and understanding my own strengths and areas for improvement," he says. Card explored M.B.A. and master's in health care administration programs before deciding the Physician Leadership College was a better fit.

Return on investment

The programs appear to be meeting a need. According to a study of more than 900 graduates of leadership and M.B.A. programs conducted by the American College of Physician Executives, more than 97 percent said they would recommend such training to their colleagues. In addition, the majority said their education helped their career. More than 75 percent said they had changed jobs at least once and 60 percent had received a salary increase since completing their studies.

UST's Militello says graduates of the M.B.A. program have gone on to become chief medical officers, hospital or clinic CEOs, and medical directors of pharmaceutical and device companies. Graduates of the Physician Leadership College's 2013 class have moved from hospital chief med-

ical officer to system chief medical officer, staff physician to group medical director, medical director to vice president of medical affairs, and managing partner to senior vice president.

Since finishing his M.B.A. in 2008, Sielaff was named vice president for quality and innovation for Allina Health, Abbott Northwestern's parent organization. Had he not earned the degree, he says, "I doubt I would have had the skill set to evolve into that."

Sielaff sees being a physician and having business skills as being a "powerful combination." "I have a different perspective than as a physician," he says. One of the initiatives he has been working on in his new role is providing access to a care coordinator—usually an R.N.—to every new cancer patient in the Allina system. "We know it's valuable personally and professionally," he says. His challenge now is to convince Allina's leaders that offering the service at all sites, not just at Abbott Northwestern, is a good business move.

For Card, learning how to negotiate, adapt and lead change have given him newfound confidence. And as medical director for his clinic, he's been putting those skills to good use. He says Cuyuna has been undergoing a number of changes—revising quality parameters, integrating the hospital's and clinic's EHR systems, and adjusting to a new CEO and administrative team. He says the leadership training has helped him read and understand the dynamics of these situations. "It helped me understand how I can be contributing to a challenge that's happening and when I need to step back," he says.

Rutherford says having had physicians and administrators go through the leadership program together has given each an appreciation of the challenges the other faces. As a result, "people are getting things done in a more timely way," she says. One way they are doing that is by turning class projects into new initiatives. One team is leading an effort to transition from using the 5 Wishes/DNR forms to the Honoring Choices POLST form. Another figured out a more efficient way to schedule ER physicians and physician assistants at Ridgeview's Waconia hospital and emergency facility in Chaska. Rutherford says when she and other members of the quality-improvement committee had to decide whether a colleague with a medical issue was still fit to practice, they not only resolved the situation but also established a group that will provide support to other physicians who are experiencing a health or personal crisis.

In addition, she has noticed a change at Ridgeview's monthly board meetings since bringing in the leadership training. Says Rutherford: "I hear people speak up and thoughtfully approach topics and utilize the things they learn to make our clinic better. Some may not have had the confidence or tools to do that effectively before. But I sense they now feel more confident about how they prepare for and present things." **MM**

Kim Kiser is senior editor of *Minnesota Medicine*.

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Minnesota Medical Association

PHOTO COURTESY OF ROGER LINDHOLM

RPAP student Brian Holmgren and his preceptor, family physician Roger Lindholm, M.D.

SEE one, DO one, TEACH many

Preceptors have become a precious commodity.

BY JEANNE METTNER

Although he has practiced medicine for nearly 40 years, Paul Van Gorp, M.D., remembers his medical school days as clearly as if the decades that have passed were months. He fondly recalls shadowing the University of Minnesota cardiovascular team, watching open-heart surgeries from the observation deck above the old university hospital's operating rooms and visiting recovering patients the next day as the surgeons made their rounds. But his most career-shaping moments occurred during the weeks he spent with Leon Nesvacil, M.D., a St. Paul family physician who served as his preceptor during his first year of medical school. "He had this little office above a drug store," says Van Gorp, a family physician with CentraCare Health System in Long Prairie. "He saw every variety of patient, managed so many problems, answered so many phone calls, helped so many people. I was impressed with his knowledge and stamina, and my experience with him definitely influenced my decision to become a family physician."

Like so many others who have been influenced by a mentor, Van Gorp went on to become a preceptor—a role he finds fulfilling in many ways. "You see them [students] develop the ability to elicit information from patients and coalesce it into an accurate diagnosis, and you see them be empathetic and compassionate as they help people find a solution to the problem they came in for," he says. "It's just wonderful to watch these young people become competent, thoughtful, confident family physicians."

The picture this seasoned preceptor paints would be entirely rosy were it not for a sobering footnote: There aren't enough preceptors. In Minnesota and the United States, a perfect storm of increased medical school enrollment, competition from nonphysician trainees, a widespread shortage of primary care physicians and ever-increasing demands on physicians' time has sent medical schools scrambling to find willing teachers.

Although Van Gorp and his colleagues try to do their part, their clinic has had to decline a number of pleas from educators. "We are constantly barraged with requests—by email, by phone, by postal mail, from medical schools as well as nurse practitioner programs and physician assistant programs—and we can say yes only to the ones we think we can handle, which is usually just two at one time," he says.

Hundreds of preceptors needed

Although there is no central repository of information on preceptors in the state, one need only do the math to begin to understand how many are required. Consider the University of Minnesota Medical School, which enrolls an average of 230 students each year—170 at its Twin Cities campus and 60 at its Duluth campus. All of

those students require some form of precepting—whether it's for the required Essentials of Medicine course, during which first- and second-year students shadow physicians; for clerkships during their third and fourth years; or for the Rural Medical Scholars Program (offered to first- and second-year students in Duluth) or for the nine-month Rural Physician Associate Program (RPAP) and MetroPAP (in which a total of 43 students from both campuses participate).

In many ways, patients end up benefiting as well. "They enjoy watching these teaching moments."
–PATRICIA LINDHOLM, M.D.

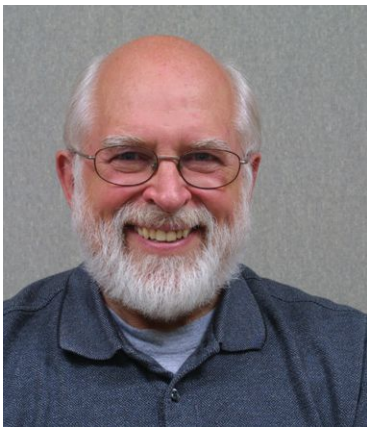
And it often takes more than one physician to mentor a student. As Kathleen Brooks, M.D., director of RPAP and an assistant professor of family medicine and community health on the Twin Cities campus, explains, the student-to-preceptor ratio often is not 1:1. "When we look at who evaluates and engages with RPAP students alone, it's about 300 community preceptors in family medicine, ob-gyn, urology, orthopedic surgery, general surgery, emergency medicine and pediatrics in about 35 sites across the state," she says. "That gives a sense for how much we need committed preceptors and how much we really need to collaborate with our colleagues in the community in order to educate the next generation of doctors."

Mayo Clinic's Medical School, which is much smaller, doesn't have as much difficulty finding enough physicians to teach students.

Preceptor perks

The time doctors spend precepting one student varies enormously. It usually consumes several hours a day, and their involvement with a student can last from several weeks to nine months. Although clinics get a small amount of money from the state's Medical Education and Research Costs (MERC) fund that may be used to help cover some of the costs associated with training students, the physicians who precept don't do it for the money. "It keeps me sharp; the quality of my care is much better because I am explaining what I am doing and why I am doing it," says Roger Lindholm, M.D., FAAFP, a family physician at Allina's New Ulm Medical Center.

In many ways, patients end up benefiting as well. "They enjoy watching these teaching moments because I have to explain things in a certain way to the student and they have the privilege of listening in and getting a better explanation for the care I am giving them," says Patricia Lindholm, M.D., FAAFP, a family physician at Lake Region Health Care in Fergus Falls. "Oftentimes, you don't have the time to articulate your entire thought process for clinical decision-making to patients, but when you do, it's enlightening and educational for them."



Precepting "is just something that I felt I needed to do; medicine is a wonderful profession, and we need to give back."
–RAY CHRISTENSEN, M.D.

Preceptors also have much to learn from the students—particularly when it comes to using technology. Back in the 1990s, Roger Lindholm precepted a student who was adept at doing online research. He and the student would race each other to find answers to questions. "He would have his PalmPilot, I would have my PDR book, and we'd see who could come up with the information the fastest; he beat me 95 percent of the time," Lindholm recalls. "The next year, I had a PalmPilot."

In addition to being educational for all involved, preceptorships are a way for clinics to recruit future physicians, particularly in rural Minnesota. "The student gets to see your lifestyle, your community, how you practice. They see you don't have to be within a 20-mile radius of the Twin Cities to practice good medicine," says Patricia Lindholm. "So when they get done with their training, they begin to consider settling down here with their practice. It's easier to recruit once they've had some exposure to your organization."

Perhaps above all other reasons why physicians decide to become preceptors, though, is the sentiment of "paying it forward." "It's just something that I felt I needed to do; medicine is a wonderful profession, and we need to give back," says Ray Christensen, M.D., associate dean for rural health and associate director of RPAP in Duluth.

Reasons for the decline

One of the main reasons why many physicians decide not to become preceptors is the time commitment involved. Patricia Lindholm notes that although she tries to be efficient during the day, it can be a challenge to stay on schedule when working with a student. "I do spend more time at work when I am precepting a student—probably in the neighborhood of 90 minutes—catching

up on paperwork after the student is gone for the day," she says.

Time seems to have become more of a factor in recent years. Ruth Westra, D.O., chair of the department of family medicine and community health at the University of Minnesota Medical School, Duluth, first noticed physicians declining requests to precept about 10 years ago, as clinics began transitioning to electronic health records. "They were trying to learn a new system, which was affecting their productivity, and they felt that having a student could complicate things," she recalls.

On his group's decision to offer stipends for teaching students: "It sends a clear message that as an organization we value precepting."
–RICHARD WEHSELER, M.D.

Patricia Lindholm adds that concern about the financial impact also prompts some physicians to turn down preceptor opportunities. "If they are in a large corporate health care system, the production of the physician becomes the bottom line," she says. "A young doctor may say, 'I'm at a stage in my career where I have to ramp up; I have kids and I've got to make as much money as I can. I can't afford to have my income reduced because I have a student.'"

Keeping precepting paramount

A number of efforts are underway to ameliorate the preceptor pinch. Last year, the Minnesota Legislature restored $12.8 million to the MERC fund. The additional dollars brought the program back to its 2011 funding level of $57 million. But that money doesn't always find its way to the physicians doing the training, as it is not earmarked for such purposes. Says Christensen: "The problem with the MERC dollars is that they get sent to the clinic administrator and get dumped into the general fund, so physicians never know it's even there."

Some organizations acknowledge the value of preceptors' work and offer them a stipend for teaching students. One of those is Willmar-based Affiliated Community Medical Center (ACMC), which provides physicians about $2,000 for a four-week medical school rotation. "That amount certainly doesn't compensate for all the hours they spend teaching, but it sends a clear message that as an organization we value precepting," says Richard A. Wehseler, M.D., medical director of staff development. About 75 of ACMC's 110 physicians precept medical students in some way.

Interested in precepting?

Physicians interested in precepting for the University of Minnesota can contact the following individuals:

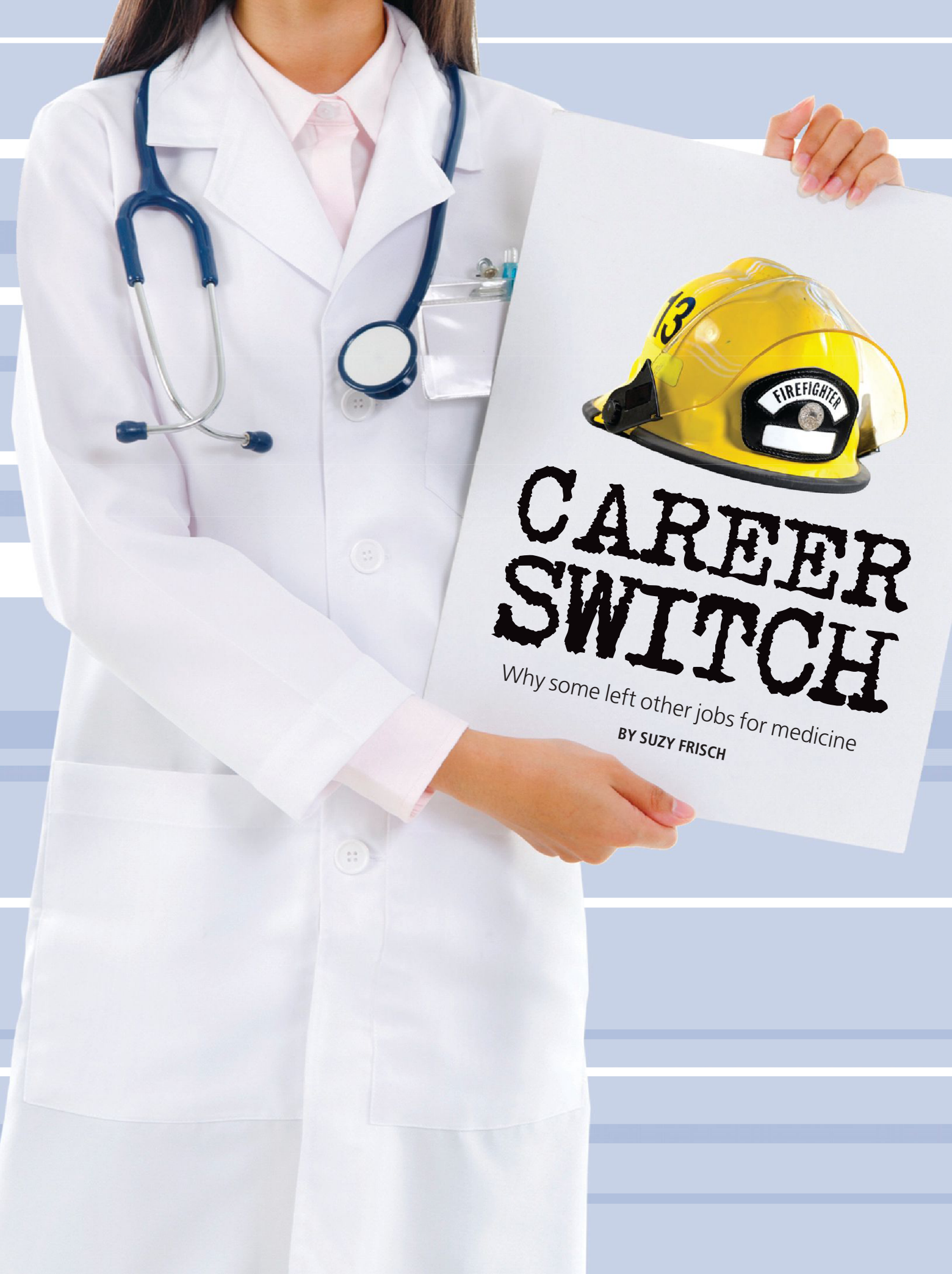
For RPAP or MetroPAP: University of Minnesota, Duluth, William Fricke, frick002@umn.edu; University of Minnesota, Twin Cities, Kathleen Brooks, M.D., kdbrooks@umn.edu.

For other programs or clinical rotations at the University of Minnesota: Brooke Nesbitt, nesbi029@umn.edu.

For Mayo Medical School, contact the rotation or clerkship leaders in the department in which you are interested in teaching.

Patricia Lindholm hopes other organizations will look for ways to re-ignite interest in teaching tomorrow's physicians. "If health systems refuse to participate, we will dry up the pipeline of preceptors, we will not have a pool of medical students or residents in the long run, and our society as a whole will be in trouble," she says. "You just can't do medicine online. You have to be with people." **MM**

Jeanne Mettner is a frequent contributor to *Minnesota Medicine*.



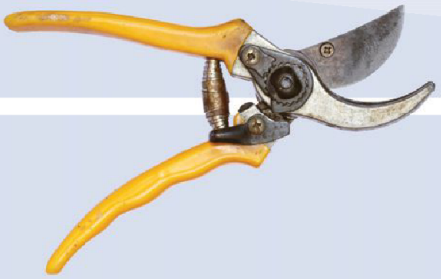
CAREER SWITCH

Why some left other jobs for medicine

BY SUZY FRISCH

Becoming a physician is a long haul for anyone. But it's especially so for those who first pursue another passion or profession. They may not have been in a classroom for years. Some never took a college-level science course. And many have families, homes and other financial obligations.

Despite the debt, the years of schooling and the late start, they do it anyway, propelled by a desire to help others and make a difference in new ways. Once they get to medical school, these career switchers discover they are not alone. Quite a few of their colleagues started out doing something else as well.



"There is no such thing as a traditional candidate," says Susan Romanski, M.D., a general internist at Mayo Clinic who chairs its medical school admissions committee. She says she is always surprised when she hears applicants apologize for their previous careers. "We all have our own journey, and what's important is that when we arrive here, this is what we want to do and we're committed to medicine. This is our passion and we're dedicated to our patients."

Each class of about 50 at Mayo's medical school has several students who have come from other careers. Recent classes included a former military pilot, a professional basketball player and a composer/trumpet player. The University of Minnesota has reported an uptick in students enrolling in medical school after leaving other careers since 2009. Between 2000 and 2009, about 1 percent to 4 percent of the 230 matriculating students at the Twin Cities and Duluth campuses had other careers first. Since 2009, that percentage has grown to between 11 and 14 percent, says Tricia Todd, assistant director of the University's Health Careers Center.

Both Romanski and Todd note that career-changing students are a welcome addition to medical school classes because they bring life experience, perspective and strong motivation. "These students are looking for greater meaning in their work and to make a contribution to humankind," Todd says. "They weren't having the kind of impact on fellow humans they wanted, and they want to help people live healthier lives."

Although studying medicine after working in another field is becoming more common, it's still a road less traveled than the one taken by most to medicine. We asked a few career switchers when and why they made a change. Here are their stories.

PHOTO COURTESY OF KARA PACALA

Kara Pacala says having a social worker's perspective helps her care for patients.

Kara Pacala, M.D.

Social worker turned family physician

As a newly minted social worker in the late 1980s, Kara Pacala spent a significant amount of time educating teens about HIV and AIDS and volunteering with people who had the disease. She often found herself advocating for those individuals, trying to help them obtain medical care and other services. In doing so, she frequently interacted with physicians and was increasingly drawn to the work they did.

"I got to be on a care team for a dear friend who ultimately died of AIDS-related complications, and I was incredibly influenced by that and what I saw with her physicians, who were outstanding," Pacala says. She decided then, after spending seven years as a social worker, to make a career switch.

Pacala spent two years catching up on the science courses she would need for medical school. By the time she enrolled in the University of Minnesota Medical School in 1996, she was 29 years old and one of a handful of nontraditional students in her class. Pacala says the timing was perfect: She was still single, and she had the benefit of perspective—knowing completely that she wanted this new career.

But medical school was not easy. "It tested everything I had," she says. "It was hard work, but I didn't feel like I gave up anything. I just gained."

After graduating in 2000, Pacala completed a residency at Smiley's Family Medicine Clinic in Minneapolis. Today, she is a faculty physician there. She also is an assistant professor of family medicine and community health at the University. "It's the best match of the two things I know best, which is the science of medicine and how to take care of people," she says of family medicine.

Now married with two children, Pacala says her social work training helps her identify concerns that could have an impact on her patients' health, such as inadequate housing, lack of food, inability to pay for medications and lack of transportation. "Most family doctors are interested in caring for the whole person, which is also a social worker's perspective. I think that's ultimately why family medicine has been such a good fit for me," she says.

Richard Oeckler, M.D., Ph.D.

Firefighter/researcher turned pulmonary and critical care medicine physician

For seven years, Richard Oeckler raced into burning buildings to rescue people before his crewmates doused the flames. As a firefighter, he needed to stay calm under extreme pressure, which served as excellent training for the next chapter in his life as a pulmonary and critical care physician at Mayo Clinic. Today, Oeckler still calls on his field experience when caring for people in precarious medical situations.

"It's why I like critical care," he says. "Certain people can stay cool and calm and some can't. When you've been in certain situations, from that experience you can control yourself."

Oeckler had a long career as a firefighter before going into medicine. He started out as a volunteer firefighter while growing up in Connecticut. After college at Fairfield University, where he earned a bachelor's degree in biology and philosophy in 1994, he worked in a biochemistry lab for a couple years, researching how cells sense oxygen levels. Oeckler went on to earn a master's degree in physiology from New York Medical College in 1997. At the time, he happened to live next door to a fire station, so he figured he would work his way through school doing a job he knew and enjoyed.

PHOTO COURTESY OF RICHARD OECKLER

Richard Oeckler (right) during his days as a firefighter.

Getting back into firefighting made him realize he didn't want to spend his days in a lab. He wanted to help people directly. Oeckler completed an M.D./Ph.D. program in physiology at New York Medical College, all while working shifts in the firehouse. He came to Mayo Clinic in 2003 for his internal medicine residency.

Oeckler's work as a firefighter and his experience working in the New York City area during the days after September 11 charted his path into critical care and pulmonary medicine. Many of his friends worked long days at Ground Zero, and they now face severe health problems. Today, his research centers on inhalational lung diseases and acute lung injuries as he seeks to uncover therapies to prevent or treat ventilator-related lung injuries, acute respiratory distress syndrome (ARDS) and other conditions.

Oeckler says there's a common thread connecting firefighting, working as a researcher and being a physician: problem-solving. The reason why medicine won out over the other professions is because it is people-focused.

"I'm a doctor for the same reason I ended up in the fire department: it's helping people, especially in the field. And that doesn't always mean having the greatest outcome," Oeckler says. "Some of my most rewarding times, unfortunately, are when I'm speaking with patients at the end of their lives."

David Hilden, M.D., M.P.H.

Electrical engineer/information technology specialist turned internal medicine physician

Always strong in science and math, David Hilden followed his father's footsteps into engineering. He studied electrical engineering at the University of Minnesota, graduating in 1987. Although he realized at the time that it might not be his dream, Hilden worked as a computer programmer and network specialist for about nine years.

Ready for a change, he took a couple classes in horticulture and landscape design. Hilden had always enjoyed gardening and being outdoors, and he thought it would make for a good career that would take advantage of his science background. He quickly realized, however, that it might not be the most lucrative path.

As Hilden considered other options, he kept returning to the notion of becoming a community doctor. He had thought about a career in health care when he was in college—perhaps doing biomedical engineering—but always came back to the idea of practicing medicine.

PHOTO COURTESY OF DAVID HILDEN

David Hilden found he enjoyed teaching people about health more than engineering.

Not having any friends or family members who were doctors, he didn't know how to go about making such a career change. After listening to Hilden talk about how much he disliked his job as a network engineer, his wife encouraged him to go back and study medicine. He called the U to learn what it would take and then decided to go for it, despite the long road ahead of him.

Hilden knew it wasn't going to be easy. The couple had two very young children at the time, and Hilden hadn't taken any of the right science classes during college. At age 28, while still working full-time in IT, he began tackling medical school prerequisites. It took him two years to complete them. "Those were the hardest years, when I was working and taking night classes, and we had little kids," Hilden says. "It was worse than medical school."

After graduating from the University of Minnesota Medical School in 2000 at age 35, Hilden completed an internal medicine residency at Hennepin County Medical Center (HCMC). He has worked there ever since, first as a primary care physician, then as a hospitalist. Now he serves as director of HCMC's hospitalist division and is an assistant professor at the U. One of his favorite parts of the job is teaching residents.

Hilden's education didn't end with medical school. He went on to earn a master's degree in public health in 2012 and now educates the public through his WCCO radio show, "Healthy Matters," online videos produced by the hospital and speaking engagements.

Despite the years of hard work, the financial hit, and juggling school, training and family, Hilden is happy with his decision to go into medicine. "This is so much more of who I am as a person," he says. "It's science-based, which is my underlying skill, but it's far more people-oriented, and that's fulfilling."

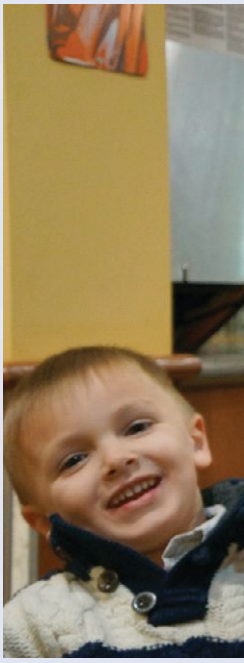
Hilden believes that racking up life and work experience before medical school—including having children and handling adult responsibilities like paying bills and navigating insurance benefits—prepared him to succeed. "I can relate to patients better," he says.

John Koo's diverse work background helps him put himself in others' shoes.

John Koo

Fisherman/traveler/writer/filmmaker turned medical student

For the first decade after he graduated from college in 2001, John Koo went wherever his interests guided him. He worked on a fishing boat for several summers in Alaska, which funded extensive travel throughout Asia, including to China, Nepal and India. He wrote. He substitute taught at-risk youths in Minneapolis. He got into film production in New Orleans and Los Angeles, working on lighting crews for documentaries and feature films.



Then Koo hit a crossroads. He wanted to do something that truly made a difference, and he debated between journalism and medicine. Thinking back on the three months he spent in Indonesia, Koo recalls being inspired by a group of ophthalmologists from New Zealand who were performing cataract surgery on elderly blind individuals.

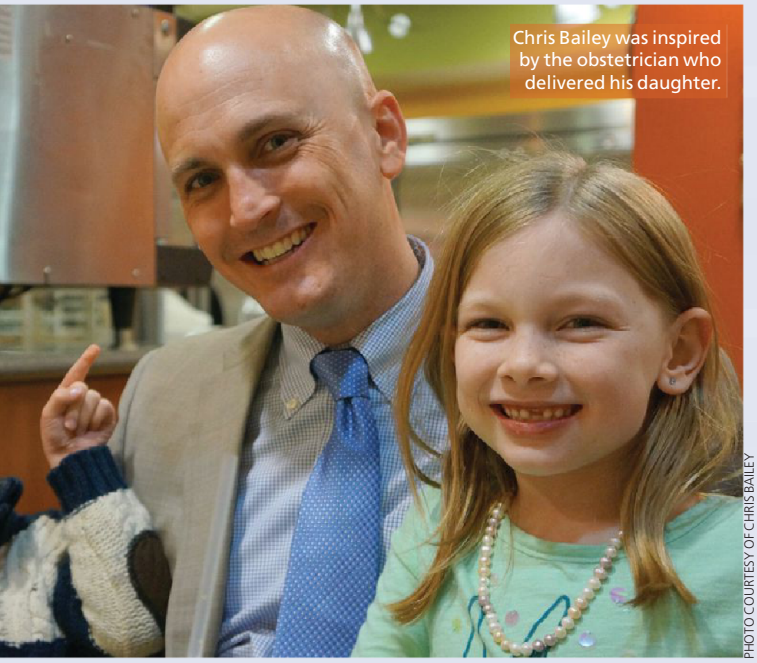
"I was blown away by everything they were doing, compared to what I was doing at the time—which was hanging out and trying to write," he says. "They swooped in and were there for a week, and they made a pretty significant impact during that time."

Koo chose medical school over journalism, intending to one day provide care overseas. But the English literature and creative writing major hadn't taken any medical school prerequisites, so he took community college courses in California while continuing to work in film production. Next came a post-baccalaureate pre-med program at the University of Southern California and a couple of years working in a renal physiology research lab to earn money and gain experience. Koo produced a few original abstracts and even presented at a few national conferences.

Volunteering in the Los Angeles County Medical Center emergency room and other clinics for the needy while doing his basic science training affirmed Koo's desire to pursue medicine. He applied to the University of Minnesota, where he had earned his bachelor's degree. "Going from having a respectable income to being grossly in debt has been a bit of an adjustment," he says. The other adjustment is trying to relate to some of the other students, who are much younger. Koo is 36.

He believes his diverse work background will make him a better physician when he graduates this year. "I think I know myself better from having all of that experience. I know my limits, my strengths, understanding how to handle stress and being more balanced," he says. "I've worked with a lot of different people in a lot of different industries and met people while traveling, so you have an easier time putting yourself in other people's shoes."

Koo plans to do a general surgery residency and then specialize in trauma and critical care—a combination he believes will open doors for him around the world.



Chris Bailey was inspired by the obstetrician who delivered his daughter.

PHOTO COURTESY OF CHRIS BAILEY

Chris Bailey

Graphic designer turned medical student

Some people buy a sports car or a boat when they have a midlife crisis. Chris Bailey went to medical school. Bailey was enjoying a successful graphic design career, rising to creative director of one company before opening an agency in Phoenix with his wife in 2003. And while he had dreamed of being an artist since he was 11 years old, his chosen profession turned out to not be as rewarding as he had hoped. "I was always thinking, 'I'm enjoying this, but I don't feel fulfilled,'" Bailey recalls. "I started volunteering, and that was a much brighter part of my day. What I was doing was really benefiting people in a tangible way. I realized I might want to do something that brought me that kind of joy in my professional career as well."

Bailey's inspiration to go into medicine came from the obstetrician who cared for his wife when she had an emergency Cesarean section in 2006. "It was a huge thing, and I was really impressed," he says. "I really wanted to help people in the way she did."

Before deciding on medical school, Bailey considered other professions including law, dentistry and business. He shadowed several physicians and came away feeling energized and excited despite knowing they often worked 12-hour days. "I kept coming back to being a doctor because I couldn't think of another area of life where a single person had a greater impact on my life or my family's life," he says.

After spending 14 months taking prerequisite courses while still running his graphic design firm, Bailey applied to medical school. He was accepted at Mayo, his first choice, and moved his wife and two young children to Rochester in 2011. He is now in his third year.

Although medical school has been challenging, Bailey, now 41, admits the hardest part has been starting over professionally. "It's difficult to go from advising clients and corporations on how to do things to becoming someone who is on the bottom of a very tall totem pole," he says. "Sometimes it can be tough on your ego, but in a way that's good because it grounds you when you're speaking with patients. It's very humbling."

For now, Bailey is unsure what his specialty will be. But he does know that becoming a doctor was the right decision for him. "My maturity has given me the ability to recognize what I'm doing is the right thing for me," he says. "I feel happier with the way I spend my time professionally than I ever did in the past." **MM**

Suzy Frisch is a Twin Cities freelance writer.

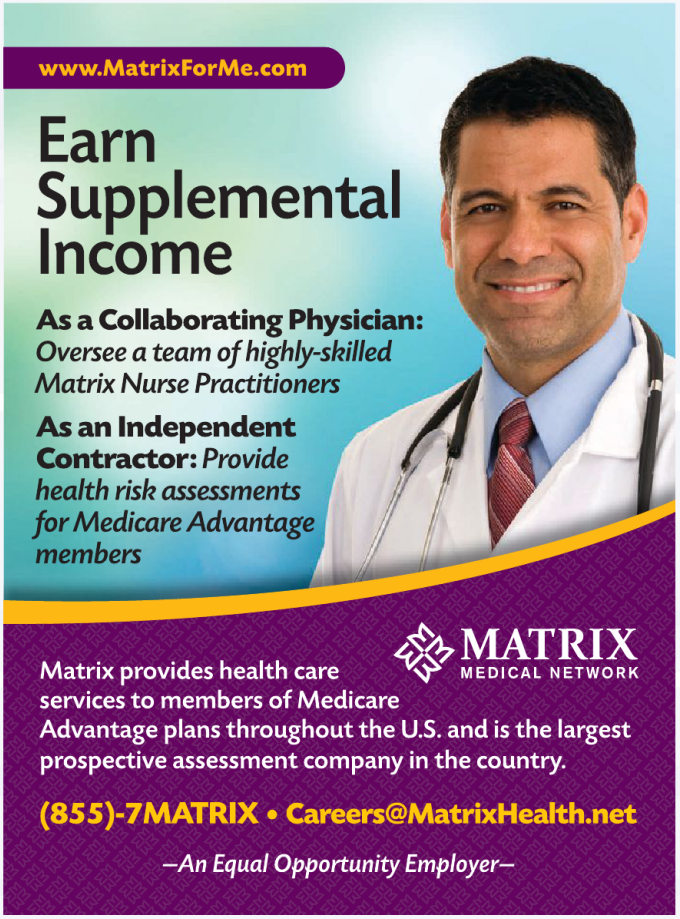


PHOTO COURTESY OF NEIL SHAH

Neil Shah, M.D., took a leap of faith when he opened Clarus Dermatology last year.

Leap of faith

What I've learned by starting my own practice

BY NEIL SHAH, M.D.

Go West, young man,
go West and grow up
with the country.
–HORACE GREELEY

Midway through my dermatology residency at Mayo Clinic, it occurred to me that I should start considering life post-residency. Where would I work? What would I do? I knew that medicine was undergoing a change. Large, multispecialty groups were buying solo and small-group practices. Hospital systems were swallowing up multispecialty clinics. The medical industry was evolving from individual, physician-led and managed practices into commoditized corporate medicine.

One of the assumptions underlying this shift was that younger physicians did not want the responsibilities of running a medical practice. The business of medicine had become too complicated; the overhead too high. Young physicians simply wanted to punch the clock and return home to their families. I was a young physician and had no reason to think I was any different. So I chose to start by developing a dermatology department for a large, multispecialty group. I believed in the management team that hired me. They believed in my vision of the future of medicine. We both believed we would make a wonderful team.

In the beginning all was well. The group provided financial stability. I had a beautiful office stocked with the newest devices. Physicians who worked for the system were told that all dermatology referrals had to go to me. My clinic was busy.

Revenues for the system were very good. Administrators handled every concern, from hiring to complaints to finances. I punched the clock and got a paycheck.

Change I couldn't believe in

As that first year progressed, the organization began to change. A new CEO came on board. The members of the management team that hired me either moved on or were purged. I began to run into operational issues. One particular event underscored the tension between me and the new administration: A patient had paid for an expensive cosmetic procedure. The outcome was not what either the patient or I had expected. If I wasn't happy with the results, then why should the patient pay for the procedure? I was shocked to learn that I could not refund her the money to make things right. I found this profoundly upsetting. Who else was more qualified to determine if a refund was reasonable?

As the year wore on, more administrators whom I cared about, and who believed in me, were let go. The organization was changing—and it was not change I could believe in.

I began to see the downside of working for a large organization: loss of autonomy, leadership that could change without warning, and the potential for financial instability that was beyond my control. For me, those factors started to outweigh the benefits of a ready-made referral base and not having to bother with the day-to-day concerns of running a practice. I began to consider building my own clinic.

There were many hurdles: Where do I start? Would anyone give me a loan? Who would refer to me? The reality was that I was not doing anything novel. Thousands before me had successfully walked the same path. I spoke with independent physicians and learned that none of them regretted their decision to go out on their own. Moreover, those physicians were all willing to help me through the process.

I began to form a business plan. I found a location. I secured funding. One by one, the checklist of tasks grew smaller. I learned that starting a practice is no more insurmountable than getting into medical school, matching into residency or passing the dermatology boards. In fact, it was much easier than any of those things. But I quickly discovered that those preliminary steps were the easy part. As the lyrics to Metallica's "No Leaf Clover" go, "Then it comes to be that the soothing light at the end of your tunnel/Was just a freight train coming your way."

A new beginning

By the time Clarus Dermatology opened in February of 2013, I had accumulated debt that would far exceed my medical school loans. I had given up a large paycheck and a generally stress-free life for an unrelenting 24/7 commitment. Not only was I a physician, now I was also a small-business owner. My daily worries included making payroll, paying rent, growing my referral base—and practicing dermatology.

The hardest part of this entire process was weathering the first few months. When you go from seeing 50 patients a day to five, your mind starts to wander. Was this the right decision? What if I fail? Will it be worth it?

With time, my calendar started to fill up. Loyal patients from my previous practice sought me out. Physicians, old and new, entrusted me with the care of their patients. The time I spent dealing with the business side started to slowly decrease. The practice gained its own rhythm. Slowly, I began to gain control over my schedule. I was able to catch up on my journal reading and attend conferences.

Fast-forward one year

My practice has been open now for nearly a year. Our volume continues to grow. My staff and patients are happy. My worry is no longer about making payroll but rather how we can continue our aggressive growth. In October, I was able to hire a second dermatologist; a third will join us this year.

What I have found profoundly gratifying is the level of control that I now have. I am able to empower my staff to do what's right for the patient under all circumstances. It might mean buying food for a surgical patient who is having a long day or allowing patients who have fallen on tough times to pay their bill over a few months. If my staff identifies a need for equipment, we can have it on order within minutes—not weeks. My organization is efficient and flexible in a way that no large organization could ever to be. I'm finding that living by the Mayo Clinic axiom, "the needs of the patient come first," is easier than ever.

Not only was I a physician, now I was also a small-business owner. My daily worries included making payroll, paying rent, growing my referral base—and practicing dermatology.

Lessons learned

Having gone through the process of successfully starting a clinic, I can share a few lessons. First, it is both immensely stressful and satisfying to run your own medical practice. Some of that stress will resolve with time. But the low-level stress associated with running a business never completely abates. Then again, neither does the stress of having limited control over your own destiny—and that of your patients—within a larger corporation.

Second, you are neither alone nor doing anything novel. Consultants, mentors and colleagues will help you through the process. Properly constructed and executed physician practice startups do not fail. Trust in your consultants; do not panic when plans require change midstream. Lean on your mentors. They have all been in the exact same place and will help you keep the faith.

Third, do not dwell on what you could have done better. You will make mistakes. I did. For example, our marketing and PR plan was a bust. Initially, we focused our efforts on online ads and Facebook. It turns out that neither of these are really good avenues unless you have lots of money. In the end, we took a more of hands-on approach that included meeting with physicians and administrators from clinics in our catchment area, participating in health fairs, and visiting assisted living and nursing facilities to promote our services. Those efforts paid great dividends.

If you are considering starting your own practice, understand that referral patterns are sticky. In other words, convincing doctors to try a new physician, even if you're well-trained and more conveniently located, is difficult. Double-down on building relationships. Give in-service talks at clinics, teach residents and organically build a loyal patient base.

In summary, I encourage physicians to explore the possibility of starting their own practice. Take solace in the fact that all of us who have walked this path are almost universally happy that we did. Understand that designing, executing and continuously improving processes to deliver the best medical care possible is so profoundly gratifying that it outweighs the uncertainty and pain that come with breathing life into a new business.

At the end of each day, I go home knowing that, to the extent that modern medicine allows, I have been the master of not only my own destiny but the destiny of my patients, and we—both doctor and patient—are better for it. **MM**

Neil Shah is the owner of Clarus Dermatology in St. Anthony, Minnesota.

Special thanks to Bryan C. Schultz, M.D., and Charles E. Crutchfield III, M.D., who mentored me through this process.

PHOTO COURTESY OF ACMC

Donald Menya, D.O., now considers Willmar home.

UNEXPECTED BLESSINGS

How Hurricane Sandy influenced my career

BY DONALD O. MENYA, D.O.

The water began pouring under the door, filling the living room in our Long Beach, New York, home. My wife and I grabbed our two kids, ages 1 and 6 at the time, and took them upstairs to our neighbor's apartment. Then we began the fruitless task of gathering what little we could before our belongings became unsalvageable. Eventually, the lights flickered and the power went out. There was nothing to do but wait out the storm—with no power, heat or running water. What had begun as a normal night at home quickly became one of the scariest of our lives. But sometimes the perfect storm brings all of the pieces of your life together. That's what Hurricane Sandy did for us.

The water began to subside the next morning so I decided to try to make it to St. John's Episcopal Hospital, where I was an ob/gyn resident. I knew after a long night the hospital staff would need relief. What I saw on the way to work was devastating. Beautiful landscape was destroyed, landmarks gone, cars washed out and homes unrecognizable. Long Beach was deserted. I later learned the famed boardwalk, the one my family had once loved to visit, was gone.

Despite our efforts to clean our home, like many others, it was inhabitable. We were forced to leave. With nine months still left in my ob/gyn residency, the rebuilding process had to begin. A few days after Hurricane Sandy, my wife and kids flew from New York to Washburn, Wisconsin, to stay with her parents. They stayed there for nine months while I remained in New York. I jumped from place to place, first staying with a neighbor and then living in the hospital for a week before finding a temporary home in Jamaica, Queens.

Putting the pieces back together

I can't really begin to describe the terror and uncertainty of that time of my life. I'm thankful my children are too young to really remember what happened. Though Sandy took much in its wake, it left me with a new outlook on life. Sometimes you can get so caught up in getting through the day that you stop really living. You take things for granted. We lost almost all of our belongings in the storm, but what you thought you really needed can be replaced. Many of the things we once thought so important to our daily lives weren't things we truly needed. It's given me an appreciation for things that are really important—my wife, my kids, my faith.

As my residency came to a close, we wanted a fresh start—somewhere we could rebuild our lives. My wife and family selflessly followed me across the United States in pursuit of my career. So when I began to look for the place where I would set up practice, my wife and I seriously considered what we were looking for. She wanted to get back to the Midwest. Her family is from Wisconsin and much of mine lives in the Twin Cities. The Midwest was the kind of place where we wanted to raise our kids. After interviewing at ACMC in Willmar, I was excited at the possibility of joining their health care team. I was impressed not only with ACMC, but with its physicians and staff and the community. It is the kind of place I can see raising my family for many years to come.

A new place to call home

We're settling in to Willmar. We've found a house, and my wife is busy making it a home. Willmar has so much to offer my family that the East Coast couldn't. We're enjoying the feeling of a close-knit community, getting involved in our church and the community, meeting new friends and exploring the area. For the first time in a long time, we're close enough to our families that we can drive to see them whenever we want. I've found a balance in Willmar that I couldn't have imagined in New York. I have more time to spend outside of the clinic, making memories with my family and exploring old hobbies and learning new ones.

Sometimes the perfect storm brings unexpected blessings. And bit by bit, we're rebuilding our lives in our new home. **MM**

Donald Menya is an ob/gyn physician at ACMC-Willmar.

This article is reprinted with permission from ACMC. It originally appeared in *Discover ACMC* in December 2013.

PHOTO BY STEVE WEWERKA

Physicians will once again take over the Capitol on March 13 at the MMA's annual Day at the Capitol gathering.

A Capitol Clinic

The MMA prepares for the 2014 legislative session

With news of a budget surplus of more than $1 billion coming with the November forecast, special interest groups will be lining up to urge lawmakers to fund their projects. The MMA is no exception.

"It's pretty uncommon to see a surplus, let alone one as significant as this," says Dave Renner, the MMA's director of state and federal legislation. In fact, last session, the state faced a $1 billion budget deficit. "We anticipate that this surplus will open the door for a lot of lobbying."

So, should Minnesota physicians expect increases to health care spending across the board?

"Absolutely not," Renner says. "While we are optimistic, given the size of the surplus, you can never predict how the Legislature is going to act. We are dealing with a short session. Committees will have quick deadlines. It's going to be a frenzied pace. And, everyone should keep in mind that many legislators and the governor want to cut taxes, if the surplus holds."

The 2014 legislative session could be further complicated by the fact that Gov. Mark Dayton and all 134 House seats will be up for election in November. Will this cause the governor and lawmakers to act (and vote) differently than last session?

"There's a lot we'll be keeping our eyes on," says Eric Dick, the MMA's manager of state legislative affairs. "We are hearing a lot of rumbling about public health issues such as e-cigarettes and opioid abuse. We also want to monitor how the state implements the Affordable Care Act and its impact on physicians and patients." The MMA also will monitor other concerns related to health and health care delivery that may bubble up.

In other words, it should be another interesting session in St. Paul.

THE MMA'S **LEGISLATIVE PRIORITIES** FOR 2014

Increasing Medicaid payment for primary care

In the fall, the Centers for Medicare and Medicaid Services (CMS) approved Minnesota's plan for increasing the Medicaid payment rate for primary care services for the managed care side of Minnesota's Medicaid program.

The Department of Human Services (DHS) was still working on how it will pay for such an increase for the managed care portion when this issue went to press. The increase is the result of a provision in the Affordable Care Act that provides Medicare-equivalent payment rates for primary care services delivered through Medicaid in 2013-2014.

According to DHS, the law requires the increase to be paid to clinics, and clinics should begin receiving those enhanced payments for 2013 services by the end of January 2014. The increased payment rate only lasts through 2014, so legislative action may be needed to continue it into 2015 and beyond.

Encouraging physician-led team-based care

Last session, lawmakers introduced legislation to alter the scope of practice for advanced practice registered nurses (APRNs). In particular, APRN leaders began lobbying for completely independent practice. Sixteen states currently allow APRNs to practice independently.

The MMA continues to oppose this legislation, contending that a collaborative, interdisciplinary approach to health care best serves patients. The MMA will argue that allowing for completely

independent practice for APRNs runs counter to the move toward collaboration as demonstrated in health care homes and ACOs, and may endanger patients.

Although bills that would change APRNs' scope of practice did not receive a hearing last session, the issue remains alive for 2014.

Regulating e-cigarettes

The fight against Big Tobacco will continue in 2014 but on a different front. Last year, the MMA supported raising the tobacco tax because doing so is a proven strategy for getting smokers to quit and preventing youths from starting. Now, the focus will be on e-cigarettes, which are growing in popularity in Minnesota, especially among teenagers.

E-cigarettes resemble cigarettes. They contain nicotine, which is vaporized and ingested by the user, and come in a variety of kid-friendly flavors. E-cigarettes do not contain tobacco; thus, many states are still wrestling with how to classify them.

The MMA is weighing options on how to approach regulating their use. "We are working with partners like Clearway Minnesota and the American Cancer Society to determine a course of action," Dick says.

One option is to add e-cigarettes to the list of products prohibited in public indoor spaces such as workplaces and bars by the Freedom to Breathe Act. One possible approach the MMA will explore in-depth is closing the "sampling loophole," which allows retailers to allow sampling of such products in their stores. In essence, Dick says, these retailers are able to create smoking lounges.

"We are also looking at some additional retail regulations such as requiring tobacco sellers to get a license to sell e-cigarettes and requiring that they put them behind their counters," he says. Requiring ingredient disclosure on the product's packaging is another option being considered, as there is now virtually no oversight on the manufacture of these products.

Prescribing opioids

For the past year, the MMA has been actively working on preventing prescription opioid abuse, addiction and misuse. Momentum for addressing this issue is building in Minnesota, and legislation is anticipated in 2014.

The MMA supports strengthening the Minnesota Prescription Monitoring Program so that alerts are sent to prescribers on patients who are potentially "doctor shopping."

The MMA also supports "911 Good Samaritan and Naloxone" legislation, also known as "Steve's Law," which is named after Steve Rummler, who died of an accidental overdose in 2011. According to the Rummler Foundation website, the law would "reduce the number of opioid overdose deaths by 1) providing immunity to those who call 911 in good faith to save a life and 2) increasing public access to the antidote naloxone." It would allow first responders to carry naloxone and make the drug available through community-based agencies that work with intravenous drug users.

"While the MMA supports the prevention of prescription opioid abuse, we need to be careful on this issue," Renner says. "We can't allow prescribing restrictions to go too far or else state policies may lead to undertreatment of pain."

Aligning data practices

The MMA is working closely with the Minnesota Hospital Association and the Minnesota Council of Health Plans to align state privacy and federal HIPAA requirements. Currently, Minnesota is one of only two states that are not aligned with HIPAA.

"Minnesota is an outlier on this issue," Dick says. "Current state regulations make coordinating patient care difficult. If we are going to effectively adopt innovative health care delivery models such as medical homes, accountable care organizations and total cost of care structures, we need to be able to share data more efficiently while carefully guarding patient privacy."

Phasing out the provider tax

The MMA will continue pushing for the phase-out of the provider tax. During the 2011 session, lawmakers voted for the eventual repeal of the tax. But last year, they briefly toyed with the idea of indefinitely extending it. The MMA was able to quickly persuade them not to.

The 2 percent tax has driven up the cost of health care, is unfair to Minnesotans who are insured through individual policies or by small employers, and falls more heavily on sick and low-income individuals.

Set to be reduced as surpluses grow in the Health Care Access Fund, the "sick tax" is slated for full repeal at the end of 2019.

ADDITIONAL ISSUES

Prohibiting use of tanning beds by minors

In addition to its key priorities, the MMA will continue to monitor several long-standing issues including bills that prohibit the use of tanning beds by those under the age of 18. Such a bill was introduced last session but failed to gain traction.

"There's clear evidence of the link between rising skin cancer rates and artificial UV exposure," Dick says. "Minnesota needs to treat this carcinogen just as we do tobacco, and that means prohibiting minors from using artificial tanning facilities."

Current Minnesota law allows children under the age of 16 to use tanning facilities with parental consent; there are no restrictions on those 16 and older. Eleven states already have banned tanning beds for children, ranging in age from 13 to 18 years.

According to the American Cancer Society, each year, approximately 120 Minnesotans die from melanoma, making it the most deadly form of skin cancer.

Protecting newborn screening

Continuing an ongoing debate regarding the state's newborn screening program, lawmakers passed a bill last session that calls for a report outlining a plan for long-term storage and use of newborn screening test results. Under the provision, the Department of Health will consult with pediatricians, specialists in metabolic care, immunologists, epidemiologists, medical geneticists, and representatives from patient advocacy and data privacy groups to develop such a plan.

Changes to the newborn screening program came about as the result of an unfavorable Minnesota Supreme Court ruling in 2011 and subsequent legislation in 2012 that dramatically narrowed how the health department can handle newborn screening test results and data. The MMA will work with the Minnesota Chapter of the American Academy of Pediatrics to restore Minnesota's program to what it used to be.

Reforming no-fault auto insurance and worker's compensation

Legislators are likely to consider a number of proposals related to both the worker's compensation and automobile no-fault insurance systems, particularly how they pay for medical services. The MMA will closely monitor any proposed changes for their impact on reimbursement and potential additional administrative burdens placed on clinics and hospitals. Both of these issues saw some action in 2013, and they may be back for consideration in 2014.

At last year's Day at the Capitol, the MMA's Dave Renner addresses physicians and medical students.

Day at the Capitol: March 13, 2014

Plan to join the MMA on Thursday, March 13, for the 2014 Day at the Capitol event.

"Legislators really do want to hear from physicians," says Dave Renner, the MMA's director of state and federal legislation. "Day at the Capitol provides physicians with access to their lawmakers face to face. What better way to discuss the health-related concerns that you and your patients face?"

The event includes briefings and updates from MMA staff, remarks from key legislative and administrative officials, meetings with individual legislators as well as a late-afternoon reception for physicians.

Watch *MMA News Now* for more details.

News briefs

Starbuck physician chosen "Country Doctor of the Year"

Robert Bösl, M.D., the only physician in the town of Starbuck, Minnesota, was named "2013 Country Doctor of the Year" by Staff Care, a physician staffing company.

Bösl was cited for using his retirement savings to open a clinic after the town's only hospital closed in 2005.

"My wife says you have to be a little bit crazy to practice in a small town," he told *USA Today*. "If being a little bit crazy is one of the criteria, then I'm probably overqualified." Bösl has been a member of the MMA since 1976.

Since 1992, Staff Care has given the national award to one physician in a community with 30,000 or fewer residents. As part of the award, the company will provide Starbuck with a temporary physician for two weeks when Bösl takes a golf vacation this spring.

Bösl was featured in the March 2012 issue of *Minnesota Medicine*.

Members sought to serve on new Policy Council

The MMA is seeking applicants by January 10 for five at-large positions on its newly created Policy Council, a 40-member group that will help determine the organization's position on various issues.

As part of the at-large appointment process, the MMA Board of Trustees will consider all candidates but will give strong consideration to those who are able to commit to serving the entire term (initial term will last through September 2016 with the option of serving an additional three years) and attending all council meetings and are actively engaged in medical practice. In addition, the board is looking to build a policy council that represents the diversity of MMA membership in terms of age, gender, race/ethnicity, geography, specialty and practice size/type.

Overall, the council will be comprised of 40 members, none of whom can be MMA committee chairs or MMA board members at the time of their appointment. Five members will hold at-large positions. Three will be from the Medical Student, Resident/Fellow and Young Physician sections. Thirty-one members will be chosen by the five largest component medical societies in Minnesota (Twin Cities Medical Society, Zumbro Valley Medical Society, Stearns Benton Medical Society, Lake Superior Medical Society and Range Medical Society). The MMA president-elect will hold the other position.

The council will meet approximately six times a year. Two of those meetings will bring together a broad group of MMA members to discuss identified topics. For 2014, one of those meetings will be held in the spring and the other during the MMA Annual Meeting in Brainerd on September 19 and 20.

Physicians from the five largest component societies or the sections who are interested in serving on the council should contact those organizations directly.

Members who are interested in the at-large positions should submit a brief statement of interest (including name, specialty and health policy interests/experience) to Janet Silversmith at jsilversmith@mnmed.org, MMA director of health policy, by January 10.

The council was created by the 2013 MMA House of Delegates as a way to simplify and expand opportunities for physician input on key issues and challenges facing medicine in Minnesota.

End-of-life case to go to state Supreme Court

In November, the Minnesota Supreme Court granted the MMA's petition to act as a "friend of the court" in the case of the "Guardianship of Jeffers A. Tschumy." The MMA supports a legal guardian's ability to authorize removal of a ward's life support without court approval.

This past spring, the MMA submitted an amicus brief to the Minnesota Court of Appeals supporting the argument that legal

guardians have the inherent power to make medical decisions on behalf of their wards, including the decision to decline medical care and terminate life support. The MMA urged the Court of Appeals to reject the district court's assertion that all guardians must obtain a court order before authorizing end-of-life care for their wards.

In July, the Court of Appeals sided with guardians and the MMA. Since then, those opposing the Court of Appeals' ruling have taken the case to the Supreme Court.

In its updated amicus brief, the MMA will ask the Supreme Court to affirm the Court of Appeals' ruling that a court-appointed guardian has inherent authority to authorize termina-

tion of life support when appropriate. The MMA will highlight the policy and practice implications of the case.

Minority Affairs Service Award presented to Rochester doc

Rochester psychiatrist Dionne Hart, M.D., received the MMA Foundation's 2013 Minority Affairs Meritorious Service Award.

Hart is chair of the MMA's Minority and Cross-Cultural Affairs committee and chair of the American Medical Association's Minority Affairs Section. She is also active with the Zumbro Valley Medical Society (ZVMS) and the Minnesota Psychiatric Society.

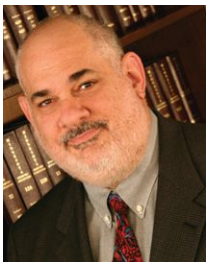
"Dr. Hart advocates daily for the rights of those impacted by health care disparities not only at the local and state level but also nationally," Juan Bowen, M.D., ZVMS president, said at the award ceremony held at Mayo Clinic in November.

"To empower young minority men and women, Dr. Hart regularly volunteers at local schools in Rochester and in her hometown of Chicago as a part of the Doctors Back to School program to influence minority students to choose a career in medicine," Bowen said.

ZVMS President Juan Bowen, M.D. , presents Dionne Hart, M.D., with her award.

Choosing Wisely webinar available on MMA website

A free 60-minute webinar on the Choosing Wisely campaign is available on the MMA website. The program, for which CME credit is available, provides background on the initiative and includes videos that help educate physicians on how they can decrease harm and improve outcomes by avoiding unnecessary tests and procedures. Find it under the "Events" tab.


Robert Meiches, M.D.


Dave Renner


Janet Silversmith


Eric Dick

MMA in action

In November, **Robert Meiches**, M.D., MMA CEO, **Dave Renner**, director of state and federal legislation, and **Janet Silversmith**, director of health policy, met with Health Commissioner Edward Ehlinger, M.D., Assistant Commissioner Ellen Benavides and Assistant to the Commissioner Manny Munson-Regala to discuss Minnesota's provider peer grouping project and its implications for physician clinics.

Silversmith and Renner also met with representatives from MMGMA to discuss the ACA-required increase in the 2013-2014 Medicaid managed care payment rates for primary care services.

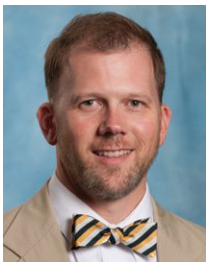
Eric Dick, manager of state legislative affairs, and **Brian Strub**, manager of physician outreach, attended the Lake Superior Medical Society's annual legislative dinner in Duluth in late November. Physician attendees and their guests heard a recap of the 2013 legislative session and a preview of the upcoming debates from three Duluth-area state lawmakers including Rep. Tom Huntley, Rep. Erik Simonson and Sen. Tony Lourey.

In November, **Mandy Rubenstein**, MMA manager of physician outreach, met with physicians at Sanford East Grand Forks and administrators at Sanford Perham.

Manager of Physician Outreach **Kathleen Baumbach** and Strub met with Julia Halberg, M.D., General Mills' chief medical officer. Baumbach, Strub and **George Schoephoerster**, M.D., also met with Northwest Family Physicians in Crystal to discuss prior authorization for medications.

MMA staff also met separately with Bill Monn, executive director of the Minnesota Chapter of the American College of Cardiology, and Rosemary Lobeck, executive director of the Minneapolis Surgical Society, to discuss how the MMA and specialty societies can better work together.

The MMA recently hosted several lunch-and-learns for medical students. In November, the MMA and the Twin Cities Medical Society hosted "Exploring Nontraditional Careers in Medicine" at the University of Minnesota Medical School, Twin Cities campus. Panelists included: **Joshua Riff**, M.D. chief medical officer, Target Corporation; **Susan Alpert**, M.D., Ph.D., principle, SFA Consulting LLC and formerly with Medtronic and the U.S. Food and Drug Administration; and **Peter Dehnel**, M.D. medical director of utilization management for Blue Cross and Blue Shield. In late November, the MMA and the Lake Superior Medical Society (LSMS) hosted a program, "Things Every Doctor Should Know about Mental Illness," at the University of Minnesota Medical School, Duluth campus with Sue Abderholden, executive director of the National Alliance on Mental Illness of Minnesota. In December, the MMA and the LSMS hosted Troy Taubenheim of the Minnesota Council on Graduate Medical Education, who discussed GME funding.


Brian Strub


Mandy Rubenstein


Kathleen Baumbach

VIEWPOINT

Filling the pipeline

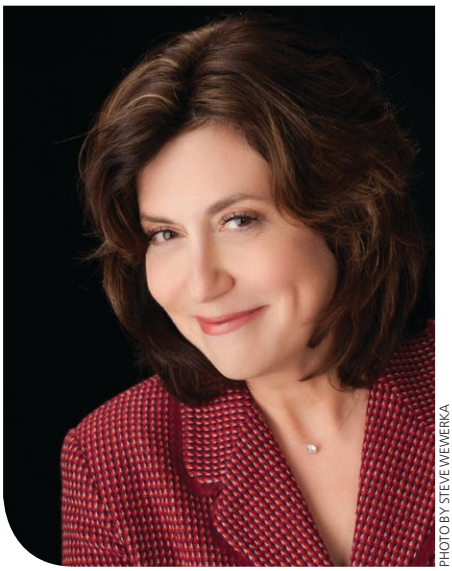


PHOTO BY STEVE WEWERKA

Cindy Firkins Smith, M.D.

None of my children went into medicine. My youngest came the closest. For her, the decision came down to medicine or clothing design, and the latter won. This wasn't the easy choice; the clothing design program at the University of Minnesota is incredibly demanding, and she probably put in more hours as an undergrad than I did. Also, the field is very competitive, and finding a job is a challenging endeavor with no guarantee of success. But she did it, and she loves what she does. She still occasionally thinks about medicine but has decided, at least for now, she doesn't have the "fire in her belly" to go to medical school.

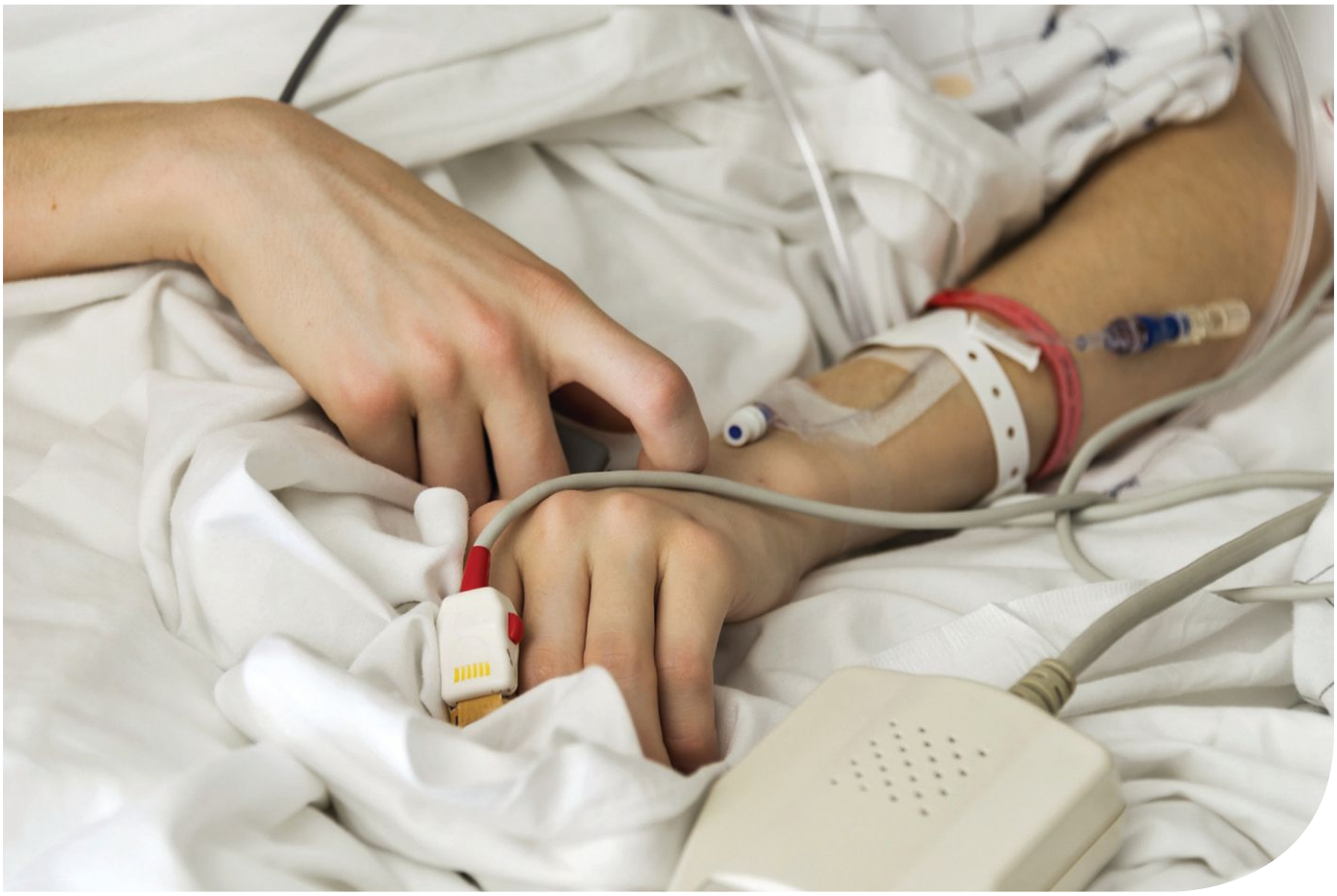
Fortunately for medicine, many of our children have that fire. Medscape reports that 2012-13 medical school enrollments were at an all-time high. In 2012, 48,014 students applied to medical school, a 6.1 percent increase over the previous year, and 20,055 enrolled, a 2.8 percent increase. These men and women are no slouches; applicants had an average GPA of 3.5 and a median MCAT score of 29. Three-quarters had research experience and two-thirds had performed volunteer community service. College students still see medicine as an attractive career despite the uncertainties, the prospect of graduating with approximately $170,000 in debt and the fact that there may not be a residency position waiting for them.

When I graduated from medical school, I knew getting a dermatology residency position would be difficult. But I never considered that I might not match *any* residency. Currently, roughly 28,500 first-year residency positions are available each year, with graduates from U.S. allopathic and osteopathic medical schools and foreign medical schools as well as physicians from other countries competing for those slots.

The Association of American Medical Colleges projects a shortage of more than 90,000 physicians by the end of the decade and 60,000 as early as 2015. We already see a shortage of primary care physicians in rural and underserved areas. In order to meet the demand, medical schools have set a goal of increasing enrollment by 30 percent by 2020. In 2013, four new schools opened, and existing schools have increased the size of their incoming classes. But without a corresponding increase in residency slots, the physician shortage will persist. We need to solve this and quickly. Not only do we need physicians to care for patients, it's unconscionable to graduate a medical student with no prospect of a residency position and considerable debt to repay.

We can fix what ails medical education, and we must—for our kids and for our future. Every day we go to work, we do something important: we take care of people. We want the best and brightest of our children to follow our path. I haven't given up on my daughter. She would be an amazing surgeon; she can already stitch.

It's unconscionable to graduate a medical student with no prospect of a residency position and considerable debt to repay.



The business of caring

We owe all of our patients respect and compassion, regardless of how they treat us.

BY JOHN BENSON, M.D.

My earliest memory of medical school is also my fondest. It was orientation day, and the keynote speaker was a woman well-known to Minnesota's medical community. She was the mother of a young woman who had suffered a tragically long series of illnesses. As her daughter became increasingly physically and mentally disabled, she became the girl's advocate, traveling with her from hospital to hospital and ensuring that she received the best care possible.

In her speech, the woman told us about the health care professionals she encountered, from the inspiring to the incompetent. As the years passed, she had—inevitably—run into frustrations. But instead of responding with anger, she set out to improve things for others. She began giving talks on how to be a better caregiver. The woman was incredibly moving; forceful, yet kind. I'm sure every student at that orientation was thinking: I hope I can become one of those great examples she's talking about.

"I don't want a McDreamy or a McSteamy," she said at the end of her speech. "I'm not looking for a House. What I want is a

doctor who will creatively and intelligently help me care for my daughter."

As I neared the end of my coursework, I met a man whose situation was curiously similar to the woman's. He was a caring father who had dutifully seen his profoundly mentally retarded daughter through 22 years of clinic visits, hospitalizations, imaging studies, lab draws and invasive procedures. He, too, had seen health care at its best and worst.

Yet his response was quite different. The years spent drowning in medical bills and watching the slow decline of his daughter had taken a brutal toll. By the time his daughter was admitted to the hospital where I was rotating during my final year of medical school, the man was more than withdrawn, more than cynical. He was angry and resented everything related to the health care system.

How had the medical system's inefficiencies, hierarchy and endless supply of naïve students created resilience in one person and intolerance in the other?

When I first met him, he was standing directly in front of the door to his daughter's room, his arms folded across his chest. Behind him, I could see his daughter lying on the bed, the room filled with posters, cards and flowers. Intubated and stuck with IV needles, she was rolling her head back and forth, grimacing.

"Ah," he said to me, his voice thick with contempt. "A student."

In the weeks that followed, I tried futilely to make a connection with him. I visited his daughter's room often, offered comforting words and did my best to provide emotional support. Every gesture was greeted with anger. Any word I spoke beyond reporting the most recent lab results elicited the same response: "I don't need an editorial," he would snap. "Let's just wait until the real doctors get here."

To him, I was just one more eager student, ready to try my hand at raising his spirits. So I was careful not to become a nuisance; I didn't pester. I never asked about the years he had spent bouncing from one hospital to another, caring for his daughter's ever-growing list of debilitating illnesses. Nor did I ask what he felt when he had to re-tell the story of his daughter's progressive demise to a new team of doctors. I suppose I didn't have to ask about his feelings. They were etched on his face every time he searched her back for new bedsores and every time he waved a creased, worn picture in front of a resident's face and yelled, "Look! *This* is what her baseline looks like!"

Eventually, I stopped going to his daughter's room without the rest of the team. Even the residents learned not to enter the room alone or offer their opinions during a care conference. In the end, despite his fierce advocacy, his daughter almost certainly received worse care than she would have had he not been present. The turbulence the man created whenever "repetitive" labs were drawn or when anyone touched his daughter in a way that he considered disrespectful kept both the nursing staff and the attendings at a cautious distance.

That isn't to say that the man was always challenging. There were times when I saw the kinder side of him, times when I had glimpses of the person who lovingly and passionately cared for his child. One afternoon, as I rushed toward the elevator carrying my grilled cheese sandwich and onion rings from the cafeteria, I looked up to find him holding the door open for me. "Big mistake," he said, smiling, as he glanced down at my lunch.

I raised my eyebrows. "No good?"

"No," he laughed and winked at me. "I meant it was a big mistake not taking the stairs. With a lunch like that, you'll need to burn off every calorie you can."

On another day, our team entered his daughter's room to find him leaned over her, his hands clutching the sheets of her bed. He had clearly been crying but tried to hide it. "Any chance we can get her off the ventilator today?" he asked, turning his face away from us as he wiped away his tears. Our attending physician sighed and explained that no, we were sorry, but we still thought it was too early. The faces of everyone on our team visibly softened. "Let's see how it looks tomorrow," the attending said. The man nodded slowly. But then his eyes narrowed. "And why has no one told me about the results of her morning labs yet?" he demanded.

As we made our way back to the workroom, it was clear that the moment of sympathy had passed. The residents and students began making comments, the nurses rolled their eyes and even the attending muttered something about looking forward to her week off.

What is it, I wonder, that caused those two parents to respond so differently to their situations? How had the medical system's inefficiencies, hierarchy and endless supply of naïve students created resilience in one person and intolerance in the other?

I guess it doesn't really matter. What's important is how we physicians, nurses, lab technicians, students and others respond to each of our patients. We will meet many types of patients, both the courageous and the defeated. For every one of them, we have to try to live up to our ideals about being respectful, kind and compassionate. After all, ours is a business of caring for all—not just the ones who persevere. **MM**

John Benson, M.D., wrote this while he was a fourth-year medical student at the University of Minnesota. He is now doing a radiology residency at the university.

Signing off

How a student's attempt to reach out to his deaf patient both failed and succeeded.

BY DEREK LEROUX SMITH, M.D.

As I reflect on my years as a medical student, I recall spending the majority of my time amassing a thin veneer of knowledge about a variety of subjects—enough to make me appear competent as I moved from one clinical rotation to the next. The unspoken lesson was "fake it 'til you make it," and the learning process involved distilling experiences into the basic components of knowledge that would allow me to pass my shelf exams and impress my supervising residents and attendings. Nuggets of true learning were often obscured by my hubris, and at times my misguided focus was on testable material rather than on what truly mattered—my patients. However, one patient proved to be my greatest teacher, providing me with a valuable lesson about humility.

I met the young man, whom I'll call Alex, when I was in my third year. Alex's story, like too many others, began as a tragedy. Born into a large family that had recently immigrated to the United States, he had been physically abused as an infant. To silence the cries of the wailing infant, a family member regularly "boxed" his ears, causing complete deafness by the age of 2. Alex had been fortunate enough to receive early intervention, becoming proficient in American Sign Language (ASL) and initially doing well in school.

However, as he came into adolescence, his peers' curiosity turned to ridicule and even violence. Although his family was supportive, Alex suffered in silence until he attempted suicide, after which he was transferred to our facility for emergent care and psychiatric assessment.

As I read the intake notes on Alex the morning after he was admitted, I was touched by his story. I had taken ASL as a high school elective and thought I might be able to establish rapport by introducing myself in sign. As I prepared my introduction, I expected to see Alex smiling broadly as I signed my salutation. I imagined myself being personally responsible for navigating the choppy waters of communication, surmounting the gap between physician and patient with grace, earning accolades from my colleagues and attending physician, and ultimately facilitating the care of my patient.

So as my team walked into the room, I eagerly positioned myself at the front and implemented my plan. Alex initially looked surprised, then turned to the interpreter and quickly signed a response. As I stood beaming with satisfaction, the interpreter translated, "You suck at signing!"

The remainder of the interview was less than productive, and although I wore a smile on my face, it was merely a half-hearted attempt to hide my feelings of failure. I typed my notes and attended my lectures in a daze, distracted by the fresh wound to my pride and my inadequate performance in a scene that played over and over in my mind. I limped home, my ego deflated. Yet, as I reflected on what had occurred, I felt a new sense of resolve: I was going to connect with this patient.

So I made a game of interacting with Alex. Every day, I learned to sign a few new phrases and would try them out. Alex, in return, would respond with "you suck at signing." The game continued over the next few days, and with growing enthusiasm, Alex responded every time with "you suck at signing" (often adding a few expletives). Yet with each interaction, I would see a smile replace his scowl.

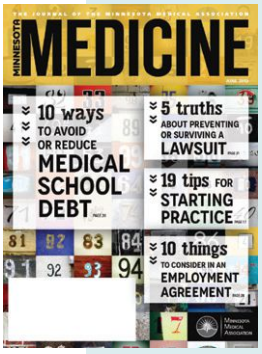
Alex soon reveled in mocking my attempts at connection, yet through our daily interactions, I got to know him. I learned that he was an accomplished artist, that he wanted to be a chef when he grew

up, that his favorite movie was "Finding Nemo," and that he was the best Dance Dance Revolution player I had ever seen. I watched as he started making friends on the unit, participating in groups and laughing with others. And as time went on, I witnessed him cautiously emerge from the depths of his depression, thanks to antidepressant medications and the daily therapeutic interactions on the unit. I felt a sense of wonder as I watched him progress toward recovery.

On the day of discharge, I stood back as Alex solemnly collected his belongings and accepted well wishes from the nursing staff. In place of the timid youth who withdrew to his room and refused to talk to anyone during his first few days stood a confident young man.

As he was preparing to leave, he told his family that he had forgotten something. He turned and walked back toward the front desk where I stood. Alex had amassed quite a number of drawings and craft projects while on the unit, so I immediately assumed he had forgotten one. Yet as I hurriedly scanned the room for it, Alex tapped me on the shoulder. I turned, expecting him to tell me what it was he had forgotten, and was equally surprised and terrified as he squeezed me in a tight embrace. Before I fully realized what was happening, he let go and walked quickly out the door without looking back. It took several seconds before I noticed the crumpled envelope in my hand. Inside was an equally crumpled piece of paper. I slowly unfolded it and read words that had been scrawled in green marker. "Thank you for all that you've done. And you still suck at signing!" **MM**

Derek LeRoux Smith is a psychiatry resident at the University of Minnesota. This was adapted from a talk he gave at the medical school's white coat ceremony last fall.



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Treating Childhood Obesity

BY RUSS KUZEL, M.D., AND JESSICA LARSON, M.D.

Nearly a third of children and adolescents are overweight or obese, which puts them at higher risk for diseases such as hypertension, type 2 diabetes, stroke, coronary heart disease and some cancers. This article discusses strategies physicians can use to address the issue of weight with children and their families. It also describes the efforts of a Minnesota collaborative that is working to improve obesity care and ensure insurance coverage for it.

Allie is a 10-year-old girl who is being seen for a well-child visit. Her BMI is at the 87th percentile—a three-point increase from where it was last year. When asked about her diet and exercise habits, she says she drinks chocolate milk every day at school, has a TV in her bedroom and gets less than an hour a day of exercise. Her family lives in an apartment building, both parents work full time and the nearest park is more than a mile away.

Ryan is a 12-year-old boy who has come to the clinic for an asthma recheck. At his last visit six months ago, his BMI was at the 94th percentile. At that time, his family set diet and exercise goals. Today, his BMI is at the 96th percentile, and his asthma is getting worse. His parents would like to see a dietician, but they want to make sure their insurance will cover the visit.

Shannon is an 11-year-old girl who was recently diagnosed with type 2 diabetes. Her BMI is over the 99th percentile. Her mom is a single parent, and she struggles to afford healthy foods. Shannon spends a great deal of time unsupervised and sedentary. Her diabetes is poorly controlled, and the endocrinologist has recommended that she be evaluated at a weight-management clinic. Shannon's mom says she can't miss any more work to take her daughter to an appointment and asks if there is anything available close to their home.

Most pediatricians and family physicians have become all too familiar with scenarios like these. Nationally, about 30% of children are overweight or obese. The numbers are similar in Minnesota. According to 2010 data, 20% of 9th and 12th graders are overweight or obese.[1] Additionally, 13% of 2- to 5-year-olds enrolled in WIC in Minnesota are obese and 16% are overweight.[2]

Because obese people are at higher risk for many diseases including hypertension, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, depression, osteoarthritis, sleep apnea and some cancers, obesity needs to be considered a serious health concern. Yet addressing overweight and obesity can be challenging for physicians with a busy office practice. Discussing a child's weight with their families can be difficult, and clinicians often hesitate to broach the subject, knowing it can be emotionally charged. Parents or guardians often are not ready to admit that their child is overweight or they may face significant barriers to making meaningful change. In addition, many practitioners do not feel they have the appropriate training and resources to make an impact. So, where do you begin?

In the Clinic

At a minimum, physicians should be documenting all children's BMI in their medical record yearly and initiating a discussion with the family about the importance of having a healthy weight. Ideally, this would be done in the context of a well-child visit. Children in the fifth to 84th percentile of

BMI for their age are considered to have a "healthy weight;" children in the 85th to 94th percentile are "overweight;" and children with BMI measures over the 95th percentile are "obese."

Children who have a healthy weight should be encouraged to keep up the good work. With children who are overweight or obese, careful wording and focusing on health instead of weight are the keys to having a successful conversation. A good way to open the discussion is to request permission to talk about the topic. For example: "As I look at your child's growth, I see that his weight may not be healthy for his height. I'm concerned that this could have an impact on his long-term health. Can we talk about this today?"

The American Academy of Pediatrics (AAP) published guidelines in 2007 to assist physicians in tackling the issue of weight management.[3] They recommend using a staged approach to obesity management, with the intensity of treatment increasing at each stage. Most children can be treated using the first or second-stage approach. A child with significant health issues related to obesity may need more intensive treatment.

Stage 1

The first-stage interventions are done in a primary care setting. They involve giving the family of a child who has been identified as overweight or obese a brief message about the importance of working toward a healthy weight and encouraging them to set specific goals. A helpful tool for counseling patients is "5-2-1-0," which is the recommendation to consume five servings of fruits or vegetables, spend less than two hours in front of a screen (including time in front of a computer), engage in one hour of active play, and consume zero sugary beverages each day. These strategies are all evidence-based and can have a significant impact on children, especially younger ones.

Other strategies can be tailored to an individual child. For example, in Allie's case, the treating physician could help her mother set goals such as having Allie drink low-fat white milk at lunch, rather than chocolate milk, and suggest removing the television from Allie's bedroom. These could be documented as a "prescription" for the family to take home. One tool for making such lifestyle prescriptions is the AAP's Rx for Healthy Active Living. It can be downloaded at www.aap.org.

Stage 2

For children who do not show improvement with a brief intervention, a second-stage intervention may be needed. In such cases, families would meet with a dietician and/or other professional either in the clinic or in the community who can provide a more extensive evaluation and offer more guidance and closer follow up regarding healthy diet and exercise.

Stage 3

For children who are severely obese (BMI greater than the 99th percentile) or who have a weight-related co-morbidity, third-stage treatment—intervention by a weight-management team—is needed. These teams are typically led by a physician who is a pediatric weight specialist and include dieticians, mental health specialists and exercise specialists. They are usually clinic-based, but some community programs may provide a similar level of care.

Stage 4

The fourth stage involves bariatric surgery and medications. Treatment generally would be offered at a tertiary or quaternary care center.

Family Readiness

When thinking about how to intervene, clinicians should not only consider the child's BMI but also the family's readiness for change. If parents do not realize or believe that their child is overweight or obese, they may not be ready to talk about it, let alone embark on a plan of action. The physician's role may just be to raise the concern and get families thinking. Motivational interviewing can be used to help move families toward making positive changes in regard to their child's health. It can help families solidify their goals and identify barriers to success. For example, you might say, "You said you would like to walk as a family for 30 minutes three days a week. On a scale of 1 to 10, how likely are you to do this?" Once they respond, follow up with a question such as "What made you say 7 and not 5?"

Measures Used to Make a Case for Insurance Coverage

- Race/ethnicity
- Height
- Weight
- Age
- BMI % (kids), counseling
- Cholesterol panel (only 9-11 year olds)
- 5-2-1-0 counseling
- Blood pressure

The full list of measures is available at www.mnaap.org/obesitycoding.html.

Other Challenges

Physicians face a number of practical challenges when managing the care of a child who is overweight or obese. One is that the patient's health plan may not cover visits with a dietician or weight specialist. If a family is paying out of pocket, a community-based program may be too costly. Another challenge is getting paid for the time spent talking with the patient's family about the importance of limiting sugary beverages or exercising.

A number of resources are available to help physicians meet such challenges. One is a chart created by the Minnesota Department of Health that briefly outlines appropriate coding for weight management services and summarizes Medicare's, Medicaid's, Blue Cross and Blue Shield's, HealthPartners' and Medica's policies. (It can be accessed at www.mnaap.org.) Had Ryan's physician referred to this, he would have known that dietician services for obesity are generally covered by Blue Cross and Blue Shield, Health Partners, Medica and Medicaid.

A remaining challenge for both providers and health plans is identifying the data needed (about overweight/obesity prevalence, associated co-morbidities and the effectiveness of interventions) to justify health insurance coverage for weight management services. Toward that goal, the Minnesota Partnership on Pediatric Obesity Care and Coverage has developed a menu of measures clinics can use to build the case for reimbursement. These are closely aligned with other guidelines for pediatric obesity care as well as those used by MN Community Measurement, which is conducting a pilot related to pediatric obesity.

The Partnership is also developing a list of community resources and programs that support healthy weight management. The list is online at: www.mnaap.org. Shannon's physician could have used this list to identify a program at a community center that provides nutrition services and group exercise classes. Her doctor would continue to provide medical monitoring while Shannon received other services through that community program. This kind of partnership may be very effective for a patient with a motivated family.

Concluding Thoughts

The American Medical Association's decision to classify obesity as a disease, along with provisions in the Affordable Care Act, will likely mean that most health insurance policies will cover obesity care in the future. Although these are positive steps, a number of challenges related to the prevention and treatment of obesity remain.

Battling the obesity crisis will require the efforts of many stakeholders. Physicians and other health care practitioners must continue to consistently identify children who are overweight and obese and work with their families to help them make healthy changes. Clinics and health systems must collect and report data on these children and families and the interventions they receive, so we can learn which ones are most effective. Health plans must continue to look more closely at novel models for reimbursing pediatric obesity care.

The U.S. Centers for Disease Control and Prevention recently reported that many states, Minnesota included, are showing declines in their rate of childhood obesity. Clearly, this is a good sign. But it does not mean the battle is over. Physicians are on the front line and need to continue to improve their skills and build their knowledge if we are to make continued progress. **MM**

Russ Kuzel is senior vice president and chief medical officer of UCare. Jessica Larson is a pediatrician with Fairview Medical Group and co-chair of the Minnesota chapter of the American Academy of Pediatrics' Obesity Workgroup.

REFERENCES

1. Minnesota Department of Education, Minnesota Student Survey, St. Paul, MN, 2010.

2. Pediatric Nutrition Surveillance System Report: Health Indicators Minnesota Children Enrolled in WIC 1995-2010. Minnesota Department of Health

3. Barlow S and Expert Committee. Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report. *Pediatrics.* 2007;120 (supplement 4):S164-192.

The Minnesota Partnership on Pediatric Obesity Care and Coverage

In an effort to address barriers to pediatric obesity care, physicians and representatives from health plans began meeting in 2012. Their discussions led to formation of the Minnesota Partnership on Pediatric Obesity Care and Coverage (MPPOCC).

The partnership is overseen by the Minnesota chapter of the American Academy of Pediatrics and the Minnesota Council of Health Plans. Its members include representatives from health plans, health systems, professional organizations, government agencies, hospitals, clinics and community organizations.

The mission of MPPOCC is to improve pediatric obesity care and insurance coverage by identifying referral pathways and advocating for reimbursement for necessary, evidence-based services. The goal is to reduce the overall incidence of pediatric obesity in Minnesota.

Individual physicians and organizations may join. If you or your organization is interested in becoming part of MPPOCC, please contact Janny Brust, brust@mnhealthplans.org.

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AD INDEX

Just one more step

BY SHERRY-ANN BROWN, M.D., PH.D.

I could give in to the challenge before me
Or yet I could give out.
Alternatively, I could give all.

All I have in me
All I have left
To step.

I could stay in this position
I'm sure I could find justification.

But just as I could choose to stop …
I could instead choose to step.

If I could take
Just one more step,
I know I will be all right.
I know I won't be back at the start.
I know this with all my heart.

If I could take
Just one more step,
I will be closer to the finish line,
Where an earned-yet-gracious victory will be mine.

If I could step
I know I'll make it
I know my dreams will come true.

I must keep on stepping
Whether with my pen or my finger
With my voice or my pointer
With my legs or my walker
With my feet or my wheeler.

With a clear gaze,
Or through the haze,
With my muscles cooperating
Or with me overcoming,
I must just step.

With the software freezing
Or running smoothly,
Running out of memory
Or making things easy,
I must step.

With the tears and the fears,
Literally and figuratively,
Respectively,
I must just step.

Until I achieve my goal
And until the race is o'er
I must keep on stepping.

No matter what stage,
I must still take
One more step.

Sherry-Ann Brown is an internal medicine resident at Mayo Clinic.

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