FALL 2017 • VOL.1 • NO.4

MFP

MINNESOTA FAMILY PHYSICIAN

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OUR COMMUNITY

Located sixty-five miles northwest of the twin cities of Minneapolis and St. Paul, the City of St. Cloud and adjoining communities have a population of more than 100,000 people. The area is one of the fastest growing areas in Minnesota, and serves as the regional center for education and medicine.

Enjoy a superb quality of life here—nearly 100 area parks; sparkling lakes; the Mississippi River; friendly, safe cities and neighborhoods; hundreds of restaurants and shops; a vibrant and thriving medical community; a wide variety of recreational, cultural and educational opportunities; a refreshing four-season climate; a reasonable cost of living; and a robust regional economy!

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Photo at top: Attendees large and small enjoy the first-ever MAFP "Destination CME" conference in Alexandria this past August. It was fun for the whole family!

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

By David Bucher, MD, FAAFP, MAFP President

BACK TO SCHOOL, FOOTBALL, LEAVES BEGINNING TO CHANGE... FALL.

After we all go our separate ways much of the summer, we rejoin and regroup and have more interactions. Last spring, I spoke about how important our interactions are with one another, as family physicians, teachers, learners, leaders and community members.

SOME RECENT ACTIVITIES:

We had a great turnout at our August Destination CME which was held at Arrowwood Resort in Alexandria, MN, with 50 present and a KSA (formerly SAM) on Childhood Illness completed by many of our colleagues. The weather was hospitable as we shared supper on "The Lawn" together Friday night. Thanks to all who participated.

In mid-September your MAFP delegation to the AAFP returned from San Antonio, Texas, where we provided your voice with the work of our national organization. While **Lynne M. Lillie, MD, FAAFP**, was not installed as president-elect, we appreciated her vigorous campaign which addressed the many issues facing us as family physicians in the current environment. Senior delegate **David Hutchinson, MD**, shares his summation of the Congress of Delegates' actions and activities on page 10.

ALSO IN THIS ISSUE:

- **Jay-Sheree Allen, MD** shares her journey and why she chose to come to Minnesota to continue her education; (We are pleased that she was appointed to be resident member to the AAFP Foundation Board of Trustees, providing another Minnesota voice in the national conversation.)
- **Katie Freeman, MD** shares insights on focusing on the "patient story"; and
- The next installment in our ongoing series on palliative care for family physicians.

Cooler weather offers abundant opportunity for us to interact with each other to exchange knowledge, ideas, perspectives and wisdom. I hope to continue to work to facilitate more opportunities for us all to interact in productive ways.

Your Board of Directors invites your ideas and suggestions to improve interaction within your Academy as well as in your communities and in the state, and I encourage you to see if you might find an MAFP work group, or committee whose work speaks to you. Send your interest(s) to **office@mafp.org**.

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

Representing more than 3,100 family physicians, family medicine residents and medical students, the Minnesota Academy of Family Physicians (MAFP) is the largest medical specialty organization in Minnesota. It is the state chapter of the American Academy of Family Physicians (AAFP), one of the largest national medical organizations in the United States, with more than 124,900 members.

The MAFP promotes the specialty of family medicine in Minnesota and supports family physicians as they provide high quality, comprehensive and continuous medical care for patients of all ages.

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Edition 4

RESIDENT AND LEADER JAY-SHEREE ALLEN, MD, TALKS FAMILY MEDICINE, MENTORSHIP AND MINNESOTA

Jay-Sheree Allen, MD, is an emerging leader in Family Medicine. She's in her final year of residency at Mayo Clinic and has been actively engaged in leadership and advocacy, both locally and nationally.

Most recently, she was appointed as a resident member of the AAFP Foundation Board of Trustees. She's looking forward to providing input into resident programming and hoping to work on an initiative addressing resident wellness and burnout.

Her past leadership roles have included being a resident member of the AAFP Commission on Continuing Professional Development and president of the Mayo Fellows Association.

Allen credits mentoring programs and strong mentor relationships for getting her interested in medicine and helping shape her career path. As an immigrant and the first doctor in her family, mentorship provided her with the guidance she needed to find success in the field.

EARLY YEARS

Allen grew up in Montego Bay, Jamaica, and moved to New York when she was 11 years old. Her mom came to the U.S. to study nursing. At a young age, Allen accompanied her mom to work. Her mom would find other minority doctors to talk with her, encourage her and mentor her.

She participated in two mentorship programs in New York: the Science and Technology Entry Program (STEP) and Mentoring in Medicine. The goal of STEP is to introduce historically underrepresented and economically disadvantaged students in grades 7 through 12 to STEM (science, technology, engineering, and mathematics) careers. Mentoring in Medicine pairs health professionals with students from third grade through health professional school in socioeconomically disadvantaged communities.

Allen and her mother

Its mission is to ignite an interest in a health career for students and then help them execute a plan to get there.

Mentors have continued to influence Allen's path throughout her undergraduate, medical student and residency education. She appreciates all those who have sacrificed on her behalf to help her get to where she is today and hopes to be of similar service to those coming up the pipeline.

We asked her about why she chose family medicine — and Minnesota — for residency, why she hopes to stay here to practice, and what she's hoping to accomplish in her time on the AAFP Foundation Board of Trustees.

Allen's medical school graduation

Q&A WITH JAY

Why did you choose family medicine?
My first answer: Mentors! Mentors! Mentors!

I went to medical school at Meharry Medical College in Nashville, Tennessee. When I began, I had no idea what type of doctor I wanted to become. Family medicine is big there—it's a highly respected specialty in the south.

My first year of medical school, we were paired with a family medicine physician to shadow in clinic. I was blown away by the relationships he had with his patients and how much they trusted him. I remember watching him spend 20 minutes convincing a patient that she needed to see a specialist—that he wouldn't be able to provide some of the care she needed for her condition. She had so much faith in him that she had a hard time accepting she needed to see someone else to continue her care.

On my family medicine rotation, during my third year of medical school, I had the opportunity to work with one of the most brilliant physicians I've ever known. I listened to him talk with one of his patients about mindfulness. It was the first time I had heard a physician talk with a patient about the mind-body connection.

My third mentor during medical school was Rachel Ross, MD, who previously appeared on the daytime talk show The Doctors. She was an alumna of my medical school, and we brought her back to talk about interesting careers in family medicine. She was so dynamic and powerful. I was intrigued to learn all the career possibilities in this specialty.

I wanted to be like each of these mentors. I liked how they operated. I liked the personal relationships with patients, the whole-person care, and the diversity of practice options.

My second answer is that one of my mentors, Millard Collins, MD, an associate dean and interim chair for family and community medicine at Meharry Medical College, told me why he chose family medicine. He said, "You can do the most good for the most people in this specialty." That really resonated with me, and I have adopted that answer as my own as well.

Why did you choose Minnesota for residency?
Minnesota was not originally on my list for residency. In my fourth year of medical school, I completed a visiting clerkship at Mayo Clinic. I was so impressed by my experience. I had an opportunity to learn a lot and participate in a lot. I figured that if I could learn that much as a visiting medical student, there was much more to be learned during my three years of residency.

I also knew my success in residency would be determined by my mentors. The faculty I worked with during my visiting clerkship made a positive impact on me, especially Kurt Angstman, MD, FAAFP, who also happens to be a long-time MAFP leader.

And, I was interested in the quality of life in Minnesota—the focus on family, slowing down for the simple things, and even being able to get a parking spot (unlike in New York).

What are your plans for after residency?
I don't know where I'll end up just yet, but I do hope to come back to Minnesota to practice at some point. Minnesota is an awesome place to live. I have built a network of friends and colleagues here. I appreciate the quality of life in Minnesota. And, I have the tools and resources to do my job well here. Patients are appreciative too, which makes my job more rewarding.

As a resident member of the AAFP Foundation Board of Trustees, you will have an opportunity to provide input into resident programming. What would you like to see the board address, this year, when it comes to resident education?
The hot topic right now is still physician burnout. It's a real problem. I would love to see the AAFP Foundation work on programming to address resident wellness and burnout. During my time at Mayo, we worked on a campaign called MayoWell which was

designed to address physician burnout and suicide rates. We also wanted to alleviate feelings of isolation and loneliness in residents. When we value resident wellness and satisfaction, residents can be more engaged learners and more effective physicians, i.e. everyone benefits when we make wellness a priority.

The AAFP Foundation's overall mission is advancing the values of family medicine by promoting humanitarian, educational and scientific initiatives that improve the health of all people. Which of these areas are you most excited to work on—humanitarian, educational or scientific?
Educational! I'm excited to work with the Emerging Leader Institute. We need to develop more family medicine physicians as future leaders. We need to focus on training up strong voices already in our ranks. We need strong mentors and leaders to represent family medicine.

Any thoughts on future leadership roles?
I'm still growing and evolving so much. I'd love to wait and see. From my experience this past year on the AAFP Commission on Continuing Professional Development, I learned that as much as I love policy, I have a heart for execution. I'm open to what doors open to me. Every opportunity teaches me something new. I'll see where the needs are and how I can be of service.

If you could sum up your residency experience in Minnesota in four words, what would you choose?
It was worth it! Minnesota was worth it. It was a pretty big sacrifice to move away from my family and friends to a new state to pursue big dreams at a world-class institution, but I have benefited from every bit of my time here.

By Kathryn Freeman, MD

MOVING AWAY FROM DATA POINTS AND BACK TO THE PATIENT STORY

This past spring, I consciously moved away from learning clinical skills and spent time at two conferences: the National Medical Legal Partnership Conference (MLP), and the AAFP Family Medicine Advocacy Summit. There, instead of learning about medicine, I learned about stories.

When I reflect on what I learned in medical school, it was all about taking a patient story and converting it into a formal presentation. We spend years training our residents to boil down a patient's history into discrete facts in a defined structure, using medical terminology to convey a message that only other physicians can understand. But that only allows us to communicate with each other, not with the world around us, or with the people, partners, groups, and leaders who have the potential to make a larger impact our patients' health.

At both of these conferences, I heard about the importance of authentically sharing patient stories. How data by itself doesn't reach people. How hearing facts and figures (or alternative facts and figures), won't change people's minds or engage them in conversation. How these stories, real stories, full of emotion and consequences, have the power to influence those who hold the power; those who make big decisions affecting the coverage, services, funding, and the overall health care available to our patients.

How then, do we teach residents to tell stories? How do we teach them to take out the technical details, the medical jargon, and convey the human nature and the inner battle patients face in their health care decisions? How do we teach them to identify the values and interests of their intended audience to build connections and relationships? How do we make it non-medical, and instead about real people? Especially when we began training them to deconstruct stories from the first weeks of medical school.

And, if I am honest, are we as physicians really the ones to share these stories in the first place? Should we instead be training our patients to be storytellers, so they can own and share their story in a way that is authentic to their own experience? Are we then only acting as a proxy, hijacking the stories of others for our own benefit?

Despite the inner struggles, following the Family Medicine Advocacy Summit and the MLP National Conference, I have found myself repeatedly and thoughtfully reaching for the right story. Experienced physician advocates, community-engaged practitioners, lobbyists, and health minded civil aid lawyers demonstrated where the story fits into the work of policy change. I can see where the personal nature of a story can stand out among the objective data, and I strive to capture the story in a way that is authentic to the patient and provider experience.

I needed that story of a young man's battle with his landlord to gain support for our new medical legal partnership. I found the story of a refugee family's struggle to schedule their child's surgery was the right message for a phone call with the insurance company. And I hope that my patients' positive and patient-centered delivery experiences will be enough to reinvigorate and redefine our program's OB experience.

While I don't always feel confident sharing these stories, these conferences have helped me understand their importance and have given me the courage to use them, and my privilege as a physician, to bring about positive change.

I hope I can help residents learn to cherish their patients' stories and share them to advocate a greater audience. Perhaps I can help residents convey the realness they are privy to each day in the exam room. Perhaps I can help residents use their privilege to stand up for the needs of patients. And perhaps, one day, we will train residents to coach patients to tell their own stories, and we can use our privilege to get them through the front door to create meaningful, lasting change.

Dr. Freeman is a University of Minnesota St. Joseph's Hospital Family Medicine Residency graduate who joined faculty in 2014. Her clinical interests include full spectrum family medicine, obstetrics, geriatrics and community health.

Originally published on the STFM Blog at blog.stfm.org. Reprinted with permission of the Society of Teachers of Family Medicine.

By David Hutchinson, MD

CARRYING THE FLAG

A Report from This Year's Congress of Delegates

I write from San Antonio, Texas, as we close the 2017 AAFP Congress of Delegates (COD). This is my final year as a delegate for you from the MAFP, and I want to THANK YOU once again for the opportunity to be here to represent family physician concerns and patient needs at our national organization's legislative level.

Part of the pleasure of being here is in the company, of course. Your Minnesota delegation — **Julie Anderson** (St. Cloud), **Daron Gersch** (Albany), **Dania Kamp** (Moose Lake), **Glenn Nemec** (Monticello), **Dave Bucher** and **Renee Crichlow** (TC metro), AAFP board member **Lynne Lillie,** and our MAFP staff (**Maria, Tara, Missy**) — are dear, gifted, talented, energizing individuals. Two terrific resident and student members were also in attendance, **Lauren Williams** and **Paul Stadem**, respectively, who will be caring for us after we're done. They all demonstrate clearly that you are exquisitely well represented within the AAFP and MAFP for years to come.

This year at the COD we had the uncommon task of promoting Lynne Lillie, MD, FAAFP in our campaign for her to become AAFP president-elect, as she finishes her three-year term on the AAFP Board of Directors. Dr. Lillie worked extremely hard for us in this pursuit. Her preparation, her presence at meet-and-greet sessions, her presentation, her speech to the Congress, and her formal Q&A performance were exemplary. So, too, were the efforts of her many family members who came to help with hospitality on her behalf, many other Minnesota members, and especially of our MAFP staff, who have been working on this campaign for months.

Dr. Lillie has been an absolutely amazing representative for family medicine and our patients, at many levels of the AAFP for decades. We were not successful, sadly, at helping to achieve her election, but it was an exciting ride. The Congress had multiple gifted candidates to choose from. John Cullen, MD, from Alaska, will be a great AAFP president in 2018.

At the COD, we considered/debated resolutions about invigorating issues such as:

- Organizational declaration of health care as a right, not privilege
- Protection of telemedicine maternity care abilities by providers
- The increasing member interest in Single-Payer health systems
- Initiatives for burnout prevention
- Advocacy for directed spending for post-grad medical education to incent primary care training
- Advocacy for changes to Maintenance of Certification
- Developing a feature searchability function for the residency program directory
- Physician aid-in-dying/assisted-suicide terminology promotion
- Protection of incarcerated patient's rights
- Tobacco sales restrictions to minors in the military
- Health Impact Assessments as potential requirements for commercial and public works projects
- Increasing member diversity
- Support for family physicians as leaders in employed health systems
- Advocacy for alteration of the Medicare '3-midnight' rule
- Stabilization of drug pricing
- Limitations to Prior Authorization
- Focus on consideration of 'health' in all policies
- Study of violence in the healthcare workplace, and support for those who experience it
- Member education in the field of Integrative Medicine
- Systems to refine practice and outcome metrics
- Reduction in administrative burdens

For the future of medicine in America, for our patients, for our families, for our health, we need to be courageously obtrusive.

It was a week of inspiration and substance. Being surrounded for four days by strong, intellectual idealists from around the country loosens one's sense of the possible. It is restoring to be here, among our own members, and to strive for better together. Annually, after engaging here, I am amazed at how quickly I realize that group advocacy is medicine for the soul of the advocate. I realize, too, how silly it is that I must discover this over and over, and how in the course of the sprint and grind that can be our daily and weekly work lives, I forget to take this medicine.

If you long to believe that…

…it is possible for you to spend most of your work energy in the service of clinical encounters and relationship-building

…you could spend less of your work time (and free time) navigating administrative BS

…your patients can have the affordable and sensible care and health system that they deserve and that we deserve to offer them

…you can be provided better resources and remuneration for your labor and expertise

…politicians, society, and the house of medicine will recognize the primacy of family medicine as the cure for an ailing health system,

…our outcomes can be measured meaningfully instead of expediently

…the MD degree and your family medicine specialty certification have unique and outstanding value

…there can be justice in medicine for patients and for primary care

…then consider investing pointedly in ADVOCACY efforts.

Advocacy is empowering, affirming of our values, and creates change. Many of us aren't particularly good at this, myself included. Stating our beliefs and desires isn't easy in a crowd where other individuals have their own interests. Drawing attention to ourselves isn't necessarily our first nature. Willingly engaging in ways that could stimulate contrary reaction or conflict isn't in the first nature of most Minnesotans.

In family medicine, we've learned to be nicer than this, to be unobtrusive. For the future of medicine in America, for our patients, for our families, for our health, we need to be courageously obtrusive. I believe that what we as family physicians want for health care is as unselfish as any agenda in medicine.

What we want support for offering is what creates contentment for patients, saves costs, leads to better overall health outcomes, and preserves providers. We know this, and we're obliged to continue to say so. I also believe that family physicians are as well suited to this advocacy task as ANYONE in medicine. We navigate conflict gracefully, we are inclusive, we listen, we advocate from a noble position.

This is me, advocating for you, to advocate for us. Please convince yourselves to attend your health system staff meetings, lead your departments, and increase your involvement with your professional member associations, especially the MAFP and MMA, toward advocacy (#healing).

Carry the flag.

Become delegates, committee members, board members, officers.

The return to you will be greater than your investment.

All of us in the Minnesota delegation recognize all of you in Minnesota family medicine as our family, not just as constituents; we recognize you as the source of our moral and communal support, not just our electoral support. We need your participation, and your feedback. I cheer for your fulfillment as family physicians, and I cheer for your inspiration, your boldness, to make a noise for family medicine.

I have many heroes, and you are highest among them.

Adios, from San Antonio.

Dr. Hutchinson is a family physician at Lester River Medical Clinic/St. Luke's health system in Duluth. He is retiring from the delegation this year after serving as an MAFP delegate or alternate delegate to the AAFP for the last eight years.

HPV-RELATED CANCERS ARE A BIG DEAL

With one in four people currently infected with human papillomavirus (HPV) in the U.S., family physicians are crucial to introducing the **HPV vaccine** as a cancer prevention vaccine to all adolescents aged 11-12. That's why the MAFP has teamed up Minnesota Department of Health to increase HPV vaccination through a quality improvement (QI) project with family physicians.

We have a team of family physicians trained to work with one-on-one with you and your clinical and administrative team to:

- Integrate current evidence for HPV vaccination effectiveness into clinic practice for a strong HPV recommendation;
- Create a clinic level plan to engage all clinic staff members in giving a strong HPV recommendation; and
- Embed and sustain strong recommendations in ongoing clinical care.

As a participant in this project, you'll create a **customized plan**, which relies upon MIIC data, to improve HPV vaccination rates for your patients. The plan will help your clinic address multiple quality metrics and you'll earn CME credit for participating. The 30-minute training is free and is available in person or via webinar in the morning, noon hour or late afternoon.

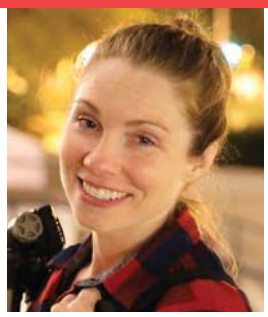
If you don't know your clinic's HPV immunization rate, you should, and now easily can find out by signing up for this free QI project today! Visit **www.mafp.org/hpv**.

"Our patients and their families depend on us to make a clear and strong recommendation for evidence-based therapies, and the HPV immunization should be one of those recommendations."
— Barbara Yawn, MD, MSC, FAAFP
HPV Vaccination Champion

MINNESOTA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR MINNESOTA

DEPARTMENT OF HEALTH

By Jennifer Kuyava, MD



APPROACH TO DIFFICULT CONVERSATIONS

Palliative Care for Family Physicians: A Four-Part Series

As physicians, we are now, more than ever, needing to learn the skills of how to have end-of-life conversations with an older, sicker, more medically complex population. Patients and families look to us to help them understand their medical options and make decisions consistent with their values. Many of us were never trained in how to have these difficult conversations. Mix that in with dealing with a death-denying culture and it's no wonder many physicians find these conversations challenging.

WHY ARE THESE CONVERSATIONS SO DIFFICULT?

Many physicians simply do not feel they have the skills nor the training, so they avoid discussing important issues. Some are worried they might provoke emotional distress in a patient or family and not know how to handle this.

Understandably, we like to focus on positive things; however, avoiding talking about bad news because it makes us uncomfortable does a disservice to our patients. Some physicians worry patients/families might blame them for a poor prognosis. Additionally, many of us have strong emotional connections with our patients, especially people we've cared for a long time. Dealing with their illness can be stressful for us personally.

Finally, if we admit it is important for us to have these difficult conversations with our patients, then we are ultimately admitting our own mortality…and, well, that's just not something people like to think about.[1]

WHY IS THIS IMPORTANT?

Unfortunately, patients and families often do not know or understand as much as we think they do. This is not for lack of good, informative discussions with previous providers. Rather, when people are bombarded with bad news, there is only much they can absorb, process, and remember. It can take having similar conversations multiple times before someone facing a serious illness can fully grasp what it all means.

We owe it to our patients to first make sure they understand their complicated disease(s). They also deserve to be heard. After that, it's our job to make sure they understand their options and feel supported no matter what they choose.

A HELPFUL TOOL

One tool I use on a daily basis is SPIKES. It was created by Bob Beckman and Walter Baile and stands for Setup, Perception, Invitation, Knowledge, Emotion, and Summarize.

Setup is what we do to deliver important news. Appropriately setting up means you are well informed about your patient's medical conditions. It means you have taken the time, before the appointment, to discuss the complex situation with other providers (if necessary). It also means you have allotted enough time for this important meeting and you will not be bothered during the visit (i.e. pagers silenced). You have secured an appropriate, private room with enough chairs. Tissues are easily accessible. Only after all that is done can you start the meeting by everyone introducing themselves. This may sound like a lot of effort, but it only takes a moment. By doing this, you have conveyed to your patient and their family that they are important…and that is exactly how you want to start.

During a difficult conversation, we want to hear from our patient first. **Perception** is about us assessing out patient's understanding. In a new consult, one of the first questions I ask is, "What have the other doctors told you about [your heart, your lungs, the cancer, etc.]?" This is one of the most valuable questions I ask! No matter the response, the answer is incredibly informative. Sometimes we learn a lot about what a patient knows and where they are at with their illness. Sometimes we can save ourselves (and our patients) needless minutes of us telling them things they already knew. Other times we realize patients have not learned (or not retained) much information about their complex illness at all. This is valuable because it tells us where we need to start.

Asking a patient for an **Invitation** to discuss their situation might seem silly to some; however, this is an underutilized and immensely valuable tool. One, it helps set the stage so that patient and family realize something important and serious is going to be discussed. It helps prepare them. Two, politeness and courtesy go a long way in establishing and supporting the patient-physician relationship. Building good rapport is essential when one is about to discuss bad news. How does one ask for an invitation? You have to find words that work for you, but I typically say something such as, "Would it be okay if we discussed where things are with [your heart, your lungs, the cancer, etc.]?" or "There are some important issues we should discuss, would now be an okay time?"

After we have received the okay to discuss serious news, it's then our job to inform patients and families and provide them with the necessary **Knowledge**. During this part of the visit, we need to be careful to speak in a very straightforward way that is accessible. It is unfortunately too easy for us to use medical jargon, but that does not help our patients or families. We must deliver news in a clear, compassionate way that is understandable to those who are non-medical. It is okay to discuss the uncertainty of the situation. Prognostication is both an art and a science. Sometimes it is best to focus on the big picture and leave technical details for a later time. After giving an important piece of information, it is recommended to pause. This allows time for patients and families to process and digest the news.

Another reason to pause after giving bad news is because it might bring up a strong **Emotion**. It is imperative we acknowledge the emotions of our patients and families. Sometimes this means we pause and give them space to cry, be scared, or be angry. Often it is best if we don't say anything. We are not trying to fix the emotion; rather, we are simply acknowledging it. The offering up of silence and presence can be incredibly powerful when it comes from a genuine place of caring. It is in these moments we are allowing our patients and families to feel heard and supported. Additionally, providing space to acknowledge emotion also helps us continue to provide important cognitive information. If we haven't given our patients and families the needed space to express their feelings after hearing bad news, then we cannot expect them to hear and retain any subsequent information.

After we have delivered the information and responded to emotions, then we must **Summarize** the plan at the end of the visit. This can be a discussion of the big picture and major points that were talked about during the visit. Importantly, this should include the next steps. I often type out a summary and hand it to patients because I feel it keeps things clear in my mind (and hopefully in the minds of patients and families, too) and demonstrates a commitment to the plan we came up with together. Also, I never expect people to remember much of what we have discussed, so I think a written reminder is valuable. I often ask patients and families to summarize for me, in their own words, what we discussed. I do this to make sure I have done a good job in conveying important information.[2]

WHEN YOU DON'T KNOW WHAT TO SAY

While using SPIKES is almost certain to help make difficult conversations less difficult, there will be times when one feels stuck. If that is the case, there may be some emotion that needs to be acknowledged or a time of silence might be beneficial. Additionally, the following phrase can often help:

"Tell me more."

This one simple phrase can open up so much. Our patients have rich lives behind their illness. When we deliver bad news, we have uprooted this life and it is our duty and privilege to help support them as they try to navigate what this all now means for them.

"Tell me more about why you ask that question."
"Tell me more about your concerns."
"Tell me more about what you are thinking."
"Tell me more about your hopes."

After we ask these questions, we need to just be silent (for longer than what probably feels comfortable).

IN SUMMARY

These conversations are not easy to have. By being prepared, assessing our patients' understanding, asking for permission, providing complex medical facts in a clear manner, giving space to express emotions, being silent, and reassuring our patients we support them, these difficult conversations can be quite meaningful.

In my humble opinion, the honor of having these conversations is one of the greatest rewards of being a family physician.

Dr. Kuyava is board certified in Family Medicine and Hospice and Palliative Medicine. She practices Hospice and Palliative Medicine at Allina. She enjoys cycling, music, photography and doing anything outdoors, especially in northern Minnesota.

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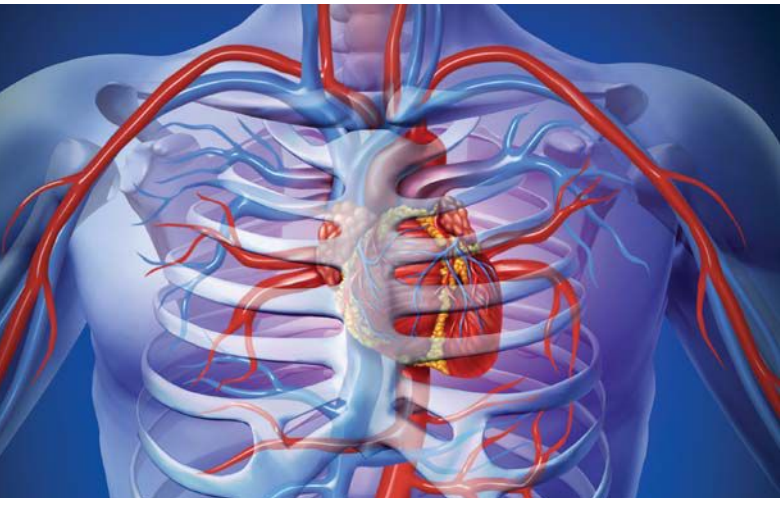
By Osama A. Ibrahim, MD, FACC

PERIPHERAL ARTERY DISEASE

The New Cardiovascular Challenge



WHERE WE ARE TODAY

Peripheral Artery Disease (PAD) is atherosclerosis of the peripheral arteries, which includes primarily the Iliac, Femoral, Popliteal, Infrapopliteal, and Renal Arteries. Over the past decade, PAD has emerged as one of the most prevalent, deadly, and costly challenges our healthcare system and providers face.

Let us pause and read that last sentence again: "most prevalent, deadly, costly" — all are hallmarks of a potential healthcare crisis which continues to grow and consume substantial resources of an already fragile and challenged healthcare economy.

In 2015 the annual economic burden of PAD was estimated between $216-398 billion (compared to $176 and $144 billion for Diabetes (DM) and Coronary Artery Disease (CAD) respectively) with Medicare picking up ~75% of that bill.

The annual Medicare expenditure for a PAD patient is ~$70,000 as compared to $11,000 for the average Medicare beneficiary. In 2015 the cost of PAD was more than DM and CAD combined.

PREVALENCE

Latest data reveal that more than 200 million patients are affected by the disease globally and approximately 18-20 million Americans harbor the disease. Several prevalence trials performed within the past few decades have illuminated the abundancy of such a disease state.

The PARTNERS trial (Hirsch et al) demonstrated elegantly that ~30% of patients over the age of 70 years have this disease. More importantly, it showed that patients between the age of 50-69 years of age with either DM or smoking also have ~30% chance of having this disease. These numbers are more prevalent than CAD, Heart Failure and Atrial Fibrillation, and they are worse than almost all cancers combined.

Shockingly, when dealing with PAD, several prevalence trials have also demonstrated that up to ~50% of the time, patients present in an asymptomatic state. Several factors contribute to such an obscure presentation:

- Several elderly patients "blame" any lower extremity fatigue/heaviness symptoms on the natural aging process;
- A lack of strenuous exercise in the population does not allow for symptoms to be unmasked;
- As these "blockages" are developing, the body is also undergoing "neoangiogenesis" which is a process known as collateral vessel recruitment or collateral vessel formation.

RISK FACTORS AND PRESENTATION

The cardinal risk factors for PAD are age, DM and smoking. As we all know, age and DM are only becoming more of an issue given that patients are living longer and DM is becoming more prevalent. Some reports indicate that ~50% of adult Americans will suffer DM by 2050. Other risk factors include Hypertension and Dyslipidemia.

Several of my colleagues ask me, "If the patient is asymptomatic, then why do we care?" The issue is not the "asymptomatic state," rather that, in asymptomatic patients that have abnormal vascular testing such as an Ankle Brachial Index (ABI), based on the severity of the ABI, they carry up to a 7-fold increment of having a fatal myocardial infarction or a deadly stroke. These are not easy numbers to swallow, especially when discussing fatal myocardial infarction and/or fatal strokes.

There is a spectrum of presentations of PAD, anywhere from an asymptomatic state to Intermittent Claudications (IC) to the most

feared, Critical Limb ischemia (CLI), which carries a one-year 40% major amputation rate, and a 2-year 50% mortality rate. These are horrifying statistics, but unfortunately, they are all true. The hallmark of CLI is rest pain and tissue loss, which may be represented by toe gangrene, non-healing wounds and/or non-healing foot ulcers.

THE ROLE OF SCREENING

Unfortunately, in dealing with an extremely abundant, costly, dangerous disease state that ~50% of the time presents with no symptoms, and when it finally does present with symptoms, usually amputation is unavoidable, we know we are facing an uphill battle. We have to change our approach to the equation.

All the above-mentioned criteria of the disease state are similar to that of cancer. How were we able to challenge various cancers? The only method of targeting cancer was to identify the patients at risk and then start screening them accordingly.

For example, if we are dealing with an elderly patient with extensive smoking history, we may think of ordering a chest X-ray; for a young, sexually active female we provide PAP smear screening; for females over age 40 we perform yearly breast exams and even order mammography; for males over age 50 we always think of screening for prostate cancer, and many other examples to follow.

PAD is no different. When we are dealing with patients above the age of 50 with smoking or DM, we should always think of PAD. That is how we deal with such a disease state — we outsmart it and attempt to actively target this disease. These are actually the guideline recommendations from the American Heart Association/American College of Cardiology but unfortunately not many providers are aware or adhere to such recommendations. To be clear, this is not general population screening, this is patient population targeted screening.

DIAGNOSIS

Diagnosis of PAD is done primarily by looking at the patient's risk factors and constantly being on the lookout for PAD as a disease. Initial diagnosis of PAD can be done by a simple, non-invasive test known as an Ankle Brachial Index (ABI). This simple test is done as both a resting and post-exercise test, and if done accurately, carries a greater than 95% sensitivity and specificity. If the ABI is abnormal then referral to a vascular specialist is encouraged. Other vascular imaging modalities are used to confirm the ABI such as Ultrasound (US), PVR, CTA, MRA, and/or conventional angiography. Each modality has its advantages and/or limitations, but overall the US and CTA are the two most widely used imaging modalities.

A vascular specialist may be either Vascular Surgeons, Interventional Cardiologists, Vascular Medicine specialists and/or Interventional Radiologists. All are fully trained in managing various PAD states, and usually collaborative and multidisciplinary approaches to such a disease state are in place. Over the past decade several specialists now collaborate to form limb salvage and amputation prevention programs. Such an effort requires close multidisciplinary collaboration between all above mentioned parties.

MANAGEMENT

The cornerstone of PAD management is, surprisingly, risk factor modification and supervised walking exercises — not necessarily revascularization per say, optimization of blood pressure control, aggressive glycemic control, smoking cessation and vigilant lipid control.

In regard to pharmacotherapy, unfortunately only Cilastozol (Pletal) therapy has been linked to improved walking distance and improved endurance in patients with claudications.

Supervised exercise has been proven again and again to improve the quality of life scores and increase distance of ambulation in claudicants. Such a profound impact was noted with these supervised exercise programs that just recently CMS approved reimbursement coverage for these programs.

If the above conservative approach fails, then revascularization has a role. Over the past three decades a tremendous shift has occurred from surgical bypass to an "endovascular first approach," especially now that advancements in the medical device industry have allowed endovascular procedures to become the mainstay of lower extremity revascularization. There is morbidity, mortality, infection risk and early recovery benefit to endovascular procedures over surgical procedures, but this does not undermine the fact that sometimes a hybrid approach and/or a purely surgical approach is required to treat certain patients with complex anatomy.

FOLLOW-UP

PAD is a lifelong, progressive disease, and despite our advancements in management and newer revascularization approaches, they do not come without limitations. Unfortunately, denovo disease and restenosis requiring additional future procedures are not uncommon, hence patients should maintain regular follow-up with their vascular specialists for life and also be enrolled in vascular US programs. This is also backed by various medical society guidelines.

This disease, similar to other cardiovascular diseases, such as CAD or Carotid Artery Disease, requires lifelong surveillance to ensure that the disease remains in a controlled state. MP

Dr. Ibrahim is the Director of PAD, Limb Salvage, and Amputation Prevention Programs and Director of Peripheral Endovascular Therapies at North Memorial Heart and Vascular Institute. He presented on PAD at the 2017 MAFP Spring Refresher.

By Amos S. Deinard, MD, MPH

FIGHT DENTAL CARIES WITH FLUORIDE VARNISH

The Mouth Is Part of the Body, Too

Dental caries (the process, the end result of which is a cavity) has presently reached silent epidemic proportions in this country because no one writes about it. The condition is the most common chronic disease of childhood, five times more common than childhood asthma, ten times more common than childhood hay fever, and twenty times more common than childhood diabetes.

Fortunately, because caries is an infectious disease, it is theoretically preventable.

Those children who are most likely to develop caries are:

1. Those who are covered by Medicaid/MNCare, because most general dentists, who see 15 times more children than do pediatric dentists, are reluctant to take on Medicaid/MNCare enrollees for a variety of reasons. In addition, they have no comfort level with children under the age of three years because they never saw those early ages in Dental School (the ADA, AAP and AAFM all endorse twice yearly dental care commencing at the time of the eruption of the first tooth or by age one at the latest); and

2. Those who are covered by commercial medical insurance but whose family cannot afford purchase of dental insurance or to pay out-of-pocket for dental care.

Readers of this article are in a position to take advantage of the Child and Teen Checkup (C&TC) well-child examination, or visits for episodic care, to provide caries prevention services (CPS) on a routine basis. CPS includes an oral evaluation (if the mouth looks like a train wreck, find a dentist who will label the condition and then together, you can decide who should treat the child), a risk assessment (if the child is on Medicaid/MNCare and has no dental home, i.e., a dentist who will provide twice yearly preventive care and as many visits as necessary for restorative care), anticipatory guidance for the caregiver about:

1. Caries etiology (bacteria in the mouth digest the sugars from food and drink creating acidic excrement which etches the enamel of the tooth thereby starting the caries process); and

2. The important role that the caregiver plays in such domains as twice daily tooth-brushing with fluoridated tooth paste and feeding practices (bottles and sippy cups should only hold water except at mealtimes), fluoride varnish (FV) application, and making sure the caregiver understands that FV is not a substitute for sealants or for the child having a dental home. Application of FV is a non-invasive procedure. It takes three to five minutes to cover all the teeth in the mouth and the varnish dries on contact.

Because CPS is routinely a covered, reimbursable service with the primary care medical provider (PCMP) doing the oral evaluation and the other tasks listed above being delegated to a member of the ancillary medical clinic staff (AMCS) i.e., CMA, MA, NA, LPN, RN who have been trained by a PCMP and their tasks covered by standing orders on how to do the tasks, and overseen by the PCMP (akin to the immunization process).

In 2015, the US Preventive Services Task Force recommended that FV be applied starting with the eruption of the first tooth and quarterly thereafter up to the child's sixth birthday. Minnesota will reimburse PCMPs for FV application quarterly up to the child's twenty-first birthday.

In view of the daily demands on PCMP time, it makes great sense for the AMCS to be involved in four of the five components of CPS. Of the five components, all but FV application are reimbursed under the C&TC billed CPT code(s) while CPT code 99188 will lead to reimbursement for FV application applied by a non-dental trained health professional.

Dr. Deinard is Associate Professor in the Department of Pediatrics and Adjunct Associate Professor in the Division of Epidemiology and Community Health at the University of Minnesota. His research interests include improving the oral health of low-income children and the parenting skills of high-risk mothers.

NATIONAL CONFERENCE: BY THE NUMBERS

The AAFP National Conference is the annual meeting for residents and medical students from across the country to gather and learn more about family medicine, explore residency programs, and connect with potential employers. This year's conference was held July 27-29, 2017, in Kansas City.

$16,000

Scholarships pledged. Thank you MAFP local chapters, Mayo Clinic Department of Family Medicine, University of Minnesota Department of Family Medicine and HealthCare Associates Credit Union!

$9,200

Sponsorships received for Minnesota Reception

220

Attendees at the Minnesota Reception (up from 175 last year!)

65

Medical students who applied for scholarships (with 50 in final attendance)

4

Residents and Medical Students who ran for national office: **Lauren Williams, MD** – UM North Memorial for Resident Member, AAFP Board of Directors; **Peter Meyers, MD** – United for Resident Delegate to AAFP Congress of Delegates; **Jay-Sheree Allen, MD** – Mayo for Resident Member, AAFP Foundation Board of Trustees (elected!); and **Emilia Vesper, MS4** – University of Minnesota for Student Delegate to AAFP Congress of Delegates

Lynne M. Lillie, MD, FAAFP, (center) with our residents and medical students who ran for national office

3

Poster presenters: **Lauren Williams, MD** – UM North Memorial & **Peter Meyers, MD** – United presented "Advocacy 101" and **Seun Acquah, MD** – UM Methodist presented "Food Insecurity"

> *"...[It's] great for all medical students regardless of their year in training! For first and second years there are plenty of informative lectures and workshops to choose from. For third and fourth years, there is an invaluable opportunity for networking residency programs."*
>
> *— Ahren Wippermann, UMD, MS4*

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- Mayo Clinic
- Sanford
- Scenic Rivers Health Services
- St. Cloud VA Health Care System

COMING UP NEXT

DEADLINE > Innovation Grants for Residents & Medical Students
December 1, 2017
www.mafp.org/apply

Intro to Advocacy for Residents
Saturday, January 13, 2018
Surly Brewing Company
Minneapolis, MN

Give to the Max Day
Thursday, November 16, 2017
www.mafp.org/max

Research Network Dinner
Friday, March 2, 2018
University Club
St. Paul, MN

Innovation & Research Forum
Saturday, March 3, 2018
HealthPartners
Bloomington, MN
(location tentative)

Day at the Capitol
Wednesday, March 14, 2018
Minnesota State Capitol
St. Paul, MN

MAFP House of Delegates
Wednesday, April 11, 2018
Saint Paul RiverCentre
St. Paul, MN

MAFP Spring Refresher
Thursday & Friday
April 12-13, 2018
Saint Paul RiverCentre
St. Paul, MN

MAFP Destination CME
Friday & Saturday
August 17-18, 2018
Inn on Lake Superior
Duluth, MN

By Arne Vainio, MD

SAUNA IS A PLACE FOR REBIRTH AND CLEANSING

Another Saturday morning and I'm hoping to sleep in.

My friend Steve sends me a text, "The sauna will be hot in 40 minutes."

My week has been long and I just want to sleep. I diagnosed one of the nicest people I know with metastatic liver cancer on Tuesday and I was hoping I was wrong. I had to start a baby on morphine for opiate withdrawal and I just found out I have eight online training assignments and each takes about a half hour. Those will be on my own time. Call kept me up all night and I was in the hospital three times and barely had time to take a shower before rounding and heading to work. I forgot to finish billing my charts on Wednesday and that was in my task list among all the phone calls to return and countless prescription refills. I received faxes from two nursing homes that patients were due for rounds in the next two days and I wished I would have rounded on them on my call weekend.

I just wanted to sleep.

I got up and made my coffee and headed over to Steve's house. He claims he's 110 percent Finnish and I have no way to verify that. Saunas are important to him. I'm 50 percent Finnish on my father's side and saunas are also important to me.

Also important is pronouncing it right. "Saw-na" isn't correct and that's a touchy point with Finnish people. "SOW-na" is the correct way to say it.

I get to Steve's and we visit for a while and we drink our coffee. Then we head into the basement to the sauna. Steve has an electric sauna, but it's a good one and it holds about 150 pounds of rocks. He has towels on the top benches and the thermometer is at 170 degrees Fahrenheit and this is perfect. I sit closest to the stove and we talk a little bit, then we let the heat settle in. The ticking of the stove is the only sound and after a while I take the wooden dipper from its hook on the wall and dip it into the bucket full of cold water. I pour the water on the rocks and the *löyly* (spirit of the steam) gently fills the room as the water hisses on the rocks. The steam hits suddenly from the ceiling and works its way down and we have to bend forward to breathe.

My father committed suicide when I was four years old and I only have maybe four actual memories of him. One of them was in my grandfather's sauna and the wood-fired stove was so hot my father was standing at the changing room door opening and closing it to try to get some of the cool evening air to come in and I could feel the coolness and I could smell

the pine walls and the hot water and the steam and my hair was wet and clean.

I remember him carrying me to the house.

My grandfather came from Finland when he was a young man and he built the sauna first when he homesteaded his land. My grandmother traveled alone on a ship from Finland and came to Ellis Island in New York when she was nineteen years old and met my grandfather when she answered an ad to be a housekeeper. My father and my two aunts were born in the sauna. My grandfather's father certainly would have had a sauna in Finland and the *löyly* would have been the same for both of them.

The heat and the steam soak in and I remember my father and my grandfather.

Their lives were every bit as stressful as mine, but in different ways. I am the same and I need the heat and the steam to wash away what I cannot wash away at the sink in the exam room at the clinic. I need to be in the sauna with Steve and my father and my grandfather. Burnout among physicians is real and all of us are aware of the sanctity of the trust and overwhelming responsibilities placed upon us and we carry that alone. I cannot say any of these things in the sauna and words are not necessary.

There are articles written on the health benefits of taking saunas. Like any other information, a quick web search will pull these up.

Burnout is real and we need to do what we can to keep it away. My Ojibwe side tells me we travel a circle from birth to death and the very young and the very old hold hands across the doorway where we begin and end that journey. No one is closer to that doorway than we are as physicians and we are the helpers for those crossing through that doorway in either direction. We see things others rarely see and we are entrusted to keep it to ourselves. No one else carries this burden.

Healing happens in ways we don't always recognize. The sauna is a place for rebirth and cleansing; spiritually, physically and mentally. It's a place to laugh and to cry, to talk or to sit in silence with someone you trust.

The steam is ancient and it carried away some of my grandfather's grief and uncertainty when my father died. I will let it carry away mine.

Dr. Vainio is Finnish on his father's side and is an enrolled member of the Mille Lacs Band of Ojibwe. He is a family physician on the Fond du Lac reservation in Cloquet, MN, and was a finalist for the 2017 MAFP Family Physician of the Year.

John Bachman, MD – Rochester

CENTRAL AMERICA

I have led 11 brigades to Central America with incoming Mayo Medical Students, premed students and support staff. The average brigade is about 35 people. The brigade provides primary care, dental health and education to the same communities until they graduate to be self-supporting. Students learn about primary care and global health in the eight-day experience and present posters, lectures and written papers on the projects they have initiated.

Kathleen Culhane Pera, MD – St. Paul

THAILAND

As a family physician and medical anthropologist working with Hmong in St. Paul, I went to Chiang Mai Thailand to learn from Hmong people and work with the Department of Family Medicine, Chiang Mai University. For five years out of the past 29 years, I have shared life with the Hmong villagers. Listening to, learning from, and sharing my life with them has improved my ability as a family doctor to communicate, connect and partner with the Hmong in Minnesota.

FAMILY DOCS WHO SERVE ABROAD

Glenn Nemec, MD – Big Lake

JAMAICA

Each February we have a mobile clinic and pharmacy that goes to areas where there are no doctors for people to see – as in NONE – and do outpatient clinics. Jamaica has national health coverage, but since there is such a shortage of providers and little transportation for the poor to get to them, the coverage is not able to do much good. While I can't fix their systemic issues, the experience has re-taught me that what I do is to do the best I can for each individual patient. It is still worth "throwing one starfish at a time back into the water."

Pete Olsen, MD – St. Paul

KENYA

Our family moved to Tenwek Hospital in rural Kenya three months ago as full-time missionaries for our first two-year term. Tenwek Hospital is a 300-bed mission hospital located just outside of Bomet, Kenya. It serves a catchment area of just over one million people! I am one of five full-time faculty members of the Tenwek Hospital Family Medicine Residency Program (and one of two Minnesota family medicine physicians on staff! Eli Horn, MD and I both trained in Duluth). We initially thought we'd be doing language training as soon as we arrived, but due to physician staff shortages and a concurrent national nursing strike, I've needed to start working right away.

The United Family Medicine Residency Program's welcoming art for community members attending the United Family Medicine Clinic Healthy West 7th Community Block Party on August 17, 2017.

IN THE NEWS

Jay-Sheree Allen, MD, PGY-3 at Mayo, was elected Resident Member of the AAFP Foundation Board of Trustees at the AAFP National Conference July 27-29 in Kansas City. Congratulations Jay!

Two members will be presenting at the St. Louis County Health & Human Service Conference October 12-13, 2017, in Duluth: **Emily Anderson, MD**, Medical Director, Lake Superior Community Health Center on "Under One Roof: Integrated Care Model"; and **Jamie Conniff, MD, MPH**, Faculty, Duluth Family Medicine Residency Program, Essentia Health on "Expanding Transgender Health Services in a Large Health System: Essentia Health's Process to Becoming More Trans Friendly."

Ethan Harris, MS4, and **Heidi Wipf, MS2**, have been instrumental in Smiley's Somali Health Initiative, a three-year, grant-funded collaborative project with Wellshare International, to support and study hiring a Somali Community Health Worker for Smiley's Clinic. Smiley's and WellShare are collaborating with the Minnesota Department of Health to determine best practices for community health workers.

Amanda Hinrichs, DO, graduate of Smiley's Family Medicine Residency Program and the University of Minnesota Palliative Fellowship, published her MAFP funded research on the transgender and gender nonconforming patient perspective in Academic Medicine. Anna Larson, DO, PGY-3, at Smiley's Family Medicine Residency Program, presented at the first national meeting of the United States Professional in Transgender Health (USPATH) on the experiences of transgender and gender nonconforming patients in a residency clinic, an MAFP-funded project. In addition, she just completed the Family Medicine Emerging Leaders Institute Fellowship with the AAFP.

Tim Ramer, MD, has been instrumental in providing EMR expertise and making clinic flow better for patients and providers. He is an "unsung hero" at Smiley's Family Medicine Residency Program regarding transgender and gender nonconforming (TGNC) initiatives. He has worked with and within Epic to develop tools that are in-line with the global recommendations on best practices in the electronic record for TGNC patients.

George Rounds, MD, Bigfork, received the 2017 Minnesota Rural Health Lifetime Achievement award for his 37 years of work as a family physician in Bigfork. His commitment to providing access to quality health care has led to a thriving medical campus serving a large swath of rural Minnesota whose residents would otherwise have to travel many miles for medical care. His leadership included helping found the Scenic Rivers Health Services

Bigfork Medical Clinic and serving as chief of staff at Bigfork Valley Hospital.

Smiley's Family Medicine is excited to announce their new biweekly Gender Support Clinic. They are happy to consult on a patient that needs gender-related expertise in a primary care setting.

As part of the 'Art of Medicine' welcome-to-the-neighborhood project, residents, faculty and medical students at the **United Family Medicine Residency Program** created welcoming art for community members attending the United Family Medicine Clinic Healthy West 7th Community Block Party on August 17, 2017.

NEW TO THE LAND OF 3,100 FAMILY DOCS

Christopher Anderson, MD, Paynesville, has transferred from South Dakota. **Ingrid Anderson Beck, MD**, St. Paul; **Nicholas Smith, DO**, Moorhead; and **Brian Wariboko, MD**, New Market, have transferred from Virginia. **Elizabeth Bodnia, DO**, Eden Prairie; **Kelli Roenfanz, DO**, Minnetonka; and **Kristen Steidl, MD**, Mankato, have transferred from Iowa.

NEW RESIDENT MEMBERS

Emma Erickson, MD, St. Louis Park
Benjamin Dummer, MD, Duluth
Amanda Honsvall Hoefler, MD, St. Louis Park
Kiran Sidhu, MD, Minneapolis
Adrian Tomes, MD, Woodbury
Carrie Wojick, MD, St. Paul
Zareen Zaka, MBBS, St. Cloud

NEW STUDENT MEMBERS

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U OF M MEDICAL SCHOOL – DULUTH CAMPUS
Rachel Anderson, Cook
Christy Atkinson, Duluth
Michael Beckmann, Duluth
Jacob Bentley, Austin
Brandi Bollig, Duluth
Michael Burgdorf, Duluth
Alycia Chmielewski, MD, Duluth
Ryan Colakovic, Mankato
Hannah Fordahl, Duluth
Spencer Goble, Duluth
Nissa Grina, Hutchinson
Alec Haug, Duluth
Sarah Reyna, Duluth
Rakin Solaiman, St. Peter
Allicen Waxlax, Willow River
Courtney Wirtanen, Duluth

IN MEMORIAM

Anthony "Tony" Spagnolo, MD, of Shakopee, passed away September 3, 2017, at the age of 81. He is survived by his wife of 57 years, Marcia Adams; children, Mark (Amalia), and Lauren, (fiancé Rick Pearson); grandchildren David and Grace; and brother Samuel Spagnolo, MD. He practiced as a family physician in Shakopee for 48 years and was recognized for his compassion and high quality of care.

BE RECOGNIZED!

Send your news to office@mafp.org or submit online at www.mafp.org/membernews.

THANK YOU DONORS!

Your generous donations this past year have helped support the next generation of family physicians in Minnesota a.k.a. **#NexGenFM**

The following members and organizations donated to the MAFP Foundation between July 1, 2016 and June 30, 2017. Every effort has been made for accuracy, but if we inadvertently overlooked your gift, please let us know.

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