THE JOURNAL OF THE MINNESOTA MEDICAL ASSOCIATION

# MINNESOTA MEDICINE

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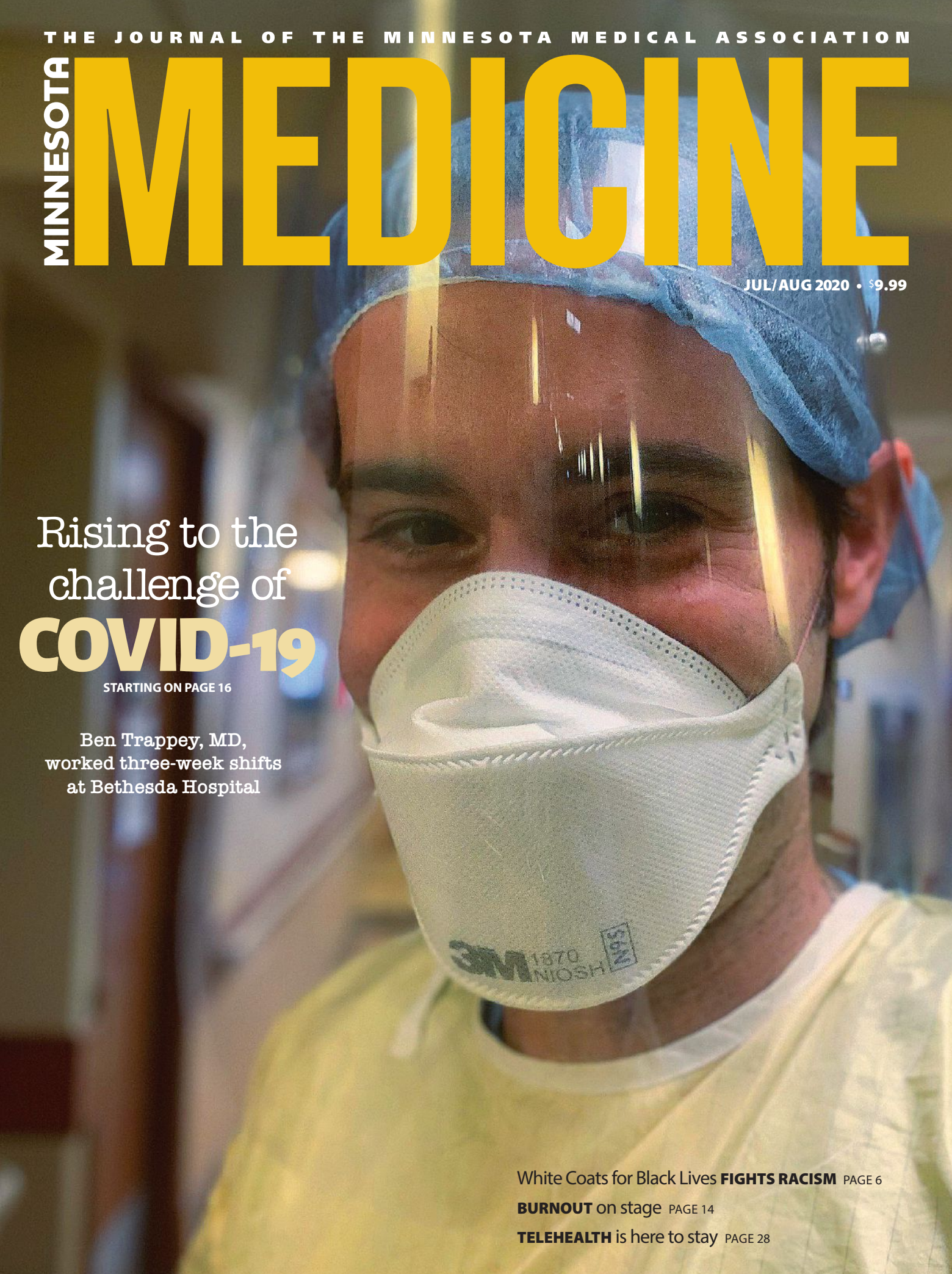


## Rising to the challenge of COVID-19

STARTING ON PAGE 16

Ben Trappey, MD, worked three-week shifts at Bethesda Hospital

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*COVID-19 dominates much of our lives and health care today. It's part of the concern about racism in medicine—people of color are more likely to contract it and more likely to die of it. It inspires reflection and art in medicine. It's the impetus for the sudden growth of telehealth. Many of the articles in this issue of* Minnesota Medicine *focus on COVID-19 and its impact.*


PHOTO COURTESY OF BEN TRAPPEY, MD

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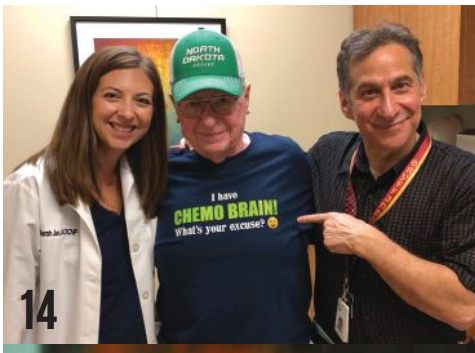
## ON THE COVER



## FEATURES



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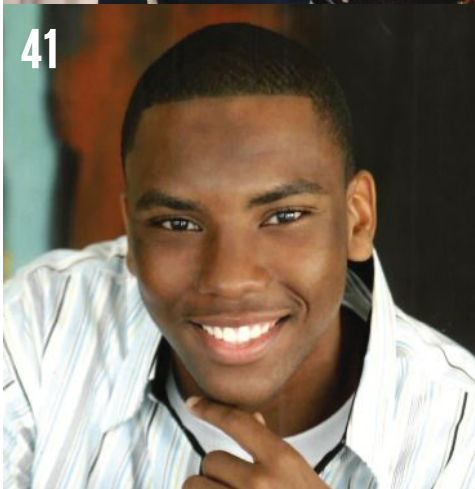

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## Clinical AND Health Affairs









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Zeke J. McKinney, MD, MHI, MPH

# Pursuing justice for our Black patients and communities

We are living in a challenging time, bringing to light issues of equity and justice within and outside of medicine. The history of inequity in our Black community is at the core of these issues.

The COVID-19 pandemic is affecting the Black community with disparately high rates of morbidity and mortality associated with contraction of the disease. For example: COVID-19 mortality rates in New York City are twice as high for Blacks as for whites, and as much as 18.5 times higher in Wisconsin. Many Black physicians, including myself, are working with community leaders or in public forums to explain the realities of the pandemic and how social determinants of health, including mistrust, have led to these inequities.

Police violence against the Black community has been a health disparity for decades. The death of George Floyd at police hands stoked local civil unrest by both Blacks and whites because of the powerful video showing a police officer kneeling on George Floyd's neck while he repeatedly said, "I can't breathe."

Although these two issues—COVID-19 and police violence against Blacks—seem to have different causes, the inequitable outcomes for Black people are actually symptoms of a longer-standing issue: structural racism. Our ability to treat patients is limited by the social determinants of health that structural racism creates and reinforces. We can see this in the inequitable rates of Black mortality from acute infectious disease, chronic disease, acute trauma and many other injuries or illnesses.

Our ability to treat patients is limited by the social determinants of health that structural racism creates and reinforces.

George Floyd's death is a metaphor for the Black condition in the United States, where an enormous weight is on our necks all the time. This is true for me as a Black man, where many spaces presumed to be benign, including medical school, have rarely felt safe. Is it any surprise that we physicians struggle with gaining the trust of our Black patients, when even I hesitate to visit the doctor?

The situation appears bleak, but it is not hopeless. Current conversations are starting to face the realities of the Black experience in a serious way. We now have an opportunity to more openly and honestly engage each other moving forward. Physicians must take this moment to reflect on how to pursue justice outside of our individual practices. We have an ethical responsibility to build, promote and protect the health and safety of our Black communities.

How can we do this? Remember that every Black person you meet has been traumatized by their American experience; George Floyd's death is a stark reminder of this for them. Start by scheduling a longer visit with your Black patients to ask them how you can best help them meet their health goals—and don't try to do anything else during that visit.

Ask your Black medical students and colleagues about their experiences and how you can do better. Ask the institutions where you trained to address gaps in representation. Support local Black businesses and media sources, such as the *Minnesota Spokesman-Recorder* or *Insight News*. Find out what your own practice or health system has done to address these issues, determine what more needs to be done and push for change.

Ultimately, treat everyone as an individual and approach patients gently; most of the time, they do not have the privilege we have as well-educated and highly-paid members of our society. **MM**

Zeke J. McKinney, MD, MHI, MPH, is the chief medical editor of *Minnesota Medicine*.


PHOTO BY ABBE PENZINER-BOKOE, MD

Physicians and medical students demonstrated against racism at the Minnesota Capitol on June 6.

WHITE COATS FOR BLACK LIVES

# Medical students stand against racism

Hundreds of medical students and physicians stood on the Minnesota State Capitol lawn June 6 to demonstrate their anger at the murder of George Floyd—and their strong commitment to fighting racism in their communities, their practices and their classrooms.

White Coats for Black Lives (WC4BL) is a national organization of medical students that began in the wake of the 2014 killings of Michael Brown and Eric Garner, both black men, by white police officers. Medical students at the University of Minnesota joined protests in 2015 and formed one of the early regional organizations to be chartered as part of the group.

The demonstration at the Capitol was "really powerful," says Mary Thomas, just finishing her first year of medical school at the University of Minnesota and one of the 2020-2021 board members of WC4BL. "For the last two or three months, I haven't been around that many people at all. Then to see that many people show up to a protest is amazing. The south lawn of the Capitol was blanketed in white coats—all 6 feet apart, of course."

The June 6 gathering was initiated by several OB/GYNs at Hennepin Healthcare, who asked the leaders of WC4BL if they wanted to organize a silent sit-in at the Capitol. "It was a great collaboration," says Thomas. "They supported us in the planning, in getting things off the ground, in the logistics, but allowed us to fill in the content and to center on our voices."

Thomas said the group focused on the three goals of WC4BL: foster dialogue on racism as a public health concern, end racial discrimination in medical care and prepare future physicians to be advocates for racial justice.

The demonstration was a success, Thomas says, but "we are hoping to answer our own call and go beyond just showing up to a one-day protest. While those can mobilize a lot of people, they don't get things done on an institutional level."

At the end of May, WC4BL, in collaboration with several other University of Minnesota medical student organizations representing Latino, Asian-Pacific and

LGBTQ students and with the Student National Medical Association, asked for changes in the medical school curriculum, building on work already done by medical school faculty. Changes included a mandatory curriculum on racism, "robust, mandatory infections disease/epidemiology curriculum on the causes and effects of global and national pandemics," removal of race-based medicine, establishing and strengthening ties with communities of color in the Twin Cities and recruiting diverse patients—"As part of our medical training, it should be required, not optional, to have encounters with standardized patients who come from different paths than our own."

For more information about White Coats for Black Lives, go to https://whitecoats4blacklivesumn.weebly.com

The student groups were expecting to meet with medical school administration this summer.

"We're going to try to figure out how to keep the pressure up and not only effect change in the medical school but in other health professions, in their schools and their hospitals," says Thomas. **MM**


PHOTOS BY ZEKE MCKINNEY, MD, MPH

White Coats for Black Lives is a student organization at the University of Minnesota that is working with other groups, including Minnesota Association of African American Physicians, to foster dialogue on racism as a public health concern in their communities, their practices and their classrooms.

# Suicide prevention for physicians

Asking the right questions

BY JOSHUA STEIN, MD

The best place to have a heart attack is a Las Vegas casino. Why? Because there are many eyes, electronic and human, on you at all times and because so many people working in a casino, from the security guards to the dealers to the servers, are trained in CPR as a part of their job. You have a high rate of surviving a heart attack in a casino because you will be seen and then treated quickly and effectively.

We need to create that for people thinking about and at risk of committing suicide: more eyes on them and getting them into treatment as needed.

That's where QPR comes in. QPR stands for Question-Persuade-Refer:

- **Question**. Asking about the presence of suicidal thoughts—and doing it in a way that encourages an honest response.
- **Persuade**. Persuading the person at risk to let you help them right now.
- **Refer**. Helping the person at risk find the right resources.

I'm a psychiatrist who works with children and adolescents and I trained as an instructor in QPR, so that I can train others—particularly physicians and teachers—to be "eyes" on vulnerable people. It's not just physicians, of course, it could be lacrosse captains or fraternity and sorority leaders or ministers … the more people who know how to recognize when someone is struggling, the greater the chance of reducing suicide. But one in five of those who die by suicide saw their primary care physician within 24 hours of their death; nearly half of elderly suicide victims saw their physician within a week before their death.

## Suicide among physicians

Data from the Centers for Disease Control show that physicians are 2.5 times as likely as other groups to die by suicide. At least 23 percent of medical interns and 28 percent of residents say they had suicidal thoughts. Our competence is also our risk: physicians have a higher completion rate of suicide because we know what works.

We did QPR training at the University of Minnesota Medical School last year after students asked for it following a suicide. I Most people have been touched by suicide, either directly or indirectly.

## Asking the right questions

Physicians already have many of the skills needed to do QPR, but we may not feel confident about putting them into play. QPR training helps us ask the right questions—in the right way.

Often, when we ask someone whether they have suicidal thoughts, there's so much guilt and shame that we hear only the answer they think we want from them: "No, I don't have suicidal thoughts." And then we move on to the next question.

QPR has been a good reminder for me and my staff that when we ask these questions, we need to ask them in ways that validate the individual and that show them we have time to respond to them.

So, instead of saying, "You're not suicidal, are you?" which seems to call for only one possible response, we might say, "When people are as sad as you are and have struggled so much and lost so much, they often think about dying. Have you had those thoughts?" Or, "Have you ever wished you could go to sleep and just never wake up?" Or, "I'm really worried about you and I wonder if you're thinking about suicide."

There are also indirect or direct verbal cues that we might miss if we aren't paying attention. Someone might say, "Soon you won't have to worry so much about me," or "I'm tired of life and just don't want to take it anymore." Or the person might suddenly become very interested in religion—or might lose interest in religion. Someone who has been struggling for a while suddenly has a mood lift.

Situational changes—divorce, a bad breakup, health crises, bankruptcy, loss of status—can challenge anyone. For someone with issues of depression or mental illness, they can be much more than a challenge. As physicians and as friends, we need to be alert to how patients and friends are negotiating these challenges and whether they need more help than they're comfortable asking for directly.

## Means restriction

We often know why people attempt suicide, but we tend not to ask "how" they might do it. If we can restrict their access to the means they have been considering—drugs, a gun, a car—we can greatly reduce the chances that they will attempt suicide. There is no substitute of means when the primary means is removed. The idea that someone who is suicidal will use whatever means they can to kill themselves is simply not true.

In fact, in the 1960s, the United Kingdom reduced the toxicity of the natural gas used in homes for heat and cooking—and for some suicides. The number of suicides were reduced—not just those in which natural gas was the means, but the overall number. **MM**

Joshua Stein, MD, is a psychiatrist and clinical director at PrairieCare—a University of Minnesota Medical School affiliate. He is president of the Minnesota Society of Child Adolescent Psychiatry.

QUESTION | PERSUADE | REFER

# Mindfulness in medicine

A way to improve physician well-being

BY BARBARA WINGATE, MD

Chances are you've heard the term "mindfulness," or heard references to mindful meditation. It's important for you to know practicing mindfulness is an easy way to achieve well-being and improve job satisfaction and patient care.

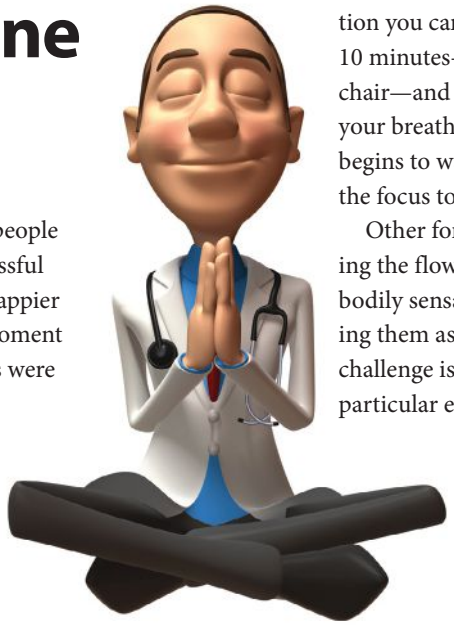
Although the origins of mindfulness are in Buddhist teaching, the recent popularity of mindfulness in the West is generally considered to have been initiated by Jon Kabat-Zinn, PhD, founder and former director of the Stress Reduction Clinic at the University of Massachusetts Medical Center.

Kabat-Zinn defines mindfulness as, "paying attention in a particular way, on purpose, in the present moment, nonjudgmentally." The purpose of mindfulness is to assist you in keeping your mind from wandering to distracting, worrisome thoughts that prevent you from being present in the moment and that may negatively impact mood and energy.

### Wandering vs. focused minds

According to a large-scale study conducted by Harvard psychologists, our minds wander more than half the time and this wandering significantly correlates with unhappiness. "No matter what people are doing, they are much less happy when their minds are wandering than when their minds are focused," say Daniel Gilbert and Mathew Killingsworth, authors of the study. The study also found people's negative moods appeared to be the result, rather than the cause, of a wandering mind.

A wandering mind can provide mental escape from extremely difficult or stressful situations and, for some individuals, it can serve a creative purpose. However, our minds often focus on laments related to past events and worries about the future; both tend to negatively impact mood. Gilbert and Killingworth also found that, for the most part, even if people were experiencing stressful situations, they were happier being present in the moment than when their minds were wandering.



If greater happiness isn't enough of an incentive, scientists have discovered mindfulness techniques help improve physical health in a number of ways. Mindfulness can help relieve stress, treat heart disease, lower blood pressure, reduce chronic pain, improve sleep and alleviate gastrointestinal difficulties.

### Benefits of mindfulness for physicians

Some research on the benefits of mindfulness specifically for the physician population found the following:

- Physician participation in a mindful communication program was associated with short-term and sustained improvements in well-being and attitudes associated with patient-centered care.
- Participating in an abbreviated mindfulness training course adapted for primary care clinicians was associated with reductions in indicators of job burnout, depression, anxiety and stress.
- Mindful physicians engage in more patient-centered communication and have more satisfied patients.

The key to success in gaining the benefits of mindfulness is regular practice, but the investment of time does not need to be significant. Even a brief, 10-minute daily practice can enhance well-being and functioning.

### Simple mindfulness meditation

The most basic form of mindfulness meditation involves finding a comfortable position you can maintain for at least 10 minutes—often sitting in a chair—and staying focused on your breathing. When the mind begins to wander, gently return the focus to your breath.

Other forms involve observing the flow of emotions and bodily sensations without judging them as good or bad. The challenge is not to latch onto a particular emotion or sensation, or to get caught in thinking about the past or the future. Instead, you observe and fully experience yourself in the moment.

There are a variety of opportunities for practicing informal mindfulness besides meditation. For busy medical practitioners, informal mindfulness practices provide a simple and effective way to manage stress and build resiliency.

### Informal mindfulness strategies

Tips to keep in mind:

- Take a few deep breaths from the diaphragm throughout your day, focusing on the flow of your breath.
- Spend time out in nature with focused attention on all that is around you.
- Pause before you move on to your next case and observe the sights and sounds surrounding you.
- Ask yourself what you are feeling a few times a day. You don't need to fix difficult feelings, just be aware of them.
- Take a brief walk and be aware of your feet carrying you and the sensations experienced by your feet as they move.

Whether you engage in a more structured mindfulness meditation practice or incorporate informal mindfulness practices into your day, the potential benefits are great. **MM**

Barbara Wingate, MD, is a physician peer coach at VITAL WorkLife, a national behavioral health consulting firm supporting all dimensions of well-being in the workplace. For more information, or to access additional tools designed to help organizational leaders support physician well-being, go to www.VITALWorkLife.com.

# Is the governor's Executive Order on COVID-19 disclosure good practice?

*During its May meeting, the MMA's Ethics and Medical-Legal Affairs Committee explored Governor Tim Walz's Executive Order 20-34, which provides for the disclosure of the addresses of COVID-positive individuals to first responders. Margaret Kelly, assistant commissioner of the Minnesota Department of Health (MDH), and Robin Benson, MDH interim general counsel, described how the Executive Order (EO) was being implemented. Committee members engaged in robust discussion about a number of issues, including patients' rights and the safety of first responders. While the committee ultimately decided to support the EO, there were many viewpoints expressed and concerns raised. Two committee members agreed to highlight their conflicting views on the EO.*

## YES

### *There are plenty of safeguards for individuals' privacy*

MARILYN PEITSO, MD

Executive Order 20-34, directs the Commissioner of Health to share information about COVID-19 positive test results with the Department of Public Safety, 911 dispatchers and first responders. In doing so, MDH must comply with the Minnesota Government Data Practices Act, which controls how the government collects, uses and discloses private health data to control or prevent the spread of disease. The Health Insurance Portability and Accountability Act (HIPAA) also allows sharing protected

## NO

### *It can't be applied equitably, efficaciously or effectively*

DAVID THORSON, MD

When I first heard of Governor Walz's executive order, I was stunned. The order fails to follow three important guidelines of public health and epidemiology policy. Furthermore, it does not make sense if we are worried about protecting first responders and limiting exposures.

Three principals of public health policy and epidemiology are equity, efficacy and effectiveness. Equity is the ability of a process to be applied across the population evenly. Efficacy is the ability

## YES *(continued)*

health information without authorization during a public emergency to first responders when the disclosure is needed to provide treatment, or to prevent or control the spread of disease.

Strict safeguards accompany these disclosures. Only very limited information is provided, just the address at which a positive patient resides, be it a private residence or long-term care facility, by encrypted transmission of a list which must be destroyed within eight hours. This information is not shared with other government agencies, such as U.S. Immigration and Customs Enforcement (ICE), and addresses are deleted from the list after the known contagious period. 911 dispatchers must screen all callers for COVID symptoms before using this information. First responders are told to assume that every household they encounter is positive for COVID, and the information is provided on an emergent need-to-know basis. Care cannot be delayed or refused due to COVID-positive status. In addition, although not specified in the order, MDH staff obtain permission to disclose the information from the positive patient for use only during the known contagious period, using Tennessen (privacy notice) language.

I walk you through the extensive safeguards provided for COVID positive patients to demonstrate the great care taken to protect individuals' privacy with EO 20-34. The order was thoroughly vetted with privacy protections in mind, but also considered the legitimate concerns of first responders on the front lines of the COVID 19 response. In a pandemic, ethical objectives call for attempts to promote systematic fairness. For those putting their lives and possibly the lives of their loved ones at risk by showing up to serve others in the course of their work, that principle of fairness is jeopardized in the conditions of chronic shortage and threat of shortage of adequate PPE. In dire pandemic circumstances, the principle of protecting the population's health and public safety can also be jeopardized if these workers are disproportionately affected by illness. The provision of available information about addresses where COVID-19 is known to be present, even if incomplete, is an attempt to add an extra layer of protection for first responders. To withhold this information, even if imperfect, is to make the perfect be the enemy of the good. With the limited testing and PPE available, especially in the earliest days of the COVID-19 pandemic, it is critically important to provide whatever protections we can to first responders.

Marilyn Peitso, MD, is a pediatrician with CentraCare Clinic in St. Cloud and president-elect of the MMA.

## NO *(continued)*

for the process to be implemented successfully in an ideal situation. Effectiveness relates to the ability to have the process work well across a wide range of situations.

The policy as described by Executive Order 20-34 cannot be applied across the COVID-19 positive population equitably because MDH does not get addresses from all positive patients and, based on my conversations with MDH representatives, in fact, does not even get the majority of the addresses; MDH only gets addresses of patients tested in outpatient settings. Positive cases identified in the workplace, emergency room and hospital are not linked to private addresses.

When first responders are dispatched, they are notified if the address houses a positive case, so the responders are aware of the exposure risk at the address. However, the first responders will be unable to trust the information due to the lack of a comprehensive list, as there are people who are not on the list but are COVID-19-positive. It is unknown whether possessing this information affects EMS response times. In addition, the potential for addresses to be released to ICE may prevent some populations from participating in community mass screenings for fear of ICE intervention, again affecting equity. The potential for law enforcement and ICE to obtain addresses of positive patients, allowing for the identification of undocumented immigrants, may prevent voluntary testing and therefore will not be equitable because of an inability to identify communities at risk for COVID-19 outbreaks.

In an ideal situation, the process developed by MDH would work to notify EMS of the addresses of COVID-19 positive persons in a timely way. However, this is far from an ideal scenario. The MDH process has not yielded home addresses for the majority of cases. The case investigators' requirement to give the Tennessen warning, a legal consent obtained by the state to explain who will have access to information, further delays and complicates the efficacy of the situation.

Consider the non-ideal environment in which we live and try to apply the MDH process to a widely varied population. Its ability to be effective is unlikely. Given the situation we are experiencing, where MDH knows only a minority of addresses and there are asymptomatic carriers, it is impossible for every address to be known, so no first responder should base their PPE use on whether an address has been listed as COVID-19 positive. Doing so would be both ineffective and potentially dangerous for all involved.

Since the executive order is not equitable, efficacious or effective, it should be rescinded. **MM**

David Thorson, MD, is in family practice with Entira Family Clinics in White Bear Lake.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Stuart Bloom plays the piano--and himself--with Eric Ringham as his inner voice in Bloom's play, "How to Avoid Burnout in 73 Minutes."

# FROM THE *stage* TO THE *clinic* AND BACK

## STUART BLOOM, MD, EXPLORES MEDICINE—AND BURNOUT—IN HIS PLAY

BY LINDA PICONE

The surprise isn't so much that Stuart Bloom, MD, a well-known Twin Cities oncologist, has written and acts in a play, with music. It's more that Stuart Bloom, an aspiring actor, comedian and composer, became a well-known Twin Cities oncologist.

"How to Avoid Burnout in 73 Minutes" has sold out every performance at Open Eye Theatre—including those this May that couldn't be presented because of the coronavirus pandemic. It's two-actor play with music, humor and pathos, focusing on what it means to be a physician today.

Not surprisingly, the play represents Bloom's somewhat unusual path to becoming a physician. "The show is me and about a dozen songs," Bloom says.

Bloom grew up in the Twin Cities and had, he says, "the most storied high school acting career ever. I really felt I was going to be rich and famous."

He went to college, then headed to New York City, where every aspiring actor and comedian hopes to make a splash. While there, he started writing songs in order to get more work and because "I've always written songs; it's kind of the way I journal."

And then he turned 30 and wasn't rich and famous. His father, a physician, was sick with stomach cancer. His wife was reading a book, *Love, Medicine and Miracles* by Bernie Siegel, MD, and Bloom read it as well. Although he says he looks at the book now and is a little embarrassed, the combination of a career that wasn't skyrocketing, his father's illness and the message of the book (basically, love and healing) got to Bloom.

"I thought maybe I should become an oncologist," he says. "My wife said, 'That makes sense.'"

It's just that he was missing a few prerequisites: he had never taken a pre-med course. He needed five classes to qualify for possible admittance to the University of Minnesota Medical School—easy stuff, like physics, organic chemistry and calculus.

Bloom tore into those classes and got straight As. He was 33 when he started medical school, 37 when he started residency. "When I started med school, there were 40 people over 30 there—and some were over 40," he says. "Some have had amazing careers, some haven't. But I think being older when you start med school makes you deeper. You engage your head, your heart, your energy, your soul. I'm so glad I got in."

Through medical school, residency, fellowship and practice, Bloom has been writing songs about what was going on in his life at the time; sometimes that was work, sometimes it was personal. About five years ago, he started wondering if what he had written might add up to a show. He wrote songs and narrative for a show on the way to and from his 60 and 70 hours per week as an oncologist. And so "How to Avoid Burnout in 73 Minutes" was born.

Bloom showed several versions of the show to various people, including former theater collaborators in New York City. "Every person I played stuff for, I thought, 'Huh, they have to say they like it.'" He says. "I just wasn't really sure what we had, but everybody said it was really good." It's a little Tom Lehrer, a little Randy Newman, a little Comden and Green, Bloom says.

He showed it to local director Peter Moore, who liked it immediately. Bloom

still wasn't sure what he had: "Is it a niche musical for medical people, or is it for the general public?"

He rented Open Eye Figure Theatre for a four-day run in late 2019 and got a production team together to see if there was an audience. The show sold out in two weeks, with about 350 to 400 people seeing it. "The audiences loved it from start to finish," Bloom says. "I thought maybe we did have something here."

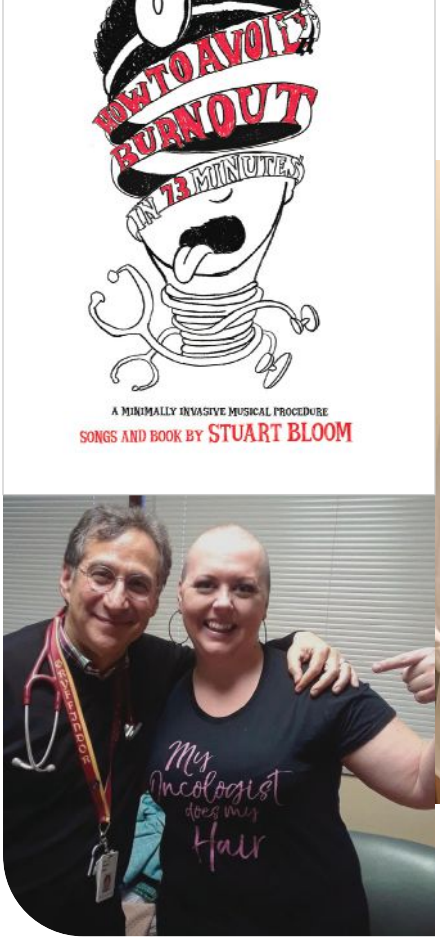
It was scheduled to be performed for several nights over a weekend in May this year—and sold out in less than a week. The pandemic meant those performances never happened, but Bloom is hoping he'll be able to put the show on sometime this fall. "One thing is for sure: the show does have a life," he says.

Bloom does all the singing, but longtime professional journalist and part-time performer Eric Ringham plays Bloom's inner voice. "Eric says he's the second actor in a one-person show," Bloom says.

Over the course of the play, the lead character—Bloom—gets deeper and deeper into both medicine and burnout. "Things keep coming at me, more and more, then we hear the sound of a pinball machine and then I'm on the floor, face down," he says.

But, not to spoil any surprises, the character Stu Bloom learns what the real-life Stuart Bloom has learned: "The way to avoid burnout is to realize that it matters. Every interaction with patients matters. We don't live in a cold, cynical nihilistic world."

Bloom says some nurses and physicians who have seen the play said they liked seeing what they do and what they confront every day on stage. "One nurse said, 'Thank you for reminding me of why we do this.'"








Stuart Bloom says he practices medicine in a personal way, spending time with each patient and getting to know them. Many have his personal cell phone number.

Bloom has no doubts about why he practices medicine. "What a privilege it is to do what I do," he says. "I practice in a personal way and spend a lot of time with each patient to get to know who they are."

He says he loves his patients—and they respond to that. Several years ago, a patient with metastatic breast cancer established the Shapiro-Bloom scholarship at the University of Minnesota, in gratitude for his care. "Things like that have happened to me," he says. "It's the universe telling me I'm doing the right thing."

That connection to patients—many have his cell phone number—has sometimes led other physicians to warn him about burning out. Despite his seemingly boundless energy, Bloom confronts the dark side of his practice as anyone would. So does his play. "The show gets dark; the pressure is there," he says. "Many of us who go into medicine and care about people find that the harder you work, the harder you work. If you do something well, people say, 'Well, do this now.' And you do that, and then it's 'Let's see what else you can do.'"

Although the kind of medicine Bloom practices is hard, he's more than up for it. All the time, it seems. His wife Carolyn has been with him since they met as teens at Jewish summer camp. "She married an actor and ended up with a doctor," he says. She's been a support through the lean years and the insanely busy years. Their three adult children all work in media and the arts. "When they were growing up, we always tried to make each other laugh," Bloom says.

The years of auditioning and scraping by in New York—the Blooms had two of their children while living there—haven't completely been superseded by 20 years as a practicing physician; it's more a matter of it all adding up to something special. "My lack of success as an actor and comedian has been replaced by this enormous success," Bloom says. **MM**

Linda Picone is editor of *Minnesota Medicine*.

# Ingenuity and effort in the face of COVID-19

## Physicians use creativity, leverage and hard work to help meet patient and social needs

*The world changed dramatically in March, almost overnight, and perhaps nowhere was it more changed than in the world of health care.*

*Every physician in Minnesota was impacted by the onset of the coronavirus pandemic. Some were essentially furloughed, some were suddenly overwhelmed—or preparing to be overwhelmed—by an influx of patients who might or might not have COVID-19. Many were faced with a shortage of PPE. Telemedicine was suddenly an important part of providing patient care. Medical students went to online learning. Surgeries were canceled, clinics shut their doors temporarily, patients—even some who needed regular care—stayed home rather than risking infection through a visit to a clinic. Drive-through test sites—even drive-through prenatal exams—popped up.*

*Physicians across the state adapted and innovated in ways that may have surprised even themselves in order to meet patient needs and perhaps find treatments for COVID-19.*

Minnesota Medicine *reached out to a number of physicians who were cited by their peers for their creative and dedicated work on COVID-19. Their comments show their insight and commitment to providing care.*

### RUTH LYNFIELD, MD

**State epidemiologist**

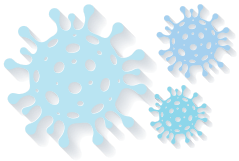
One could say I have prepared for this pandemic all my professional life, and yet how can one prepare for something so unprecedented? As an infectious disease physician, I respect the microbial world and I appreciate the fragile balance of health and disease. As an epidemiologist, I study the emergence of infectious diseases and help craft prevention and control measures. A pandemic by its very nature is overwhelming. It is merciless. It exposes flaws in our system and highlights disparities. The murder of George Floyd during this troubled time has demonstrated how much work needs to be done in establishing equity and equality. These are critical determinants of health in a population.

My work at MDH over the past two decades has taught me that training, study and expertise are useful, but not instrumental; the most effective prescription for a "wicked problem" is collaboration. A wicked problem is one that is difficult or impossible to solve because of incomplete knowledge and interconnectedness with many other challenges. I have never been more grateful to learn from colleagues and to share observations, to query stakeholders and to work with multidisciplinary teams, and to have so many dedicated partners and co-workers. Many things about this virus and this pandemic are unexpected. Humility, compassion and resilience are vital. Humility because there is so much we need to learn; compassion because the impact is so brutal on so many, and resilience because the work and stress are relentless. We can and we must collaborate and solve this wicked problem together—our communities and our grandchildren's communities are depending on us.

### ROSE MARIE LESLIE, MD

**Family medicine resident, University of Minnesota**

*Leslie has been creating lively videos on the social media platform TikTok to educate young people about COVID-19. Her videos can be very personal and often humorous, but they also pass along important information. Check them out at drleslie on TikTok.*

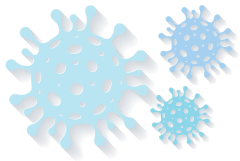


## JOSHUA THOMPSON, MD

**Mill City Clinic**

The pandemic has been incredibly disruptive to so many lives: for our patients, our doctors in training, and our entire health system. I have had the opportunity to be a part of an impressive effort by the University of Minnesota and M Health Fairview to offset some of that disruption. At the start of the pandemic in Minnesota, a few forward-thinking individuals rapidly created a network of telehealth systems to continue essential patient care and corresponding electives for our residents and medical students to learn about these systems and how to deliver high-quality care virtually. I was brought on as a faculty lead for the electives and have been working to keep them going ever since.

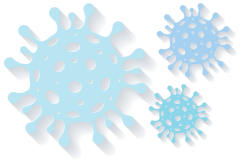
One of the new telehealth systems of which I am particularly proud is our GetWell Loop program. Originally conceived as a tool for post-operative monitoring, it was redesigned to monitor patients with presumed COVID-19 quarantined at home. The program provides patients with information about COVID-19, checks in on their symptoms each day and allows them to reach out any time with questions and concerns. It is currently staffed during the day almost exclusively with medical students, nurse practitioner students and residents, under appropriate supervision. Students are happy to be back interacting with patients and practicing their clinical assessments. Patients are overwhelmingly satisfied with the service and the additional support it provides. Finding innovative ways like this to engage learners and care for our patients is one of the positive things I have found to come out of the tragedy of this pandemic.



## LAURA BREEHER, MD

**Occupational health services medical director, Mayo Clinic**

*Breeher was one of several researchers at Mayo Clinic who integrated several digital tools into the electronic health record to identify staff members who may have come in contact with coronavirus or who tested positive for the virus. The new tool allowed Mayo Clinic to identify clinicians who might be at risk of developing COVID-19 within hours, rather than several days.*



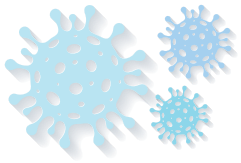
## BRIONN TONKIN, MD

**Physical Medicine & Rehabilitation director at University of Minnesota**

Like most physicians, my world was turned on its head as the novel SARS-coronavirus 19 stormed into America as a global pandemic. In a matter of days, decisions were made at the highest levels of the health systems in the twin cities to shut down non-essential patient operations. Among all the changes that came with that, there were many physicians who suddenly had no patients to see, an entirely foreign concept to the practicing clinicians who spend the vast majority of their week providing care for people and the tasks associated with that.

With "nothing" to do, we had time to watch the developments of the virus as it battered the East Coast. It quickly became apparent that many of these patients who would survive their severe illness were not able to go home, as they were too weak to walk and certainly couldn't care for themselves. There were other concerns about their ability to infect family members and caregivers who might provide help at home. As a specialist in physical medicine and rehabilitation, this was what we are trained to do.

At the Minneapolis VA Medical Center, work began to reduce the number of patients in the hospital to create capacity; into some of this empty space we started to work on the COVID Rehabilitation Unit (CRU). This turned out to be the creation of an entirely new rehabilitation unit, since it could not use the same space, staff, equipment, etc. from our standard rehab unit. We allocated a separate team of therapists, designated physicians to work in this unit, moved in new equipment and sealed off the unit as an extension of other "hot" (or COVID +) units. We are fortunate to have some forward-thinking leaders in the rehab department at our facility and we were the first VA in the country and the first spot in the Twin Cities to stand up a dedicated unit and begin taking patients on April 22, just a little over a month from the initial shutdown. We have discharged over a dozen patients now that were severely affected enough to require rehab. Rehabilitation is a team effort and this is no exception but special thanks to doctors Mike Armstrong and Larisa Kusar, as well as lead therapist Alisha Beckett for their efforts on the leadership team.



## JOHN HICK, MD, HCMC

I became involved in disaster response and EMS during my EMS fellowship at HCMC and, as faculty, took on the role of Medical Director for Emergency Preparedness as well as getting involved with a metro-area Metropolitan Medical Response System federal grant that was instrumental in getting EMS and hospitals to work together with emergency management and public health. Following 9-11 we moved ahead locally with one of the first hospital disaster compacts in the nation and I worked part-time for MDH until 2014 as a medical advisor for the federal Hospital Preparedness Program (HPP). In 2014 I started working for HHS/ASPR with the HPP program and helped develop the ASPR TRACIE preparedness website. So, when the pandemic started I was asked to engage to help work with our eight regional healthcare coalitions and the Minnesota Hospital Association and MDH to help implement an effective health care response to COVID-19.

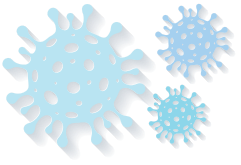
It's been gratifying to see the systems and relationships that have been built over the last 20 years paying off and seeing both public and private partners pulling together to try to solve problems together. This virus is a challenge, a shape-shifter that we weren't ready for and don't have a lot of precedent to fall back on. Our biggest challenge is staffing—we just need more qualified nurses in particular—and I hope that we'll both devote more attention to long-term solutions and also re-invent strategies to use their skills better on a daily basis and in disasters.

We're trying to learn as much as we can as fast as we can. I hope that we continue to fill some of the gaps in our knowledge about antivirals and perhaps this will drive us to improve in several areas; we need to develop better and scalable testing methods, figure out better how to use the data available in electronic health records to more rapidly define treatment strategies and prognosis and develop, test, and produce vaccines.

We did not learn our lesson from 2009 H1N1 about the need to re-think respirators for health care workers and it is costing us in time, money and lives. We have to do better; we need to dedicate ourselves to inventing better respiratory protection.

Finally, you can't have a successful response without a prepared public and private sector. Minnesota is better off than most states, but we need to keep supporting hospitals and public health to build capacity. We need clear expectations at the hospital, state and federal level and transparent goals and benchmarks that we all can work towards.

I'm worried about our next year for many things—winter outbreaks that could be at least as bad as this summer, continued shortages of PPE, etc.—but I'm hopeful that we can come out of this with more focused priorities and a recognition of how the humanity of medical practice is important no matter how technologically advanced we become. In the end, it comes down to the providers and the patients … and doing the absolute best that we can with both our hearts and our heads.

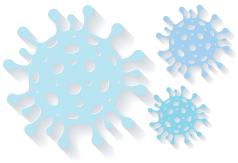


## MN COVIDSITTERS

*A group of medical students at the University of Minnesota created MN COVIDsitters (mncovidsitters.org) to support health care workers in the Twin Cities with free childcare, pet-sitting and household errands. Although the board of the organization is made up of medical students, other students from Twin Cities colleges and universities also volunteered their time.*

*Any health care worker, from physicians to cafeteria workers and cleaning crew to people working overtime to produce PPE and ventilators, could request free help. MN COVIDsitters did background checks on all student volunteers, many of whom already had CPR training.*

If you have an anecdote about what COVID-19 has meant to your practice, or if you want to recommend another physician for us to talk to, contact Linda Picone, editor, at lpicone@mnmed.org or 612-669-0623.

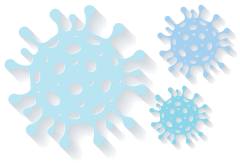


## RAHUL KORANNE, MD

**Head of Minnesota Hospital Association**

I am proud of Minnesota's hospitals and health systems, which have come together over the past four months to prepare for and treat COVID-19 patients across our state while ensuring the health of our communities and protecting the health and safety of our front-line care team members. We are grateful for our partnership with the governor, the congressional delegation, the Minnesota Department of Health and emergency preparedness structures in all regions of the state for an incredible amount of work to prepare for a surge and hot spots of COVID-19 patients.

Our collective top priority remains having the spaces, staff and supplies necessary in our hospitals and health systems to continue to provide high-quality care to all of our patients and fully support our care team members. Our success in caring for patients in our hospitals and in our systems depends on our nurses, physicians, respiratory therapists, environmental services workers and the whole care team feeling supported. Hospitals and health systems will continue to do our part—caring for the patients and communities we serve.



## JOHN GOEPPINGER, MD

**Retired**

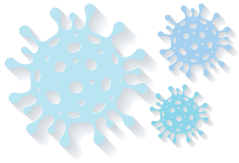
*Goeppinger was one of a number of retired physicians who offered to help with health care in ways that did not place them at risk for contracting COVID-19.*

I have worked for the Care Clinic since its inception. We just celebrated our 10-year anniversary. Julie Malyon, RN, deserves accolades for her work in developing the free clinic to serve the county's underserved.

I was scheduled to work the evening of April 9. I learned that those over 65 were considered "high risk."

What to do?

I told Julie I would be onsite but remain in my car. I could fulfill the requirement that a licensed physician be on site, but not actively care for patients. Julie thought this was "creative." There were only several patients that evening. I signed a few prescriptions and consulted on a patient.



## PAUL ERICKSON, MD

**Northpoint Clinic**

We've always had a food shelf here at Northpoint, but our demand has increased dramatically during the pandemic. During the first few months of the pandemic, we saw a 70 percent increase in the demand for food. Our normal operations of providing a choice shopping experience had to be suspended and moved to a pre-packed model that provides staples like beens and rice, and also provides meat, dairy and fresh vegetables and fruit, based on family size. Our mobile food shelf provides the same pre-packaged options as the food shelf to seniors and those with limited mobility at six locations on the North Minneapolis area. Most of our food comes from Second Harvest Heartland and the Food Group—dollars are by far the best way to donate. With the pandemic, we adjusted our human resource model as well, redeploying staff to the food shelf as we suspended the use of volunteers for safety due to the pandemic. As the COVID-19 restrictions are changing, so will our operational models, with the hope of bringing volunteers back and providing some choice options for those who visit our food shelf. Our ultimate goal is to continue to provide healthy food access to the community. Our mission is partnering to create a healthier community. We have a human services department that exists to address some of the social determinants of health. The community that we serve is a very diverse. Many of the folks are challenged economically. With the pandemic, people were losing their work and their source of income, putting them at risk of losing their homes. Food is essential.

North Minneapolis is essentially a food desert. We had one grocery store that is now closed because of protests and riots after the death of George Floyd.

We also initiated a drive-up clinic for COVID testing to serve the North Minneapolis community. We've tested over 2,000 patients and have a relatively high positivity rate, with significant racial and ethnic disparities. MM

# LIVING —and writing— HISTORY

## Ben Trappey, MD, devoted weeks to treating patients at Minnesota's first COVID-only hospital

BY SUZY FRISCH

As a novel coronavirus started making an appearance in Minnesota, M Health Fairview transformed its Bethesda Hospital into the state's first facility solely for people with COVID-19. Ben Trappey, MD, signed up to be a part of that history in the making. He treated the first patient to arrive on March 26, and he ultimately discharged the same man—the first to be released from the St. Paul hospital. "That is definitely a patient I will not forget," he says.

Trappey is normally an internal medicine-pediatric hospitalist at M Health Fairview University of Minnesota Medical Center in Minneapolis. But as conferences, workshops and other commitments were canceled for his work as an assistant professor of internal medicine and pediatrics, he suddenly found himself with more unscheduled time than planned.

He had other reasons to volunteer at Bethesda. His wife is pregnant and due in the fall, so he wanted to take extra precautions and isolate himself from her. By working at a hospital devoted solely to the treatment of COVID-19 patients, Trappey could take shifts for three weeks while staying in a nearby hotel, then quarantine himself for two weeks to make sure he wasn't infected before heading home. After three weeks off, he returned to Bethesda for another three-week stint in May.

The days leading up to his first shift at the 90-bed hospital were uneasy for Trappey. He didn't know what to expect and he was unsure whether he'd feel safe. Would there be enough personal protective equipment (PPE)? "It was a little nerve-wracking at first," he says. "Because it was uncertain, there was anxiety about not knowing what it was going to be like. How protected would we be and how secure would we feel in that protection? But once I got there, I actually felt very safe."

Paradoxically, one thing that reassured Trappey was knowing that every patient at Bethesda has COVID. It takes away the guesswork, prompting the medical staff to wear protective gear every time they see patients. "At Bethesda, you protect yourself during every patient encounter," Trappey says.

### Writing through it

At the University of Minnesota, Trappey belongs to a group of physicians and residents who meet monthly to work on their writing. He is a fan of narrative medicine, viewing every encounter with patients as a story and a chance to learn about them. "As providers, being interested in their stories helps you to be a better doctor. It reminds me to listen in a way that I might not otherwise and get to know the patient a little bit more, on a personal level," he says.

"When something is bothering me or my mind is full, I feel compelled to write. If I have something in my head, I can't get it out until it's on the page. That act of smoothing it out into something beautiful helps my mind take the sharp edges off what I'm feeling."

As a medical student at Vanderbilt University, Trappey spent the summer between his first and second years honing his writing with a poet at the school—a new experience for him. He continued writing throughout medical school, including an unfinished novel. He was especially drawn to the University of Minnesota's med-peds residency, a decision that was cemented when it became clear that his passion for writing would be accepted and supported.

When he faces a stressful experience, Trappey turns to writing. It's a comfort that regularly helps him process the experiences and emotions that unfold from his life as a physician. He is a lifelong writer who uses the craft to deal with things that bother him, to connect with patients and then to build on that connection and insight to become a better doctor. He wrote a few blog posts about the coming tsunami of COVID patients and his fears about how the virus would affect him and oth-

PHOTO COURTESY OF BEN TRAPPEY, MD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ers working at Bethesda. He anticipated continuing to write while working at the COVID hospital, but as the hospital got busier in May, he just didn't have the time or energy after working 11-hour shifts with few days off.

Currently, Trappey, with Jon Hallberg, MD, and Maren Olson, MD, MPH, manages the blog, "Artistic Antidote to COVID-19" (https://clinicalaffairs.umn.edu/artistic-antidote), an effort by the Medical School's Center for the Art of Medicine to offer a refuge and an outlet for posting prose, poems, music or visual art. Trappey is one of the Center's coordinators and a core faculty member for the med-peds residency program.

Eventually, Trappey will help expand the Medical School's program for storytelling in medicine. For several years, he has been helping medical students and others use reflective writing to guide them through the process of becoming and working as a physician.

Trappey also is working on a second novel, a fantasy-ish story set in the swamps of his native Louisiana. With another physician, he's writing an article about COVID and what the disease reveals about our health care system, bringing in his experience with discharging patients who are on the road to recovery from COVID.

"A lot of hospitals are doing some sort of celebration, and we feel like it's a necessary thing in a way it wasn't before," Trappey says. "COVID makes us more mindful of the fact that modern medicine is a miracle, and we take that for granted. Because we're in this state of shock and uncertainty, it's stripped away that these routine things [like recovering] aren't as routine as we let them seem."

## Fully protected

Celebrating the discharge of patients is one of Trappey's favorite parts about working at Bethesda. He feels fortunate that M Health Fairview was able to design the hospital for COVID patients from the ground up. A robust ICU wing with experienced caregivers was prepared to treat the sickest of the sick, and there was enough needed PPE.

Ben Trappey, MD, turns to writing as a way to reflect his experiences and his thoughts.

As physicians learned more about how to effectively treat people with COVID, the Bethesda team adapted protocols and medications accordingly. And when patients got sick enough to require a ventilator, critical care and other ICU specialists took over. "I didn't have to practice outside of what I felt comfortable doing," Trappey says. "Dealing with COVID is providing really good supportive care, which we are already good at. It feels like practicing normal medicine with a lot more protective equipment."

That gear—so vital for keeping staff safe from the virus—does change the way that clinicians practice. Before, Trappey might pop into patients' rooms to ask a question or chat with them after rounds. Aiming to limit visits to preserve PPE, caregivers now consolidate trips into patients' rooms or communicate with them via an iPad when they can.

"The threshold for entering the room is different," Trappey says. "You don't want to use more gowns and gloves per day than you have to because there is a shortage of everything. But medicine is still medicine and you do what needs to be done."

"The scarcity of PPE makes every encounter seem a little more precious, and I find myself a little more present than I might have been in the past," he says.

Health care professionals from across the M Health Fairview system staff Bethesda, giving Trappey new colleagues to meet and learn from. Each hospital has its own way of doing things, and Trappey finds it useful to see other effective approaches or protocols in action.

His three weeks at Bethesda went so well, he volunteered for another three-week stint in May and is considering returning again in the summer. Though it was hard to be away from his wife, especially during her pregnancy, the couple found ways to see each other from a distance. Trappey also is relieved that he hasn't faced one of his biggest fears: needing to ration care for patients.

"It speaks to the system and our leadership [at M Health Fairview]. We had everything we needed and felt very supported. It really was less stressful than we thought it was going to be," Trappey says. "We're fortunate to be in Minnesota; the leadership at the state level has been great and we did a good job of delaying 'the surge,' although ultimately we may be hit harder than I first thought." **MM**

Suzy Frisch is a Twin Cities freelance writer.

Minnesota Medical Association

**ONLINE COURSE**

# Best Practices for Prescribing Opioids

## *AND OTHER CONTROLLED SUBSTANCES*

***You need to earn 2 CME credits to fulfill the legislative mandate.*** Where better to turn than the Minnesota Medical Association, the state's largest physician advocacy organization?

During the 2019 session, the Minnesota Legislature passed a law that requires individuals with licenses with the authority to prescribe controlled substances to obtain CME on best practices in prescribing opioids and controlled substances.

To help physicians comply with this mandate, the MMA has developed an online, self-assessment activity that includes content on best practices in prescribing opioids as well as non-pharmacological and implantable device alternatives for treatment of pain and ongoing pain management.

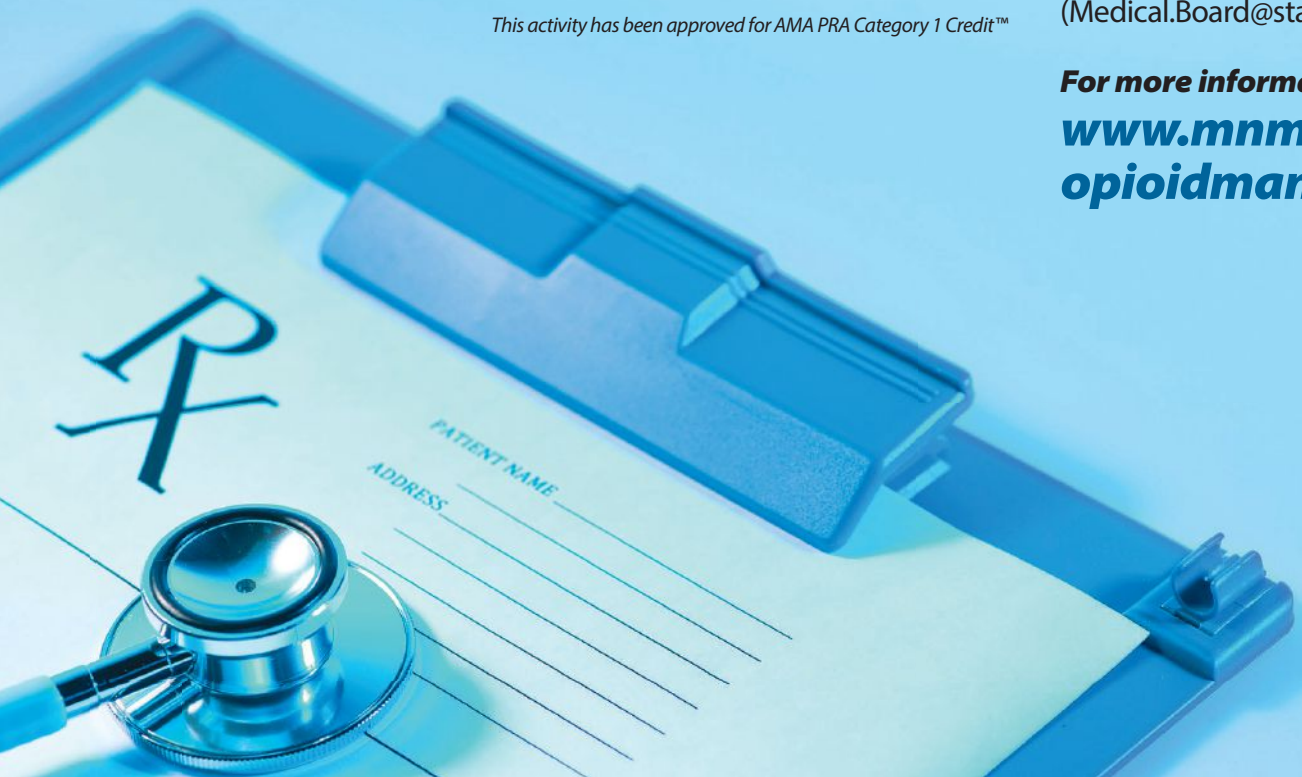
*This activity has been approved for AMA PRA Category 1 Credit™*

***Cost***
MMA members are free, others pay $60.

***Questions on the activity?***
Email the MMA (cme@mnmed.org)

***Questions about the mandate and how to provide documentation of course completion?***
Email the Minnesota Board of Medical Practice (Medical.Board@state.mn.us)

***For more information, visit***
***www.mnmed.org/opioidmandate***



# PUTTING A PANDEMIC INTO WORDS

The pandemic and the changes it's caused in everything from daily life to medical care are the source of reflection and writing for many physicians. *Minnesota Medicine* readers offer their thoughts.

## Medical school—from a distance—during COVID

BY KATE HANSON

In September 2019, I started my third-year clinical rotations. After about a week of anxiously trying to piece together perfect presentations and come up with perfect diagnoses—I had a couple of realizations. (1) I couldn't do either of those things very well. (2) Those things were not my only job. In fact, I think as students, many of us take on other roles. We spend a little more time getting a patient history. We make a call to the family. We grab an extra blanket or we keep a pen handy. We try to find ways to add value and be a part of the team.

Cut to March 2020. I was standing in the operating room when a doctor entered and politely told me I could leave. The University of Minnesota had pulled all medical students from rotations due to COVID-19. I stepped out of the OR to check my email and was disappointed to read my rotation would be over at the end of the week. Medical students have been removed from direct patient contact since then, with hopes to return before the fall but no certain timeline.

Now, our courses are online and virtual; we spend lots of time in Zoom lectures, often with our kids and pets crawling into the frame. At the same time, we are still expected to take exams that are now remotely proctored, requiring us to learn how to take tests in our own homes or to make other accommodations. USMLE Step 1 and 2 exams have had unpredictable and repeated cancellations, causing confusion and sending many of us into testing limbo without clear rescheduling. We also are waiting to see what will become of the USMLE Step 2 Clinical Skills exam, which has been suspended at this time.

Rising fourth-year students are juggling the ramifications on the impending residency application process. Per the recommendations from the Coalition for Physician Accountability, we are expecting the interview process will be conducted virtually, which feels like the equivalent of buying a house sight-unseen. Under those same recommendations, most of us will be unable to attend away rotations. This means difficulty in obtaining letters of recommendation or even demonstrating interest in specific programs or areas of the country. On top of that, the entire Match process will be delayed this year. In a time usually full of transitions and unknowns, COVID has only amplified students' concerns.

Beyond those practical struggles, it has been easy to feel disconnected from medical training—removed from our place on the team. We can't do those little things that make up the medical student job when we aren't actually there. However, as a result, we've seen some pretty amazing responses from medical students, finding new ways to add value and be part of the medical community. The student-led Minnesota COVIDSitters pulled together a band of students ready to take on childcare and other needs of health care workers. Students have jumped into efforts to gather personal protective equipment and pioneered student participation in the Minnesota Department of Health's contact tracing. Others have worked to support each other, contributing their voices to the school's COVID Action Panel. Our school also has created COVID-specific courses, allowing us to learn about the changes in telemedicine and media.

As a student, I know that when I return, there will be so much more to learn. As I watch the incredible efforts of the medical community, I think I speak on behalf of all of us that we will be excited to rejoin that community when it is safe and appropriate to do so. Until then, we will be Zooming and studying and learning to be members of the team from afar.

Kate Hanson is a fourth-year MD/JD student at the University of Minnesota Medical School, Twin Cities campus.

# Justice in a pandemic

BY KELLIE LEASE STECHER, MD

I've been told my whole life that it takes all kinds of people to make the world go around. In my inexperienced mind, I believed no one would go through the trenches to become a physician or work in health care unless they had an overwhelming desire to help people. To me, medicine was a calling. During the most recent battle with COVID-19, and now, in the handling of a racial injustice, I again find myself in the trenches. I began to wonder why? Why aren't more people willing to fight to protect others?

This virus has shed light on disparities that exist in the world today. We have seen strong international divides as to how the pandemic was handled. We have become more aware of race, gender and socioeconomic challenges facing people when it comes to the ability to obtain care and testing. For me, it also has shown the huge discrepancy between people who are willing to fight for what's right and people who will hide from the storm. Why is the majority able to let the minority shoulder the work and responsibility of fixing our country and our health care culture?

Over the last couple of months, we have seen the politicizing of a medical issue. There should be no question about whether this is a credible threat to the safety of our citizens. As a physician I have been reading the cases, research and literature from around the world. I have tried to learn everything I can about this virus to better care for our community.

In medical school, we take an oath. Lately, the relevance of this oath has been questioned. For most of us, I think the oath's truths still hold. It is an ethical duty that binds us to a profession that used to be viewed as noble and selfless. In the first Hippocratic oath is the phrase, "*primum non nocere.*" This is where we were taught "first, do no harm." In its current form, I swore to "prevent disease whenever I can, for prevention is preferable to cure." I vowed to maintain our "special obligations to all my fellow human beings, those sound of mind and body as well as the infirm."

When I stood in my medical school honors society and stated this oath, I drank it in. It was my duty to uphold it. Medicine and the military have always been hierarchical systems rooted in duty. In both systems, we feel an enormous responsibility to protect those below us in rank. What happens when the people at the top stop fighting for what is safest? What happens when these systems fail? If we don't feel responsibility to each other, the entire fabric degrades.

Over the last two years, I have heard the expression, "a fish rots from the head down," to describe situations related to health care, politics and the military. I have merged these establishments for this discussion because right now we are fighting a war and the commander in chief is in charge of all our fates. Captain Brett E. Crozier, former commander of the aircraft carrier Theodore Roosevelt, is in many ways symbolic of all of us in health care. He had data, he knew his crew was going to get infected. His hierarchy, steeped in tradition, was failing him. He had to choose between his career and his sailors' safety and he chose the latter, making his concerns public. For that, he was removed from his command and his ship. Sadly, health care professionals speaking out about conditions sometimes meet the same fate. Physicians have been terminated or reprimanded for speaking out about the climate that they work in. Why are we so afraid of hurting our reputations that we are willing to sacrifice the most valuable part of life, our brothers and sisters, our partners, our comrades?

We need to get mad and we need to stand up for what is right. If we can't stand together now we may as well lay down our masks and surrender. A life in which we don't fight to protect each other is a life not worth living. We need to come together during this time and learn to trust again, be vulnerable and forgive each other. Unfortunately, you can't legislate peoples' minds and hearts. There needs to be a cultural reformation to fix the underlying problems.

To my health care worker colleagues: "Take courage, my heart: you have seen through worse than this. Be strong, saith my heart; I am a soldier ... (The Odyssey)." We are on this journey together. We need to lead by example, however hard that is, and whatever consequences that brings.

Kellie Lease Stecher, MD, is an OB/GYN

# Life with COVID: A tale of two cities

BY SIU-HIN WAN, MD

During the first week of March, I traveled to Arizona for the onset of my away rotation in transplant cardiology. At that time, the RNA virus from the coronavirus family had just claimed its first fatality in the United States in Washington state. COVID affected very few people directly in early March but, over the course of a couple of weeks, cases were announced across the country. By mid- to late-March, announcements were made to lock down states. Arizona at that time had very few cases of the virus, and there were certainly discrepancies and disagreements on the severity of restrictions required for social distancing. First, museums closed. Then restaurants. Golf courses and beauty salons remained open early on. Denial turned to reluctance then eventually to frustration and fear.

Due to the relatively low case count in Arizona, compared to the rest of the country, coupled with wonderful spring weather, people enjoyed the outdoors, so much so that trails and parks became crowded and congested, requiring further clampdown on social distancing. While most people tried to maintain social distancing and were respectful, mask usage was extremely rare. I encountered restaurant owners and small business workers who were quite friendly, yet frustrated, afraid that employees would have to be let go. Many tried to be creative: if the government allowed no more than 10 people to gather, then businesses would only allow a maximum of nine people at a time. Instead of in-person group activities, businesses offered take-home kits or even home delivery of goods, services and food.

I was scheduled to fly home the first week of April, but there was great uncertainty due to flight schedules and cancellations. When I went to the Phoenix airport the first week of April, Sky Harbor was an eerie site. The car rental areas were straight out of a zombie film: cars everywhere but not a single person to be seen, contrary to what it had been just four weeks earlier. The flight board was almost completely red, signaling the majority of flights being cancelled. The family near me in line said that they drove from Tucson to catch a flight, because their flight out of there was cancelled. Airport shops and restaurants were all closed. Surprisingly, the flight was more full than I expected, approximately half capacity, perhaps due to all the cancellations.

I was glad to be back home in Minnesota, but the Minneapolis-St. Paul airport was just as quiet as Phoenix on a weekend afternoon, like nothing I remembered seeing before. Perhaps due to the perceived greater density of Minneapolis-St. Paul, or due to more aggressive social distancing measures, or just due to the fact that several weeks have gone by since early March, I noticed a significantly greater use of masks in public. The highways were much less crowded than I had seen in Arizona. In early April, Minnesota hospitals remained at a very low capacity, likely due to the combination of restricted travel as well as fear of going to a health care facility. When I left Minnesota the first week of March, life for the most part was normal. The severity in change in environment over just a month spoke to the rapidity of COVID spread.

The whole ordeal still feels unreal. Over a period of three weeks, in two different states, life changed from normal to what could only be described as seeming like an Armageddon movie scene. Yet in both Arizona and Minnesota, the crisis and pandemic has brought people together and, most importantly, reminded us of our humanity and what the priorities are in life.

Siu-Hin Wan, MD, is a fellow in Advanced Heart Failure and Transplant Cardiology, Department of Cardiovascular Diseases, Mayo Clinic.

# The distance between

BY YU-HUI HUANG

**I no longer know how to comfort,**
**The touch once so powerful now frowned upon**
**In fear of contracting or spreading COVID-19.**
**We all keep our distance**
**Out of safety, respect, and fear.**
**When the tears run down my patient's face,**
**I consciously restrain my hands to myself**
**And cautiously nudge the box of tissue,**
**Allowing only our gaze to meet**
**With my eyes being the only feature visible**
**Just beyond the shield on my face.**
**There lies so much pain within those eyes**
**Yet I can only observe them from afar**
**And hope the box of tissue can keep them at bay.**

Yu-Hui Huang, MD, is a transitional-year resident at HCMC, to be followed by radiology at the University of Minnesota Medical School.

# Take care of yourself

*So you can continue caring for others*

## Up to 40 percent of physicians report symptoms of burnout.

The cause of burnout is complex — structural complexities in U.S. health care, workplace demands and constraints, and personal stressors. In addition to the personal toll, burnout can also harm patient care.

The MMA advocates to make Minnesota the best place to practice medicine. And to help support the personal well-being of physicians, **the MMA has partnered with Heartwood Healing to offer physicians and trainees the Heartwood Self-Mastery Program** — evidence-based tools and strategies to prevent and manage stress and help you reconnect to your purpose.

The program, consisting of a series of short videos, downloadable audio recordings and tools, will help physicians and physicians-in-training enhance their inner strength and design a life of fulfillment. **The course includes 15.75 CME credits.**

## START TODAY!

## Visit www.mnmed.org/heartwood

*MMA members receive a 20 percent discount on the course.*

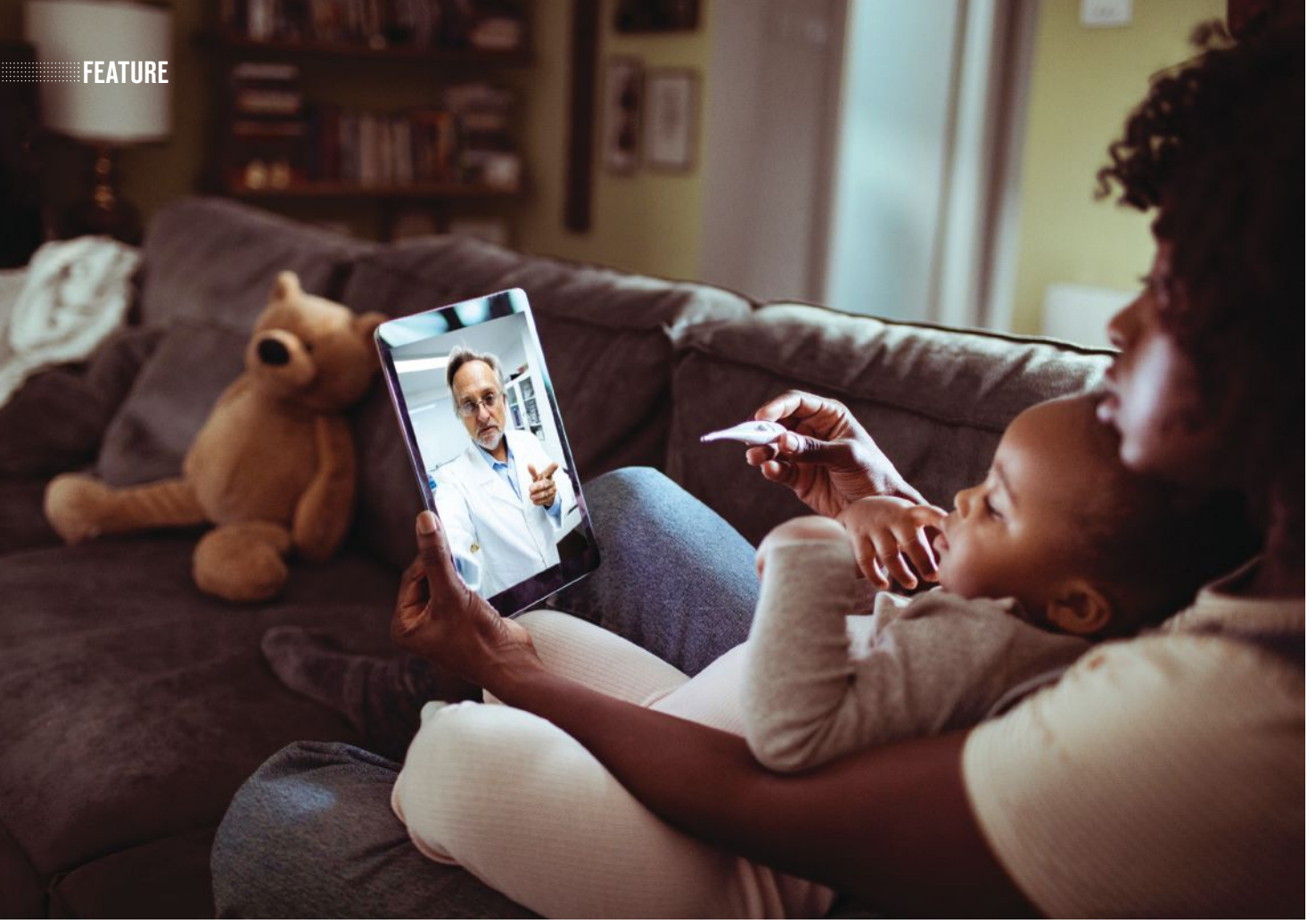
*This activity has been approved for AMA PRA Category 1 Credit™*

**ABOUT HEARTWOOD HEALING**

Heartwood Healing, founded by Jacquelyn Fletcher Johnson, is an education, training and coaching organization that creates ways to help businesses whose people are experiencing high levels of stress, facing burnout and compassion fatigue, or other challenges. Heartwood Healing's techniques provide people with access points to their inner core of strength and resilience so they can create sustainable health and well-being.

HEARTWOOD HEALING

MINNESOTA MEDICAL ASSOCIATION



TELEHEALTH

# COVID-19 quickly changed physician-patient interactions

BY JACK EL-HAI

"There's no question," says Jon Hallberg, MD, medical director of the University of Minnesota Physicians Mill City Clinic in Minneapolis, "this is a tipping point."

Before the COVID-19 pandemic swept Minnesota, starting in March, telehealth technologies—the use of virtual medical visits with patients on the phone, videoconferencing, mobile sensors and online text-based applications—were plodding ahead in the state, advancing slowly. They had been doing so since the introduction of telemedicine decades ago to bring medical care to isolated and rural areas.

As patients stayed home and medical facilities tried to protect their staffs, COVID-19 instantly accelerated the adoption of telehealth. "The pandemic has forced us to make changes and make changes very quickly," Hallberg observes. Telehealth visits in Minnesota climbed from 1,100 per day before the pandemic to 15,000 per day in late April. Zipnosis, a Minnesota-based provider of telehealth technology, saw a 3,600-percent increase in the use of its platform in the first few weeks of the pandemic. Allina Health, which operates clinics and hospitals throughout Minnesota, used to conduct less than 1 percent of its appointments online; during the pandemic it has consulted with more than 60 percent of its patients virtually.

At the same time, the federal government relaxed restrictions on telehealth in the Medicare program and temporarily waived enforcement of HIPAA. The expansion of telehealth is sure to further increase, with agencies like the Federal Communications Commission giving Mayo Clinic Health System and other health care organizations seven-figure grants to expand their use of videoconferencing and remote patient monitoring to fight COVID-19.

**A change in course**

Not only has the velocity of the adoption of telehealth increased, the course of the technology's evolution has curved. No longer a benefit just for patients too far away from doctors or otherwise unable to make it for an in-person visit, telehealth is leading Minnesota physicians, medical institutions and payers to reshape relationships with patients.

After the pandemic, there will likely be fewer face-to-face meetings between physicians and patients, more medical measurements and tests done at home and more people communicating with their

## VIRTUAL VISITS

# *A cure for physician burnout?*

BY SALLY BERRYMAN, MD, FACP

While there certainly are challenges to practicing outpatient medicine during the COVID-19 pandemic, the rise of virtual visits has personally reduced my level of burnout dramatically.

**Clinic hours are far more reasonable: 8am to 4pm, as opposed to 7am to 7pm**, Monday through Friday, and 8am to noon on Saturdays. I can sleep more, and I don't wake with morning dread. There is a relaxing start to my day, including breakfast, coffee and prepping to look somewhat presentable. No more watching the clock while I try to fight traffic and find parking on my way to work. I don't have to change into winter or rain gear. I can say "good morning" to my family. There is more time for my dog's morning routine (short walk, food, water and affection). He can hang out on the couch instead of his kennel while I work. I can wear a comfy sweater instead of a stiff white coat.

**I can sit where I want to, and I have more work space** (a whole table to myself, as opposed to 3 feet of a shared counter top). For the first time ever, ergonometrics have been applied to my work station. My work area is spacious and quiet. I have windows where I can look out and see trees, birds and people strolling by. I can open the windows for fresh air and there is natural lighting.

**I remain on time to "see" my patients throughout the day.** While video conferencing, I can face my patients and my computer at the same time. This allows me to type a note throughout the visit and more readily find pertinent information in the electronic records. Telephone conferencing also frees up my hands for typing and for navigating electronic records.

**There is no need for a patient to travel to clinic, find parking, wait in line to get checked in, and wait to be roomed.** There is no competition for exam rooms, and I no longer have to wait for rooming staff to complete their portion of the visit. Interpreters are a phone call away.

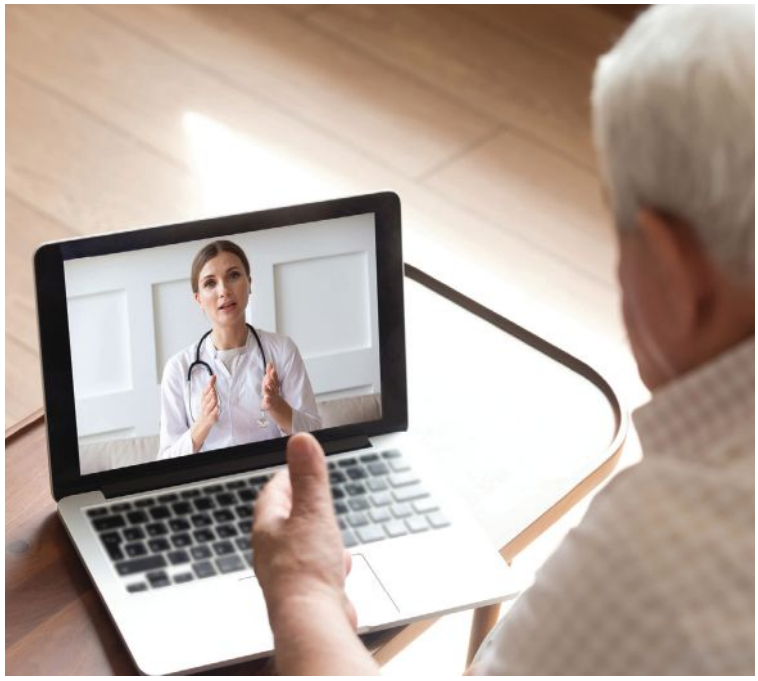
**There are far fewer interruptions** while I am working. I can eat and drink where I work. I can use a clean bathroom, shared only by my family and me.

**Despite having the same number of patients on my schedule, I spend less time after clinic working on "paperwork."** I have more time to work on other professional activities, like advocacy for virtual visit reimbursement parity with face-to-face encounters.

No exercise, healthy diet, mindfulness, wellness apps or programs can substitute for a quiet day that allows for more control of how I tackle my life and work demands. I can offer my patients more focused and quality time. I'm sure they can sense that I'm more relaxed and less distracted.

Even once the pandemic subsides, I think substituting in-clinic days with virtual visit days will be the way to go—at least if we want to provide more access to care and quality care for our patients, and reduce physician burnout.

Sally Berryman, MD, FACP, is assistant professor of medicine, division of General Internal Medicine, University of Minnesota.



health care providers via devices. "I don't think things will be going back to the way they were done before," says Lisa Ide, MD, chief medical officer at Zipnosis. "The pandemic has made providers realize that there are a lot of things they don't necessarily need to have patients come to be seen in person for."

While Hallberg's Mill City Clinic has been helped by the considerable resources of a large health care system in its transition to relying on telehealth, smaller organizations have also managed the change. Alissa Light, executive director of the 49-year-old Family Tree Clinic in St. Paul, which provides reproductive care, gender care, primary care and sexual health services to mostly LGBTQ patients, says her clinic looked into telehealth before the pandemic and would have adopted it years ago if outdated payment restrictions from insurers and the Centers for Medicare and Medicaid Services (CMS) had not been in place. Changes in those restrictions did not come until the coronavirus had already reached Minnesota, and her clinic had to act quickly to remain accessible to its patients. Because of its gender-affirming hormone care program, Family Tree draws patients from a seven-state area, many of whom in normal times drove overnight to fill the clinic's waiting room. Light recognized telehealth as a way to become more accessible to its geographically dispersed patients, and she led the clinic toward a rapid transition to telehealth.

After training its providers, Family Tree began relying on phone-based telemedicine in early April and launched videoconferencing with patients a few weeks later. To educate patients about the changes, the clinic's staff called, texted or emailed every patient to move scheduled in-person visits to virtual visits. A revamped triage system helps the staff determine whether telehealth or face-to-face visits are most appropriate. The clinic's providers have found "some loveliness in the opportunity for a more intimate and connected type of medical visit because patients are in their home," Light says. "It can shift the power dynamic. For some patients, not having to come into the provider's medical space with an exam table and harsh lighting enables them to talk about their health care needs in a more open and safe way."

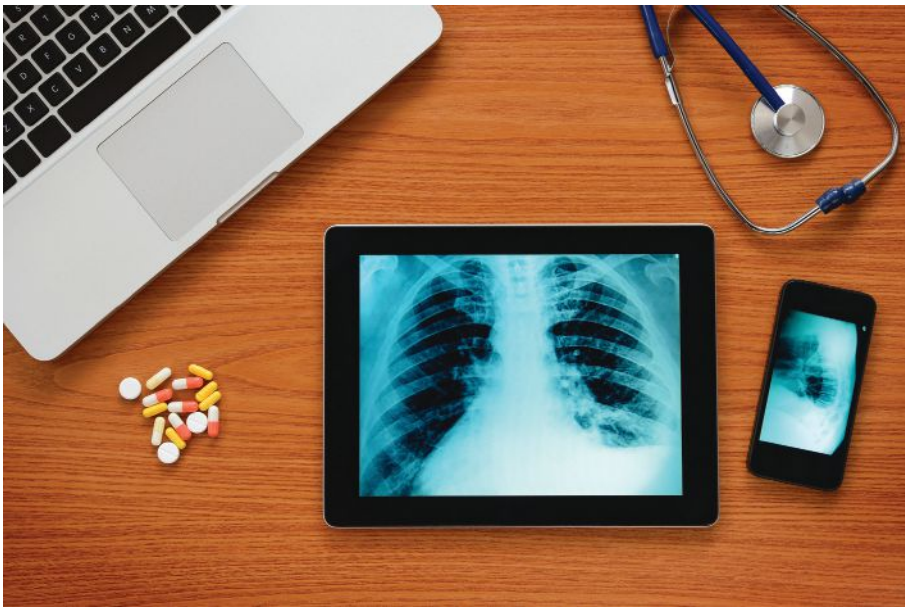
Light is happy with the results. "Reducing that barrier of having to travel such long distances to be able to get to Family Tree, particularly for folks getting gender-affirming hormone care who often experience profound difficulties in so many health care systems, has been a huge silver lining."

COVID-19, a disease with uncertain effects on pregnant women, similarly forced the physicians at OBGYN Specialists, a seven-physician private practice in Edina and Burnsville, to rapidly set up a telehealth program. The big question for her and her colleagues, says Krista Olsen, MD, was how to keep appropriate and high-quality care going during this pandemic. Using phone and videoconference visits, they could keep in personal contact with patients while deciding which patients with urgent needs should receive in-person care.

Olsen, whose experience includes life-coaching female physicians across the country, was familiar with videoconferencing. She knew the clinic's telehealth platform had to be secure, and she realized the benefits of giving physicians individual meeting rooms at their clinics for the virtual visits. Olsen's colleagues quickly adapted to virtual meetings with patients, and there were "minimal hiccups along the way," she says. "And by day two of hosting virtual appointments, most of them had been ironed out." A video visit "provides a different angle and experience for the patient and the physician," she says. She

*"[Teleheath] truly is something we needed to do for a long time, and it took [a pandemic] to make it happen. If we can shift [some visits] to virtual visits of one kind or another and still provide great care, it's a huge benefit from a time perspective and from an ecological perspective."*

– JON HALLBERG, MD; MILL CITY CLINIC



can visually examine patients in surprising detail, "and if I'm doing an anxiety or depression follow up, I'm able to see their face and see their affect." Often, patients are more talkative than in face-to-face visits, and virtual appointments frequently take more time than in-person meetings. In addition, patients get to see their providers without the dehumanizing barriers of masks and other protective garb and equipment.

The barriers to effective telehealth care are well known and formidable. Some patients have no access to the internet or their area is without broadband, they do not own smartphones or other devices with cameras, they lack private spaces at home or work where they can talk to a provider or they feel uncomfortable with virtual visits. More than a few physicians feel uncomfortable with the virtual approach, as well, although many resist discussing their reluctance. And, of course, some medical specialties require in-person meetings with patients. As the use of telehealth increases in Minnesota, "the question of equal access is going to be an equity issue," says Ide. "Equity holders and health systems are going to have to come to grips with it."

Rick Dublin, a Minneapolis video producer and commercial photographer, had a telehealth appointment for the first time in his life as a result of the pandemic. He had experienced an abnormal heart rhythm earlier in 2020 and, when COVID-19 became widespread, his scheduled in-person follow-up appointment at his cardiology clinic was cancelled. The clinic instead proposed a phone consultation. A nurse practitioner called him. They went through his symptoms, side effects to his medication and how he was feeling. Everything, Dublin told the nurse practitioner, was back to normal. "It saved me time and gas. I didn't feel there was any urgency [to having an in-person appointment]," he says. The cardiology clinic billed him just as if it had been a face-to-face appointment, and Dublin's insurer covered it in the same way.

## Payers reappraise telehealth

Many insurers and other payers have historically restricted their coverage of virtual appointments or required patients to pay a higher share of the cost of telehealth visits than in-person meetings, but that situation has rapidly changed. Marc Baer, vice president for health services at Blue Cross Blue Shield of Minnesota (BCBSM), explains that the insurer has long had policies in place to cover virtual care, but the pandemic has changed them. In addition to expanding that coverage as a result of COVID-19 and encouraging members to make virtual visits, BCBSM went into a partnership with the national telehealth provider Doctor on Demand to provide free services, at least through mid-June, to its geographically far-flung members. These services include behavioral consultations, speech therapy and physical therapy—areas often not previously covered under BCBSM plans. "Our objectives will be to ensure that the use of telehealth is sustainable for both providers and for our members long term," Baer says. Ultimately, "It will be up to the provider and the patient to determine the most effective options and the location for the care to be delivered."

Understandably, many physicians still worry that a slowdown of the pandemic will encourage insurers to return to their old ways. Insurance companies contacted for this article would not promise that the temporary changes in telehealth coverage now in effect would continue and believe it is overly speculative to forecast how coverage will look after COVID. Medica, which has seen a 40-fold increase in the scheduling of virtual visits among its providers, issued a statement confirming its commitment to collaborate with physicians to understand the future of telehealth. "We do believe there is a role for the technology to play in the future," the statement says. "All of the health care industry and public are working together to define exactly how telehealth fits into the overall delivery of health care. We are learning more every day about this new approach. Everything we consider is done in the interest of advancing better, more affordable health care with a high degree of consumer satisfaction."

## The future of telehealth

"This truly is something we needed to do for a long time, and it took [a pandemic] to make it happen," Hallberg says. His clinic serves patients in 300 different zip codes, and "if we can shift some of those visits to virtual visits of one kind or another and still provide great care, it's a huge benefit from a time perspective and from an ecological perspective. It's going to invigorate a lot of us in primary care; how we get through our days that—no matter how much we love human beings and being with people—can be overwhelming sometimes, going from room to room to room." He sees the increased use of telehealth, along with many other aspects of the pandemic, as change that forces us to rethink much of our approach to health care.

Olsen sees the future demand for telehealth coming not from doctors, but from patients who have grown accustomed to the convenience and fear meeting the coronavirus in the waiting room. She believes her patients with childcare complications, postpartum depression, breastfeeding demands and other time constraints will say, "I'm going to pop online for my 15-minute visit" instead of taking time to go to the clinic or missing in-person appointments. As a result, "we're going to be able to see better follow-up with patients," she says.

Ide of Zipnosis anticipates a vast change in our approach to medicine, mostly spurred by the ubiquity of telehealth. "The days of coming in for care for every concern will be gone," she says. Instead, we "will follow a continuum of care" providing patients with a range of approaches that includes interviews powered by artificial intelligence, at-home testing, virtual visits and face-to-face meetings with providers. **MM**

Jack El-Hai is a Twin Cities freelance writer and author.

# 2020 Legislative Session in Review

*The 2020 legislative session saw three distinct phases: pre-pandemic normalcy, a month-long pause while all parties came to grips with a worldwide shut-down and, finally, an awkward finish as legislators worked on bills in less-than-normal circumstances.*

*Heading into the session in early January, legislative leaders and Gov. Tim Walz had a long list of priorities, including using some of the projected budget surplus for tax relief or additional spending on priorities such as pre-K education. But with the arrival of the COVID-19 pandemic in March, legislative action ground to a halt. Following an extended Easter/Passover break, the Legislature continued to process bills, though in a much different manner than usual. All committee hearings were held remotely, and activity on the floors of the House and Senate slowed to a crawl as the bodies strictly followed social distancing guidelines by restricting the number of individuals allowed to congregate. That meant that roll call votes—usually processed in minutes with each legislator voting at his or her desk—took far longer as legislators voted in shifts from remote locations or via voice vote. The pandemic and global economic slowdown that resulted also served to turn Minnesota's estimated $1.2 billion surplus into a projected budget deficit of more than $2 billion.*

*Despite this, the MMA had a very successful year at the Capitol. Two long-time, major MMA priorities—reform of the prior authorization (PA) process and passage of Tobacco 21—cleared the Legislature with strong bipartisan majorities and were signed into law by the governor. The MMA has been working for multiple sessions to pass these bills despite strong opposition. Their passage will lead to a healthier Minnesota while reducing frustration and headaches from burdensome PA requirements for physicians and patients alike. The House PA bill was authored by physician and MMA member Rep. Kelly Morrison, MD (DFL-Deephaven); the Senate bill was carried by Sen. Julie Rosen (R-Vernon Center).*

*As this issue went to press, Gov. Walz had just called the Legislature back for a special session. State law requires the Legislature to be in session if the governor wants to initiate or continue a peacetime emergency declaration. Legislative leaders and the governor hope to pass a bonding bill, other COVID-19 relief, and legislation to address the George Floyd killing.*

*Here's a review of the 2020 session including reports on MMA priorities as well as other health care-oriented legislation:*

## MMA's priority issues at the Legislature

| ISSUE | RESULT |
|---|---|
| ***Reducing minors' access to tobacco and e-cigarettes*** | After years of debate, the Legislature voted to increase the age to purchase tobacco and nicotine products from 18 to 21. The measure was needed to align the state with federal law, as well as ensuring effective enforcement and compliance by tobacco retailers. |
| ***Preventing firearm injury and death*** | The DFL-led House had planned to pursue several measures to reduce firearm injury and death, including expanded background checks and a "red flag law" to allow law enforcement to temporarily remove firearms from individuals who may be a threat to themselves or others. With the focus shifting to the pandemic and because of strong opposition from the GOP-led Senate, there was no action taken on these bills. |
| ***Increasing immunization rates*** | Minnesota has among the weakest vaccination requirement laws in the country; parents are able to opt out based on a personal objection to the vaccine. The MMA is working to strengthen the law in order to increase vaccination rates. The measure did not receive a hearing. |

## MMA's priority issues at the Legislature *(continued)*

| ISSUE | RESULT |
|---|---|
| ***Reducing third-party interference in patient care*** | Legislation was passed with several broad patient protections and reforms to reduce the administrative burden of prior authorization and ease the delivery of care to patients free from interference. The timelines that health plans have to determine whether to grant approval for a drug, procedure or diagnostic test are dramatically shortened. Other elements of the law include:<br>• Requiring that PA denials of procedures and diagnostic testing be made by Minnesota-licensed physicians who practice in the same or similar specialty as the service being reviewed.<br>• Requiring that health plans provide a 60-day transition period for patients who have approved services, should they change health plans.<br>• Requiring health plans and utilization review organizations (UROs) post on their website the clinical criteria for their PA procedures. Changes to the criteria they use for PA must be transmitted to providers at least 45 days prior to the change taking effect.<br>• Precluding health plans from retroactively denying PA approvals once granted.<br>• Precluding health plans from changing coverage terms or clinical criteria during the plan year for patients who have an approved prior authorization.<br>A separate measure to protect patients against mid-year changes in their health plan's drug formulary cleared the relevant committees in the House but failed to gain traction in the Senate. Patients—particularly those with chronic conditions—often select their health insurance product based upon the plan's formulary, yet nothing in law precludes the health insurer from changing the formulary in the middle of an enrollee's contract year. The state's health plans opposed this legislation. |

## Other health-care legislative issues

| ISSUE | RESULT |
|---|---|
| ***Advance care planning*** | ***Legislative action:*** Honoring Choices, the advance care planning organization created by the Twin Cities Medical Society, was pursuing funding to expand its effort to communities of color. The bill passed through Senate committee, but did not pass because of the pandemic focus.<br>***MMA position: support*** |
| ***Clinical trial costs*** | ***Legislative action:*** The Legislature passed a provision requiring Medical Assistance and MinnesotaCare to cover ancillary health care services for a patient participating in a clinical trial. The effort to pass the law was led by Be the Match, a national advocacy group for bone marrow transplants and cord blood donation.<br>***MMA position: support*** |
| ***COVID-19 funding*** | ***Legislative action:*** With emergency actions taken by the governor to limit elective procedures and because of fear among patients of infection at health care facilities, many physicians, clinics and hospitals have seen their patient volume and revenue drop sharply. The Legislature has appropriated $200 million to help offset the economic impact felt by health care providers.<br>***MMA position: support*** |
| ***Insulin*** | ***Legislative action:*** After many years of contentious debate, the Legislature acted to ensure access to insulin for low-income Minnesotans and those with high drug costs. Under the new law, insulin manufacturers will be required to provide insulin at reduced costs for eligible individuals. The MMA raised concerns about the bill's original intention to use physician's offices as distribution sites for insulin, and the bill was amended to have patients pick up the drug from pharmacies.<br>***MMA position: support*** |

| ISSUE | RESULT |
|---|---|
| *Liability protection* | ***Legislative action:*** Given the rapidly changing environment due to the pandemic, the MMA and other health care stakeholders sought limited liability protections for physicians providing care in these extraordinary times. Lack of adequate PPE, possible deployment of a physician outside of their usual specialty and patients delaying care have resulted in physicians and other health care providers practicing at a different standard of care. Legislation to provide limited immunity for care during the emergency cleared the Senate HHS Policy & Finance Committee but was not heard in the House. Efforts continued during the special session. ***MMA position: support*** |
| *Mandated reporting changes* | ***Legislative action:*** Legislation to no longer require physicians to report to social service agencies a pregnant woman in their care who is using illicit drugs was signed into law. Previously, physicians were required to report if they believed a pregnant woman was using drugs other than cannabis or alcohol. The new law is intended to ensure that women feel comfortable seeking prenatal care without fear of being reported to the authorities. ***MMA position: support*** |
| *Medical cannabis* | ***Legislative action:*** An effort to allow the use of raw, leaf-form cannabis in the state's medical cannabis program was considered and passed by several House committees but was not adopted by the Legislature. The current program allows the use of cannabis-derived topicals, tinctures, capsules and oils that can be inhaled. ***MMA position: oppose*** |
| *Postpartum coverage for Minnesota Care patients* | ***Legislative action:*** Current Minnesota law provides 60 days of postpartum health insurance coverage for low-income Minnesotans, the minimum required by federal law. Evidence is overwhelming that extending coverage for postpartum mothers leads to both healthier women and babies. Legislation to extend coverage to 12 months following childbirth cleared its first committee stop in the House, but did not become law. ***MMA position: support*** |

| ISSUE | RESULT |
|---|---|
| *Prescription drug pricing transparency* | ***Legislative action:*** New law requires drug manufacturers to report to the Minnesota Department of Health when a drug's price increases sharply within a given period. The effort, supported by the MMA, the Minnesota Council of Health Plans, the Chamber of Commerce, labor organizations and disease advocacy groups, will help patients and policy makers better understand and address prescription drug pricing. ***MMA position: support*** |
| *Scope of practice—traditional midwifery* | ***Legislative action:*** The professional association of traditional midwives sought the authority to order ultrasounds, other point-of-care testing and laboratory testing. The language was amended to satisfy concerns raised by the Minnesota Chapter of the American College of Obstetricians and Gynecologists (MN-ACOG). The language was included in an omnibus health and human services bill and was signed into law. ***MMA position: neutral*** |
| *Scope of practice—optometry* | ***Legislative action:*** The Minnesota Optometric Association sought to expand its scope of practice to remove existing limits on optometrists' prescribing authority, as well as allowing them to perform interocular injections. The Minnesota Academy of Ophthalmology strongly opposed the legislation. The bill was tabled in committee and did not move this session. ***MMA position: oppose*** |
| *Scope of practice—physical therapists* | ***Legislative action:*** The Minnesota Physical Therapists Association sought to repeal an existing cap of 90 days for patients to access a physical therapist without a referral from a physician, podiatrist or chiropractor. Opposed by the Minnesota Orthopaedics Society and the MMA, the legislation did not receive a hearing in the House and did not become law. ***MMA position: oppose*** |

# Other health-care legislative issues *(continued)*

| ISSUE | RESULT |
|---|---|
| *Scope of practice—pharmacy* | ***Legislative action:*** Minnesota law now grants pharmacists limited prescribing authority. Under the new law, pharmacists are authorized to prescribe nicotine replacement drugs, oral contraception for the purposes of birth control and acute opioid antagonists. As a result of concerns raised by the MMA and the Minnesota Psychiatric Society, particularly related to nicotine cessation drugs, the bill was amended to allow pharmacists to prescribe only nicotine replacement drugs such as gums, patches and lozenges. The new law requires the Board of Pharmacy to develop training materials for pharmacists in partnership with other health licensing boards, the MMA and other stakeholders. ***MMA position: neutral*** |
| *Scope of practice—physician assistants* | ***Legislative action:*** Following extensive negotiations between the MMA and the Minnesota Academy of Physician Assistants, a compromise was reached to alter the relationship between physicians and physician assistants (PA). The new law preserves a relationship between a physician and a PA and does not change the current PA scope of practice, but does reduce the administrative burden of supervision. ***MMA position: neutral*** |
| *Smoking in cars that contain children* | ***Legislative action:*** Minnesota sought to join a growing group of states that prohibit smoking or the use of e-cigarettes in vehicles when children are present. The bill passed the House committee with bipartisan support, though it did not receive a hearing in the Senate. ***MMA position: support*** |
| *Tobacco and e-cigarette flavoring prohibition* | ***Legislative action:*** Legislation to ban the use of flavoring in tobacco and e-cigarettes found bipartisan support in the House but failed to gain traction in the Senate. The bill sought to reduce the appeal of e-cigarettes and tobacco products in child-friendly flavors, while also banning menthol cigarettes. ***MMA position: support*** |


## MMA launches Practice Good Health campaign

In late May, the MMA launched Practice Good Health, a unified effort of its 10,000 members to empower Minnesota families to proactively care for their physical and emotional well-being, especially during COVID-19.

"COVID-19 care remains vital, as does continuing to proactively manage chronic conditions, vaccinations and preventive care," says MMA President Keith Stelter, MD. "Practice Good Health is designed to make it easier for Minnesotans to navigate care decisions to stay healthy and well."

In addition to providing patient clarity, the campaign directly supports physicians across the state to create the safest possible care environments and experiences. This includes physician resources and educational opportunities for their clinics and practices as well as their own well-being.

Practice Good Health will support its members and Minnesotans in three important ways:

- **COVID-19 care**. Best practices to slow the spread of COVID-19 and information about when to get tested or seek care.
- **Seeking safe care**. Guidance for seeking ongoing and preventive health care or emergency care.
- **Physician care**. Resources to support physician health and well-being, along with resources to support safe care environments and ongoing education.

"Health care is deeply personal, and we know Minnesotans trust their physicians to help them make good care decisions," Stelter says. "Recently, confusion and fear have prevented people from seeking the regular care needed to stay healthy. We encourage them to work closely with their physicians to proactively Practice Good Health, and to share their experiences and tips with their friends and family."

Practice Good Health is a direct extension of the MMA's mission to make Minnesota the healthiest state in which to live and practice medicine.

Join the conversation online via Facebook and Twitter and share ways to #PracticeGoodHealth.

Resources will be available and will be regularly updated on mmed.org/PracticeGoodHealth.

## Virtual Annual Conference to focus on advocacy and COVID-19

The COVID-19 pandemic has changed many aspects of our daily lives; how the MMA hosts events is one of them. Plans are underway to convert the Annual Conference from an in-person event to a virtual event, scheduled for late September.

With the virtual platform, the conference will be spread out over several days to maximize learning and engagement while minimizing inconvenience. The conference will include many of the activities seen at past annual conferences, including education sessions, policy discussions, MMA awards, MMA business update, the president's inauguration and the medical student/resident/fellow poster symposium.

Conference sessions will help mobilize physicians and physicians-in-training to create change across a variety of health care issues. In addition, attendees will have the opportunity to evaluate the current state of the COVID-19 pandemic, assess opportunities for growth in our health care systems and discuss tools needed to address future public health emergencies.

Stay tuned to *MMA News Now* for details about this and other virtual events planned for later in the year.

## MMA, TCMS release statement on George Floyd death

On May 28, the MMA and the Twin Cites Medical Society (TCMS) issued a statement on the death of George Floyd in Minneapolis on Memorial Day. "His death serves as a stark reminder that violent police tactics, discrimination in crime laws, and bias in incarceration pose serious threats to health," said the statement signed by MMA President Keith Stelter, MD, and TCMS President Ryan Greiner, MD. "Minnesota's deep and persistent racial and ethnic disparities, including disparities in health, can only be dismantled by changing historic policies and cultures built on racism. The physicians of Minnesota stand prepared to work with local and state leaders to prioritize the health and well-being of all Minnesotans and to try to prevent future tragedies."

## Philanthropy in Practice campaign raises $26,000 to help the homeless

The MMA Foundation's Philanthropy in Practice campaign raised more than $26,000 for homeless shelters and food banks during its spring fundraising effort. The Foundation collaborated with the Twin Cities Medical Society and the Zumbro Valley Medical Society to launch and publicize the campaign. All funds raised in the campaign, which were disbursed to 17 agencies across Minnesota, were used to help find alternative housing for people who need a safe place to quarantine and isolate, purchase and distribute basic necessities including food and personal hygiene supplies, and fund street outreach efforts. For more information about the MMA Foundation's work, contact Kristen Gloege at kgloege@mnmed.org.


**COVID-19 webinar presentations now online**

If you have been unable to attend the free lunch-time webinars on COVID-19, you can find copies of the presenters' presentations online at www.mnmed.org/education-and-events/Virtual-Physician-Forums. The series includes experts on a variety of topics from how to effectively implement telehealth in your practice to why racial and ethnic data on COVID-19's impact is needed.

**Liability insurance carrier to defer payments until September**

COPIC, the MMA's endorsed medical liability insurance carrier, is committed to supporting MMA members during the COVID-19 pandemic by deferring premium payments.

Policyholders have the option of deferring premium payments until September 1 of this year. The deferment option is available for both new and existing policyholders, including those who choose to switch their coverage to COPIC midterm. There are no late payment or finance charges.

In addition, policyholders have direct access to expert support to help navigate COVID-19 challenges through its Legal and HR Helplines, as well as a 24/7 Risk Management Hotline, which connects you with an experienced physician. COPIC has also set up a COVID-19 Physician Program policy that will provide temporary liability coverage that can be accessed by existing policyholders who have a need.


To learn more about COPIC, contact your current agent or contact Jerry O'Connell, director, regional development, at joconnell@COPIC.com or 720-858-6182.

# FROM THE CEO

**The eyes of the nation are on Minnesota.** The killing of George Floyd brought unwanted but necessary attention to Minneapolis. The public outcry for justice and change was painful, powerful and unprecedented. For medicine, too, the response was unprecedented. Everyone in medicine—young, old, rural, urban, organized, informal—declared loud and clear that police brutality and racism are health issues of crisis proportions. Minneapolis officials have pledged to fundamentally change their model of policing and public safety. Other communities across the country will be watching and taking notice. Minnesota health care, too, has an opportunity to let George Floyd motivate us to root out racism in our organizations and communities, to reimagine health care for those most in need, and to make real our goal to achieve health equity. Please share your ideas and passion and help hold your profession accountable for doing its part.

**Practice Good Health.** The public trusts physicians. That fact—both simple and critical—underscores the MMA's new campaign and statewide call to action: Practice Good Health. Launched in late May, Practice Good Health amplifies physicians' expertise to bring accurate and trusted information to Minnesotans during a new, confusing and, occasionally politicized, pandemic. Look for the campaign, help spread the word and access campaign resources on the MMA website (www.mnmed.org/practice-goodhealth).

**Quantifying the impact of COVID-19.** In June, the MMA launched a two-pronged analysis of individual physicians and of medical group administrators to quantify the financial, care delivery, staffing and personal impacts of COVID-19. The MMA must have relevant and reliable data to advocate for physicians and their ability to provide care to all Minnesotans. The final results from the analysis are expected by mid-August. Look for results in future MMA publications. Thanks to those who provided input.

**MMA policy now captures The Pulse of members.** In June, the MMA launched The Pulse (thepulse.mnmed.org) to make it easier for MMA members to influence the direction of their association. The Pulse can be used by members to submit policy proposals for MMA consideration, to vote on policy proposals prior to MMA Board action and to provide feedback on decisions made by the MMA Board. Practicing medicine is hard work; influencing the direction of medicine's voice in Minnesota has never been easier. Raise your voice and use The Pulse.

**Hundreds of physicians Zoom with MMA.** The response to our biweekly, virtual physician forums focused on timely and valuable COVID-related topics has been tremendous. Many hundreds of physicians have fine-tuned their Zoom skills with lunchtime programs that covered telehealth changes, ethical considerations, surge preparedness, COVID-19 epidemiology, COVID in congregate care settings and more. I hope to see you at an upcoming session; if you missed one, you can find the full series archive online.

**August is MMA election time.** The MMA's annual leadership election will be held August 3–31. Members will elect a president-elect, trustees and AMA delegation members. To ensure reliable and accurate voting, the MMA uses an external ballot vendor. Look for the electronic ballot in your email inbox beginning August 3.

**Did you know?** The MMA Foundation (MMAF) raised more than $26,000 in just nine days to support homeless and food-insecure Minnesotans. Recognizing the unique challenges that COVID-19 poses to individuals who don't have safe, permanent housing, the MMAF's Philanthropy in Practice campaign, launched in collaboration with the Twin Cities Medical Society and the Zumbro Valley Medical Society, resulted in the distribution of funds to 17 different organizations, including those serving clients across the state as well as those in Duluth, St. Cloud, Mankato, Rochester and the Twin Cities.

Please share your thoughts and comments at any time.
Stay safe,

Janet Silversmith
JSilversmith@mnmed.org

VIEWPOINT

# The fierce urgency of now for Minnesota physicians

PHOTO BY KATHRYN FORSS

Randy Rice, MD
MMA Board Chair

Out of a horrible, senseless death comes an opportunity for Minnesota physicians, as leaders in the health care industry and in their communities, to finally address and fix our state's health inequities. It is time to fix structural, institutional and systemic racism in America and, frankly, around the world.

As if battling a worldwide pandemic wasn't enough to strain our health care system and stress an already anxious health care team, the death of George Floyd on Memorial Day at the hands of Minneapolis police has thrown a match into a tinderbox of centuries of racial injustice.

Though often lauded as a vanguard in the health care field, our state is woefully behind in treating all Minnesotans equally.

According to MN Community Measurement in its 2019 report, *Minnesota Health Care Disparities by Race*, Hispanic Ethnicity, Language and Country of Origin, American Indian/Alaskan Native, Black/African American and Hispanic patients have significantly lower rates of optimal care compared to the statewide average in all reported measures.

Drilling down, we see more specific examples of health disparities in Minnesota:

American Indian and African American babies in the state are twice as likely to die in their first year compared to Asian and white babies, according to the Minnesota Department of Health (MDH). In fact, Minnesota's infant mortality rates are lower than the national average.

Adults from Indigenous communities, ages 35 to 64, are four times more likely to die from heart disease than whites. African American adults are twice as likely as whites to die from heart disease, according to Minnesota Vital Statistics.

African American women are 24 percent more likely to die from breast cancer than white women, according to MDH.

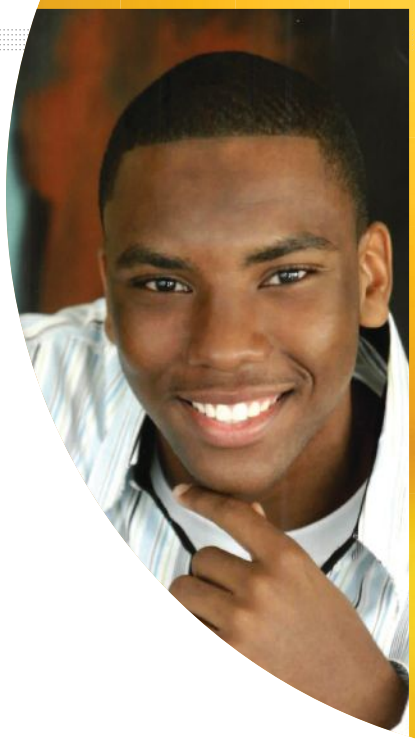
These are just a few of many examples. It's clear from this data: we are not all equal.

If you need more proof, look at the pandemic. According to the state's COVID-19 website, "as a result of systemic disparities, communities of color and Indigenous communities are at a higher risk of multiple health issues such as diabetes, heart disease, severe asthma and obesity. This puts them at higher risk for severe illness from COVID-19." Furthermore, Indigenous communities have the highest proportion of positive cases that have been hospitalized or placed in the ICU. It is believed that people of color have a higher percentage of COVID-19 cases because they work in businesses that are considered essential and, as a result, have more exposure to the virus.

Because of social and economic inequities, all Minnesotans do not have the same opportunities with their health care. This needs to change. I am talking real change. The MMA has convened task forces to look at health disparities over the past few years. While they have done great work, more needs to be done. We need solutions that will make a difference.

As we revealed in a June "Insights" article by our President Keith Stelter, MD; Dionne Hart, MD, board member and co-chair of the MMA Health Equity Advisory Committee; CEO Janet Silversmith; and me, the MMA has called upon its Policy Council, Public Health Committee and Health Equity Advisory Group to work together to identify both urgent short-term and long-term additional actions that the MMA must take.

This is just the beginning. We need to fundamentally change how we practice medicine so that all Minnesotans can be treated equally and have a real chance to be their healthiest.



*"It took six different doctors to diagnose my brother. Do you want to be doctor number one through five, or doctor number six?"*

—SISTER OF JULIAN BAULTRIPPE

Julian Baultrippe was a healthy 19-year-old University of Minnesota student who experienced right shoulder pain while playing basketball. Seen by multiple clinicians over an extended period of time, he was treated for a presumed sports injury despite persistent and worsening pain. Eventually, an MRI revealed osteosarcoma and Julian underwent amputation and aggressive chemotherapy. He died two years after diagnosis of metastatic disease.

# SARCOMA

## *A rare and deadly cancer*

## Not just another lump, bump or bruise

BY ELSA N. KEELER, MD, MPH, AND
NIKKI L. MILLER, MA

*"I had a soft, non-painful lump on my wrist."*

—RUTH, WHO HAD AN UNDIFFERENTIATED PLEOMORPHIC SARCOMA (UPS)

Sarcoma—a rare and deadly cancer—isn't the first diagnosis that comes to mind when a patient presents with a lump, bump or unexplainable pain. More commonly, hematoma, lipoma or vascular or other benign tumors are in the differential diagnosis. Therein lies the dilemma: common and often insidious symptoms are the most likely presentation in patients eventually diagnosed with soft tissue or bone sarcoma. Patients with sarcoma often experience a "wait and watch" approach and delay in referral, leading to delay in diagnosis. Education and awareness within the health care community about this rare group of cancers can change that scenario.

Just over 16,000 new cases of sarcoma were diagnosed in the United States in 2019, representing less than 1 percent of new cancers in adults, according to the National Cancer Institute. This highly heterogeneous group of cancers arise primarily from connective and skeletal tissue of mesenchymal origin—and they can occur anywhere in the body. The majority of tumors in adults (80 percent) are classified as soft tissue, represented by more than 50 subtypes based on their tissue of origin. Bone tumors represent 20 percent of new sarcomas in adults. Among children, soft tissue and bone sarcomas account for almost 15 percent of childhood cancers.

REIN IN SARCOMA
Increase awareness. Increase survivors.

Rein in Sarcoma is the largest and best-known sarcoma foundation in the Upper Midwest.

### The "red flags" of sarcoma cancer

*His knee became more and more swollen"*

—DAUGHTER OF A MAN WHO HAD A MISSED DIAGNOSIS OF SYNOVIAL SARCOMA AND DIED AT AGE 58

The signs of soft tissue and bone sarcomas are often attributed to muscle strain, joint injury, hematoma, lipoma or growing pains. But any soft tissue mass that is enlarging—with or without history of trauma—is suspect. Key findings include:

- Location deep to the muscle fascia, and/or
- Size > 5 cm

These criteria are associated with increased risk of malignancy and should prompt referral to a sarcoma center for evaluation. Pain, especially at night, is concerning for bone tumors. The presence or absence of mobility or transillumination is not a predictive factor.

Awareness of appropriate work-up among practitioners remains a critical first line of defense. Unfortunately, primary care clinicians may see only one or two patients with sarcoma in their career, among many hundreds with benign lesions. Based on this, a feasibility study is in progress at HealthPartners Institute exploring ways to use the Electronic Medical Records (EMR) to improve primary care provider evaluation of soft tissue masses. (For more information or to support this project, contact Randy W. Hurley, MD, at randy.w.hurley@healthpartners.com.)

### Imaging is essential for early and accurate diagnosis

*"For five years I was told there was nothing to worry about … that it was just a fatty tumor"*

—LISA, WHO WAS EVENTUALLY DIAGNOSED WITH FIBROSARCOMA

Ultrasound is a readily available and useful means of evaluating superficial lesions, especially on the extremities, but if there is any thought of malignancy, if a mass is deep, rapidly enlarging and/or >5 cm, MRI is the recommended imaging. Primary CT or MRI is recommended for thoracic,

spinal or abdominal masses. MRI provides optimal soft tissue contrast, potential for local staging and direction for biopsy.

If sarcoma is suspected, once imaging is performed, further evaluation and treatment should be managed by a multidisciplinary team with expertise and experience in treatment of sarcoma, preferably at a designated center. This team may include a musculoskeletal radiologist, a pathologist and orthopedic, medical and radiation oncologists. A carefully planned core needle or open biopsy is critical and should be performed by a skilled surgeon to avoid contamination of structures and surrounding tissues. Because sarcomas inherently carry a high risk of recurrence, a chest CT is recommended for staging, as the lungs are the most common site of metastasis.

### Avoid unplanned excision

*"It was a painless lump"*

— VICKI, DIAGNOSED WITH LEIOMYOSARCOMA

Vicki, 55, discovered an enlarging pea-sized lump between her gum and cheek. Without prior imaging, oral surgery was performed to remove the mass, assumed to be benign. The surgery was extensive: her lower teeth were removed and the tumor morcellated and excised—all before a pathology diagnosis of leiomyosarcoma, one of the more common soft tissue sarcomas. Within months she had local and systemic recurrence requiring a jaw transplant, and she was diagnosed with Stage 4 disease. She has survived multiple recurrences.

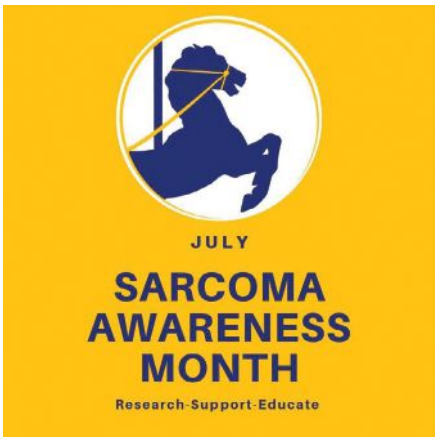
Unplanned excision refers to removal of a mass without understanding potential malignancy and subsequently risking inadequate tumor margins. It happens often, with a frequency of 30 to 70 percent. This failure to consider sarcoma leads to secondary surgeries and potential risk of local or regional recurrence, especially in high-grade tumors.

Uterine sarcomas present a particular risk for unplanned excision. Representing less than 5 percent of uterine malignancies, sarcoma is mistaken for the far more common benign uterine leiomyoma. Preoperative imaging is not of benefit. Furthermore, advances in minimally-invasive laparoscopic techniques, such as morcellation, put women at risk for dissemination of disease. This is particularly devastating for uterine leiomyosarcoma, the most common form of uterine sarcoma, where the five-year survival drops from 50 percent in Stage One to 0-20 percent in advanced disease.

Fortunately, more than half of soft-tissue sarcomas are localized at the time of diagnosis; with early diagnosis and appropriate treatment, five-year survival is over 80 percent. Tumor staging has a significant impact on mortality, where five-year survival drops to less than 20 percent with distal metastasis.

### Treatment options

The National Comprehensive Cancer Network (NCCN) is the source of evidence-based guidelines for diagnosis and treatment of all cancer types. NCCN guidelines for treatment of soft-tissue and bone sarcomas support the most up-to-date work-up, treatment and follow-up surveillance. Although surgery remains the primary means for treating sarcomas, individualized treatment is based on tumor type, grade and tumor genetics. Treatment may involve conventional chemotherapy, radiation therapy and newer targeted therapies. Treatment outcomes include improving long-term survival, preventing recurrence and/or limiting progression. Patients are encouraged to enroll in clinical studies, as conventional treatments have not shown success in advanced disease. Sarcoma cancer research has served as the foundation for the evolving field of immunotherapy, where treatment can be tailored to a tumor's genetic mutations through the use of monoclonal antibodies.



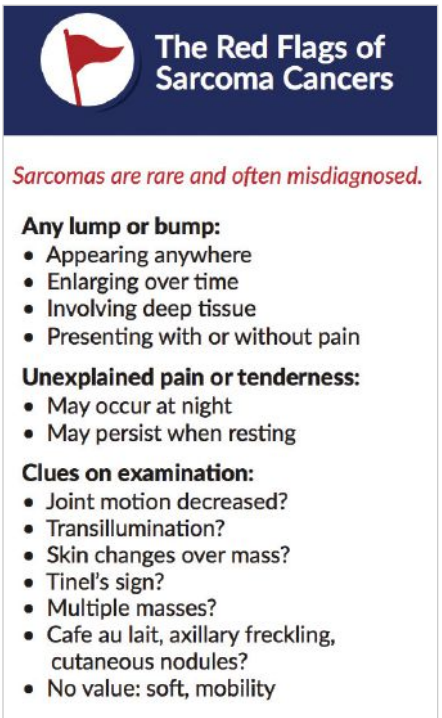

*Patients with sarcoma often experience a "wait and watch" approach and delay in referral, leading to delay in diagnosis.*

### Rein in Sarcoma is changing the sarcoma story

Founded in 2001 by 25-year-old Karen Wyckoff during her battle with synovial sarcoma, Rein in Sarcoma (RIS) is the largest and best-known sarcoma foundation in the Upper Midwest. The organization's three-pronged mission includes educating the public and medical community about sarcoma, supporting sarcoma patients and families and funding research to develop new treatments and find a cure for sarcoma cancers. RIS resources include:

*Medical education*

- The Jan Maudlin Sarcoma Scholars program provides scholarships to sec-



ond- and third-year medical students to complete projects and presentations that increase sarcoma awareness among medical students and the larger health care community.

*Patient support*

- National distribution of the *Sarcoma Patient Starter Notebook* (https://www.reininsarcoma.org/patient-notebook/) with resources for newly diagnosed sarcoma patients.
- Peer-to-peer support groups and events to connect patients, survivors and caregivers.

*Research funding*

- RIS helps provide $2 million in sarcoma cancer research funding at the University of Minnesota, Mayo Clinic and Children's Minnesota.
- An annual sarcoma research symposium.

## Hope for sarcoma patients and survivors

Changing the sarcoma story requires a collaborative effort among patients and doctors. It involves listening, pausing and investigating—not dismissing. It involves leveraging the tools readily available to heed the "red flags" of sarcoma. These "flags" should be flying in every practicing physician's and clinician's office. Only then will we change the conversation from, "I never heard of it" to "We caught it just in time." **MM**

Elsa N. Keeler, MD, MPH, is a pediatrician with HealthPartners. Nikki L. Miller, MA, is a freelance writer based in Minneapolis.

**REFERENCES**

Charoenlap C, Imanishi J, Tanaka T, Slavin J, Ngan SY, Chander S, Choong PF. Outcomes of unplanned sarcoma excision: Impact of residual disease. Cancer Med. 2016; 5(6);980-988. doi:10.1002/cam4.615

Comprehensive Cancer Information. http://www.cancer.gov/.

George S, Barysauskas C, Serrano C, Oduyebo T, Rauh-Hain JA, Carmen MG, Muto MG. Retrospective cohort study evaluating the impact of intraperitoneal morcellation on outcomes of localized uterine leiomyosarcoma. Cancer. 2014; 120(20);3154-3158. doi:10.1002/cncr.28844

Haduong JH, Martin AA, Skapek SX, Mascarenhas L. Sarcomas. Pediatric Clinics of North America. 2015;62(1);179-200. doi:10.1016/j.pcl.2014.09.012

National Comprehensive Cancer Network. http://nccn.org/

Styring E, Billing V, Hartman L, Nilbert M, Seinen JM, Veurink N, Rydholm A. Simple Guidelines for Efficient Referral of Soft-Tissue Sarcomas. Journ of Bone and Joint Surgery-American Volume. 2012; 94(14);1291-1296. doi:10.2106/jbjs.k.01271

Weber M, Lalam R, Trattnig S, Bohndorf K, Vanhoenacker F, Tagliafico A, Noebauer-Huhmann I. Soft Tissue Tumors in Adults: ESSR-Approved Guidelines for Diagnostic Imaging. Seminars in Musculoskeletal Radiology. 2016;19(05). doi:10.1055/s-0036-1572350

Zaidi MY, Ethun, CG, Liu Y, Poultsides G, Howard JH, Mogal H, Cardona K. The impact of unplanned excisions of truncal/extremity soft tissue sarcomas: A multi-institutional propensity score analysis/US Sarcoma Collaborative. Journal of Surgical Oncology. 2019;120(3); 332-339. doi:10.1002/jso.25521

For more information about Rein in Sarcoma, visit reininsarcoma.org. For more information about the Jan Maudlin Sarcoma Scholars program, contact execdirector@reininsarcoma.org.

# Culture of safety

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

Effectiveness of communication, with focus on standard communication during handoffs, has been the Joint Commission National Patient Safety goal. Lack of safe culture can make employees afraid that they might be considered stupid, incompetent, negative, or disruptive. This can lead to disengaged employees who shy away from providing feedback or pointing out concerns and can negatively affect innovation.

We describe two real-world case studies, one focusing on improving interdepartmental conflict and the other focusing on delay in patient transfer. These cases demonstrate how a culture of safety improved team work and collaboration between various stakeholders.

Culture of safety improvement forms the very foundation of preventing and reducing errors and improving health care quality. The main ingredients of successful safe culture and team engagement are: active and visible leadership/sponsorship, change management, daily interdisciplinary huddles where members feel free to speak up, reviewing key metrics for success, and team work.

A non-punitive error-reporting system that ensures confidentiality without fear of punishment encourages error reporting. All errors provide an opportunity to learn by identifying people, process, or systems issues that have contributed to the error or harm. This also builds organizational learning and memory and leads to the creation of systems or processes that mitigate and prevent future errors.

## Introduction

Health care is a complex field in which professionals from various backgrounds interact and provide care to patients. Most organizations now have employees from diverse backgrounds in education, religious beliefs, age, ethnicity, gender, physical abilities, and marital status. For employees to care safely for patients, organizations have to provide a culture that promotes safe behaviors, collaborative care, fairness, and justice.

Employees influence not only the financial performance of the institution but also the safety and quality of patient care. Hence, staff satisfaction and retention should be at the heart of all clinical improvement strategies.[1]

Sub-optimal communication results from patients receiving medical care from multiple providers in different settings with limited access to patient health care information. The landmark report by the Institute of Medicine, "To Err is Human," focuses on preventable medical errors as a leading cause of death in United States. Most errors are caused by faulty systems, processes, and conditions or actions that lead people to make mistakes or that fail to prevent them.[2] The National Patient Safety Foundation (NPSF) expert panel in 2015 issued recommendations for patient safety for the next 15 years. These include: leaders establish and sustain a safety culture, patient safety oversight, common meaningful metrics, increased funding, addressing safety across the entire health care continuum, supporting the workforce, and ensuring safe and optimized technology.[3]

FIGURE 1

**ED physician-hospitalist conflict**

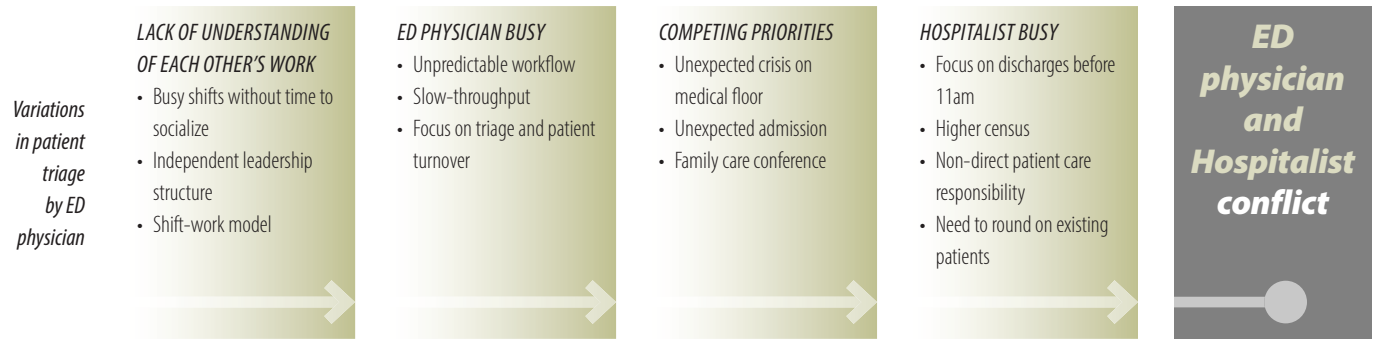
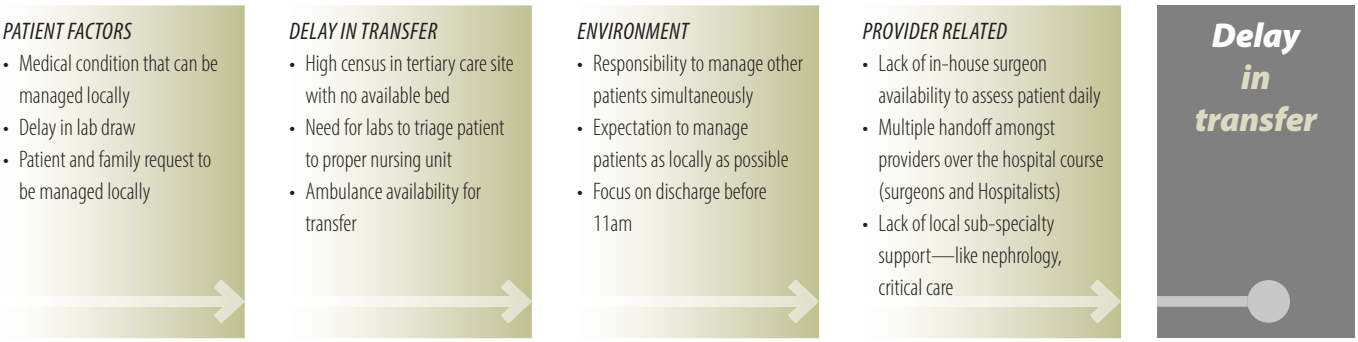


FIGURE 2

**Delay in transfer to a tertiary care center**




Lack of safe culture can make employees afraid that they might be considered stupid, incompetent, negative, or disruptive. This can lead to disengaged employees who shy away from providing feedback or pointing out concerns and so can negatively affect innovation.[4]

In the two case studies given below, we demonstrate how a culture of safety improved team work and improve collaboration between various stakeholders.

## Case Study 1

A small community hospital experienced interpersonal conflicts among hospital medicine and Emergency Department (ED) staff. There were many differences of opinion about patient care resulting from a sub-optimal interdepartmental relationship. A collaborative approach was undertaken with a subgroup of providers using open communication to understand the problem and come up with potential solutions to the problem. [5] (Figure 1)

## Case Study 2

Our southeast Minnesota practice is a six-site regional practice consisting of four community sites and two critical-access sites. Patient and practice expectations require that patients with complex medical needs are managed locally with very limited sub-specialty support. When tertiary care is required, patients are transferred to Saint Mary's Hospital (tertiary care center) in Rochester. These transfer requests are triaged and managed via an Admissions Transfer Center (ATC) and a hospital medicine physician who serves as the medical officer of the day. Typical expectation is that most appropriate patients get transferred out of the smaller site within 2 hours. We recently reviewed a delay of transfer that took >8 hours and potentially added to increased morbidity and length of stay. Interdisciplinary team members included various stakeholders—clinicians, nursing staff, admission transfer center staff. Specialty staff from both campuses reviewed the case in a collaborative non-judgmental fashion. (Figure 2)

## Discussion

High-reliability organizations focus on a culture of safety and carry out complex and hazardous work with minimal adverse events. These organizations are committed to safety at all levels, from managers/executives to front-line employees. Salient features of safety culture are: acknowledgment of the high-risk nature of an organization's activities and the determination to achieve consistently safe operations, a blame-free environment where individuals are able to report errors or near-misses without fear of reprimand or punishment, encouragement of collaboration across ranks and disciplines to seek solutions to patient safety problems, and organizational commitment of resources to address safety concerns.[4,6,7]

Safety culture is when an organization engages members and creates an environment that minimizes adverse events. This includes employees working together in collaborative teams where expectations and roles are clearly defined. Psychological safety exists where staff can speak up without concerns of retribution and where patient and staff safety incidents are treated as learning opportunities.[4,8]

In Case Study 1, improvement of the interdepartmental relationship was considered to be a top priority by both departments. A collaborative approach that included a joint interdepartmental retreat to focus on conflict resolution and improve interdepartmental relationships was adopted. Short-term strategies were created that included visiting each other's work place as time allows and having the ED provider help the busy hospitalist with writing holding orders or holding patients in ED. Long-term strategy included conducting joint meetings, appointing an inter-departmental liaison, new hires shadowing faculty members of other departments, and socializing outside of work.

Good people plus good processes equals a good outcome—safety. When safe behaviors and safe systems overlap, we eliminate preventable harm. A just culture recognizes that employees go to work every day with the best of intentions, yet errors may be made due mainly to process issues, not provider issues. When there is a gap, we take it seriously and try to find out in a non-punitive way whether it is employee-related or system-related. A just culture leads to an effective peer-review process.[9]

Case Study 2 emphasizes the value of interdisciplinary, blame-free root-cause analysis of near misses and adverse outcomes with a focus on education and on identifying systems/process issues that lead to adverse outcomes, while maintaining individual accountability for reckless

behavior. The outcomes of root cause analysis help identify causes of errors and fix any process issues. In an organization that subscribes to the tenets of fair and just culture, the response to a behavior is matched with the intentions and standards around work expectations. Consoling, teaching, or learning is appropriate when inadvertent human error due to a lapse or a genuine mistake is noted. Risky behavior when the risk was unrecognized or justified requires coaching and teaching others. Reckless behavior with clear disregard for risk is managed with corrective action.[10,11]

A culture of safety is created by the interplay of three organizational elements: 1) environment structure and processes, 2) attitudes and perception of workers, and 3) safety-related behaviors.[12] (Table 1)

Mayo Clinic's commitment to safety includes a combination of safe behaviors, a fair and just culture, and a team-engagement model, along with a strong supporting base of communication, psychological safety, and a non-punitive learning system that creates and provides a much-needed "umbrella of safety" to our patients as we care for them. Commitment to the safety program is built on five key elements as described in Table 2.

The team-engagement model (TEM) is a model for improvement work built upon a shared understanding of safe culture, leadership essentials, and a learning system. Mayo Clinic is a learning organization where employees have a shared understanding of common goals, form partnerships with multidisciplinary teams that work together, and use metrics to drive process improvement.

## Leadership role in commitment to safety

Strong, visible, engaged leadership that models and prioritizes safe culture is crucial. Leadership can play an active role, including: placing safety as a priority agenda item; meeting, monitoring, and evaluating safety trends; creating and sustaining effective safety policies and procedures; recognizing efforts for improving safety; and allocating resources for safety-improvement efforts. Leadership is crucial to communicate vision and direction, clarify roles and the decision-making process, promote learning and improvement, and promote psychological safety by being respectful and approachable.[13,14]

## Communication

Clear communication that is independent of an organization's hierarchy empowers employees to speak up and avoid errors, and report system or process vulnerabilities. When all stakeholders understand the background, are engaged, and collectively make decisions that have their buy-in, it increases compliance with any decisions. The Incident Decision Tree from United Kingdom's National Patient Safety Agency supports creating open, fair, and accountable culture.[15]

## Conclusion

Measurement of safety culture is one of AHRQ's "10 patient safety tips for hospitals" and is also mandated by the National Quality Forum's safe practices for health care and the Leapfrog Group. Safety culture is typically assessed by tools like observations, surveys, or interviews. It is equally important to address any weaknesses uncovered by those tools.[3,7]

Culture of safety improvement forms the foundation of preventing and reducing errors and improving health care quality. The main ingredients of successful safe culture and team engagement includes: Active and visible leadership/sponsorship, change management, daily interdisciplinary huddles where members free to speak up, reviewing key metrics for success and team work. Investing in strategies like learning environment, senior management support, psychological safety, commitment to organization, and time for improvement is associated with high performance and helps hospitals in their efforts to improve clinical outcomes.[16] A non-punitive error-reporting system that ensures confidentiality and fear of punishment encourages error reporting. All errors provide an opportunity to learn by identifying people, process or systems issues that have contributed to the error or harm. This also builds organizational learning and memory and leads to creation of systems or processes that mitigate and prevent any future errors.[17]

Approachability includes words or actions that promote trust and reduce or

TABLE 1

**Culture of safety and interplay of three organizational elements**

| ENVIRONMENT STRUCTURE AND PROCESS | ATTITUDES AND PERCEPTION OF WORKERS | SAFETY-RELATED BEHAVIORS |
|---|---|---|
| • Redundancy<br>• Required workplace standard operating procedures<br>• Man-machine interfacing<br>• Working patterns<br>• Work environment<br>• Resource allocation<br>• Emergency preparedness | • Beliefs, attitudes, and values about the organization<br>• Sub-culture with a dominating "cultural" theme.<br>• Personal commitment<br>• Perceived risk<br>• Job stress<br>• Role ambiguity<br>• Safety knowledge<br>• Attributions of blame<br>• Commitment to organization<br>• Job satisfaction | • Internal psychological factors<br>• Person job fit<br>• Safety training<br>• Competencies<br>• Planning/standards/monitoring/<br>• Control<br>• Task complexity<br>• Goal conflict<br>• Involvement in decision making |

TABLE 2

**Five key elements of commitment to safety program**

| SAFE CULTURE ASSESSMENT | FIVE SAFE BEHAVIORS + SAFETY AS A VALUE | FAIR AND JUST CULTURE | SAFETY CULTURE PRINCIPLES FOR LEADERS | SAFETY CULTURE PRINCIPLES FOR STAFF |
|---|---|---|---|---|
| • Observations<br>• Surveys<br>• Interviews<br>• Address weakness uncovered | • Paying attention to detail<br>• Clear communication<br>• Having a questioning and receptive attitude<br>• Effective handoff<br>• Supporting each other | • Non-punitive work environment<br>• Just response to patient safety incident after assessing behavior that led to error | • Orientation and development programs for leaders<br>• Leaders support and integrate culture of safety throughout an employee's career | • Orientation and development programs for staff<br>• Support work environment where culture of safety is embedded<br>• Team-building PEARLS (partnership, empathy, apology, respect, legitimization and support)<br>• RICHTIES (respect, integrity, compassion, healing teamwork, innovation, excellence, stewardship)<br>• Team engagement model-TEM (plan forward, structure communication, reflect back, and manage conflict) |

eliminate fear of interaction. Organizations can be proactive and create a process to identify and assist providers who were viewed as less approachable. [18]

Mayo Clinic uses a model that has been successful in diffusing best practices across the enterprise and that enables standardization, improved effectiveness (outcomes, safety, and service) and reduced costs of health care delivery. [19] **MM**

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## REFERENCES

**1** Berry JC, Davis JT, Bartman T, Hafer CC, Lieb LM, Khan N, Brilli RJ. Improved Safety Culture and Teamwork Climate Are Associated with Decreases in Patient Harm and Hospital Mortality Across a Hospital System. J Patient Saf. 2016; Jan 7. [Epub ahead of print]

**2** Kohn LT, Corrigan JM, Donaldson MS, editors. To Err is Human: Building a Safer Health System. Institute of Medicine (US) Committee on Quality of Health Care in America; National Academies Press. 2000.

**3** National Patient Safety Foundation. Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err is Human. National Patient Safety Foundation. 2015. http://www.npsf.org/freefromharm. Accessed June 11, 2019.

**4** Developing a reporting culture; learning from close calls and hazardous conditions. AHRQ: Sentinel Event alert. A complimentary publication of The Joint Commission. December 10, 2018;(60):1-8. https://psnet.ahrq.gov/resources/resource/32494/Developing-a-reporting-culture-learning-from-close-calls-and-hazardous-conditions

**5** Sharma U, Ghosh A. Conflict management: how to manage when you can't avoid one. Minnesota Medicine. Sept-Oct 2018.

**6** Institute of Nuclear Power Operators. Traits of a Healthy Nuclear Safety Culture. Revision 1, 2013.

**7** Agency for Health Care Research and Quality (AHRQ). https://psnet.ahrq.gov/primers/primer/5/safety-culture?q=patient+safety+culture. Accessed June 11, 2019.

**8** Reason J, Jobbs A. Managing Maintenance Error. A Practical Guide. Ashgate. 2003.

**9** Edwards M. An assessment of the impact of just culture on quality and safety in US hospitals. AJMQ. 2018;33(5);502-508.

**10** Reason J, Jobbs A. Managing Maintenance Error. A Practical Guide. Ashgate. 2003.

**11** Donaldson LJ; Lemer C; Titcombe J. In harm's way. BMJ. 2019;365:12037.

**12** Cooper M.D. Towards a model of safety culture. Safety Science. 2000; (36);111-136.

**13** Keeping Patients Safe: Transforming the Work Environment of Nurses. Institute of Medicine (US) Committee on the Work Environment for Nurses and Patient Safety; Page A, editor. Washington (DC): National Academies Press (US); 2004.

**14** Leonard M, Frankel A. How can leaders influence a safety culture? The Health Foundation Thought Paper. May 2012.

**15** Meadows S et al. The incident decision tree. Guidelines for actions following patient safety incidents. Advances in patient safety. (4);387-399.

**16** Curry LA, Brault MA, Linnander EL, et al. Influencing organizational culture to improve hospital performance in care of patients with acute myocardial infarction: a mixed-methods intervention study. BMJ Qual Saf. 2018;(27);207-217.

**17** Birk S. Accelerating the adoption of a safety culture. Healthcare executive. March/April 2105;19-26.

**18** Deyo-Svendsen ME, Palmer KB, Albright JK, Phillips MR, Schilling KA, Cabrera Svendsen ME. Provider Approachability: An All-staff Survey Approach to Creating a Culture of Safety.J Patient Saf. 2017 Aug 17. doi: 10.1097/PTS.0000000000000409. [Epub ahead of print].

**19** Dilling, J. Hoover, M, Dankbar, G, Murad, H, Mueller, J et al. Accelerating the Use of Best Practices: The Mayo Clinic Model of Diffusion. Joint Commission Journal on Quality and Patient Safety. 39(4); 167–176.

## EMPLOYMENT OPPORTUNITIES

## KAYLIE EVERS

- Third-year medical student, University of Minnesota Medical School, Duluth Campus
- MMA member since 2018, co-chair MMA-MSS committee
- Grew up in Rochester and graduated from the University of Minnesota Rochester. Worked as a CNA before starting medical school in Duluth.
- Family includes two "very supportive" parents and two younger siblings, plus Rocko, the dog.

### *Became a physician because …*

My best friend and next-door neighbor growing up had a rare condition known as linear nevus sebaceous syndrome. I was fascinated by her extensive medical journey and more than 60 procedures. I watched her medical struggles on a daily basis until she died in 2012 at the young age of 15. I was heartbroken. I decided to funnel my emotions into something that could make a difference: becoming a physician. Instead of hoping someone would find a way to help people like Carly, I would instead do something myself to help people like Carly.

### *Greatest challenge facing medicine today …*

I believe the greatest challenge facing medicine today is the inequalities surrounding access. Growing up in Rochester, I was used to having Mayo Clinic in my backyard. It was not until I moved to rural Minnesota that I realized how much medical care can differ by area. I look forward to the day that I can help lessen the rural physician shortage and become a rural family medicine physician.

### *Favorite fictional physician …*

Dr. Dane Logan from the *Frontier Doctor* trilogy. He was the lone doctor serving a small town in the Rocky Mountains in the late 1800s. No matter what challenges he and the town faced, he was always there for his patients. He measured his success by the trusting relationships he formed and the excellent care he provided.

### *If I weren't a physician …*

I have always enjoyed volunteering in special-needs classrooms throughout my education. If I were not a physician, I would become a special-needs teacher so I could work with kids like my childhood best friend every day.

## MATTHEW YOUNG, MD

- Interim division director, Hospital Medicine, and transitional year residency program director, Hennepin Healthcare. HeLIX Longitudinal Integrated Clerkship director, University of Minnesota Medical School.
- MMA member since 2019
- Grew up in West Allis, Wisconsin. Went to the University of Wisconsin-Madison for both college and medical school. Internal medicine residency at Hennepin County Medical Center and hospitalist at Hennepin Healthcare since 2014.
- Family includes wife Jessica Young and two daughters, Frances, 2, and Ada, 5. Plus a "very bizarre" dog, Beatrice.

### *Became a physician because …*

My application to medical school was based on minimal understanding of the profession and an overly simplistic calculation that I liked science and didn't enjoy my time in the laboratory setting. Reflecting on that, I feel very lucky to have stumbled into a career that brings me joy in many ways. I work hard to make "luck" a much smaller requirement for the future physicians I interact with.

### *Greatest challenge facing medicine today …*

Health inequity and racism in health care. Our advances in medicine should not be celebrated until they are accessible to all and delivered with respect and compassion. The disproportionate impact of COVID-19 on vulnerable populations, along with the horrific murder of George Floyd (and so many others) have given many of us a much-delayed wake-up call. My hope is that we learn from our shortcomings at societal, institutional and personal levels so that we may deconstruct and solve longstanding problems with health care delivery in America.

### *Favorite fictional physician …*

Mehmet Öz's character on "The Dr. Oz Show" is the most interesting to me. He portrays such a perfect caricature of society's misperceptions of health care providers as magical healers. Mehmet Öz trained at prestigious institutions and is clearly well-versed on the scientific method, but his character on TV is a powerful case study in conflict of interest and the corrupting effect of money in health care. Lastly, his extreme celebrity spotlights the disproportionate weight the voice of a "doctor" carries and the dangers of good physicians allowing that void to be filled by others.

### *If I weren't a physician …*

Probably a high school science teacher. One of those cool ones that sits in their chair backwards and "gets real" with their students.

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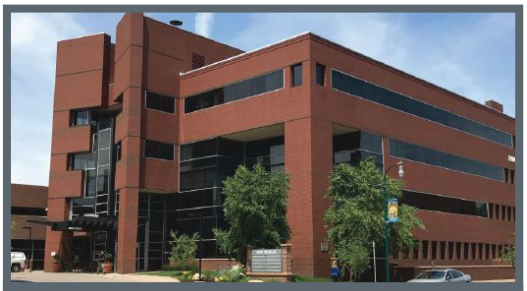

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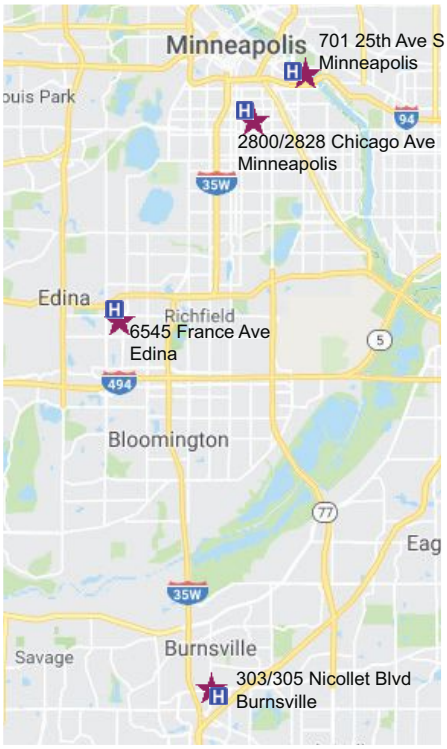


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