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Minnesota physicians face a rising tide of assaults at work. Employers and clinic owners are trying to head off violence and verbal abuse before they occur. PAGE 20

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CONTENTS

Spring 2026 | VOLUME 109 | ISSUE 2

IN THIS ISSUE

Physicians don't need data to illustrate that healthcare facilities can be unsafe places to work.

ON THE COVER

FEATURES

DEPARTMENTS

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6

8

14

16

PHOTO BY RICH RYAN

36

44

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Christopher J. Wenner, MD

Coded to death

Another year. Another code. The bureaucrats have been at it again—levying yet another time tax, another simplicity killer, another soul-sucking number that is antithetical to the foundation of medicine. The intent may have been admirable; however, the implementation has further diluted our capacity *and* our profession.

I'm referring to the fresh cohort of codes that The Centers for Medicare and Medicaid Services (CMS) put forth for 2026; a mirepoix of nothingness. Said codes, too numerous for this article, are purported to enhance value and bolster primary care reimbursement, while maintaining budget neutrality. As a primary care physician who resides at the bottom of the medical food chain, I appreciate the nod by CMS to lessen the pay gap between PCPs and specialists. However, the nickel and dime increases do little to enhance the bottom line when a legion of new staff is required to implement these codes. Much more concerning, these codes are anything but budget neutral when the finite commodity of physician time is accounted for. Another box to check, another cookbook phrase to document, another moment stolen from the physician-patient experience.

If the administrative elite spent a fraction of the mental energy required to develop this litany of numbers on more efficient, equitable care, the result would be most certainly a positive for our patients, physicians, and the system at large—a boon for our collective health.

Like a thousand paper cuts, we are slowing being bled dry of our healing capacity by those who don't practice medicine. They think that just because the problem is complex, a complex solution is required. As we learn in our first year of medical school, more medicine is not always better medicine. If the administrative elite spent a fraction of the mental energy required to develop this litany of numbers on more efficient, equitable care, the result would be most certainly a positive for our patients, physicians, and the system at large—a boon for our collective health.

Not only is this coding carcinoma laying waste to the medical profession. Its invasive filaments are already attacking the health of the populace. Risk scoring is a popular game perfected by payers so they can collect more from their government contracts. These payers dangle more nickels and dimes in front of us so we can do their scut work and document how "sick" these patients are. Side note—the fact that we do not code for "wellness" illuminates the misalignment of goals between physicians and payers. It is a wonder that any of our patients remain alive with the sheer weight of the codes thrust upon them. Another side note—still waiting for the code that indicates the patient has my cell number.

What to do? First, stop making things more complex—which means physicians need to wrestle back power from the administocracy that pulls all of medicine's levers. More complexity means more job security for these folks—at the expense of our profession. Second, assess value in a straightforward way—value = quality x patient experience/cost—and assign more dollars to those who provide more value and less to those who provide less. Third, and most important, keep the patient first in any decision tree.

In our medical training, we learn to understand the value of diagnostic parsimony—Occam's razor. Training at the administratum appears to espouse an opposite heuristic, also known as Hickam's dictum: "A patient can have as many diseases (or codes) as they damn well please." **MM**

Christopher J. Wenner, MD, is the founder of Christopher J. Wenner, MD, PA, an independent family medicine practice in Cold Spring. He is one of two medical editors for *Minnesota Medicine*.

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Minnesota sues federal government over $259M Medicaid withholding

In early March, Minnesota Attorney General Keith Ellison and the Minnesota Department of Human Services sued the Trump administration for its decision to withhold an estimated $259 million in Medicaid payments to Minnesota until further investigation of fraud in the state is completed.

"CMS is done trying to catch fraudsters with their hands in the cookie jar—instead, we're padlocking the jar and letting them starve," said Center for Medicare and Medicaid Services (CMS) Administrator Mehmet Oz, MD. "This proactive approach will help us crush fraud, protect taxpayer dollars, and make sure the vulnerable Americans who depend on our programs get the care they need."

"The Trump administration's MO is to cut first, no matter what the law says or who gets hurt, and ask questions later, if at all," Attorney General Ellison said in a press release. "These cuts are the latest in a long series of efforts to go around the law to punish Minnesotans—but just as we fought back and won when they illegally tried to cut funding for childcare, hungry families, and our schools, we are suing them again today to make them follow the law."

The MMA called the announcement "a direct threat" to the health of all Minnesotans who rely on Medicaid for their care, medications, and nursing home services. "This action is also an insult to the physicians and other healthcare professionals who provide services to Medicaid patients and now face the threat of delayed or no payment," said MMA President Lisa Mattson, MD, who took part in a press conference on the issue in early March.

In a statement, Department of Human Services (DHS) Commissioner Shireen Gandhi said, "Deferring $259 million will significantly harm the state's healthcare infrastructure and the 1.2 million Minnesotans who depend on Medicaid."

The Trump administration is asking for the Walz administration to develop a "comprehensive corrective action plan to stop the problem." Until this plan is complete, the federal government said it will withhold funding.

"These cuts will be devastating for veterans, families with young kids, folks with disabilities, and working people across our state," Gov. Tim Walz wrote on X.

CDC cancels $38M in public health funds to Minnesota

In February, the Centers for Disease Control and Prevention (CDC) confirmed that it had cancelled about $38 million in public health investments for Minnesota.

That same day, a federal judge blocked the Trump administration from eliminating the funding. Minnesota Attorney General Keith Ellison joined the attorneys general from the other targeted states (California, Colorado, and Illinois) in filing a lawsuit to maintain the funding while the lawsuit proceeds.

The funding is from the Public Health Infrastructure Grant (PHIG). The five-year grant began in 2022, and was set to expire in 2027. Nationwide, 107 health departments across all 50 states received this funding, but only Minnesota and

State to receive $193M for rural health efforts

In late December, the Minnesota Department of Health (MDH) announced that it will be awarded more than $193 million from the federal government for rural healthcare across the state.

This first year of Rural Health Transformation Program (RHTP) investments from the Centers for Medicare and Medicaid Services (CMS) includes base funding distributed to approved states, as well as significant additional funds recognizing Minnesota's innovative plan to stabilize and strengthen healthcare delivery in rural communities.

The funding will support strategic investments in new technology tools to bring care closer to home for rural residents; improve health outcomes for Minnesotans with or at risk of developing cardiovascular disease, diabetes, and chronic kidney disease; and expand the rural healthcare workforce through education and training pathways. Funding will also be used to enhance technology-enabled care delivery, including mobile and community-based services, strengthen provider partnerships, and bolster the financial stability of rural providers through targeted investments in technology and data infrastructure.

"With rural Minnesota facing unprecedented access and funding challenges, this award comes at a crucial time," said Health Commissioner Brooke Cunningham, MD, PhD. "It is an important investment in our rural communities, and we are excited to begin working with our partners to advance access to high-quality care, improve outcomes, and ensure sustainable services in Greater Minnesota for years to come."

Minnesota's approved plan was built on extensive collaboration with rural community stakeholders, hospitals and health systems, safety net clinics, tribes, and local public health agencies.

MDH's application was submitted in November, and asked for $1 billion over five years for an average of $200 million per year. The application reflected input from more than 40 stakeholder meetings and nearly 350 public responses; state officials will continue engaging stakeholders when the implementation process begins in early 2026.

The Rural Health Transformation Program provides up to $50 billion nationwide over five years to support innovative rural health initiatives. In 2026, all 50 states will receive first-year awards from CMS.

CDC public health funding cuts… *(continued from previous page)*

three other states are having their funds cancelled.

"These cuts by the federal government, and other cuts to public health funding over the past year, highlight a total disregard for promoting health and well-being," said Minnesota Health Commissioner Brooke Cunningham, MD, PhD. "The ongoing cuts create an environment of chaos and confusion for communities."

Minnesota has been using the PHIG to strengthen Minnesota's public health workforce; modernize its data systems; support emergency planning and response work; build public health services and capacity at the local level, especially in Greater Minnesota; enhance efficiencies and effectiveness of public health programs; and much more.

MDH was also notified last week that the CDC cut about $250,000 in funds for the Core State Injury Prevention Program (SIPP), which supports public health infrastructure, as well as data and partnerships to identify and respond to existing and emerging injury threats with data-driven public health actions.

Additionally, MDH is aware that the CDC has notified Congress that it plans to cut additional grants starting soon. Those grants are the Preventive Services Block Grant (PBG), as well as the HIV Surveillance and Prevention-Strengthening STD Prevention and Control for Health Departments grant. These actions further erode Minnesota's ability to prevent and respond to a myriad of public health challenges.

Vaccine Integrity Project, AMA announce new vaccine review process

The Vaccine Integrity Project (VIP), in collaboration with the AMA, announced in February the start of a structured, evidence-based review process to assess vaccine safety and effectiveness for the 2026–2027 respiratory virus season. The review will focus on immunizations for influenza, COVID-19, and respiratory syncytial virus (RSV).

Building on the evidence review completed for the 2025–2026 season, this new effort will establish a process for evaluating the science underpinning respiratory virus immunization.

The VIP, based at the University of Minnesota's Center for Infectious Disease Research and Policy, and the AMA will convene leading medical professional societies, as well as public health and healthcare organizations, to help define a comprehensive set of policy questions.

The goal of the work is to ensure a deliberative, evidence-driven approach to produce the data necessary to understand the risks and benefits of vaccine policy decisions for all populations—the approach traditionally used by the federal government.

Single dose of nonprescribed Adderall raises blood pressure, heart rate in healthy young adults

A single 25 mg dose of a combination of amphetamine-dextroamphetamine salts (Adderall) can have measurable cardiovascular effects in healthy young adults, a Mayo Clinic study found. Researchers, whose findings are published in *Mayo Clinic Proceedings*, aimed to better understand how the stimulant affects those who use it without a medical prescription.

"The primary objective of our study was to investigate how a single dose of Adderall acutely affects cardiovascular hemodynamics—blood pressure and heart rate—and sympathetic activity in young adults who do not have a medical indication for the medication," said senior author Anna Svatikova, MD, PhD, a Mayo Clinic cardiologist.

While Adderall is safe and effective when prescribed and monitored for ADHD, Svatikova said the risks of unsupervised use are often underestimated.

"We have seen an increase in nonmedical Adderall use, but many users are unaware that it can place acute stress on the cardiovascular system," Svatikova said.

"Adderall is sometimes used without a prescription outside of a medical setting," she said. "We found that even in individuals with no prior exposure, a 25 mg dose triggers significant increases in blood pressure, heart rate, and activation of the body's stress-response system."

Researchers also noted that even when people simply stood up after taking Adderall, their heart rates spiked much higher than usual.

"The average heart rate increase on standing was 19 beats per minute before Adderall. After taking Adderall, that response doubled to 38 beats per minute," said first author Kiran Somers, DO, a resident family medicine physician at Mayo Clinic Health System in Northwest Wisconsin.

The findings highlight how stimulating effects can be in individuals who are not accustomed to the medication, the researchers say.

"These results demonstrate measurable, acute cardiovascular effects of Adderall used by those not regularly using Adderall prescribed for specific medical reasons," Somers said.

The researchers underscore that these findings apply to off-prescription use and do not reflect the long-term supervised use of the medication for the treatment of ADHD. These findings should not be extrapolated to the long-term supervised use of Adderall for the treatment of ADHD or other specific medical conditions, where the therapeutic benefits are well established and significant, Svatikova said.

–Vincent Jacobbi, Mayo Clinic

Report finds that most Minnesota maternal deaths were preventable

The latest maternal mortality report from the Minnesota Department of Health (MDH) found that 95% of maternal deaths occurring in the state were preventable. These preventable maternal deaths were most common among American Indian and Black patients.

The report calls for Minnesota to prevent deaths by addressing lack of access to care, disconnected care, and a lack of follow-up, as well as needed additional emotional, physical, and mental health support before and after pregnancy.

Based on the data from the Maternal Mortality Review Committee, the state's 2021 pregnancy-related mortality ratio was 34.1 deaths per 100,000 live births, slightly above the national average of 33.2. Most maternal deaths occurred after childbirth, a trend consistent with national findings.

Having a baby in Minnesota is much more life threatening for American Indian and Black parents. During 2017–2021, the statewide maternal death rate was 17.9 deaths per 100,000 live births. The maternal death rate for American Indians was 217.7 deaths per 100,000 live births, more than 12 times higher than the state rate. The rate for Black parents was 40.3 deaths per 100,000 live births, 2.3 times higher.

The report highlights how stark racial disparities impact American Indian and Black parents in Minnesota. A healthy pregnancy, birth, and time after birth requires that basic needs be met in a safe and stable environment, free from harm, according to the report. This includes safe and consistent housing, nutritious food, and freedom from substance abuse.

"These findings are deeply troubling and underscore the urgent need for action to ensure every family receives the supports and services required for a safe and healthy pregnancy," said Minnesota Commissioner of Health Brooke Cunningham, MD, PhD. "Addressing the racial disparities outlined in this report will require the collaboration of multisector partners, community organizations, and state leaders."

The report was the work of the Minnesota Maternal Mortality Review Committee, whose members include healthcare providers, experts, and community members. The committee reviewed the 162 maternal deaths that were recorded in Minnesota between 2017 and 2021. The committee's in-depth review of each death found that 59 of the deaths were directly connected to pregnancy. The top five leading causes of death were mental health conditions (including substance use disorders), injury, infection, hemorrhage, and cardiomyopathy.

The report focuses on recommendations for preventing future maternal deaths. Several key actions are noted, including providing more follow-up and support to families after pregnancy; improving access to basic needs like housing and transportation; strengthening mental health support before, during and after pregnancy; incorporating care that responds to cultural considerations; better referrals for people in crisis and new policy initiatives.

The Minnesota Maternal Mortality Review Committee reviews cases of pregnancy-associated deaths and makes recommendations aimed at improving policies, programs, systems, practice guidelines, and healthcare services. The multidisciplinary committee was established by Minnesota statute and comprises diverse representation from the maternal health field, public health, and community organizations.

"I appreciate the hard work of this committee, which has identified important opportunities to reduce preventable mortality surrounding pregnancy," said Cresta Wedel Jones, MD, FACOG, FASAM, committee cochair and associate professor in the Department of Obstetrics, Gynecology, and Women's Health at the University of Minnesota Medical School. "I call upon our state leadership to examine possible opportunities to integrate the recommendations in working towards more optimal outcomes for Minnesota families."

Minnesota, other states, sue federal government over vaccines

The attorneys general from 15 states, including Minnesota, have filed a lawsuit challenging the Trump administration's overhaul of the nation's childhood immunization schedule.

The lawsuit challenges a Centers for Disease Control and Prevention (CDC) "decision memo" in January that stripped seven childhood vaccines—those protecting against rotavirus, meningococcal disease, hepatitis A, hepatitis B, influenza, COVID-19, and respiratory syncytial virus (RSV)—of their universally recommended status. The complaint also challenges the unlawful replacement of the Advisory Committee on Immunization Practices (ACIP), the expert federal panel that has guided U.S. vaccine policy for decades.

"The development of safe, effective vaccines has been one of the most significant scientific achievements throughout human history," said Minnesota Attorney General Keith Ellison. "I'm taking the Trump administration to court to stop them from unlawfully overhauling federal childhood immunization policy."

Another GLP-1 benefit—improved IBD outcomes

To the long list of conditions that seem to respond to treatment with GLP-1 receptor agonists, add another. GLP-1s seem to "exert anti-inflammatory effects beyond weight loss" that were associated with improved outcomes in patients with ulcerative colitis (UC) and Crohn's disease (CD).

The data, derived from the Mayo Clinic Platform, which provides de-identified clinical data on approximately 8 million patients, was presented by Mayo Clinic gastroenterologist Amanda Johnson, MD, at the 2026 Crohn's and Colitis Congress early this year in Las Vegas.

Johnson and colleagues evaluated the impact that use of GLP-1s had on inflammatory bowel disease–specific outcomes of corticosteroid use, emergency department visits, hospitalizations, intestinal surgery, and mortality in patients with UC and CD.

In total, 580 patients with IBD who were treated with a GLP-1 were compared with controls with IBD who were not treated with a GLP-1. Of the 322 individuals with UC, the rates of corticosteroid use, hospitalization, intestinal resection, and mortality were lower in the GLP-1–treated patients. In patients with CD, rates of corticosteroid use, emergency department visits, hospitalization, intestinal resection, and mortality were lower among GLP-1 patients.

According to the report, "The use of GLP-1 receptor analogs was associated with improved IBD-specific outcomes in patients with UC and CD. Further study is needed to better define the true impact of [GLP-1s] on IBD-specific outcomes, ideally with more granular measures of disease activity."

Reducing blood sugar in prediabetes shows heart benefits

People classified as prediabetic who manage to get their blood sugar levels back in the normal range on average cut their risk of heart disease or heart failure in half, according to research published February in the journal *Lancet Diabetes & Endocrinology*.

There is long-established evidence that type 2 diabetes increases the risk of heart disease and heart failure. Some evidence shows a similar association with prediabetes, though it hasn't been clear if that has been because prediabetes often advances to diabetes.

Researchers from China and Germany analyzed two well-known diabetes prevention trials, the U.S. Diabetes Prevention Program Outcomes Study and the Chinese DaQing Diabetes Prevention Outcomes Study. Remission was assessed using the American Diabetes Association criteria after one year in the case of the U.S. study, and six years for the Chinese study. The primary endpoint was death or hospitalization for heart failure over 20 years (U.S. trial) or 30 years (Chinese trial). In both trials, remission was achieved thorough diet and exercise, and, in the U.S. study, also metformin.

According to the analysis, reaching remission of prediabetes produced a decades-long benefit of halving the risk of death or hospitalization from heart failure.

The study's finding may suggest that treatment of prediabetes should do more than halt progression to diabetes, but also aim to restore normal blood sugar levels. "Although current concepts in prediabetes focus on halting progression to diabetes, the idea that the risk profile can be improved represents a new, more optimistic (albeit more aggressive) goal, and is the basis of the prediabetes remission concept," according to the study. "Targeting remission might represent a new approach to cardiovascular prevention."

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Two major medical groups say delay gender-related surgery

Earlier this year two major U.S. medical groups supported limits on gender-related surgeries for minors. In separate announcements, the American Society of Plastic Surgeons and the American Medical Society said any transgender surgery should be put off until adulthood.

It was the first time U.S. medical groups had taken such a position. Until then, medical groups had insisted that gender-related care, such as hormone therapy—and surgery—should be based on the specific needs of the patient, in consultation with medical specialists.

Gender-affirming care has become especially controversial as the federal and many state governments have moved to ban medical treatment of minors for gender dysphoria.

In making its new recommendation, the American Society of Plastic Surgeons said its decision was based on studies of long-term outcomes of treatment of minors with irreversible procedures such as mastectomies. The organization said the evidence was of low quality and insufficient to show benefits.

The AMA said it continued to support gender-related treatment of minors but concurred with the plastic surgeons society that the evidence supporting surgeries on minors is sparse. The group remained somewhat equivocal in its position. "Currently,

the evidence for gender-affirming surgical intervention in minors is insufficient for us to make a definitive statement," said the AMA statement. "In the absence of clear evidence, the AMA agrees with ASPS that surgical interventions in minors should be generally deferred to adulthood."

Children's Minnesota suspends gender-affirming care

Faced with threats to cut millions of dollars in federal funding, Children's Minnesota announced in February that it is suspending its gender-affirming care program.

"As one of the leading pediatric providers of gender-affirming care in the region, we have recently experienced an increase in federal actions directed at health systems like ours that provide this care. These actions jeopardize the stability of Minnesota's only comprehensive pediatric healthcare system, and they threaten our clinicians' ability to practice medicine now and in the future. Due to these conditions, we have made the difficult decision to temporarily pause prescribing puberty-suppressing medications and pubertal hormones (estrogen and testosterone) for patients under age 18 in our Gender Health program," Children's Minnesota said in a statement.

"Our Gender Health program is not closed. We continue to provide supportive care, mental health services, and education regarding medical and nonmedical treatment options." MM

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Presented to physicians who volunteer medical services and contribute to their community, specifically to MMA members who go above and beyond to help address the healthcare needs of underserved populations in Minnesota.

Visit the MMA website ***(www.mnmed.org/about-us/mma-awards)*** *to make a nomination by* ***June 26.***

The names we forget, the presence we remember

It's the bedside manner that makes an impression.

BY MAJD AL-SOLEITI, MD

With a tired face and shy but sincere smile, she greeted us in one of the small infusion rooms on the ground floor.

"Sit wherever you like, auntie," she said gently to my mother, then instinctively drew the curtain around her, respecting her privacy without us asking. It was a small gesture, almost too small and basic to notice, and yet in all the long months of navigating my mother's cancer journey, I had not seen this act of respect offered this carefully and intentionally.

To this day, I regret not remembering her name. But I remember her hands. Thin, graceful, steady, as she prepared the iron injection for my mother's weakened body with low hemoglobin and iron stores. She didn't ask my mother to adjust herself; instead, she leaned forward, humble and unassuming, and softly requested permission to roll up her sleeve. My mother, exhausted from chemotherapy, complied without a word.

Just before the needle slid in, she asked my mother to let her know if it caused any pain. Again, it sounds like the most basic courtesy, the kind taught early and often in healthcare training. Yet in a system where such basics are too often lost in the noise, her gentleness stood out like a star in a dark sky.

She didn't stop there. She explained what to expect from the infusion, how long it would take, and the side effects that might follow. By then, I was quietly moved. There was something in her presence, unrushed, attentive, profoundly human, that spoke loud and clear.

I finally broke my silence. "You know," I said, "you're the best health professional we've met in this hospital. I really appreciate you."

She smiled, almost embarrassed, and said with quiet conviction, "Thank you so much. It's only my duty."

She had no idea I was a doctor. I hadn't used that card yet, the one I often have to pull in my home country, Jordan, just to ensure my mother gets the care she deserves. But for once, I didn't need it.

Eventually, my profession came up. She responded with warm respect, offering me her chair and insisting I rest. But not out of deference. It wasn't submissive. It was the kind of kindness that doesn't come from hierarchy; it comes from heart.

Then came the detail that shattered everything: She was from Gaza. Even as her own family was under bombardment, starvation, suffering, she was here, steady, gentle, and devoted.

Maybe she was this way because of that, not despite that?

I forgot her name. But I will never forget her presence. Never forget her bedside manner. Never forget how, in a place where empathy can feel like a luxury, she made it the foundation of her care and did not wait for the "thank you" or recognition.

And here I am. Writing reflections about bedside manner, remembering her as a primary example of that, without recalling her name.

But doesn't that say something in a way?

A year before that encounter in Jordan, I was walking in Mayo Clinic Hospital, Saint Marys Campus in Rochester, alongside one of my favorite attending physicians. We were on our way to see a patient who had been referred to us for psychiatric consultation, a woman who had gone through the harrowing journey of multiple lung transplants and was now grappling with the heavy, aching fog of demoralization. Her current postoperative course had been rough, marked by complications and a daily struggle to simply breathe.

"I hope it's a quick and straightforward one," I remember thinking, almost guiltily now. I was tired that afternoon, craving calm more than learning and growth. I'd grown confident, or perhaps complacent, after seeing many medically ill patients in distress. I thought I knew how to navigate these conversations. I thought I was ready.

I began speaking with the patient, while the consultant observed silently from the

The true core of bedside manner is not the title, not the name on the badge. But a full intentional presence that leaves its mark long after names are lost.

corner of the room, as he often did with a gentle but discerning eye. Within minutes, I knew something was wrong. We weren't connecting. No matter how carefully I asked my questions, how closely I tried to listen, how intentionally I referenced her hobbies and history, it simply wasn't working. I was missing something. Everything.

Sensing the growing dissonance, my supervisor offered me chances, but the moment slipped further out of reach. The patient's frustration rose, sharp and visible, as it showed on her face and in her language. I knew then that I had lost her trust. That's when he stepped in.

With the ease of someone who has long studied the human condition, not only in textbooks but in reality, he approached her slowly, lowered himself to her level, and softened his posture until there was no trace of hierarchy or threat. And then, with that quiet, deep voice, he was not a typical psychiatrist, but rather a storyteller, he began telling her a story.

I wish I could recall the details. But what stayed with me wasn't the content, but the effect. It was a true story of a man who endured adversity and emerged more whole. And somehow, in that hospital room, he wove that tale into a mirror for the patient's own resilience, her own improbable survival, her stubborn will to live even when breath itself was a labor.

"I just want you to know," he told her, "you are a breath of fresh air."

To someone fighting every day to draw in oxygen, those words landed with weight. You could feel them settle into the space, a healing that needed no medicine.

In five minutes, through posture, tone, presence, and a well-placed narrative that he chose specifically based on the patient's needs, he did what I could not have done in 10 hours. And when he left for another meeting, I stayed with the patient, carrying forward the warmth and trust he had reignited in the room. She was more open, more alive, and surprisingly (or not?), so was I. His presence had elevated mine. I was no longer interviewing. I was truly conversing.

As the conversation neared its end, she asked me, "What's that man's name again?"

I was about to answer when she continued, "I forgot his name…but that man, he understands."

Those words still echo. And today, more than ever, they matter.

Looking back, I realize something humbling. Both in that hospital room in Minnesota, and in the infusion room in Jordan months later, the clinicians' names were forgotten. But their manner was remembered. Their presence. Their unwavering humanity.

That's the true core of bedside manner. Not the title, not the name on the badge. But a full intentional presence that leaves its mark long after names are lost.

Before I had been seasoned by the rhythm of clinical life, I listened to a didactic lecture that would echo back to me years later with new resonance. It was on the art of bedside manner. Those quiet, deliberate acts of presence that separate a healer from regular clinicians.

At the time, I was in my first year of residency. I heard his words, but I couldn't yet fully feel them. The weight of what he was offering was definitely touching me but still beyond my full reach.

But when that same lecture was given again during my third year, it felt entirely different. As if my ears had grown sharper and mind wiser, or perhaps it was my heart that had. The principles were rooted in reality rather than abstract thinking.

And I realized, with greater clarity, how our patients experience us, not always for what we intend, but for what we embody in those fragile and fleeting moments at the bedside.

A 2020 systematic review published in *JAMA* distilled effective bedside manner into five primary evidence-based practices that we discussed in that lecture: preparing with intention, listening intently and fully, agreeing on what matters most, connecting to the patient's story, and exploring emotional cues. These are the core of what we call a bedside manner, what elevates our presence from mechanical to meaningful, or what makes our presence real in the first place!

But in our busy days of clinical work, presence is not always easy. The pagers are beeping. The consults are waiting. And you are continuously pulled in so many different directions. The mind drifts. It's far simpler to retreat into autopilot and checkboxes, to flatten complexity into routine, and—to fault the patient for our own inattention.

David Foster Wallace, in his unforgettable speech, "This is Water," reminds us to remember. To stay awake. To resist the daily numbness. For while we may have so many patient encounters a day, for the person sitting across from us, that conversation may be everything, and it is certainly the most important one.

And so, here's to the sacredness of this work.

To the magical miracle of being allowed into another's story.

Here's to not taking a single moment for granted.

Here's to practicing not just medicine, but real medicine. The kind with heart and soul.

Amen. MM

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Myth-busting teen pregnancy

Poverty and family instability lead to high rates of teen pregnancy, regardless of race or geography. Programs to help overcome social disadvantage and promote connectedness can make a big difference.

BY THOMAS E. KOTTKE, MD, MSPH; STEPHANIE A. HOOKER, PHD, MPH

"Black girls have babies for the welfare benefits," a tablemate told author Thomas Kottke at a recent St. Paul fundraiser. He had reached this conclusion from observing Black teen mothers who attended the community events he sponsored in St. Paul parks during the summers.

Discussing this incident, the two of us felt that it would be important to establish whether that assertion is true, because that opinion could be used to justify withdrawing benefits from teen mothers as was done during the 1996 welfare reforms.[1] Pursuing evidence for other reasons that the birth rates for Black teen women are about three times those of their white counterparts, we searched the literature, interviewed fellow members of the Healthy Black Pregnancies team (a community-driven effort supported by the Minnesota Department of Human Services), and asked Face to Face Health and Counseling (a St. Paul nonprofit) to sponsor focus groups of teen women.

When we asked our Healthy Black Pregnancies team members, they told us that the idea that Black teens use pregnancy to access welfare was absurd because welfare assistance doesn't provide the resources that are necessary to raise a baby. In focus groups conducted in North Carolina, Black teens and their mothers agreed that teen pregnancy is an event to be avoided.[2]

The rate at which pregnant Black teens meet the criteria to receive WIC support exceeds the poverty rate for the Minnesota Black population. The same is true for pregnant white teens. According to the Minnesota Department of Health, 29% of the Minnesota Black population and 7% of the white population live in poverty, and CDC data indicate that two-thirds of both Black and white teen mothers in Minnesota accessed WIC while pregnant in the most recent three-year period. This suggests that poverty is a driver of teen pregnancy, regardless of race or geography.

But poverty is not the only driver of teen pregnancy. In analyses of longitudinal U.S. data, family instability, along with poverty, was associated with increased teen pregnancy rates.[1,3] A 2009 *BMJ* meta-analysis of 15 studies found that poverty, dislike of school, and low expectations and aspirations for the future predicted teen pregnancy.[4]

Monica Potts' memoir of growing up in the impoverished white community of Clinton, Arkansas, describes why the social conditions associated with poverty generate teen pregnancy regardless of race. In *The Forgotten Girls*, Potts writes that she and her girlfriends were vulnerable to exploitation and assault at an early age and lacked both opportunity and agency. Because the girls had neither reasons nor role models to plan or invest for the future and because "going boy crazy" was accepted as a normal developmental stage, they began having sex, babies, and marriages at the age of 14.[5] The "boys" were frequently men in their 20s. Poverty, social instability, and teen pregnancy reinforced each other. Potts was able to leave Clinton only through her own resourcefulness; she had little access to information to help her leave her community and succeed if she did.

There is evidence that becoming a mother as a teen, although associated with lifelong poverty, is not the cause of poverty. In an analysis published by Urban Institute Press,[6] pregnant teens who suffered a spontaneous miscarriage had no better outcomes than the teens who bore a baby. Both groups of women could expect to live in poverty for their entire lives, even if they delayed pregnancy until they were in their 20s. The reason? Mothers or not, teen women experiencing poverty have fewer educational opportunities than teens who have the resources to pay-to-play or pay-to-learn,[7] have fewer role models of educational success,[8] experience more violence,[9] experience frequent microaggressions, and live in communities of concentrated poverty.[10]

Breaking the poverty trap

The welfare reforms of 1996 that punished teen mothers did not have a discernable impact on teen birthing rates,[11] perhaps because almost all teen pregnancies are unplanned.[12] However, there are evidence-based interventions that have been shown to help teen women avoid pregnancy and access resources to break free of poverty. On the one hand, there are sexual health services that comprise high-quality sex education and access to highly effective contraception. On the other, there are programs that help overcome social disadvantage and promote connectedness. These

include group mentorship; youth education and development programs; and Promise Neighborhoods (a U.S. Department of Education program) and similar place-based initiatives. In the following paragraphs, we briefly describe the evidence that each of these can promote the well-being of teen women.

High-quality sex education. A review of 83 studies of curriculum-based sex and HIV education programs found high-quality sex education can reduce pregnancy and sexually transmitted infection (STI) rates without hastening or increasing sexual behavior.[13] Both the American Academy of Pediatrics (AAP)[14] and American College of Obstetrics and Gynecology (ACOG)[15] offer extensive information that clinicians can use when counseling adolescents about pregnancy prevention and other sexual health practices.

Abstinence-only programs are not considered high-quality because they neither delay the initiation of sex nor have a significant positive effect on any sexual behavior.[16] As a result, when teens become sexually active, they are not prepared to prevent pregnancy and protect themselves from STIs.

Highly effective contraception. Access to highly effective contraception reduces teen birth rates. In a St. Louis cohort study that provided free, long-acting contraception to teen women, nearly three-quarters chose a long-acting reversible contraceptive (LARC).[17] After follow-up for two to three years, both pregnancy and birth rates were 80% lower than the national average, and abortion rates were more than 75% lower. In Colorado, the fertility rate for all Colorado women aged 15–19 declined 26% between 2009 and 2011 when LARC was provided at no cost through the state's Title X–funded family planning clinics.[18] Abortion rates also declined. Both the AAP14 and ACOG15 endorse providing LARC, including intrauterine devices, to adolescents.

Group-based mentoring. A 2017 systematic review of mentoring programs for adolescent girls and young women found that the programs improved reproductive health knowledge and behavior, academic achievement, financial behavior, and social networks.[19] Exposure to violence also declined. Curriculum topics included reproductive health, gender, and financial literacy. The groups also provided access to safe social spaces outside of the home where participants were able to develop and strengthen their peer network. Group-based programs were more successful than one-to-one programs, perhaps because they promoted the generation of peer groups in which the healthy behaviors were reinforced. Meeting weekly for six months or longer was associated with the greatest improvement in reproductive health outcomes.

Youth education and development programs. High-quality youth development programs have been shown to reduce subsequent teen pregnancy rates by almost 50%, even when delivered at the preschool level.[4,20] Youth development programs for teen women up to the age of 15 have reduced pregnancy rates by 45%.[4] The Seattle Social Development Project, for example, focusing on life skills development without any discussion of sex education, reduced pregnancies by 50% and births by nearly 60% among the participating females.[21] With its home in North Minneapolis, the nonprofit Girls Taking Action serves middle school and high school girls. It reports that 95% of the participants graduate from high school on time and 75% attend college.[22] The economic return to society of the Perry Preschool program, an educational program promoting the intellectual and social development of young children living in poverty,[20] was $244,812 per participant on an investment of $15,166 per participant—$16.14 per dollar invested.[23]

> [The cause of teen pregnancy] is not just poverty; it is social disadvantage, it is difficulty accessing sexual health services, and it is inferior educational opportunities leading to low-wage jobs, concentrated poverty, and mortgage companies that prevent the intergenerational accumulation of wealth by redlining that promote high rates of pregnancy among teenagers.

Promise Neighborhoods and similar place-based initiatives. Promise Neighborhoods bring together people, services, and organizations to create a cradle-to-career pipeline along which community members have access to high-quality early care and education, smooth and effective transition to kindergarten, excellent K-12 schools, and pathways to achieve postsecondary and career success. The Harlem Children's Zone (hcz.org) was one of the first. Saint Paul Promise (saintpaulpromiseneighborhood.com), housed at the Wilder Foundation, considers the well-being of the whole family as it provides services in St. Paul. Northside Achievement Zone (northsideachievement.org) provides services in Minneapolis, United Way of Central Minnesota coordinates place-based initiatives in the region surrounding St. Cloud, and the Education Partnerships Coalition includes nine place-based organizations across Minnesota.

A Wilder Research evaluation of Northside Achievement Zone concluded that, with an investment of less than $33,000 in solutions for the average participant, society gains over $200,000 in benefits.[24] An analysis of the California Promise Neighborhood Network (CPNN) concluded that for every $1 invested, CPNN generated $3.97 in societal returns, including increased participant earnings, tax contributions, and reduced public costs.[25] An analysis of the Harlem Children's Zone concluded that, in addition to generating a positive return on investment, participating females were 71% less likely to report being pregnant during their teen years.[26]

These programs are associated with positive, nationwide impact: Between 1990 and 2012, birth rates for Black teens, and all

other race and ethnic groups, fell significantly,[11] and between 1995 and 2024, the percentage of 25- to 34-year-old Black women with a bachelor's degree increased from 14% to 38%.[27]

Putting it all together

In a recent email exchange with author Kottke, Don Berwick, president emeritus and senior fellow at the Institute for Healthcare Improvement and former administrator of the Centers for Medicare and Medicaid Services, remarked on the high cost of healthcare, "It is not one thing, it is everything." The same is true for teen pregnancy. It is not just poverty; it is social disadvantage, it is difficulty accessing sexual health services, and it is inferior educational opportunities leading to low-wage jobs, concentrated poverty, and mortgage companies that prevent the intergenerational accumulation of wealth by redlining that promote high rates of pregnancy among teenagers. It is also issues we haven't discussed like the relationship between young women and their male counterparts and the attitudes and expectations of the men in their lives. What it's not is teen women, Black or otherwise, having babies to access welfare benefits. But unlike the case of costly healthcare, there are proven solutions to help teens avoid pregnancy. Those solutions are already in Minnesota, and they can benefit teen women of every race and ethnicity.

Broadly divided into sexual education and health services on one hand and programs that promote personal development and social opportunity on the other, these programs not only improve the lives of girls and young women. They also improve the quality of life across whole communities while generating a positive return on investment. Scaling up these proven interventions and programs would universally benefit Minnesotans and ensure all girls in the state who have experienced poverty can grow into thriving, self-sufficient women with stable social networks. MM

Thomas E. Kottke, MD, MSPH, practiced at the University of Minnesota, Mayo Clinic Rochester, and HealthPartners. Retired from clinical practice, he continues to promote health and well-being for all.

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ARE YOU AFRAID
OF YOUR PATIENTS?

Minnesota physicians face a rising tide of assaults at work. Employers and clinic owners are trying to head off violence and verbal abuse before they occur.

BY SUZY FRISCH

Physicians don't need data to illustrate that healthcare facilities can be unsafe places to work—they encounter those risks regularly. What had been on a low simmer started bubbling over in the past five years, with clinics and hospitals experiencing triple the number of violent outbursts.

From verbally abusive patients or family members to physical attacks that result in severe injury or death, about 1,070 healthcare workers at privately operated hospitals in Minnesota experienced serious injuries from assault or other violence in 2023 and 2024, according to a *Minnesota Star Tribune* report of U.S. Bureau of Labor Statistics data released in January. Minnesota has the second-highest rate of violence-related injuries in the nation (behind only Connecticut), though it's unclear how much the state's culture of reporting contributed to that ranking. Overall, healthcare staff are four to five times more likely to experience workplace violence than other workers, according to the federal Occupational Health and Safety Administration.

In 35 years of practicing medicine, Matt Klein, MD, has seen temperatures rise and behavior culminate in an "astonishing amount of workplace violence."

"It's a symptom of everything we're seeing in society: increased chaos, increased stress and anxiety, and unexpected behaviors from our neighbors. I think this is a manifestation of that," says Klein, a Mayo Clinic hospitalist and Minnesota state senator. "You put people in a hospital setting where they are dealing with their own stressors and their own mental health, and sometimes they lash out at the first available victim."

Physical and psychological injuries are layered with the moral harm of being attacked while trying to help others. Dealing with angry and potentially violent people "is never what we thought our mission was or what we are all about," Klein says. "We're there to care for people in a nurturing, comforting environment, and someone comes with the intent to harm nurses or physicians. We've all had to get a lot smarter and defend our colleagues."

Any healthcare professional is vulnerable to attack, and many have sustained verbal, emotional, and physical injuries that constitute workplace violence. In fact, about three-quarters of clinicians have experienced workplace violence, with the numbers continuing to climb, according to national studies, says Colin West, MD, PhD, a general internal medicine physician and medical director of employee well-being at Mayo Clinic.

Since the COVID-19 pandemic, there has been a rising tide of conflict throughout society that hasn't abated. "Stress and discontent boil over in ways that feel different than they have in the past," West says. "Compound that with situations where healthcare professionals are under stress, patients and families are under stress, and most people are not having their best day when they see a physician or other healthcare professional. You have these forces coming together in healthcare settings."

The problems facing healthcare and society combust in the form of violence directed at healthcare workers. They bear the brunt of people's frustration over staffing shortages that keep patients waiting for needed care, underfunded mental health services, and a growing distrust of science, says Will Nicholson, MD, a family medicine physician and vice president of medical affairs at Fairview Health Services and St. John's Hospital and Woodwinds Hospital.

"Hospitals and clinics are on the receiving end of a pandemic of violence and cruelty that is rising in our country, and it is fueled by things not in our control," Nicholson says. "Hospitals, doctors, and nurses are rising to the occasion and using the best science and resources to make sure that everyone is safe. We're constantly working to improve, but the problem is constantly getting bigger and bigger."

Also triggering outbursts are the barriers patients experience from health insurance companies, such as delays from required prior authorizations for care, prescriptions, or referrals, says Tim Hernandez, MD, CEO of Entira Family Clinics and a family medicine physician. "That causes a tremendous amount of frustration," he adds, "and that anger gets focused on staff."

At PrairieCare, which provides inpatient and out-patient mental health services at nine locations in Minnesota, patients are presenting with more acute and complex mental health disorders since the pandemic. There are many factors, including limited access to care, delayed treatment, social stressors, and an increase in substance abuse, says Chief Nursing Officer Mandy Dageford, MSN, RN. "Patients are coming in with deeper crises and then the interactions are more urgent, and they can be more emotionally charged," she says. "They are feeling a loss of control and that starts the escalation process."

On top of individual impacts, there are wider consequences of workplace violence. It leads to staff turnover, absenteeism, loss of productivity, and high insurance and workers' compensation costs. Workplace violence also prompts an increased risk of depression, post-traumatic stress disorder, and suicide among staff, according to a 2025 American Hospital Association (AHA) report, *The Burden of Violence to U.S. Hospitals*.

Then there is the financial cost, an annual estimated bill of $18.27 billion, according to the report. The healthcare sector spends $14.65 billion after workplace violence incidents, including medical costs and infrastructure repairs. Another $3.62 billion goes to investments in security, technology, training, and violence prevention programs.

Workplace violence can occur in any healthcare setting, but it most often erupts in psychiatric departments, emergency rooms, geriatric units, and waiting areas, according to the report. In addition, rural areas have higher rates of incidents compared to urban settings. It's a challenge that affects any member of the workforce, with an incidence rate for physicians ranging from 24.4% to 59.3%. Half of nurses in the United States have reported being verbally abused, physically assaulted, or both by a patient or patient family member in the past two years, the AHA reports.

"You put people in a hospital setting where they are dealing with their own stressors and their own mental health, and sometimes they lash out at the first available victim."

Matt Klein, MD
Mayo Clinic hospitalist and Minnesota state senator

"Stress and discontent boil over in ways that feel different than they have in the past. Compound that with situations where healthcare professionals are under stress, patients and families are under stress, and most people are not having their best day when they see a physician or other healthcare professional. You have these forces coming together in healthcare settings."

Colin West, MD, PhD
General internal medicine physician and medical director of employee well-being
Mayo Clinic

Taking action

To address this crisis and increase employee safety, healthcare organizations have been investing resources to prevent all kinds of violence, from more robust training to technology and infrastructure improvements.

Entira, which operates nine primary care clinics across the Twin Cities, started a safety committee in 2011 that mostly focused on patient safety. The committee expanded to include workplace safety as it became a growing concern about seven years ago, Hernandez says. Training has been a key part of Entira's efforts, including partnering with law enforcement on sessions at different clinics, holding annual training for all staff, and taking advantage of workplace violence resources from the Minnesota Medical Association and the Minnesota Academy of Family Physicians.

"Hospitals and clinics are on the receiving end of a pandemic of violence and cruelty that is rising in our country, and it is fueled by things not in our control. Hospitals, doctors, and nurses are rising to the occasion and using the best science and resources to make sure that everyone is safe. We're constantly working to improve but the problem is constantly getting bigger and bigger."

Will Nicholson, MD
Family medicine physician and vice president of medical affairs
Fairview Health Services and St. John's Hospital and Woodwinds Hospital

Entira offers additional training for its clinic managers, who serve as the main resource for staff. Healthcare staff are encouraged to call on these managers when temperatures rise. Entira also guides staff to build relationships with patients and understanding of what is happening in their lives. "That can help keep everyone safe," Hernandez says.

PrairieCare emphasizes yearly training, with a heavy focus on de-escalation, collaborative problem-solving, and trauma-based, patient-centered care. It also regularly engages in risk assessments of its environments and patients, considering patients' past experiences and current symptoms. If needed, PrairieCare might place people in units with additional staffing or do more frequent checks on them. "We really try to partner with patients to de-escalate and get them what they need in their time of crisis," Dageford says.

Healthcare systems also are incorporating more protections for employees. Children's Minnesota, Essentia Health, and Mayo Clinic, among others, provide wearable devices to front-line employees that allow them to push a button and summon help when they face dangerous situations.

Entira installed locked doors that lead from the waiting area to the examination rooms. Now a key fob is required to unlock the doors, reducing the problem of patients wandering back and stealing things or threatening staff, Hernandez says. Entira has not installed metal detectors, both because of the cost and to keep its clinics welcoming.

"We care deeply about our staff and really want to make sure our staff feel safe at work and that our patients feel safe in our clinics," Hernandez says. "We prefer them to not look like small jails and be homey and open, so it's a tricky line. We will do what we need to do to continue to support our patients."

"We care deeply about our staff and really want to make sure our staff feel safe at work and that our patients feel safe in our clinics. We prefer them to not look like small jails and be homey and open, so it's a tricky line. We will do what we need to do to continue to support our patients."

Tim Hernandez, MD
CEO and family medicine physician
Entira Family Clinics

Children's started planning for and investing in a more comprehensive security approach in 2018 to better secure its environments, including two hospitals and 25 clinics and specialty care sites, administrative offices, and more, says Tracy Venne, senior director of support operations.

Children's increased staffing, added weapons detection systems, opened a security operations center, added an ambulatory security team, and boosted training for all employees. Those who work in mental health or the emergency department also complete de-escalation training that uses a team-focused, healthcare-centric approach called Welle.

An essential aspect of this work came from building out Children's internal committees that focus on safety, including a subcommittee on workplace violence prevention. Committees have members

with different professional expertise. The groups take a team approach that vets employees' safety ideas and gathers their opinions about potential changes, as when Children's decided to add weapons detections systems to its emergency departments, Venne says.

Duluth-based Essentia Health started working on a more unified approach to workplace violence prevention in 2022. The system, including 14 hospitals and 80 clinics in Minnesota, North Dakota, and Wisconsin, previously had a loose collection of committees at different locations.

Matt Posinski, MHA, senior vice president of system clinical and support services, joined Essentia then and was tasked with developing a heartier and system-wide security program. It now includes an executive steering committee on workplace violence, as well as site-specific committees. Its hospitals' committees, comprised of people from different departments, evaluate data in search of patterns that Essentia then addresses.

"Patients are coming in with deeper crises and then the interactions are more urgent, and they can be more emotionally charged. They are feeling a loss of control and that starts the escalation process. We really try to partner with patients to de-escalate and get them what they need in their time of crisis."

Mandy Dageford, MSN, RN
Chief nursing officer
PrairieCare

Essentia makes decisions based on its incident data, which vary by setting. About 60% of reportable events at clinics involve verbal assaults, threats, or harassment, while 40% are physical assaults. It's the opposite at hospitals. There, staff encounter people during more acute or volatile situations, especially in the emergency room, ICU, behavioral health units, and maternal-fetal areas, Posinski says.

Since Essentia took this data-driven approach, it has started to see assaults decline. "We made a significant push to encourage all colleagues to report situations," Posinski says. "We can't do anything if we don't have the data. That helps us drive dialogue and inform our training program."

At the system-level steering committee, the group also reviews incidents, evaluates how they were handled, and gauges what could be learned and taught from that event. Regular training is another plank of the security and workplace violence prevention work at Essentia, including departmental and facility-based training, in-person each year. A team of workplace violence program managers also visits different sites to hold educational sessions and complete specialized training for departments facing unique challenges.

Connecting with outside resources and partners to learn from each other is another way that healthcare organizations are addressing workplace violence. Children's has several outlets for safety and emergency preparedness, including a general Twin Cities group of businesses and public entities, another that connects healthcare security experts, and partnerships with healthcare neighbors like Allina's Abbott Northwestern and United Hospitals. "The power of collaboration has helped immensely," Venne says. "We're not trying to do it alone. We're utilizing our partners and trying to tackle it together."

"We made a significant push to encourage all colleagues to report situations. We can't do anything if we don't have the data. That helps us drive dialogue and inform our training program."

Matt Posinski, MHA
Senior vice president of system clinical and support services
Essentia

Setting standards

To prevent violence, healthcare employers are working to set expectations for patients and family members. Signs banning weapons are common at hospitals and clinics; healthcare organizations and practices can build on these elements with additional signage that details a code of conduct, West says: "It sets the standards. If you don't do this, maybe there's an implicit message for some people that there's no line they need to be concerned about crossing," he adds. "This establishes clarity about what the norms are in the healthcare environment."

One recommendation from the MMA Physician Well-Being Advisory Committee's recent report is to develop a compact that spells out clear expectations and mutual respect guidelines for physicians, patients, families, and visitors during healthcare interactions. It can mitigate misunderstandings and reduce conflict, says West, who co-chaired the committee.

"It's really important that practices have behavioral expectations and policies that

healthcare workers can point to," West says. In case of patients' verbal abuse, clinicians then can remind them to keep interactions professional. "Often that reminder and pointing to clinic policy is enough. And when it's not, you have back-up plans if the behavior occurs again, it's more serious, or it escalates."

Essentia has put this into practice with signs that spell out expectations for patients, visitors, and staff to treat each other with respect and kindness. Other signs state that violence of any kind will not be tolerated, Posinski says.

Another tactic Essentia uses for people with histories of threats, harassment, or violence is to notify employees by including this information in patients' electronic medical records. At Entira, the clinic does terminate care for patients who have a history of abuse, bridging their medication until they can find another clinician, Hernandez says.

Emergency departments don't have that option because of the Emergency Medical Treatment and Labor Act, but hospitals can deploy other tactics. At Mayo Clinic Hospital, Saint Marys Campus, staff sets boundaries for challenging patients and develop a behavioral care plan with expectations, such as not swearing at nurses or throwing things, Klein says. The plan might include rewards or withdrawing privileges like television access.

"The power of collaboration has helped immensely. We're not trying to do it alone. We're utilizing our partners and trying to tackle it together."

Tracy Venne
Senior director of support operations
Children's Minnesota

Potential solutions

In living with this concern daily, healthcare professionals and leaders do have thoughts on what changes would make workplaces safer. Posinski supports a legislative change that North Dakota recently adopted. Currently, Minnesota law makes it a felony to assault first responders and emergency medical personnel. He advocates for a broader statute that includes any professional providing healthcare. Klein and other DFL senators introduced such bills in 2021 and 2023, but they were not passed.

"There was some resistance among some of my colleagues on my side of the aisle to increase penalties on crimes and instead move from that approach to crime prevention and treatment. It might be gratifying to make something a felony, but that might not prevent an incident from occurring," Klein says. Before the 2026 session started, he hadn't decided whether he will introduce a similar bill again, yet he plans to work on ways to address healthcare workplace violence. "I want to give this another go," Klein says.

Financial support to help clinicians make their workplaces safer would be welcome, Hernandez says. For smaller organizations like Entira, it's painfully expensive to make infrastructure changes or hire consultants or trainers. Easing some of the pain points that make patients angry also would go a long way, such as expanding access to care and improving communication between specialists and primary care physicians.

Nicholson points to chronic underfunding of mental healthcare by government and insurers as a key contributor. "We need to have a huge investment in mental health going forward, especially geriatric mental health," he adds. "We have to have a social system that supports people so they don't become hopeless and have the resources they need to stay out of extreme situations."

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Will Nicholson, MD
Family medicine physician and vice president of medical affairs
Fairview Health Services and St. John's Hospital and Woodwinds Hospital

Nicholson finds it enormously frustrating when healthcare systems create effective approaches that are then underfunded and under-supported, despite showing positive results. He cites M Health Fairview's Emergency Psychiatric Assessment, Treatment, and Healing (EmPATH) model, a short-stay rapid evaluation center for people experiencing mental health crises. While evidence shows the model drastically reduces hospital admissions—and makes healthcare sites safer for all—reimbursement has not consistently aligned with the level of care required, Nicholson says.

"Violence against healthcare workers is unacceptable, and hospitals have a responsibility to do everything within our control to protect our teams—and we are doing that," Nicholson says. "We rise to the challenge every day in healthcare but the forces outside of our control are substantial, and they are going in the wrong direction." MM

Suzy Frisch is a Twin Cities freelance writer.

SETTING DOWN RURAL ROOTS

Members of the inaugural class of medical students at the University of Minnesota Medical School's CentraCare Regional Campus are proud of their rural backgrounds.

BY ANDY STEINER

It's an old problem with a new solution. For years, communities in Greater Minnesota have struggled to hire and retain physicians. Many young doctors have said they're not interested in working in small towns, concerned about isolation, few job opportunities for spouses, and few options for high-quality childcare. Those who do come to town don't stay.

This means that people who live in parts of rural Minnesota have a hard time getting medical treatment they need, and they often have to travel long distances to bigger towns for specialty care—and even basics like labor and delivery.

CentraCare Regional Campus St. Cloud—the University of Minnesota Medical School's first new campus in more than 50 years—was created to address this issue by educating future physicians dedicated to serving rural communities and to understanding small towns' unique needs. The school's inaugural 24 students, all of whom hail from Greater Minnesota and are committed to practicing medicine there, are now entering their second semester, and campus leaders couldn't be more excited.

Christopher Fallert, MD
Regional campus dean
CentraCare Regional Campus St. Cloud
University of Minnesota Medical School

Jill Amsberry, DO
Assistant dean of undergraduate medical education
CentraCare Regional Campus St. Cloud
University of Minnesota Medical School

Christopher Fallert, MD, regional campus dean, explained that 80% of the new med school's class are from "Minnesota towns with populations under 20,000. Fifty percent are from towns under 5,000. They represent rural Minnesota well." This rural background is important, Fallert said, because research has found that growing up in a small town makes a person more likely to want to stick around: "We know that the greatest predictor of physicians thriving in rural Minnesota is if those physicians are from rural Minnesota in the first place."

Jill Amsberry, DO, assistant dean of undergraduate medical education, said that the new campus creates a unique space for many future physicians who, for a number of reasons, formerly felt like medical school was unobtainable.

"For a long time we've had students from this area who would be incredible physicians, but for many different reasons—they couldn't leave their home town, they didn't want to leave, they didn't want to do school in a metro area or didn't feel like they could—these people weren't going to medical school," Amsberry said. "This campus has created a space for students who can now realize a dream they didn't think was possible."

When news got out that a new regional campus of the University of Medical School focused on rural medicine was opening in St. Cloud, the reaction from potential students was enthusiastic, Amsberry said, resulting in a strong and healthy applicant pool. "When the campus came, they came, too—which has been a very exciting thing," she said. "Every single one of the 24 students who were offered seats in the inaugural class accepted the offer to be on our campus."

Faculty at the CentraCare Regional Campus will teach from the same curriculum that is offered at the University of Minnesota Medical School's other two campuses, in the Twin Cities and Duluth, Fallert explained, with a special emphasis on issues unique to practicing medicine in rural areas. "We have faculty who are physicians from St. Cloud and other rural areas. They bring their personal experience working in rural healthcare to our students."

The relatively small size of this first-year cohort (the Duluth campus has 65 students and the Twin Cities 167), means that the students have already built strong bonds with each other and with faculty and administrators, Amsberry said. "I've known these students since we offered admission to them and they accepted. I can honestly say I would trust any of them with the care of my own family."

The members of this class come from a variety of backgrounds, Fallert added. While the traditional path is four years of college and straight to med school, "a higher percentage of our students are older students, maybe coming into medicine as a second career." He posits that may have to do with the campus' location outside of the Twin Cities. "Because our campus is near where they live, it has provided them with an opportunity to be able to shift their career or maybe care for a family."

The campus is housed in a 60,000 square-foot building adjacent to CentraCare Plaza in St. Cloud, with about 40,000 square feet that have been refurbished to accommodate the school. Construction was funded in part by CentraCare, a St. Cloud–based regional health system, as well as state support totaling $15 million, with $5 million designated for facility design and $10 million for program support. "It's a wonderful building," Fallert said. "The planners took the input from students and leaders at the Twin Cities and Duluth campuses to create simulation space and study rooms."

A special nod to the inaugural class's rural roots is built into the building itself, Fallert said. Each of a number of small and large rooms in the building used as study spaces or classrooms bears the name of the hometown of one member of the class. "We have a Wilmar room and a Sauk Center room and a Cold Spring room," Fallert said. "It's a way of honoring their commitment to us, of acknowledging the small towns they came from, and honoring them as our first class."

Read on for profiles of three of CentraCare Regional Campus St. Cloud's first class.

LANEY BROWN
SLAYTON

Laney Brown is proud of her rural roots. "I love being from a small town," she said. "I'm very, very fond of where I grew up." Brown hails from Slayton, a town of around 2,000 nestled in the southwestern corner of the state.

While many young people who grew up in rural communities can't wait to get out and explore the big city, Brown, 24, is just the opposite. "I go home a lot," she said. "My family is everything to me. I love Slayton. I like seeing people on the sidewalk, in the stores, in the wellness center, going to the dentist, going to the grocery store. I like being able to help your neighbor in need. I like having someone who lives a block away who you can call when you need help."

"MY FAMILY IS EVERYTHING TO ME. I LOVE SLAYTON. I LIKE SEEING PEOPLE ON THE SIDEWALK, IN THE STORES, IN THE WELLNESS CENTER, GOING TO THE DENTIST, GOING TO THE GROCERY STORE. I LIKE BEING ABLE TO HELP YOUR NEIGHBOR IN NEED. I LIKE HAVING SOMEONE WHO LIVES A BLOCK AWAY WHO YOU CAN CALL WHEN YOU NEED HELP."

Because her mother is a pharmacist, Brown said she always knew she'd find a career in medicine. And by slowly gaining experience in healthcare around her community, Brown said she learned about the specific challenges facing rural medical professionals, including aging populations, far-flung resources, and limited budgets.

After graduating high school, Brown left Slayton for South Dakota State University in Brookings (graduating with a human biology major). She took a job as a patient care technician at the Sanford clinic in Worthington, but kept her eyes trained on the prize of medical school.

When she heard that the University of Minnesota Medical School was opening a campus focused on rural medicine in St. Cloud, it felt like the stars aligned. Brown knew that this was where she was destined to earn her medical degree. "Rural medicine was all I ever knew," she said. "It's the kind of medicine I want to practice, the kind of community I'd like to be part of."

Even though St. Cloud is three hours from Slayton, Brown knew that she'd feel comfortable there. The Medical School's other two campuses in Duluth and the Twin Cities felt bigger and less like home; St. Cloud's size and location just made sense to her.

"I really like the area. It's smaller than the Cities, closer to my hometown," she said. She selected a campus apartment with two bedrooms, so family and friends from home can visit. "I can see a river and trees out of my back door," she said. "It feels like home."

Brown hopes to return to Slayton with her medical degree and take a job at the hospital there or somewhere close to it. She's considered a residency in family medicine or obstetrics and gynecology—her hometown hospital does not offer birthing services—and she'd like to one day help bring those services back to town.

"My mother drove to Worthington—that's 35 minutes from Slayton — just to give birth to her children," Brown said. "My sister just had a son and she drove all the way to Sioux Falls, South Dakota, to give birth. I'd like to help make important services like that available closer to home."

SIERRA BERMUDEZ BECKER

Sierra Bermudez has her hands full, and so when she decided to apply to medical school, she did it with her characteristic laser-sharp focus.

"There are a lot of reasons I wanted to go to the CentraCare campus," Bermudez, 25, said. "First of all, this new school focused on rural medicine happened to be opening the year I decided to apply for medical school, so it seemed like fate." She'd grown up in Becker, a town of around 5,000, about 19 miles away from St. Cloud, and settled nearby with her husband and four kids. If Bermudez could get into the program, she wouldn't have to uproot her family.

Bermudez also already had a job at the CentraCare Hospital in St. Cloud, and understood some of the intricacies of rural medicine, particularly in primary care. If she could earn her MD, she thought, she could help lessen the physician shortage in the region.

Unlike other would-be physicians, Bermudez applied to only one medical school. "The pieces really fit together," she said, with a laugh.

A first-generation college student, Bermudez got interested in medicine as she was going through her first pregnancy in high school. "I had so much support from my doctor and my medical care team," she recalled. "They never judged me. I felt I could be open and honest about my situation. I told myself, 'I want to be that for somebody someday.'"

With that goal in mind, Bermudez has hunkered down and focused on medical school. Her husband is on kid duty Monday–Friday; on Saturday–Sunday she takes over. "To make sure I'm getting my quality time with my kids," she said, "I get all of my school stuff done during the week so I can focus on my family on the weekend."

On campus, Bermudez said she and her classmates are forming a different kind of family. "Our class is amazing," she said. "On the daily, we talk about how thankful we are to have such a small class of people from rural Minnesota." The bonds formed quickly, she said. "After orientation we all felt like we knew each other. After the first week, we'd had meaningful conversations with everybody. I feel that connection every day."

And she hopes to build those kinds of connections throughout her career practicing medicine in small-town Minnesota. "I've grown to love the people and the communities in little towns," Bermudez said. "The people are tight-knit, and folks are looking out for each other. I'm excited to be part of that."

"OUR CLASS IS AMAZING. ON THE DAILY, WE TALK ABOUT HOW THANKFUL WE ARE TO HAVE SUCH A SMALL CLASS OF PEOPLE FROM RURAL MINNESOTA. AFTER ORIENTATION WE ALL FELT LIKE WE KNEW EACH OTHER. AFTER THE FIRST WEEK, WE'D HAD MEANINGFUL CONVERSATIONS WITH EVERYBODY. I FEEL THAT CONNECTION EVERY DAY."

AIDAN FORBERG SARTELL

GROWING UP HE APPRECIATED THE PERSONAL ATTENTION THAT CAME WITH SMALL-TOWN LIFE, INCLUDING HIS PEDIATRICIAN BACK IN INTERNATIONAL FALLS WHO GAVE HIM A BOOK ABOUT A FROG WHO WAS SCARED OF GOING TO THE DOCTOR, BUT WAS ULTIMATELY ABLE TO CONQUER HIS FEAR. "I STILL HAVE THAT BOOK," FORBERG SAID. "IT'S A SMALL EXAMPLE OF THE CONNECTIONS YOU MAKE AS A SMALLER-TOWN PHYSICIAN. I'M GOING TO MAKE THOSE CONNECTIONS MYSELF SOMEDAY."

Raised by nurses, Aidan Forberg always felt at home in medical settings.

"I remember visiting my dad when he was at work in the ICU in St. Cloud," Forberg said. "We'd bring him food. That environment felt weirdly comfortable to me." Because of that natural ease, Forberg grew up assuming he'd one day be a doctor. He even knew where he wanted to practice.

"When I'd imagine my work as a physician it never looked like I was in a big city," he said. "It looked like I was in a smaller community, going fishing on the weekend and having some land."

Forberg's early years were spent in International Falls, and later his family relocated to Sartell, a town of around 20,000 just outside of St. Cloud. Growing up he appreciated the personal attention that came with small-town life, including his pediatrician back in International Falls who gave him a book about a frog who was scared of going to the doctor, but was ultimately able to conquer his fear. "I still have that book," Forberg said. "It's a small example of the connections you make as a smaller-town physician. I'm going to make those connections myself someday."

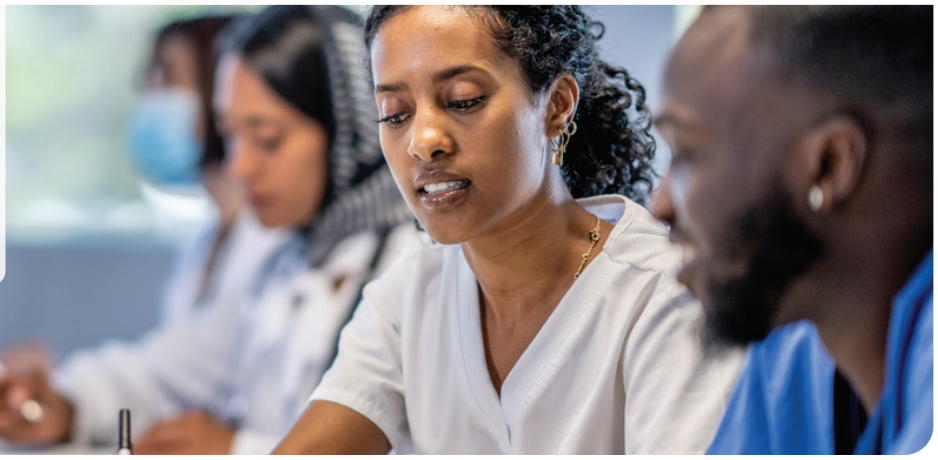
Forberg was attracted to the CentraCare Regional Campus because he liked its location and focus on rural medicine. He also applied to other schools around the country, but when he got into St. Cloud, he jumped to accept: "The school's focus is unique, and I love learning from the physicians and providers who come here to teach and have practiced in a rural environment."

His professors' deep experience in rural medicine has given Forberg more understanding of the challenges faced by rural physicians and a sense of excitement about what lies ahead for him.

"I'm just ready to see patients," Forberg said. "I love school, I love science, but I've also been studying science for what feels like the last 10 years of my life. I'm actually doing this for the more personal patient connection. Being able to get out into small-town clinics and hospitals is what I'm really looking forward to. I'm excited to get to work and learn new skills." MM

Andy Steiner is a Twin Cities freelance writer and editor.

IMPROVING CARE FOR ALL:
TOOLS & RESOURCES



The Minnesota Health Equity Community of Practice (CoP)

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

To attend a CoP meeting, contact Haley Brickner.

Intercultural Development Inventory

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

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

The MMA now offers this valuable resource, including:

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

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

Best Practices for Inclusive Communications – Training and Guide

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

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

Implicit Bias Training (CME available)

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

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

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

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

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

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

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

Conversations on Race and Equity (CME Available)

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

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

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

There are two ways to bring CORE to your organization:

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

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

FOR MORE INFORMATION ABOUT ANY OF **THESE RESOURCES**

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Minnesota Medical Association

‘We have been able to change the narrative in obesity’

GLP-1 drugs have revolutionized the treatment of obesity, diabetes, and related metabolic disorders, but they don’t work for everyone. A new genetic test helps to characterize the phenotypes of obesity and guide patients to successful treatment.

Recent weight-loss drugs such as semaglutide (brand names Ozempic and Wegovy) and tirzepatide (Zepbound and Mounjaro) have transformed the treatment of obesity and diabetes. They have also shown a remarkable effect on other diseases and disorders, including cardiovascular risk, high blood pressure, fatty liver disease, lipidemia, kidney disease, sleep apnea, and joint pain.

But the drugs don’t benefit everyone equally—some hardly at all. Andres Acosta, MD, PhD, and colleagues at Mayo Clinic have recently written about a genetic test, based on a simple mucosal swab, that can help identify which patients will most benefit from GLP-1s and similar drugs and which are better off on older weight-loss drugs such as phentermine-topiramate (brand name Qsymia). The study was published last year in *Cell Metabolism*.

Acosta focuses his research on food intake regulation and individualized treatment of obesity. His laboratory considers genetics, physiology, pharmacology, proteomics, metabolomics, and gastrointestinal and brain imaging to better characterize appetite, eating, and satiety.

The genetic test, developed by Phenomix Sciences, a Mayo spinoff company that Acosta co-founded, builds on Acosta’s earlier work on a measure he calls “calories to satiation,” how much someone eats to feel full, which varies widely from person to person. Acosta’s studies of satiety also led to the characterization of four “phenotypes of obesity,” including “hungry brain” (eating large meals), and “hungry gut” (eating often).

Minnesota Medicine spoke with Acosta about how GLP-1s are transforming the treatment of obesity and related disorders and how individualized medicine might further improve treatment. The interview has been edited for brevity and clarity.

Let’s talk for a moment about how the recent availability and popularity of GLP-1 receptor agonists such as semaglutide and similar drugs such as tirzepatide have transformed treatment of obesity, diabetes, and associated disorders.

Since 2021 with the approval of semaglutide, it has really changed, not really the management of obesity, but the acceptance and willingness of patients and loved ones to come forward and say, I want to get a medication. And the reason why I say this is because we had medications for obesity in the ’60s. Medications have come and gone. We had four FDA-approved medications, three of them approved in the 2012–2014 timeframe, and then the new two approved in ’21 and ’23. And then we have bariatric surgery. So we have always had therapy. But what’s really made it to the mainstream is the conversation about using medications for management of obesity. That has really changed the treatment of obesity.

What has brought that into the mainstream? What is different about these drugs? I mean, it seems that what is most radical about GLP-1s is that they actually work.

Well, they work. The other medications also worked. Bariatric surgery also worked. So if we look, for example, at semaglutide, the weight loss with semaglutide is 15% total body weight loss in 64 weeks. But a

Andres Acosta, MD, PhD
Mayo Clinic

first-generation medication called phentermine-topiramate (brand name Qsymia) that not many people know about, gives you 11%. So if you ask me if it works, yeah, it works better than the other one. But then when we put bariatric surgery in the equation, it gives you close to 30%. So yes, GLP-1s work. They work a little bit better than the first-generation medications, not as good as bariatric surgery.

So the question you ask is appropriate. What has changed? What really has changed is that suddenly we had a boom of academic research coming with the strong benefits of the medications, plus a lot of people—celebrities, influencers, academicians—going out there and talking, with an amazing response from the media. Not only are we talking about it, but it has also been covered by "60 Minutes" on CBS. Every single major outlet has had something about obesity since 2021. So it has been a very nice multifactorial response about obesity, as it should be because it is the most prevalent disease in the United States.

I've read comparisons between GLP-1s and bariatric surgery, and the surgery comes out ahead in some ways—more weight loss and more favorable ratio of muscle to fat. But the surgery, which has been around for a number of years, didn't transform obesity treatment in the same way that GLP-1s have. Why is that?

That's a good question, and I don't think I have the answer. You know, maybe reasons to consider is that, of course, surgery continues to be a more invasive procedure. Yes, surgery has not had the marketing and PR that the medications have had. If someone shows some benefit with surgery, usually it gets highlighted in an academic meeting and published in a journal. If someone shows some benefits with GLP-1s, it gets all the way up to mainstream media. So I think maybe that's the reason. So maybe just the invasive levels of surgery with a potential risk of surgery, plus the lack of advertisement of the benefits of surgery through the many years.

What has changed? What really has changed is that suddenly we had a boom of academic research coming with the strong benefits of the medications, plus a lot of people—celebrities, influencers, academicians—going out there and talking, with an amazing response from the media.

Bariatric surgery has always seemed to me to be a little bit extreme. I mean, the idea of somehow decreasing the size of your stomach, for example, or making some permanent change to your digestive system has seemed rather radical, and that perhaps presented an obstacle in a way that going on a drug hasn't. You know, with the drug, you can say, well, I'll give it a try. If it doesn't work, I'm no worse off than I was before. I'll just go back to what it is now. It seems like a much easier step to take than to sign up for surgery.

I cannot disagree with that, and I think that's the most common reason why our patients decide not to go to surgery because they don't want to do, to use your word, such a radical anatomy-changing procedure. I completely agree, and I can see that reasoning why surgery didn't become that popular.

Now we talk about the biology and your underlying biology that is driving your obesity, and no more about willpower—removing the stigma and the bias that we used to have against people with obesity.

What has the advent of GLP-1s told us about the nature of obesity as a chronic disease or condition? It seems to me that it's perhaps in the process of changing our attitude toward obesity as something more than simply lack of willpower.

Absolutely. I think that is where the conversation in the last three years has really changed—from obesity as a disease of willpower to really going to the understanding of obesity as a chronic disease that is biologically driven, that it is the biology that drives us to develop obesity and have difficulty losing weight. That to me is one of the most exciting areas, that we have been able to change the narrative in obesity. Now we talk about the biology and your underlying biology that is driving your obesity, and no more about willpower—removing the stigma and the bias that we used to have against people with obesity.

You're a proponent of individualized approaches to treating obesity. Why and how did you come to that idea?

The question that I ask myself and ask my patients and I ask my colleagues, is what specifically on the biology is driving your disease? And then when we pair with a treatment option, why is it that certain people on a GLP-1 have such an impressive response, and some other people don't? Not only to a GLP-1, I can use the same example with diets. For example, a ketogenic diet—some people reaching ketosis respond impressively. Other people reaching ketosis don't respond.

So the question is why. By trying to understand the biology, we actually can find

what's the underlying root cause at the individual level, and then target that biological process that is unique for each one of us with the appropriate therapy. And that's why, if we can bring that level of granularity and that level of understanding of the disease of obesity we can have success, as, for example, we have done with cancer. We treat the biology of the cancer. When we talk about he target, about cancer, we talk about molecular therapeutics in which we know what the target is doing, the cancer is doing, and we target that specifically, regardless of where the cancer is. If we can do the same thing in obesity and other metabolic diseases, we have shown that you can improve the outcomes.

But you can even change the conversation further, because we tell people what is in their biology that is driving their obesity.

You're the senior author of a recent study, published in *Cell Metabolism*, that describes a genetic test to basically show which obesity treatments, such as GLP-1s, are likely to work best on which patients, depending on their genetics. Describe that.

So by understanding the biology, we know that certain people consume higher calories to satiation, how many calories we consume until we feel full and we stop. And turns out that we are very different. Some people eat more, some people eat less. Everybody can have the same height and the same weight. So by understanding calories-to-satiation, we were able to identify that the amount of calories we consume until we feel full has a strong genetic predisposition, and that genetic predisposition of how the gut tells the brain when to stop eating can be quite useful when we use that biological trait that I call phenotype of high calories to satiation. I can use that high calories to satiation to predict who are the best responders for a medication like phentermine-topiramate, but also to show that you'll be a poor responder to a GLP-1 if you have high calories to satiation. So with this phenotype called high calories to satiation, different response to two different anti-obesity medications.

You have also discussed different responses in the framework of four basic obesity phenotypes—hungry gut, hungry brain, emotional hunger and slow burn. Describe that framework a bit.

So that is talking more about our publication in 2015 in *Gastroenterology*, 2021 in *Obesity*, in which we break down obesity and we try to classify obesity on the unique energy balance phenotypes, or energy balance going back to the biology. We were able to identify these four key groups. The first group, which we call hungry brain, have these high calories to satiation. They consume higher calories than the rest of the people. About 30% of people have this phenotype.

That's different than the people who actually consume normal calories in one sitting, but they feel hungry in between meals. These people, which we call hungry gut, have abnormal postprandial satiety. What does that mean? They eat, their stomach starts emptying faster, they feel hungry in between meals, and then they want to eat in between meals. The problem is that the gut's not sending the signals to the brain to say, "Stay feeling full." And that concept is postprandial satiety. These people have abnormal postprandial satiety. I call them hungry gut. Both hungry brain and hungry gut involve the signals of the gut to our brain.

But that is different from people who want to eat because of emotions, people who want to eat because of their feelings and stress, right? Those people have more of an emotional eating behavior. Those people with emotional eating behavior can want to eat in between meals or want to eat a lot in one sitting, but they have different cues that drive them to eat between meals or have high quantities of food. We call them emotional eating because there's usually something that's triggering that. They usually have higher anxiety and higher stress that drive them to eat. So that's the third group.

And the fourth group is people who actually are not consuming that many calories, but their metabolism is abnormal. They're just not burning enough calories. I call them slow burn. They're not burning calories efficiently, and that's the reason why they are developing obesity and having difficulty losing weight.

Those are the four key obesity phenotypes for energy balance.

Is the hungry gut, hungry brain framework based on genetics specifically, or did you characterize that more in terms of how people behaved. How did those categories come into being?

For the last 14 years we have actually invited participants to do a complete a battery of tests of energy balance. Those tests take about 10 hours. We measure everything from your energy expenditure, your body composition, how the food moves through your stomach, through radiolabeling materials and imaging, as well as different questionnaires. So it's a very complicated battery of tests. We describe that in the *Cell Metabolism* paper as well, and that's how we started describing these since 2015 and now, we have moved towards understanding the genetics. So the genetics is just the outcome of our understanding the phenotypes.

And I understand in the genetics work in *Cell Metabolism*, you tested two older drugs, Qsymia and then Saxenda, a liraglutide. I understand that currently you're studying the genetics in conjunction with more recent drugs, such as a semaglutide. What are you finding?

So we actually presented last year at Digestive Disease Week, which is our national meeting, that our genetic tests that we showed were for Saxenda also work for semaglutide at the Wegovy doses and Ozempic doses. The test not only helps you with predicting better weight loss, but also helps improve predicting your outcomes of hemoglobin A1C. That's very exciting. And I can tell you that we're going to show the

data on tirzepatide (Mounjaro, Zepbound) this year at our national meeting as well.

Now, in your experience, are family physicians and general practitioners generally aware that genetics can reveal which drugs are likely to be most effective on various patients? What should they know about the effectiveness of different GLP-1s and similar drugs on different genotypes of obese patients.

Well, we are slowly sharing the message with colleagues and their patients through publications, through this kind of interview, through talks. But what I would like my colleagues to know is that not every patient is going to be a super responder to these interventions and that genetic tests can help them—like the one we are developing and that is already used in 300 clinics around the United States. This genetic test can help patients get an answer to why they struggle with obesity, why they are living with obesity, and more importantly, improve their outcomes and have better response rate.

That leads us to the fact that you are the cofounder of Phenomix Sciences, a Mayo Clinic company selling genetic testing through some physicians' offices. I believe the test is called the MyPhenome Test, right? How does that work in a clinical setting, in a doctor's office?

So, very simple. If you have a patient who is interested in weight loss, you do a mucosal swab, you send the test to be measured. You get the results of the genetic test. And then that helps you guide whether the patient should be on a GLP-1 or other interventions based on their phenotype, so that way you improve the outcomes.

And as we discussed before, your test seems to be keeping pace with the newly developed drugs—not only liraglutide, but also semaglutides like Ozempic, and tirzepatide like Mounjaro.

That's correct.

What I would like my colleagues to know is that not every patient is going to be a super responder to these interventions and that genetic tests can help them—like the one we are developing and that is already used in 300 clinics around the United States. This genetic test can help patients get an answer to why they struggle with obesity, why they are living with obesity, and more importantly, improve their outcomes and have better response rate.

Can genetics also predict side effects that might cause people to want to quit the use of the drug that they're on, side effects such as nausea or vomiting or more serious things?

We presented last year as well in our national meeting the preliminary data of a genetic test that tells you who developed nausea. In the GLP-1–induced nausea test, we show that in a randomized trial, the same trial that we show in *Cell Metabolism*, if you test positive, you're going to have about a 60% chance of nausea. But if you test negative, you're going to have only a 20% chance of nausea. So we can start building these genetic algorithms to help us understand the side effects as well, and we already have that preliminary data.

I presume the benefit of this kind of testing is that it helps you, one, zero in on a candidate treatment more quickly, and two, do so with greater likelihood that it's going to work.

Absolutely. Developing nausea is independent of your outcome. But there are people who really don't like to feel nauseated. There are people who might not care, right—"Yeah, I'm fine with that." So if GLP-1 is a good therapy for you, you might want to know whether you're going to develop nausea or not. Those who do not want to feel nauseated, your primary care doctor can be a little bit more on top of it and already give you a prescription for an antiemetic and give you some guidance. Likely that will help you stay on the treatment and experience better outcomes. But if you're someone who is at a lower risk of developing nausea, then your primary care doctor doesn't need to spend those resources, and you, as you're less likely to experience nausea, can spend that time focusing on something else.

So describe, for me the future of obesity treatment. What is that going to look like?

Well, you know, I see two futures—the future in which every year or so, we'll have a new medication, and there is just simple trial and error. Some people will fail, really will not improve at the individual level their obesity. Or the other future that we're proposing in which people do a little bit of testing at baseline, try to figure out why they struggle with obesity, what's the underlying obesity phenotype? And based on that they go into the right intervention for their biology, and then they get better outcomes, and can stay on that treatment for longer periods and have more successful effect in the weight management journey. MM

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

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

White coats gather at Capitol to advocate for medicine in Minnesota

PHOTOGRAPHY BY RICH RYAN

It was a beautiful day to advocate on behalf of medicine at the Capitol.

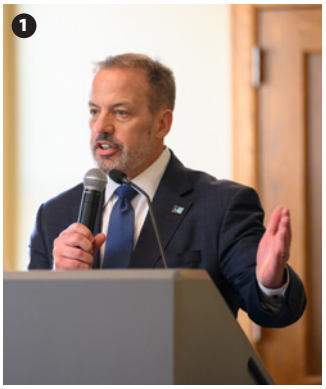
More than 180 physicians and physicians-in-training from across the state gathered at the Capitol in March to advocate on behalf of medicine, as part of Physicians' Day at the Capitol.

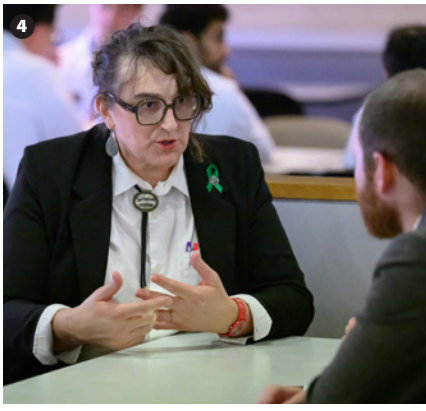
Attendees heard from Sen. Matt Klein, MD, and met with legislators to discuss the MMA's top legislative priorities:

- Support efforts to minimize the impact of federal Medicaid changes and preserve coverage for Minnesotans.
- Repeal the personal belief exemption for school and childcare facility immunization requirements.
- Support evidence-based firearm safety laws.
- Ensure clinician involvement in prior authorization reviews.
- Expand current confidentiality protections for participation in a "wellness program" to include other healthcare professionals.

Members shared information with their legislators on the MMA's priorities and other issues that were important to them and the health of their patients.

"Today is about either establishing or strengthening relationships with your legislators," said MMA President Lisa Mattson, MD, who served as emcee for the event. "Your role is crucial in promoting legislation that is good for the patients you serve."





❶ Sen. Matt Klein, MD, encouraged attendees to get engaged in advocacy.

❷ Sen. Alice Mann, MD, met with physicians from her district.

❸ Long-time Physicians' Day at the Capitol attendees: Siri Fiebiger, MD, MPH, (left) and MMA President Lisa Mattson, MD.

❹ Rep. Leigh Finke meets with a constituent.

❺ Former MMA President Will Nicholson, MD, (right) talks with Rep. Peter Fischer.

News Briefs

State healthcare leaders call for unfettered access to care

This year started out on difficult footing for many Minnesotans as thousands of U.S. Immigration and Customs Enforcement (ICE) and Customs and Border Protection (CBP) officers flooded the state to carry out "Operation Metro Surge," a massive deportation effort championed by the Trump administration.

For several weeks, Minnesota became the global focal point. Everyday aspects of life, from daycare to healthcare, were affected by the federal government's crackdown on undocumented citizens.

Physicians, physicians-in-training, and healthcare workers were pulled into the mix.

In January and February, MMA leadership and dozens of other physicians and physicians-in-training spoke out on social media, in press conferences, to Congress, and at rallies urging federal agents to allow Minnesotans unfettered access to care.

MMA members reported that many of their patients were afraid to seek healthcare services, run errands, or even attend school.

In early February, the MMA, along with several other physician advocacy groups, sent a letter to the Minnesota congressional delegation urging Congress to prohibit ICE and CBP from entering healthcare facilities and schools, and to ensure detention facilities provide appropriate medical care, food, water, and other basic human needs.

This action followed a January 20 press conference in which dozens of physicians, including two elected physicians (State Sen. Alice Mann, MD; and State Sen. Matt Klein, MD) spoke at the Minnesota State Capitol to address the issue. Numerous physicians talked about patients missing appointments and care because of their fear of being detained by ICE. They said the crisis brought more chaos to the practice of medicine in Minnesota than COVID.

"This is a moment of crisis in healthcare because of ICE and their presence in our healthcare settings," Mann said.

"We know that people are not going to their regularly scheduled doctor appointments or leaving their homes for work or school, or to pick up prescriptions, get their vaccinations, or obtain healthy food for fear of being detained by ICE," said MMA President Lisa Mattson, MD. "The MMA wants to ensure that all Minnesotans, regardless of immigration status, have access to safe, timely, and high-quality medical care and that ICE enforcement actions do not interfere with that care and undermine the health of our communities."

Many physicians were also outraged when news came out that federal agents impeded their fellow physicians from providing CPR on two Minnesota protestors were shot and killed by federal agents.

In mid-February, ICE and CBP finally announced a reduction of the number of federal agents in Minnesota.

'The conversation is easier than we worry it might be'

Despite widespread agreement among physicians that they have a role to play in promoting firearm safety and reducing the United States' high firearm death rate, relatively few routinely discuss gun safety with patients. Only about 7.5% of adult gun owners report having discussed the issue with their physicians, according to a 2021 study in the *Annals of Internal Medicine*.

Other studies have identified reasons physicians may shy away from these conversations—they don't have time, they aren't trained to do it, gun-owning patients may get angry.

An interview study on clinical firearm safety counseling, published in December in the *American Journal of Health Promotion*, dispels many of these fears and provides tips for physicians to speak to their patients about gun safety.

The study was co-authored by Kate Weis, MPH (MMA member and medical student at the University of Minnesota Medical School); Thomas E. Kottke, MD, MSPH (MMA member and member of the HealthPartners Institute); Juliana Milhofer, JD (MMA manager of public health policy and community health partnerships); Iris Borowsky, MD, PhD (Division of General Pediatrics and Adolescent Health, Department of Pediatrics, University of Minnesota Medical School); and Patricia Jewett, PhD (School of Public Health, Division of Environmental Health Sciences, University of Minnesota).

The study's key takeaways are that firearm safety counseling is easy and fast, that almost all patients react positively, and occasional less-than positive reactions can be easily defused. The authors based their findings on interviews with 16 physicians who routinely speak to patients about firearms. Most (11) were in primary care–family medicine or pediatrics. Just over half worked in cities, 27% in rural areas or small towns, and 20% in suburbs. Interviews were conducted in 2023 and 2024.

According to the authors, "Participants' strong convictions that it was their responsibility to address firearm safety helped them overcome barriers such as lack of time, training, and guidelines." Said one respondent in the surveys, "I would just encourage you to find a way to start to incorporate these conversations into your practice. Practice it and maybe build it into your templates of wellness visits, so that you remember."

Respondents reported that firearm safety conversations were typically short, often less than a minute, and could easily be discussed in the context of other general safety concerns. Some physicians distributed free firearm or trigger locks and said this practice made safety conversations easier.

To avoid political arguments, said one participant, "I think the biggest thing that I try to convey is that, you know, this is… coming from a place of safety and … this isn't about whether or not you should have a gun."

Said another physician who participated, "I think the conversation is way easier than we worry it might be."

MN physician donates more than $50K to address gun violence

A Minnesota physician (and MMA member) donated $54,600 in December to launch the Physicians for Gun Violence Prevention Fund at the MMA Foundation.

This new, physician-led resource will support nonpartisan, evidence-informed firearm violence prevention efforts, including:

- Safe-storage and lethal-means counseling tools for physicians and care teams.
- Public awareness of firearm injury prevention strategies.
- Physician-led community initiatives such as safe-storage events, youth programs, suicide prevention work, and rural outreach.

"This is not political work," said George Schoephoerster, MD, the MMA Foundation's immediate past president. "It is physician work—grounded in prevention, compassion, and patient care."

The MMA Foundation plans to use the fund to seed and grow physician-driven prevention efforts across Minnesota and to build a sustainable resource that physicians can turn to when they want to take action in their communities.

Physicians who wish to support this work can contribute:

- By check (please note "Gun violence prevention" in the memo):
  MMA Foundation—Lockbox #135091
  P.O. Box 1150
  Minneapolis, MN 55480-9917
- To support the MMA Foundation's other priorities, use this link: https://www.paypal.com/donate/?hosted_button_id=WV7YX4APFPN5S.

MMA advocates for firearm safety at recent committee hearings

The MMA continues to engage in legislative efforts aimed at reducing firearm-related death and injuries, and supporting evidence-based public health policies. The MMA, along with seven specialty societies, submitted a letter in support of HF 3433 authored by Rep. Emma Greenman (DFL–Minneapolis).

This bill would prohibit the possession, ownership, and transfer of semiautomatic military-style assault weapons and high-capacity magazines in Minnesota, with provisions for current owners to obtain state-issued certification and comply with storage and enforcement requirements. HF 3433 was heard in the House Public Safety Finance and Policy Committee February 24.

The letter highlighted the public health impacts of firearm violence, particularly on children and adolescents. Firearm deaths among ages 1–17 have increased by 106% since 2013, and have been the leading cause of death for this group since 2020. Firearm injuries also cause long-term physical and mental health consequences. Studies cited by Everytown for Gun Safety show that states with assault weapons bans experience lower mass shooting fatalities, and the 1994 federal Assault Weapons Ban reduced mass shooting deaths by 70% during its 10-year implementation.

The MMA also submitted a letter in strong support of HF 3351 (Rep. Dave Pinto, DFL–St. Paul), which would repeal state preemption and allow local municipalities to implement firearm regulations tailored to their communities. HF 3351 was heard in the House Elections Finance and Government Operations Committee on February 25. The letter highlighted that more than 500 Minnesotans die from firearms each year, with numbers rising annually, and that physicians see firsthand the physical and emotional toll of firearm injuries.

Neither bill advanced out of committee. HF 3433 failed on a party-line vote in the House Public Safety Finance and Policy Committee, and HF 3351 failed in a 6-6 tie in the House Elections Finance and Government Operations Committee.

The other specialty societies supporting this legislation include: the Minnesota Chapter of the American Academy of Pediatrics, Minnesota Academy of Family Physicians, Minnesota Chapter of the American College of Physicians, Minnesota Psychiatric Society, Minnesota Society of Child and Adolescent Psychiatry, and the Minnesota Section of the American College of Obstetricians and Gynecologists.

MMA Foundation sponsors event to urge students to follow medical career

In the fall of 2025, the MMA Foundation helped inspire Minnesota's next generation of healthcare leaders by sponsoring Gillette Children's "Medical Discovery Day for Youth"—a hands-on, community-driven event designed to open doors for students from all backgrounds.

The event brought together students, parents, educators, clinicians, and community leaders to encourage young people to explore careers in healthcare. Youth 9 years and older engaged in hands-on activities and had the opportunity to learn from—and connect with—healthcare professionals from diverse backgrounds.

As part of its sponsorship, the MMA Foundation hosted two "Growing Your White Coat" sessions for parents and guardians. Panelists included premedical and medical students from the University of Minnesota, a resident from the North Memorial Family Medicine Residency Program, and a practicing physician from MNGI Digestive Health who also serves on the MMA Foundation Board. Edwin Bogonko, MD, MBA, immediate past president of the MMA, moderated both sessions.

The conversations helped parents better understand how to support their children's interest in healthcare careers. Panelists shared candid reflections on their own pathways into medicine—highlighting the academic, financial, and mentorship experiences that shaped their journeys and continue to "grow their white coats."

MMA weighs in on gender-affirming care funding

In late January, the MMA submitted a formal comment in opposition to a Centers for Medicare and Medicaid Services (CMS) proposed rule that would prohibit the use of federal Medicaid and Children's Health Insurance Program (CHIP) funds for select gender-affirming healthcare services provided to minors.

Services subject to the rule include interventions such as puberty blockers, hormone replacement therapy, and surgeries that "attempt to align a child's physical appearance or body with an asserted identity different from their sex."

The proposed rule is inconsistent with the MMA's policy on gender-affirming healthcare. The policy, adopted in February 2023, states that the MMA "opposes laws and regulatory actions designed to restrict access to gender-affirming healthcare." Importantly, the policy states that "consistent with the prevailing evidence-based standards of care, the MMA recognizes that… under specific clinical guidelines, it is appropriate for…minors to receive certain types of gender-affirming healthcare."

In its proposed rule, CMS argues that "there is a lack of reliable, long-term evidence on the safety and effectiveness of [gender-affirming healthcare] for children and…these interventions can cause irreversible, life-altering harm, including, but not limited to, permanent infertility and loss of sexual function."

In its comment, the MMA submits that:

- "The weakness of evidence of benefits for [gender-affirming healthcare] does not indicate a lack of benefits but rather that the nature of [gender-affirming healthcare] makes it difficult to employ characteristics of traditionally 'quality' research [e.g., small sample sizes, limited ability to isolate treatments in the context of standard-of-care step-therapy, ethical considerations of randomized control trials]."
- "A body of research, while imperfect, collectively suggests that minors' receipt of [this care], consistent with the [prevailing evidence-based standards of care], is associated with reduced substance use, depression, self-harm, and suicidality."
- "There are many effective medical treatments that include aspects of varying reversibility, and there are many effective medical treatments for which we have limited understanding of long-term side-effects. For nearly all treatments, CMS respects and yields to the patient-physician relationship and its central tenets of informed consent and shared decision-making about risks and benefits of treatments without government encroachment."
- The prevailing evidence-based standards of care "provide for the protection of minor patients in that they must 'demonstrate the emotional and cognitive maturity to provide informed consent/assent for the treatment [and that] mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.'"

CMS has published a separate proposed rule that would bar hospitals from providing pharmaceutical or surgical gender-affirming healthcare services to minors as a condition of participation in Medicare and Medicaid. The MMA has opted not to comment on this second proposed rule to avoid redundancy and to defer to hospital associations.

The MMA will continue to monitor and report on CMS rules related to minors' access to gender-affirming healthcare.

Number of Minnesota kindergarteners vaccinated for measles continues to fall

Minnesota's measles vaccination rates for kindergarteners continue to decrease, according to the latest data from the Minnesota Department of Health.

The state's falling vaccination rate ranks fourth worst in the country, better than only Idaho, Alaska, and Wisconsin. According to the data, 86.5% of Minnesota kindergarteners have been vaccinated for measles, well below the 95% mark needed for herd immunity.

A leading contributor to the decline is an increase in nonmedical exemptions, especially at private and charter schools. Repealing Minnesota's personal belief exemption for school and childcare facility immunization requirements is one of the MMA's top five priorities for the 2026 legislative session.

"Minnesota has one of the weakest vaccination laws in the country," said MMA President Lisa Mattson, MD. "We have to do more to protect individuals with compromised immune systems. When you vaccinate your child, you are not only protecting your child's health, but also the health of their classmates, friends, family, and community."

Report shows that telehealth use is still on the rise

A new AMA report shows that the use of telehealth in physician practices increased dramatically during COVID-19 and remains much more widely used than before the pandemic.

The percentage of physicians in practices that used telehealth increased from 25.1% in 2018 to 79% in 2020 and remained high, at 71.4%, in 2024.

These findings came out of the AMA's Physician Practice Benchmark Survey.

The report also compares 2024 telehealth use among physicians in practices with different ownership structures and presents novel estimates on the reasons why physician practices are not using telehealth. It also compares the weekly use of telehealth across physician specialties.

Study backs HBV shot at birth

In December, the Vaccine Integrity Project (VIP) released a study on the safety, effectiveness, and public health impact of hepatitis B virus (HBV) vaccinations at birth.

VIP, a project of the Center for Infectious Disease Research and Policy (CIDRAP) at the University of Minnesota, released the report just days before the Advisory Committee on Immunization Practice (ACIP) ended the practice of vaccinating all newborns for HBV. The practice has been in place since 1991.

VIP found the following in its review of data:

- Given the long-term protection provided by the hepatitis B vaccine, the birth dose was also key in reducing HBV transmission, disease, and death in the U.S. overall.
- No safety benefits were identified for a delayed first dose versus vaccination at birth.
- Delaying the first dose leaves infants vulnerable to both undiagnosed maternal infection and HBV exposure after birth.

The data review found no benefit of delaying vaccinations.

"The MMA supports the evidence-based guidance provided by the American Academy of Pediatrics and American Academy of Family Physicians, which supports giving a birth dose of the vaccine to all infants," said MMA President Lisa Mattson, MD.

Another physician decides to leave Minnesota Legislature

Alice Mann, MD

Minnesota's Legislature will lose another physician as Sen. Alice Mann, MD, announced in December that she would not seek reelection this year.

Since 2023, Mann has represented District 50, which covers Bloomington and Edina. Prior to that, she served as state representative for District 56B from 2019 to 2021. Mann is an emergency room physician, serving patients at Northfield Hospital. She also serves as the primary care medical services director for Wayside Recovery Center, providing mental health and addiction treatment services for women, children, and families. In her time at the Legislature, Mann has authored numerous MMA legislative priorities, including legislation to prohibit insurers from changing drug formularies midyear, which passed into law in 2025.

"Minnesota's physicians and their patients have been lucky to have Dr. Mann in the Legislature," said Chad Fahning, MMA's senior manager of lobbying and legislative affairs. "She has always been particularly passionate about policies that directly impact patient care and earned a reputation for taking on challenging or complex bills and molding them into law. Her expertise and experience brought unrivaled value to the capitol, and with her announcement, we may see the Legislature absent of any physician members following the 2026 election."

Sen. Kelly Morrison, MD, left the Legislature in 2024 when she ran for and was elected to represent the 3rd Congressional District in Washington, D.C.

In May 2025, Sen. Matt Klein, MD, announced his candidacy for the 2nd Congressional District.

MMA physicians discuss many topics at AMA meeting

Physicians from Minnesota and elsewhere gathered November 14–18 for the AMA 2025 Interim Meeting in National Harbor, Maryland, to address payment reform, public health challenges,

rural healthcare, and the escalating administrative and financial pressures on medical practice.

Minnesota representatives included: Cindy Firkins Smith, MD, delegation chair; JP Abenstein, MD, delegate; Andrea Hillerud, MD, delegate; Dennis O'Hare, MD, delegate; Lisa Mattson, MD, MMA president and alternate delegate; George Morris, MD, alternate delegate; Ashok Patel, MD, alternate delegate; Laurel Ries, MD, alternate delegate; David Thorson, MD, delegate; and Katherine Holder, MD, Resident/Fellow Section sectional alternate delegate, Region 2.

Topics discussed that have particular interest to Minnesota physicians included:

- Strengthening the patient-physician relationship, reaffirming trust and clinical autonomy as core ethical priorities.
- Support for medical staff empowerment, including collective action or unionization options, referred for additional refinement.
- New ethical guidance for whole-body and body-part donation, aligning with national best practices and supporting medical education and research programs.

Delegates adopted strong policy directing AMA to advocate for:

- Removing PA requirements for low-cost medications and routine services.
- Public reporting of approval, denial, and appeal data by insurers.
- Transparency, clinical accuracy, and guardrails for AI-driven authorization systems, including protections related to the forthcoming Medicare WISeR Model.

This work directly supports MMA's priorities to reduce administrative burdens and protect patient access.

Recognizing ongoing threats to rural hospitals, the AMA endorsed minimum standards for alternative hospital payment models, including predictable fixed-cost payments, adequate reimbursement across payers, reasonable patient cost-sharing, physician-led teams, and reduced administrative complexity. These policies align closely with Minnesota's needs, particularly in sustaining rural hospitals, and maintaining local access to care.

New AMA policies supported expanded behavioral health services, improved access to medications for opioid-use disorder, and enhanced veteran-care standards—all relevant to Minnesota's statewide public health goals.

MMA website project promoting healthcare careers to Minnesota youth celebrates anniversary

HealthcareCareersMN.org, an MMA initiative that supports the healthcare career aspirations of students from across Minnesota, celebrated its first anniversary in December.

The site includes information about pathway programs and other resources that provide mentorship, training, exposure, and inspiration to students interested in healthcare careers. The goal of the MMA is to make HealthcareCareersMN.org a trusted and dynamic go-to resource to support students interested in pursuing careers in healthcare.

The MMA is working to grow its platform to educate and empower students, families, and school counselors with:

- A comprehensive set of programs and resources for students to enhance their academic journey, including mentorship programs, academic support, and extracurricular opportunities.
- Career information about the variety of healthcare careers available, including descriptions of various careers and their educational requirements.

The MMA asks that programs from across the state that may not yet be included on the site help us build and grow these resources as well. For more information, visit the site at: https://www.healthcarecareersmn.org/

Judge prevents Aspirus St. Luke's from enforcing noncompete

A state district court judge granted a temporary injunction February 17 preventing Aspirus St. Luke's from enforcing a noncompete against a Duluth family physician.

Nyasha Spears, MD, was employed by Aspirus in 2025, but sought to open her own family practice clinic in Duluth due to the discontinuation of services at the clinic where she was employed. When Spears notified Aspirus of her intent, it stated that it would enforce the noncompete provision contained in her employment agreement. The provision would prevent Spears from providing substantially similar services within 25 miles of the clinic where she was employed for two years.

During the 2023 legislative session, Minnesota legislators passed a law prohibiting the use of noncompete provisions in all employment agreements signed after the bill's enactment. The MMA strongly supported this legislation, arguing that noncompete provisions limit access to care.

Spears filed a lawsuit against Aspirus in October 2025 to prevent it from enforcing the noncompete provision. In the order granting Spears request for a temporary injunction, the judge reasoned, in part, that "[Dr. Spears'] harm is personal and immediate. She cannot start her own practice or continue her professional practice in the Duluth area if the noncompete is enforced." The order further stated that "the record reflects a documented shortage of primary care physicians in Minnesota… [and] limiting [Dr. Spears'] ability to practice locally would exacerbate an existing public health problem, in direct conflict with the public interest." Courts have recognized that noncompetes should not be enforced in a manner that harms the community.

In a statement, Aspirus St. Luke's has said: "We continue to collaborate closely with the attorney general's office and are committed to working together toward a mutually agreeable outcome. In protecting our legal rights, Aspirus St. Luke's is acting in the best interest of our organization and, more importantly, in the best interest of our patients and community."

The injunction will allow Spears to move forward with opening a direct primary care practice in Duluth where patients pay a flat fee for primary care instead of paying through insurance. MM

FROM THE CEO

MMA goes to Washington

As a state medical society, the MMA directs most of its resources and advocacy efforts at the state level. Yet national policy—particularly with respect to Medicare and Medicaid —has an increasingly outsized influence on the practice of medicine and the health of Minnesotans.

As a result, it is essential that the MMA also engage in national advocacy efforts. The MMA's role in influencing federal policy takes three primary forms—congressional delegation relations, federal regulatory engagement, and AMA policy development.

As most people know, the gears of Congress often move slowly, and the process frequently seems unproductive. Yet Congress is required to pass, at a minimum, an annual budget or "appropriations" bills. The appropriations process addresses discretionary spending, as opposed to mandatory or direct spending, such as Medicare, Medicaid, and Social Security. Appropriations bills can, however, be used to modify direct spending and this is how short-term changes to the Medicare physician fee schedule have recently been accomplished.

Congress also periodically uses the budget reconciliation process. Reconciliation is a unique mechanism that requires only a simple majority vote, thus bypassing the 60 votes otherwise needed to overcome the Senate filibuster. Reconciliation, however, can only be used to modify spending or revenue, not for policy changes. This was the process used in 2025 to pass the so-called One Big Beautiful Bill Act (OBBBA), which is projected to result in nearly $1 trillion in Medicaid cuts.

Minnesota's congressional delegation plays an essential role in the annual budget-setting process. The MMA maintains routine contact with members of Minnesota's congressional delegation and will urge their support of, or opposition to, particular bills or appropriation provisions. The MMA sends leadership to Washington at least once a year for direct meetings with delegation members or their staff. Most recently, the MMA met with delegation members in late February as part of the AMA's National Advocacy Conference. Among the issues discussed at that time were future funding for the Department of Homeland Security—asking that funding be contingent on reinstating restrictions on enforcement activities in or near healthcare facilities and other sensitive locations; seeking support for Medicare physician payment reform provisions in the year-end appropriations bills; and sharing examples of the value of Medicaid coverage across Minnesota and the importance of reversing the OBBBA Medicaid cuts.

Another way the MMA influences federal policy is through the federal regulatory or rule-making process. This is a more hands-off process by which public comments are submitted on proposed regulations. The public comment process is critical to advising federal agencies on the implications and feasibility of proposed rules. Recent federal regulatory engagement by MMA included comments on a proposal to prohibit all Medicaid funding to facilities that provide select gender-affirming care services.

Another visible way that MMA influences federal policy is via the AMA policy-setting process—the biannual House of Delegates. The MMA sends a delegation of elected physicians to represent Minnesota physicians in the House of Delegates and to help inform the AMA's national policy agenda. Although MMA and AMA are independent and distinct organizations, the MMA closely partners with AMA on national advocacy.

If 2025 is any indication, federal health policy changes will continue to change and disrupt healthcare in 2026. The MMA will continue to do all it can to bring the voice of Minnesota physicians to members of Congress, the administration, and the AMA. You can help by responding to MMA calls to action, engaging in MMA policy development, and urging your colleagues to join MMA. **MM**

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VIEWPOINT

Increasing childhood vaccination rates

Lisa Mattson, MD
MMA president

Minnesota currently has the fourth worst measles, mumps, and rubella (MMR) vaccination rate among kindergartners in the U.S. During the 2025–2026 school year in Minnesota, only 86.5% of kindergartners were vaccinated against measles. We need 95% vaccinated to achieve herd immunity.

This needs to change.

The public's acceptance of vaccine safety has declined significantly since the COVID-19 pandemic. Thirteen states, including Minnesota, have "personal belief exemption" laws that allow parents to decline vaccinations. Studies have found that there is a higher rate of disease outbreak in these states. In Minnesota, this has resulted in a decline in childhood vaccination rates by about 2% per year. Because of this trend, the MMA has made rescinding these nonmedical exemptions one of its top legislative priorities this session. We need to do better in preventing disease and keeping in line with our goal of being the healthiest state in the country.

Many specialty societies have published guidance on effective vaccine communication. One technique suggests that providers initiate conversations about vaccinations with the presumption that parents are ready to vaccinate their child. A statement such as, "It looks like Johnny is due for a shot today" or similar "announcements" have been associated with increased vaccine uptake when compared to initiating a participatory approach with open-ended questions such as "How do you feel about Johnny getting his vaccination today?" While this may not impact vaccination rates on the first visit, continued use of the presumptive method over several visits has been shown to increase vaccine uptake.

A major contributor to vaccine hesitancy is parental concern regarding the safety and necessity of vaccines. Simply addressing the evidence behind vaccine safety may not be enough to convince parents to vaccinate their children. The manner in which we communicate this information may be of more importance. We need to listen and address the concerns and questions parents have and be sure to provide evidence-based information without talking down to parents or shaming them in any way. Efforts should be made to avoid minimizing or dismissing parental concerns, and all communication should be face-to-face rather than when studying the computer screen. Asking open-ended, targeted questions when parents express concerns helps build trust. As part of informed consent, we are obligated to discuss the risks of vaccines, including common and rare side effects. Providing written information regarding vaccines including percentages, natural frequencies or visual representations of probability can be helpful. Others have argued that spending more time on the dangers of the disease may be more impactful than discussing the safety of the vaccine.

It is important that when we close a discussion with a parent who has declined vaccinations for their children that we maintain our position of support for the vaccine. A comment like "I respect your decision, but it is my professional obligation to let you know that I still recommend this vaccine for your child's health" could increase the likelihood of that child getting vaccinations in the future. One study found that nearly half of parents who initially declined vaccinations, accepted the vaccine when the physician continued to promote it.

Improving vaccination rates will be a big lift and will require a multifaceted approach. Overturning nonmedical exemptions and improving provider communications regarding vaccines will help. We need to concentrate on the population at risk of the disease and weigh this against the concerns of individual parents for their individual child, while respectfully listening to parents' questions and concerns and leveraging our shared goal of keeping our children healthy. MM

We need to do better in preventing disease and keeping in line with our goal of being the healthiest state in the country.

Ryan Carlson with daughter Rose (left), son Sammy, wife Tia, and son Benjamin.

RYAN CARLSON, MD

Ryan Carlson, MD, is a psychiatrist at CentraCare in St. Cloud. His work includes outpatient psychiatry, addiction psychiatry, integrated primary care–behavioral health through the Collaborative Care Model, and repetitive transcranial magnetic stimulation. He is also associate program director for a new rural track within the University of Minnesota's psychiatry residency program.

When did you become an MMA member?

In September 2025. As I began taking on more administrative responsibilities, I realized that my medical training hadn't equipped me for the operational aspects of leadership. A colleague encouraged me to enroll in the MMA's Physician Leadership Institute, and I joined when I signed up for the course.

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

I grew up in Anoka, in a family of seven children—five girls and two boys. We thought it was fun that our family was big enough that we could play a full kickball game with just the family. My father worked in IT, and my mother held several jobs over the years, though she was primarily a stay-at-home mom. She also homeschooled us for much of my childhood.

I moved to Utah and earned my undergraduate from Brigham Young University in Provo. During college, I worked at a community mental health center, and later spent a season working at the Utah State Hospital. This was my first real exposure to individuals with persistent mental illness. I learned things playing billiards and chess with these patients about dignity and humanity, especially for patients who are often pushed to the margins of society.

I completed medical school and psychiatry residency at the University of Minnesota.

Tell us about your family.

My wonderful wife, Tia, and I just celebrated our 11th anniversary. We have three young children. One of our favorite traditions is our monthly doughnut breakfast. My kids never let me forget!

Hobbies or side gigs?

I love running! I've run many half marathons and ran Grandma's Marathon for the first time a few years ago. I've logged plenty of miles on subzero mornings bundled in layers with a headlamp.

Why did you decide to become a physician?

Because I find people endlessly interesting. I love hearing about the experiences of individuals—how they navigate adversity and what makes them tick.

I also genuinely loved school. Medicine appealed to me because the learning never stops. Becoming a physician meant committing to a lifelong process of growth, intellectually and personally.

What was the greatest lesson of your medical education?

I was amazed by how smart my classmates were! Medical school gathers some of the brightest young minds. At the same time, I learned that being a good physician isn't just about book knowledge. So much of being a good doctor comes down to showing up for your patients: taking a few moments to chat about their life, following up on a prior auth, taking time to review the literature on a question. Patients really appreciate this effort.

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

I realized that if you want to make meaningful change, you need to understand the language of business and have a seat at the table. Physicians are in the best position to help steer the course of healthcare, so it's on us to develop the skills necessary to make that happen.

What's the greatest challenge facing medicine today?

Financial pressures. I practice in a "low-reimbursement" specialty, and most of my patients are not privately insured. Even with high demand for services, it can be difficult to keep a mental health clinic financially viable. Declining reimbursement, an unfavorable payer mix, and rising labor costs put tremendous strain on the sustainability of care. At the same time, I'm hopeful these challenges will spur positive change. I expect our healthcare system will look very different at the end of my career than it does now.

How do you keep life balanced?

Weekends and evenings with my family are sacred. Spending hours together helps me recharge. Keeping up with my hobbies makes me a better doctor. I'm in a stronger position to care for my patients when my days are filled with joy.

If you weren't a physician—?

This is a great question because I never had a solid plan B. I've always been rule-oriented, so I think I might have made a decent accountant. I also would have loved the opportunity to be a professor in a social studies field.

What has MMA membership meant to you?

It has been empowering to be part of a larger medical community. So much of our work happens in silos. Connecting with colleagues has reinforced that we're not navigating these challenges alone. MM

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