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An American Health Care Revolution

A proposal whose time has come

BY DAVID W. ALLEN, JR.

A good health system would combine quality, accessibility and affordability. Today's U.S. system fails to reach these standards. This article summarizes causes of this failure, why current proposals to repair these deficiencies would also fail, and suggests a solution that will achieve the goals of a good health system.

Quality of health care in the U.S. is uneven. On the one hand, the U.S. consistently leads other high-income nations in survival rates for complex diseases, particularly cancer.

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The Peptide Tsunami

What doctors should know

BY DAVID J. HOLT, JD

The clinical landscape surrounding metabolic health and the rapidly growing field of restorative medicine is currently facing a fundamental transformation of an unprecedented scale. As of May 2026, the professional medical community is actively witnessing an undeniable, rapidly accelerating surge in patient demand specifically for various peptide-based therapies, a demand that has unequivocally moved far beyond the highly regulated, traditional clinical setting. This overwhelming phenomenon, which our legal firm has aptly and officially termed the Peptide Tsunami, fundamentally represents a massive cultural shift in modern medicine where patients are no longer acting as passive recipients of traditional medical care, but have rapidly become active and often aggressive consumers of complex biological interventions.

While the theoretical clinical potential of these various signaling molecules is undeniably significant, the existing regulatory framework and the legal parameters surrounding them have severely struggled to keep pace with the overwhelming consumer enthusiasm. It is critical to understand that this tsunami was absolutely not a spontaneous or sudden event, but rather a gradual, persistent building of pressure that finally broke into the mainstream consciousness with the extraordinary, highly publicized clinical success of regulated GLP-1 receptor agonists. Today, these specific, highly regulated medications account for a staggering 7% of all medical prescriptions written across the entire United States. A deeply concerning parallel trend has emerged, however, alongside this medical advancement; for every single patient who

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Potential liabilities physicians face when patients request medical advice on self directed use of the exploding marketplace for unregulated peptides.

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HealthPartners Announces New Como Park Clinic

At its recent annual meeting, HealthPartners announced that it was moving forward with a major new construction project in St. Anthony Park. The new facility is scheduled to open in the fall of 2027. It will replace the existing Como Clinic, the first HearthPartners clinic that opened in 1957, when the company was called Group Health. The new facility will be well over 50% larger than the existing clinic and cost around $80 million. The new Como Clinic will significantly expand services, including primary care, urgent care, pediatrics, dentistry and cardiology. In addition, the clinic will introduce new services, including a new TRIA Orthopedics Clinic and Urgent Care, endocrinology and OB-GYN services. Advanced CT and MRI capabilities will be added, making it one of the most advanced urgent care sites in the east metro.

"Our first clinic opened on Como Avenue nearly 70 years ago with a simple but powerful idea: care should be local, accessible and affordable for the people in our community," said Andrea Walsh, president and CEO of HealthPartners. "This new Como Clinic honors that legacy while investing in the future of St. Paul. It brings more services, more convenience and more coordinated care to patients who rely on us every day. We're proud to be able to continue to reinvest in a place that is so important."

Groundbreaking for the new clinic is scheduled for this summer. Plans include approximately 250 parking spaces, with design options that explore how parking is integrated into the site — including the potential for a structured parking deck. The building itself is expected to shift from its retro triangular layout to a more navigable square design. The project is currently in the city's site plan review, giving community members a chance to learn more and share feedback as plans move forward.

Northfield Hospital + Clinics purchases Allina Health Northfield Clinic

In a move designed to address the growing pressures on rural health care and enhance the partnership between the two organizations, Northfield Hospital + Clinics (NH+C) and Allina Health recently announced that NH+C would purchase the Allina Health Northfield Clinic. The process is scheduled for completion by the end of September and should be seamless for patients.

NH+C will be welcoming 30 clinicians and additional staff members from Allina Health, who will continue to care for patients and become part of NH+C's independent health care system.

"It's exciting for NH+C to unite primary care in Northfield and keep local the services that can be done in our community. This strengthens NH+C's commitment to serve our full community with high-quality services for the entire lifespan," said NH+C President and CEO Zander Abbott. "This affiliation agreement is an example of how two organizations can collaborate to create a stronger path forward together than either of us could do on our own. "

"This innovative agreement reflects Allina Health's commitment to providing care close to home, and our reputation for excellence in specialty care," said Bill Evans, chief medical group operations officer for Allina Health. "Health care today increasingly depends on collaboration to ensure resources are used effectively and patients have access to high-quality care close to home. By aligning their strengths, NH+C and Allina Health are advancing a coordinated, patient-centered approach that expands community-based primary care while maintaining strong connections to specialty services and regional expertise."

This agreement includes the clinic building and staff, and the family medicine, pediatrics, sports medicine and mental health practices. The proposed merger between Allina Health and Sutter Health will not affect the sale of the Allina Northfield clinic.

As part of this agreement, NH+C and Allina Health will formalize their long-standing partnerships in clinical service line care such as cardiology and

neuroscience. It presents a real opportunity to show a new model in rural health care — an independent organization partnering with a larger system to better define rural health care creating success for both organizations — and for the community.

New East Lake Community Clinic Opens

The Southside East Lake Street Clinic, a new 30,000-square-foot, $35 million community health center recently opened its doors to patients. The clinic, part of the Southside Community Health Services organization founded in 1971, is located on the edge of the Midtown Phillips neighborhood, next door to the Midtown Global Market. Services are not free, but the clinic takes all types of insurance and offers a sliding fee discount program for people who are uninsured. The clinic's services include pediatric and adult primary care, midwifery, a dental office, dietetics, X-rays, mammography and behavioral health programs. In the works are a pharmacy and a sexual violence healing center. "Every service line we do is intentionally designed and intentionally done to break down the barriers and make it easier for people to access health care," said Sheila Kennedy, Southside's medical director.

Built by Ryan Companies, the state-of-the-art facility was designed to meet the holistic needs of the community. It dramatically expands the capacity of Southside Community Health Services, allowing them to grow their patient base, extend operating hours and integrate a wide spectrum of health care services. Completion of the project is a powerful example of community partnership. It was brought to fruition through the architectural vision of 4RM+ULA and Perkins&Will and the project leadership of Classic Lake Consulting.

The clinic is designated as a Federally Qualified Health Center (FQHC), receiving federal funding to provide care to underserved and low-income populations. Many of the neighborhoods surrounding the new clinic have higher rates of residents below the poverty level than the city average of 17%. Midtown Phillips in particular has a poverty rate of almost 40%. The area is also home to higher percentages of residents who identify as Black, Hispanic and American Indian. The clinic is built on the site of the former Family Dollar store that was heavily damaged during the protests following the murder of George Floyd. David Ingold, executive director of the Midtown and East Phillips Neighborhood Association, noted that the clinic's new location "is both closer to the thousands of immigrants, refugees, and low-income residents that live in the Phillips neighborhoods, and it is close to the updated rapid Metro Transit lines on Chicago (Avenue) and Lake Street."

Legislature Approves HCMC Bailout Funding

Key funding to keep open Hennepin County Medical Center, Minnesota's flagship trauma center and safety net hospital, emerged within the final hours of the 2026 session. The House voted late Sunday to adopt the conference committee report on HF4466/SF4612 and then passed the omnibus health and human services finance and policy bill 108-26. It passed shortly thereafter in a 35-32 vote by the Senate. Funding for HCMC is part of a nearly $660 million agreement between House and Senate leaders and Gov. Tim Walz. The bill allocates $205 million in direct stabilization funding for HCMC and creates a reserve account of up to $500 million that HCMC, and possibly other hospitals contending with financial burden due to uncompensated care, can draw from until 2031.

In addition to the hospital funding, legislators added language about oversight of Hennepin Healthcare. Hennepin County commissioners now serve as its leader after dissolving the corporate board last year. The bill establishes a new board that consists of 11 to 15 directors and includes 70% of members with the professional training and expertise needed to govern a health system and safety net hospital.

Gov. Tim Walz said "I'm just incredibly proud how we were able to continue to make the investments we know we need to make, whether it's roads and bridges, education, Hennepin County Medical

Center — that critical level one trauma center, dealing with the (federal) bill that came out of Congress that threw so much chaos into how we deal with Medicaid, food stamps and other things," adding that the HCMC agreement is imperative. "I'm proud of what we did, but I want to be very cautious on this," he said. "This is only the beginning of the health and the hospital crisis across the country."

"While this certainly doesn't include everything House DFLers wanted, it is a strong step forward on important issues while working in divided government," said House DFL Caucus Leader Zack Stephenson (DFL-Coon Rapids). "Providing certainty and stability for HCMC was a necessity.

State Run Psilocybin Pilot Program Moves Forward

As the legislative session recently concluded, a bill to authorize the study of the use of psilocybin mushrooms to treat a wide range of serious behavioral health issues took important steps toward becoming law. The bill proposed a pilot program that would be open to 1,000 Minnesotans 21 or older with qualifying medical conditions like PTSD, chronic pain, substance use disorder and more. Several significant research projects have shown that psilocybin can relieve major depression, ease anxiety and even help with alcohol-use disorder. The pilot program would be managed under clinical supervision in a regulated environment. The state Office of Cannabis Management, which regulates legal adult-use sales of marijuana, would be the key oversight authority and evaluate the program's effectiveness. The program is a recommendation of a task force that studied this issue.

"This program is a very conservative, slow entrance into this new area of psychedelic medicine," said Rep. Andy Smith, DFL-Rochester. The bill has received rare and overwhelming bipartisan support, passing the House as part of broader health policy legislation by a vote of 114-15. The most recent session concluded before a Senate vote could occur, however, there is a good chance it will pass in the next session and which will start early in the next year.

Minnesota would be the fourth state in the country to legalize psychedelic mushrooms in supervised settings. Colorado, New Mexico and Oregon have similar laws. Supporters noted that the Trump Administration is open to further study of psychedelic mushrooms and that $50 million in federal money is on the table for research. Minnesota is well-positioned to qualify for some of this funding and the bill instructs the Office of Cannabis Management to seek those funds. "This is a really good pilot program, and it's buoyed by the fact that the Trump administration came out and said that there's a new openness to programs like this," said Rep. Max Rymer, R-North Branch. "It's a very careful entry into this." He added, "The testimony that we heard firsthand, from especially a lot of our veterans, was that this was life-changing."

Mayo Study Advances Early Pancreatic Cancer Detection

A recently published study by the Mayo Clinic found that, through a new artificial intelligence (AI) model, specialists could detect pancreatic cancer on routine abdominal CT scans up to three years before clinical diagnosis. The new research identifies signs of disease before tumors are visible, when curative treatment may still be possible. The findings come after a multiyear research effort to enable earlier detection of one of the deadliest cancers. They validate the new AI model using data and workflows that mirror clinical practice, including CT scans from multiple institutions, imaging systems and protocols.

Researchers analyzed nearly 2,000 CT scans, including scans from patients later found to have pancreatic cancer — all originally interpreted as normal. The system, called the Radiomics-based Early Detection Model (REDMOD), identified 73% of those

prediagnostic cancers at a median of about 16 months before diagnosis — nearly double the detection rate of specialists reviewing the same scans without AI assistance.

The detection rate was even greater at earlier time points. In scans obtained more than two years before diagnosis, the AI identified nearly three times as many early cancers that would otherwise go undetected. Pancreatic cancer remains one of the deadliest cancers because it rarely causes detectable signs in its earliest stages. More than 85% of patients receive a diagnosis after the disease has already spread, and five-year survival rates remain below 15%, according to the National Cancer Institute. Projections show it will become the second-leading cause of cancer-related death in the U.S. by 2030.

"The greatest barrier to saving lives from pancreatic cancer has been our inability to see the disease when it is still curable," says Ajit Goenka, MD, the study's senior author, and a Mayo Clinic radiologist and nuclear medicine specialist. "This AI can now identify the signature of cancer from a normal- appearing pancreas, and it can do so reliably over time and across diverse clinical settings."

Researchers are advancing this work into clinical testing through Artificial Intelligence for Pancreatic Cancer Early Detection, or AI-PACED. This prospective study evaluates how clinicians can integrate AI-guided detection into care for patients at elevated risk. The study combines AI analysis of routine imaging with longitudinal follow-up to assess performance, including early detection, false positives and clinical outcomes.

U of M Expands Rural Residency Program

The University of Minnesota Medical School recently received approval from the Accreditation Council for Graduate Medical Education (ACGME) to expand its rural physician training program. In so doing it has entered into an agreement with the Lakewood Health system to create the Lakewood Rural Family Medicine Residency Program. Residents will start the three-year program with one year of training in the North Memorial Family Medicine Residency Program in North Minneapolis, followed by two years with the Lakewood Health System in Staples, Minnesota. The program will train two new family medicine physicians per year.

"We are thrilled to have the opportunity to train excellent family physicians at Lakewood. Our mission is to equip our graduates with the broad skills and deep knowledge necessary to provide high-quality comprehensive care to patients and families in underserved rural communities in Minnesota and beyond — and we cannot wait to get started," said Alex Harsha Bangura, MD, residency program director and Lakewood Health System family medicine physician.

"This new residency program is a critical investment in the future of health care in Minnesota. By training physicians in rural communities, we're not only expanding access to care where it's needed most, but also increasing the likelihood that these doctors will build their careers and lives in Greater Minnesota communities like Staples," said Shailey Prasad, MD, MPH, associate vice president for global and rural health for the Office of Academic Clinical Affairs at the University of Minnesota.

Students can start applying to the program in September 2026, with the first cohort set to begin in the summer of 2027. This new program joins the Willmar Rural Family Medicine Residency Program and the Grand Itasca Rural Family Medicine Residency Program as the only rural family medicine training programs in Minnesota — creating new opportunities for medical students seeking specialized training in rural health care.

Dignity, Inclusivity and Long-term Recovery

Brad Smith MD, DFAPA, Chief Medical Officer, The Emily Program

What can you tell us about eating disorders and how they are diagnosed?

Eating disorders are serious, biologically influenced psychiatric illnesses that affect the brain and body, not a lifestyle choice. They include conditions such as anorexia nervosa, bulimia nervosa, binge-eating disorder, avoidant/restrictive food intake disorder (ARFID) and other common presentations that fit into the diagnosis of other specified feeding and eating disorders (OSFED) like orthorexia and atypical anorexia nervosa. The diagnosis is based on DSM-5-TR criteria utilizing a careful assessment of behaviors (food restriction, binge eating, purging, laxative/diuretic misuse, compulsive exercise), eating-related anxiety and avoidance, and the degree of impairment in physical health, mood, cognition and daily functioning. A key point is that eating disorders can occur at any weight and in any gender, age or cultural group, so clinicians should not rely on appearance alone to determine severity. Assessment includes weight trajectory and analysis, vitals (including orthostatic changes), labs (especially electrolytes), ECG, and screening for medical complications and co-occurring psychiatric conditions. In summary, eating disorders are diagnosable, treatable medical-psychiatric illnesses identified by patterns of eating-related behaviors and degree of medical and/or functional impairment—not by how someone looks. Eating disorders carry one of the highest mortality rates of any psychiatric illness, yet they are highly responsive to professional treatment despite common misperceptions to the contrary.

How are they treated now and how has this changed over the years?

Evidence-based treatment today is multidisciplinary and matched to medical and psychiatric risk. Core components of treatment include psychotherapy, nutritional rehabilitation with a registered dietitian, ongoing medical monitoring and interventions, as well as psychiatric assessment and treatment — all delivered in a recommended level of care that is deemed safe and appropriate for the given condition. Levels of care remain an important concept in the treatment of individuals with eating disorders, as they represent matching the level of

> “Eating disorders can occur at any weight and in any gender, age or cultural group.”

professional treatment support needed with the severity of the individual’s condition. Once stabilization is reached at one level of care, step-wise transition to lower levels of care allows gradual preparation and practice for the individual to maintain treatment gains with less and less professional support. Levels of care typically include: outpatient, intensive outpatient program (IOP), partial hospital program (PHP), residential and inpatient. For adolescents with anorexia nervosa (and many with bulimia nervosa), family-based treatment (FBT) is strongly supported and emphasizes training and empowering caregivers to interrupt the illness and restore nutrition. For many adolescents and adults, cognitive behavioral therapy (CBT) targets eating disorder behaviors and thoughts across diagnoses. When emotion dysregulation, suicidality, or self-harm is prominent, skills-based approaches such as dialectical behavioral therapy (DBT) can be essential. Medications are typically adjunctive — useful for very common comorbid psychiatric illness (i.e. major depressive disorder, generalized anxiety disorder, obsessive compulsive disorder) and sometimes for bulimia nervosa or binge-eating disorder — while nutritional stabilization remains foundational. Over the years, care has moved toward earlier identification, trauma-informed practice, and more individualized pathways rather than one-size-fits-all programs. Modern eating disorder care is multidisciplinary team-based, evidence-driven, and tailored to severity, with psychotherapy and nutritional rehabilitation as the core interventions for fundamental change. Medical and psychiatric assessment and treatment interventions are especially important when the clinical condition has progressed to a need for a higher level of care, with particular emphasis on assessing and treating the acute consequences of the eating disorder and subsequently managing the comorbid conditions that are intertwined with the eating disorder.

What are the biggest barriers people with eating disorders face when seeking help?

Barriers often start with stigma and misunderstanding — many people fear judgment or believe they are “not sick enough,” especially if they do not fit stereotypes about who gets an eating disorder. Ambivalence is also common: the illness can feel protective or identity defining, and recovery can provoke substantial increase in anxiety about eating, weight change, or loss of perceived control. Clinically, shame and secrecy can delay disclosure, and families may misinterpret symptoms as “choices” rather than a serious illness. System barriers are significant: shortages of specialized clinicians, long waitlists, limited rural access and fragmented medical and psychiatric care. Insurance and cost issues can further delay or disrupt treatment, and practical burdens — time off work/school, transportation, childcare — can make consistent attendance in programming difficult. Weight stigma plays a major role as well; restrictive eating behaviors in people in larger bodies may be minimized or even reinforced, leading to later diagnosis and higher medical risk. People face both internal barriers (stigma, fear, ambivalence)

and external barriers (access, insurance coverage, cost and bias) that commonly delay effective care.

What are some of the challenges related to insurance coverage for eating disorders?

Insurance challenges can be a major driver of delays and discontinuity in eating disorder treatment. Common obstacles include prior authorizations, limited in-network options and frequent medical necessity reviews that may not fully account for the psychiatric and behavioral risks of the illness. Because eating disorders have medical complications (e.g., bradycardia, electrolyte abnormalities) and also require psychotherapy and nutritional care, some insurance coverage decisions can become siloed: focusing on individual components rather than the holistic health of the patient. Step-up and step-down decisions can also be contentious: some insurers focus narrowly on weight or labs while underestimating rapid weight loss, suicidality, purging frequency, functional collapse or inability to maintain nutrition without structure. Even with parity laws, families may face significant administrative burden, appeals and out-of-pocket costs. Clinicians can help by documenting objective risk, functional impairment, failed lower levels of care and the rationale for the recommended level of care. Coverage barriers often seem misaligned with the medical and psychiatric risk profile of eating disorders.

Please provide some background on the Emily Program, how it started and how it has grown.

Founded in 1993 by psychologist Dirk Miller, The Emily Program was created with a deeply personal mission: to expand access to effective, compassionate eating disorder care after his sister Emily's recovery. What began as a single center in St Paul helped pioneer a more personalized, outpatient-focused model at a time when treatment was largely hospital-based. In response to growing demand, the organization steadily expanded beyond its roots in and beyond Minnesota and now operates across multiple states, including Minnesota, Ohio, Pennsylvania, Washington, Georgia and North Carolina. One of the largest eating disorder care platforms in the U.S., it offers a full continuum of care including outpatient services, intensive outpatient programs, partial hospital programs, residential, and inpatient treatment for people of all ages and genders with all kinds of eating disorders.

Over the years, The Emily Program has been a leader of the broader conversation around eating disorders, including spearheading advocacy efforts that contributed to the passage of the Anna Westin Act within the 21st Century Cures Act. Today, the organization is known for its warmth, passion and multidisciplinary approach — integrating medical, nutritional and psychological care — and for advancing a treatment philosophy centered on dignity, inclusivity and long-term recovery.

Eating disorders are often accompanied with one or more comorbid conditions. What can you tell us about this?

Comorbid conditions are extremely common and can both contribute to and be exacerbated by the eating disorder. Psychiatrically, we often see anxiety disorders, major depressive disorder, OCD, trauma-related disorders, ADHD, substance use disorders, and self-harm or suicidality — particularly in more severe presentations. Medically, malnutrition and compensatory eating disorder behaviors (i.e., purging, laxative abuse, diuretics, etc.) can affect nearly every organ system, leading to bradycardia

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An American Health Care Revolution from cover

The U.S. boasts a nearly 70% all-cancer five-year survival rate. In comparison, the UK sits at approximately 55%, and Spain at 57%. The median time from a cancer diagnosis to the start of treatment in the U.S. is 27 days; in the UK, the target is 62 days, and even that target is frequently missed. The U.S. is the undisputed global leader in health care R&D and scientific advancement. On the other hand, the U.S. consistently ranks lower in several fundamental health metrics. Americans have a lower life expectancy, higher maternal mortality rate and higher rates of deaths that could have been prevented with timely, effective medical care than many other high-income countries.

> Physicians spend almost twice as much time on EHR documentation and coding than they do with patients.

The goals of cost and accessibility are where the most serious deficiencies reside. U.S. National Health Expenditures (NHE) exceed $5.3 trillion annually, 18.0% of GDP, are growing more than 7% annually and are up 62% since 2017. This is $15,474 per person, far more than other high- income countries, which average $6,000 to $7,000. Approximately 27.5 million Americans, 8.2% of the population, are without any form of private insurance or government coverage.

How We Got Here

The root of the problem is complex and multifaceted but boils down to defects created by employer-sponsored private insurance and government programs such as Medicare and Medicaid. Third-party payment leaves millions without access to care, dramatically increases its costs and undermines quality. It distorts what patients want and how care is provided. Tweaks intending to restore the dynamics of supply and demand through copayments, deductibles and shifting financial risk to providers don't work.

Costs increased by third-party payments are vastly larger than necessary. Obvious costs are the infrastructure to process claims, the burden of a bloated health insurance industry and the diminished productivity of complying with third-party rules. Less obvious is the aggregation of hospitals and physicians into health systems created by the need to negotiate with insurers, not because bigger is better for patients. The whole economy is distorted because employer-sponsored health insurance advantages large businesses over small businesses.

Often overlooked but very important to understand is the cost driven by third-party coding requirements. Health systems install expensive systems and employ certified medical coders and revenue cycle management specialists to ensure every interaction is captured perfectly while insurance companies weaponize their own claims adjusters to find coding errors to justify denial or down-coding of reimbursement. Documentation is an existential mission for physicians.

Reimbursement for a 15-minute office visit depends on whether documentation supports coding as Level 3, 4, or 5. A comprehensive list of secondary diagnoses, relevant and irrelevant, is helpful in inflating reimbursement. Every blood draw, diagnostic image, and separate consultation has its own code, so care must be atomized; churn is more important than efficiency or patient convenience. Innovation is suppressed; if there is no billable code, an alternative cannot be considered. Today in America, physicians spend almost twice as much time on EHR documentation and coding than they do with patients.

An example of why the current system is failing is the fate of the Fairview Experiment. Research by John Kralewski, PhD, from the University of Minnesota School of Public Health, as far back as 1991, revealed that when primary care was reconfigured into a multidisciplinary team — utilizing nurse practitioners and care guides to handle routine visits and phone consultations — the total cost of care dropped by 38%, while patient satisfaction surged by 30%. In any other industry, a 38% gain in efficiency would be a revolutionary success. In American health care, it was a financial catastrophe for the provider. The Fairview model was dismantled not because it failed the patients, but because it failed the third- party billing machines. Insurance companies generally refuse to pay for a phone consultation, a nurse-led care plan, or a check-in that doesn't have a specific, billable CPT code associated with a face-to-face physician encounter. By mandating that care be atomized into billable units, the current system forces physicians to spend 45% of their time on minor illnesses that could be managed by team members.

Potential Solutions

How can we fix these problems? The Affordable Care Act decreased the number of people without coverage, but it failed to control costs. Proposals for a universal single-payer system may achieve the goal of providing everyone with access to care but will not bring the costs of third-party payment under control. Single-payer health care will diminish quality. In the U.S., only 31% of patients wait more than a month to see a specialist while in Canada the number is 62%, and in the UK, it is 55%. The U.S. has significantly higher concentrations of advanced diagnostic tools; for example, the U.S. has roughly one CT scanner

for every 73,000 people, whereas peer nations often have far fewer, leading to diagnostic delays. New drugs and medical devices typically gain regulatory approval and clinical adoption in the U.S. years before they are accessible in many European or single-payer systems. U.S. patients report higher levels of involvement in medical decisions compared to those in more paternalistic, state-run systems. While outcomes are mixed, U.S. physicians are more likely to discuss lifestyle changes and preventive screenings during routine visits than their counterparts in high-volume, state-managed clinics. The transformation of health care under single- payer systems is ugly and should be unacceptable.

Proposals featuring Health Savings Accounts will also fail to achieve the goals of accessibility, affordability and quality. It is unclear how HSAs can lead to universal coverage. HSAs do not address the problems of third-party reimbursement. HSAs have the benefit of encouraging the prudent purchase of some health care, but they would rarely be relevant for expensive episodes of care.

An approach that will achieve the goals of accessibility, affordability and quality is to issue every American taxpayer a government-backed health transaction card to pay for health care. Responsibility for repaying charges on the health transaction card will be shared by the taxpayer and the government in accordance with the taxpayer's income. A critical aspect of this proposal is that people are cognizant they are spending their own money when purchasing health care — but doing so with a government safety net that keeps health care affordable. Third-parties would be prohibited from paying health care providers directly.

Making it Work

Let's outline how this might work. Purchases of health care services and products are made with the health transaction card. The provider processes the payment just like a credit card and is reimbursed fully and immediately. The taxpayer gets a monthly statement, just like a credit card. The taxpayer is required to make a minimum monthly payment on any balance, perhaps $100. At the end of the year, if there is an unpaid balance, a portion of this balance will be added to their tax liability and the health card will return to $0. The portion of their unpaid balance that will be added to their tax liability depends on their income level. If they have a low income, they will be required to repay only a small part of the unpaid balance. If they have a high income, they will have to pay more. A reasonable formula might require taxpayers to devote up to 10% of their income to repayment of health expenses, perhaps somewhat more in rare, high-cost circumstances.

Here are some examples. Judy is a single mom with two young children who earns $50,000 a year. Routine health needs add $2,000 to her health card and then her youngest is hospitalized resulting in a $50,000 charge. Over the course of the year, Judy has withheld $400 per month for health care federal taxes and made her required $100 per month payments. Since there was no health care purchased in the first two months and no balance on her health card statement, by the end of the year Judy had paid $1,000 on her credit card balance, had $4,800 health care federal income tax withholdings and her health care card showed a balance of $51,000 ($52,000 of purchase less $1,000 payments made). The total amount she is responsible for paying is $5,000 (10% of her $50,000 income). She has already paid $1,000, so she has an outstanding balance of $4,000. She will get an $800 tax refund! Judy is delighted with this plan because she no longer has Medicare taxes to pay and the $400 per month

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tax withholding and the $100 minimum monthly payments are far less than what she used to pay for insurance.

Bob and Barb are empty nesters in their 50's with combined incomes of $300,000. Their health care costs were also $52,000 and they also have reimbursed $1,000 through their minimum monthly payments. Bob and Barb, however, are responsible for reimbursing $30,000 for health care purchases (10% of their $300,000 income). They're not too unhappy about this because, like Judy, they anticipated this liability and adjusted their withholdings appropriately. Also, Barb is delighted her small advertising firm has been able to recruit some top talent from big agencies who previously would not have considered working for a small firm without health benefits.

Steve is an 80-year-old widower struggling to make ends meet on his social security income of $30,000 per year. Steve is happy that his new health care card has made possible health services that would not have been reimbursed by Medicare such as telephone consultations and prescription refills done over the phone or internet. He's pleased with the new health card because, while he ends up having to pay the full $100 minimum payment each month and has $200 withheld from his monthly Social Security, this is still less than what he used to pay for Medicare Parts A, B and D.

This proposal accomplishes the goals of a good health care system. All will be entitled to a health transaction card and have the means to purchase the care they need; accessibility is achieved. Providers will be able to serve patients in ways best suited to their needs; quality is achieved. The overhead of claims submission, the impositions on physician productivity, the inflation of upcoding, the huge sums removed from health care for insurance company "reserves" and the inefficiency of adhering to codes — all will disappear; affordability is achieved.

This proposal also results in profound and beneficial changes to health care and beyond. The absence of the need for expensive EHS systems, high paid administrators and negotiating leverage renders massive health care systems obsolete; physicians and small clinics are competitive once again. Care will become more geographically distributed, less expensive, more diverse, more convenient and serve patients better. Prudent consumers of health care will no longer choose emergency rooms for non-emergent needs. Government's role will shrink from determining if the coded service is covered to simple transaction legitimacy. Dead capital retained as reserves by health insurers is released. The economy improves as health care consumes a smaller portion of GDP and small businesses are no longer hobbled by the difficulties of offering health benefits to their employees.

As an illustration, consider how the removal of the billable code gatekeeper allows the team-based model used by Fairview flourish in a free market. Research suggests that one nurse practitioner per physician is the sweet spot for cost reduction. In a free market, clinics will naturally gravitate toward this ratio to offer lower, more competitive prices to the Judy's and Bob's of the world who are watching their tax liability. By removing the third-party requirement for encounter- based billing, we move from a system that pays for activity (more codes) to a system that rewards results (lower cost, higher satisfaction).

Implementation of this proposal is not simple but is doable. It satisfies a broad spectrum of political perspectives, achieving universal coverage while

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embracing free markets. It represents an existential threat to health insurers and they will employ all means to defeat it. While its benefits seem to greatly outweigh its costs, quantifying this is difficult and will surely be vigorously debated. There are likely to be disagreements about exactly how much cost borne by taxpayers will be enough to motivate prudent purchasing without being an unreasonable financial burden.

What's in a Name?

What to call this proposal? For it to be considered fairly, we should rescue it from the modern political lexicon. As George Orwell warned, political language is often designed to trigger knee-jerk emotional alignment rather than clear thought. If labeled 'Health Freedom Card,' it may be pigeonholed by the left; if called 'Universal Citizen Benefit,' it is dead on arrival on the right. To achieve what Confucius called the 'rectification of names' — ensuring our language matches the literal truth of things — we should call it exactly what it is: a Health Transaction Card or Health Ledger Card. It is not an ideological statement; it is a mechanical upgrade to the doctor-patient relationship.

Price gouging thrives in the dark; requiring price transparency enlists the consumer in the fight against abuse. Just as travel apps show a typical price for a flight, the health care apps can provide patients with local price benchmarks. To prevent exploitation during crises, the plan would include fair trade regulations; in emergency settings where "shopping" is impossible, providers would be legally required to charge prices consistent with their standard published retail rates.

The most effective guardrail against over- consumption of free care is the patient's direct financial incentive. Consumers will seek value for necessary care and avoid the churn of unnecessary follow-ups or duplicate imaging that costs our current system billions. Existing legal protections like the Anti-Kickback Statute and Stark Law will remain a bedrock of the system. Enforcement becomes swifter as any provider found guilty of systemic fraud can be immediately delisted from the health transaction card network. In a world where the card is the primary payment vehicle, this economic death penalty provides a far more potent deterrent than the current slow-moving legal settlements that large systems often treat as a cost of doing business.

In Conclusion

The health transaction card solution covers all Americans, returns the power of choice to patients, frees providers from the tyranny of third-party oversight and coding, promises tremendous improvements in efficiency and convenience, lowers cost and preserves quality... but its implementation faces two great challenges. First, the dismantling of industry built around third-party insurance will be in virulent opposition. Second, calculating the magnitude of savings (will our $15 thousand per capita expenditures be reduced to $10 thousand or $8 thousand?), the relative cost to the government of this in contrast to Medicare and Medicaid, and the fairest cost-sharing formula for taxpayers is all likely to engender vigorous debate. It is clear, however, that we need to address the crisis and the health transaction card is a promising approach to do it.

David W. Allen Jr. is a retired health care consultant and executive. He has worked extensively with health care policy issues.

The Peptide Tsunami from the cover

is appropriately receiving a regulated, Food and Drug Administration (FDA) approved peptide under the direct supervision of a licensed physician, there are countless other individuals who are diving headfirst into an unregulated multi-billion dollar industry where the lines between medicine and marketing are dangerously blurred.

As a health care law firm built specifically to serve and protect health care businesses, our firm believes it is absolutely critical for all Minnesota physicians to thoroughly understand this complex landscape, realizing that while a select few specific peptides have successfully survived the rigorous scrutiny of formal clinical trials, a vast and continuously growing number of these substances absolutely have not.

> The lines between medicine and marketing are dangerously blurred.

The Science and the Surge: The GLP-1 Halo Effect

Understanding the biological appeal of peptides is essential to grasping why this medical surge is happening. Peptides act as the body's primary signaling molecules. These short chains of amino acids govern various physiological processes, including hormone release and tissue repair. Their specific mechanism and natural occurrence in the body offer a promise of medical precision. Traditional small-molecule drugs often lack this level of specificity.

The success of GLP-1 agonists in treating obesity and type 2 diabetes has created a massive halo effect. This clinical proof of concept has triggered an explosion in consumer demand for other, less-vetted substances. Minnesota clinics now see patients requesting specific, self-directed treatments. These include BPC-157 for musculoskeletal repair, PT-141 for sexual dysfunction and IGF-1 analogs for anti- aging or muscle growth.

Flawed logic often drives consumer enthusiasm. Many patients believe that if one injectable peptide like semaglutide is safe, then all others must be as well. This mindset bypasses the essential gatekeeping role of the licensed physician. Consumers now rely on social media influencers, blogs and online forums to self-diagnose and self-prescribe these complex agents.

Patients are often confused about the nature of their care in these transactional scenarios. Many cannot distinguish between a licensed physician and a salesperson. They frequently do not understand the underlying business model or the supply chain of the peptides they use. This unregulated industry is fueled by a shift toward human optimization rather than the evidence-based treatment of disease.

Economic incentives in private-pay environments can pressure clinics to provide whatever consumers want. This often happens even when clinical data are thin or non-existent. Physicians must remember that most available peptides are clinical unknowns due to a lack of formal trials. Prescribing these unverified substances can also be outright illegal.

For Research Purposes Only

A massive regulatory gap exists between FDA-approved medications and unregulated research chemicals. Most peptides sold online today have never completed the formal clinical trial process. This lack of testing creates a significant danger for consumers in the broader market.

Instead of facing appropriate regulatory medical scrutiny, these specific chemical products currently occupy a deeply murky, highly dangerous legal gray area where they are strategically sold under the lable "For Research Purposes Only." It is crucial for modern health care providers to thoroughly understand that this label is nothing more than a carefully crafted legal fiction designed explicitly to intentionally bypass the strict jurisdictional legal oversight of the FDA, the Drug Enforcement Administration (DEA), and the Federal Trade Commission (FTC). I welcome other licensed attorneys to come forward and explain otherwise on the record. By claiming that these highly potent biological substances are strictly not intended for human consumption, these online sellers can freely distribute powerful biological agents without providing any proof regarding safety, clinical efficacy or baseline purity.

This regulatory loophole has directly allowed for the rapid rise of an emerging multi-billion dollar unregulated industry where essential core elements of basic public safety are frequently and unapologetically sidelined for massive financial profit. Severely compounding this already critical issue is the deeply disturbing, widely documented fact that even various analytical testing laboratories identifying themselves as perfectly legitimate or strictly independent testing facilities have been routinely identified by federal authorities as intentional bad actors. In an alarming number of documented cases, these allegedly independent testing labs knowingly and willingly provide completely falsified certificates of analysis (COAs) that deliberately lead both vulnerable patients and unsuspecting prescribing physicians to falsely believe a purchased biological product is 99% pure, when the unverified substance may actually contain highly dangerous levels of heavy metals, highly toxic residual manufacturing solvents, or entirely different, completely unknown chemical substances altogether.

For the Minnesota physician, choosing to routinely rely upon a certificate of analysis obtained from an unverified online vendor constitutes an unacceptable level of severe professional risk that offers zero legal protection for the practitioner in the highly likely event of a subsequent patient injury. In my professional capacity as a health care attorney, I have personally sat on numerous extensive legal consults lately dealing with peptide legal questions. During these consultations, I hear a new and incredibly creative legal argument almost every single week as to why certain established medical regulations and strict federal laws supposedly do not apply to a specific clinic practice model.

I can speak to the established letter of the law itself, and note that the prescribing physician inherently possesses multiple avenues of potential legal exposure that stem not just from federal agencies. The prescribing physician fundamentally puts their hard-earned, highly valuable professional medical license at risk. Furthermore, medical providers must clearly note that when actively prescribing an inherently un-prescribable substance, your standard medical malpractice insurance policy will very likely not cover the resulting legal exposure, leaving the individual physician with massive financial and legal exposure.

Safety and the Supply Chain

The global supply chain for unregulated peptides is a dangerous "Wild West." Many raw materials and finished products come from unverified overseas laboratories, primarily in China. These foreign facilities often operate without the Current Good Manufacturing Practice (CGMP) standards required for American pharmaceuticals.

Responsible medical professionals cannot overstate the severe risks inherent in this murky supply chain. Products sourced from unregulated overseas entities offer no guarantee of sterility. Reports show patients are buying raw, powdered peptides online and self-injecting them using unverified syringes. This unmonitored practice carries high risks of localized infection, systemic sepsis and the transmission of lethal blood-borne pathogens.

Fragile peptide molecules degrade rapidly without proper chemical stabilization. This leads to unpredictable dosing fluctuations or the formation of toxic byproducts. The danger lies both in the biological substance itself and in the unsafe delivery method.

Patients self-injecting without guidance often cannot recognize early signs of severe adverse reactions or anaphylaxis. Licensed physicians must provide a clear perspective on these life-threatening dangers during patient encounters. Most perceived benefits are based on internet anecdotes, whereas the risks involve permanent physical harm. Only time will reveal the true physiological and legal toll of this trend.

The Clinical Reality

The central, most pressing question currently facing the entire organized professional medical community is whether these highly popularized, trending peptides truly represent a legitimate, scientifically sound medical breakthrough, or if they are simply just another unproven consumer health trend heavily driven by aggressive marketing. Historically, medicine has undoubtedly and repeatedly seen many diverse products aggressively marketed to the public as absolute miracle cures that eventually, definitively proved to be entirely ineffective, or in many cases, actively and severely harmful.

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The unvarnished clinical reality facing modern practitioners today is that the vast majority of specific peptides currently available on the commercial market are largely, if not entirely, unproven in a legitimate clinical setting. While the underlying biological science regarding their mechanisms of action is undeniably interesting to medical researchers, the complete and total lack of formal, rigorous human clinical trials means that the medical community absolutely does not know the potential long-term, severe effects these unverified substances may have on complex human body systems, nor the risk of inducing serious side effects such as cancer. For example, while the specific, highly popular peptide known as BPC-157 currently shows some theoretical promise for accelerating tissue healing based strictly on animal studies, we simply do not have enough highly reliable human data to know definitively if it is actually safe for any long-term human consumption.

Given this massive lack of data, fully licensed physicians must be incredibly careful when dealing with marketing that deliberately and falsely frames these unproven substances as a guaranteed cure-all for complex physiological processes like fundamental human aging or stubborn weight loss. This entirely unregulated industry overwhelmingly relies on a patient's desire for a rapid, effortless quick fix, while simultaneously ignoring basic foundational health requirements such as a balanced diet and regular exercise. When a highly trained licensed medical doctor actively chooses to professionally endorse a completely unproven peptide, they directly risk their entire hard-earned professional reputation and valuable medical license on a commercial product that lacks the essential, evidence-based backing required by modern medicine. We must reiterate again for absolute legal clarity that taking this risky course of action undeniably has incredibly profound, potentially career-ending legal consequences.

RFK Jr. and the MAHA Influence

Powerful external forces are currently threatening to disrupt traditional pharmaceutical regulation and legal oversight, despite potential dangers and a lack of clinical testing. The federal regulatory landscape may be forced to adapt as the FDA reportedly weighs easing established limits on various unproven peptides. This shift is driven by prominent public figures such as Robert F. Kennedy Jr. and the political momentum of MAHA (Make America Healthy Again) supporters. RFK has been vocal in his support of peptides and has admitted to benefiting from them personally. A permanent easing of these safety limits due to political pressure could radically alter the legal standard of care and baseline exposure for physicians.

Physician Legal Liability Breakdown

Thoroughly and comprehensively addressing potential medical liability and actively providing a remarkably clear, highly objective perspective on the severe, deeply inherent legal risks involved is perhaps the absolute most critical, indispensable task for any medical practitioner currently considering entering the highly lucrative, yet deeply dangerous, peptide space. The incredibly complex legal minefield completely surrounding this specific medical practice area is primarily and effectively divided into three distinct, critical areas of massive immediate concern: the standard of care, informed consent and professional conduct.

The Standard of Care

Minnesota law defines the medical standard of care by what a reasonably prudent, similarly trained physician would do under similar circumstances. Most unverified peptides lack established standards of care because they have not completed formal clinical trials. Recommending or prescribing biological products without FDA approval or peer-reviewed safety data is a significant departure from medical norms. Going against explicit FDA guidance is a classic example of indefensible medical malpractice. In court, a plaintiff's attorney will argue the physician acted as an unregulated researcher conducting experiments on subjects who had not provided consent rather than as a healer.

Informed Consent

Valid informed consent is a complex, ongoing process, not just a signature on a clinic form. It requires ensuring patients understand both known and unknown risks. Providing legally defensible consent is likely impossible without rigorous human clinical trials. Physicians cannot ethically disclose the true risks of biological substances that have never been studied in a controlled environment. A signed consent form may prove legally insufficient if a patient suffers a stroke, autoimmune crisis or fatal cardiovascular event. In such cases, the physician could not have known the full extent of the risks the patient was assuming.

Unprofessional Conduct and Private-Pay Models

Many licensed doctors are generating significant revenue from private-pay patients by offering unregulated peptide protocols. This business model carries a constant risk of being labeled as unprofessional conduct by the Minnesota Board of Medical Practice. A physician loses traditional legal protections if a regulatory board perceives their motivation as primarily financial rather than clinical.

Clinics may also violate state and federal laws regarding unapproved drugs if they source products from unverified overseas vendors or bad-actor laboratories. Operating a peptide business without a necessary supervising physician constitutes

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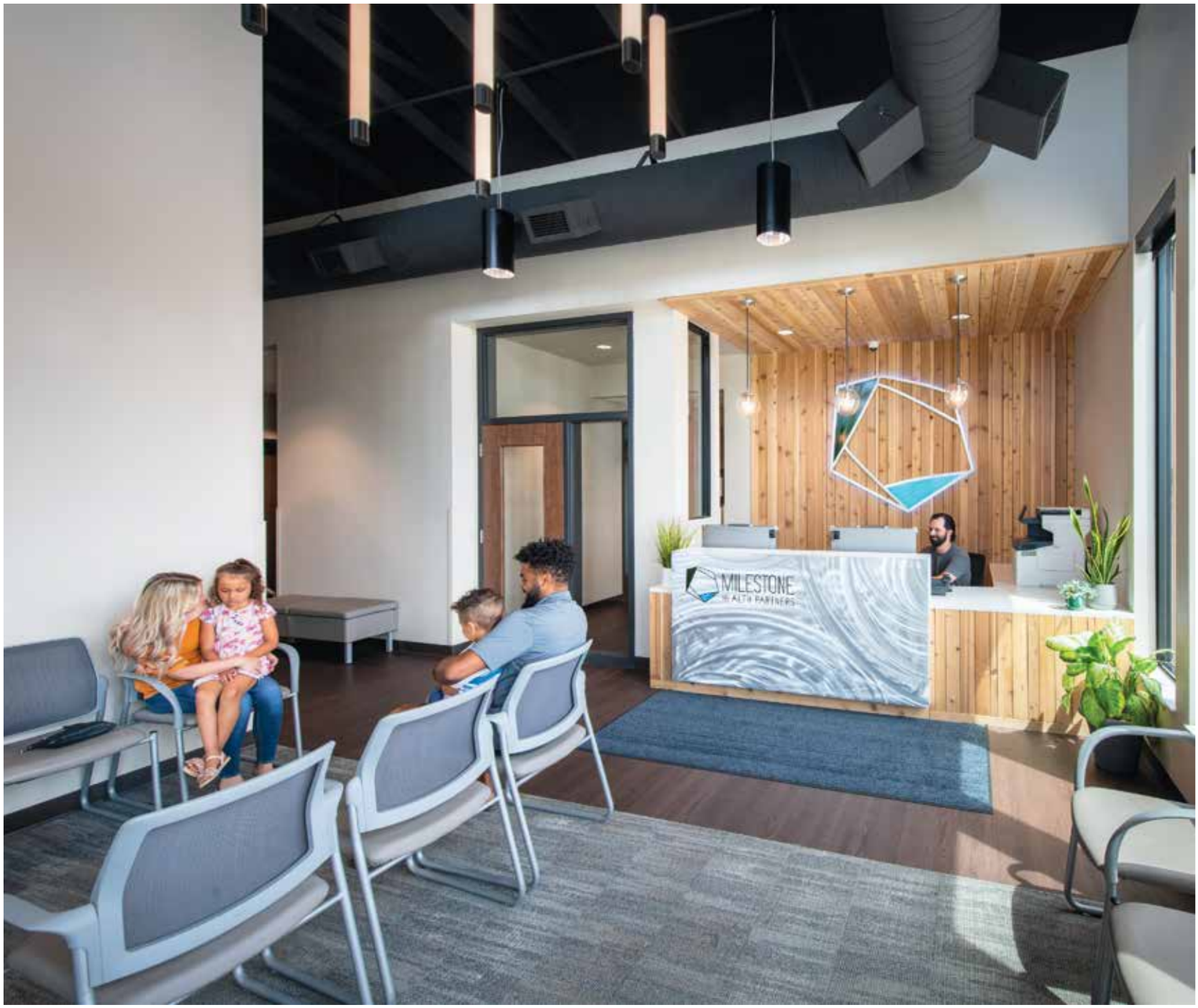

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the unlicensed practice of medicine. This is a gross misdemeanor in Minnesota and will likely attract intense interest from the attorney general's office.

Actionable Advice

For any fully licensed physicians who deliberately choose to navigate this fraught, dangerous legal landscape, actively implementing a highly rigorous, comprehensive legal risk mitigation framework is absolutely and fundamentally essential. The ultimate, essential goal of this vital framework is to carefully and ethically balance genuine patient interest with the absolute necessity of professional survival.

- **Vet Your Sources:** Meticulously vet all product sources. Never recommend or prescribe biological products from questionable research websites or unverified overseas vendors. Ensure all clinical peptides come exclusively from licensed 503A or 503B compounding pharmacies under FDA and state pharmacy board oversight.
- **Document Harm Reduction:** Shift your role to harm reduction if a patient is already self-injecting unregulated peptides. Explicitly advise the patient against using unverified supplies and document the lack of professional oversight. Treat this safety conversation like a report of dangerous street drug use by making it a permanent, heavily documented part of the medical record.
- **Clarify the Relationship:** State clearly in the medical records that you are not the prescribing or supervising physician if you are only monitoring blood labs. The record must explicitly reflect that your role is limited to monitoring the patient for potential toxicity and adverse health events related to their independent peptide use.
- **Avoid Guaranteed Outcomes:** Never market unproven peptides as guaranteed solutions or definitive cures. Maintain a cautious, conservative professional tone in all patient communications and marketing materials. Remember that the FTC actively reviews clinic websites for illegal or unsubstantiated claims.

Conclusion: The Physician as Gatekeeper

The peptide tsunami is an emerging, multi-billion dollar unregulated industry that puts lives and health outcomes at risk. A physician's role as a medical gatekeeper is now more vital to public safety than ever before. While GLP-1 agonists have opened new doors for metabolic health, they have also allowed a flood of unverified and potentially lethal substances into the market.

Legally sound pathways for prescribing popular peptides may eventually emerge through ongoing research and regulation. This process would likely mirror the evolution of GLP-1 medications. In the meantime, you can protect your patients and your medical license by grounding your practice in peer-reviewed trials. Maintain a deep respect for the established standard of care and provide an evidence- based perspective on all unproven treatments to navigate this high-risk landscape safely.

David Holt, JD, is a health care attorney at Holt Law, a firm specializing in health care law.

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Health Care Workforce Integration

Staffing Growth Doesn't Mean Stable Care Delivery

BY KENNETH BOTELHO, DMSc, PA-C

Health care organizations across Minnesota and nationally have invested heavily in workforce expansion, transition-to-practice programs, advanced-practice clinician fellowships, telehealth infrastructure and value-based care initiatives. Yet despite these investments, health care delivery continues to face many basic and predictable operational realities: persistent turnover, unstable onboarding cycles, clinician burnout, fragmented continuity of care and difficulty sustaining long-term workforce stability.

These issues entail more than just workforce supply, despite assumptions that staffing growth automatically creates stable care delivery capacity. It does not. A staffed position and stable care delivery capacity are not the same thing.

A clinician may technically fill a vacancy while the surrounding system continues struggling with turnover, fragmented continuity, onboarding strain and operational instability. In many organizations, clinicians are operationalized faster than they are integrated. As a result, newly hired clinicians may inherit operational instability before durable integration into the organization has occurred.

Clinicians entering similar roles often inherit dramatically different practice environments. One clinician may enter a clinic with graduated scheduling templates, mentorship access, protected consultation time and manageable panel growth. Another may inherit a full inbox, increasingly complex patient panels, immediate productivity expectations and limited support within weeks of starting practice. This distinction matters far more today than it did a generation ago.

The Growing Complexity of Workforce Integration

Clinicians are no longer simply entering jobs. They are entering highly interconnected care environments that require management of chronic disease populations, referral coordination, utilization pressure, quality metrics, team-based workflows and longitudinal patient relationships — all while simultaneously learning local operational culture, escalation pathways, documentation expectations and community resources.

In many cases, these operational realities are not deeply taught during formal clinical training and are also inconsistently taught within health care organizations themselves. Clinicians may therefore enter increasingly complex value-based care environments without fully understanding how longitudinal continuity, documentation patterns, utilization management, preventive intervention, chronic disease progression and risk stratification directly influence both patient outcomes and organizational performance over time.

Health care delivery depends on clinicians' functioning not only as diagnosticians and treatment providers, but also as longitudinal navigators within highly interconnected operational systems. Many clinicians, however, receive limited developmental support in understanding how their day-to-day clinical decisions influence broader organizational stability, utilization patterns, care coordination and value-based care performance across patient populations.

This creates a significant systems integration challenge. Clinicians are often expected to stabilize patient risk, prevent avoidable escalation, strengthen continuity and support longitudinal care management, while the operational logic surrounding these responsibilities often remains inconsistently developed or communicated during workforce integration itself.

It is very difficult to manage increasingly complex patient populations while simultaneously navigating organizational systems that themselves are difficult to understand. Expectations surrounding quality metrics, risk adjustment, utilization management, documentation performance, preventive care gap closure, referral coordination and longitudinal chronic disease management may all influence organizational outcomes in ways that are not always visible to frontline clinicians during training or onboarding.

The operational logistics of day-to-day clinical decision-making are increasingly interconnected. Decisions surrounding continuity, follow-up timing, escalation pathways, preventive intervention, medication management and care coordination influence not only individual patient outcomes, but also broader utilization patterns, organizational risk performance and long-term system stability.

Clinicians enter practice environments where these operational relationships are learned reactively rather than through intentionally structured integration and mentorship. They are expected to meet production goals immediately, before stable workforce integration has occurred. This contributes to both clinician strain and broader organizational instability over time.

Consequences from these oversights extend beyond clinician satisfaction. Repeated turnover and unstable onboarding processes disrupt continuity of care itself. Patients may repeatedly transition between unfamiliar clinicians who lack understanding of their baseline functioning, psychosocial issues, prior treatment responses, family dynamics and evolving disease patterns. In these settings, continuity loss becomes more than a scheduling problem — it may alter clinical decision-making itself.

Continuity as Operational Infrastructure

Continuity, workflow stability, contextual patient understanding and longitudinal disease management directly influence utilization, preventable escalation, chronic disease outcomes and total cost of care. Continuity is not simply relational. It is operational infrastructure.

Value-based care models increasingly reward continuity, longitudinal disease management, preventive intervention and contextual patient understanding, whereas many workforce environments continue operating in ways that repeatedly destabilize these same dynamics.

This said, many workforce initiatives already implicitly recognize parts of this reality. Investments in transition-to- practice programs, such as advanced practice clinician fellowships, ECHO models, mentorship initiatives and rural workforce pathways are examples. These investments reflect growing recognition that workforce supply alone does not reliably create stable care delivery systems.

Many of these efforts, however, continue functioning as isolated interventions rather than components of a broader and connected workforce integration strategy. A fellowship may improve onboarding during the first year of practice while long-term mentorship and operational support remain inconsistent afterward. A transition-to-practice program may exist in one department while another continues relying on immediate productivity expectations. Health systems may successfully recruit clinicians into rural communities while still struggling to create sustainable developmental structures that promote long-term retention and continuity. This may reflect a broader structural shift within health care itself.

> Clinicians are operationalized faster than they are integrated.

The Erosion of Longitudinal Developmental Support

Historically, many smaller physician- owned practices developed mentorship and developmental continuity programs somewhat organically. Early-career clinicians often practiced alongside more experienced physicians within relatively stable clinical environments where consultation, workflow adaptation, contextual patient understanding and gradual assumption of responsibility occurred continuously through day-to-day working relationships.

These systems were far from perfect, but they often created forms of developmental continuity that helped clinicians integrate into practice over time. As the industry expanded, consolidated, and operationalized at larger scales, many of these informal support structures weakened or disappeared. Modern systems responded appropriately by creating onboarding programs, fellowships

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and transition pathways. Broader support structures surrounding clinician integration, however, often remained inconsistently developed after the formal onboarding period ended.

This distinction matters because health care systems increasingly depend on clinicians functioning effectively within highly complex care environments over many years, not simply during the first several months of employment. The issue is no longer simply whether clinicians are hired. The issue is whether clinicians remain stably integrated into increasingly complex systems over time. This has implications not only for workforce retention, but also for continuity of care and long-term health system performance itself.

Continuity infrastructure exists at multiple levels simultaneously. Patients benefit from long-term relationships with clinicians who understand their baseline functioning, historical treatment responses, psychosocial circumstances and evolving health patterns over time. Clinicians themselves also require continuity within organizations — mentorship relationships, consultation access, operational guidance, manageable escalation pathways and developmental support structures that evolve alongside increasing responsibility and complexity.

When continuity deteriorates for clinicians, continuity often deteriorates for patients. This creates a reinforcing cycle of operational instability and contributes to clinician dissatisfaction and turnover. Turnover disrupts patient continuity and increases onboarding burden for remaining staff. Fragmented continuity contributes to workflow inefficiency, increased utilization, inconsistent chronic disease management and escalating operational strain. Systems then continue attempting to stabilize instability primarily through recruitment and staffing expansion while under recognizing the developmental and operational conditions required for durable workforce integration.

The Hidden Costs of Continuity Reconstruction

Every turnover cycle forces repeated reconstruction of continuity itself. Patient relationships, contextual clinical understanding, workflow familiarity, team dynamics and operational trust must often be rebuilt repeatedly between clinicians, staff and patients. These rebuilding processes rarely appear directly on financial spreadsheets, yet they may significantly influence utilization patterns, onboarding burden, clinician retention, workforce stability and long-term operational performance.

The operational and financial implications are substantial. In practical terms, these disruptions may appear in ways that are familiar to many health care organizations but difficult to quantify. Newly hired clinicians may inherit fragmented patient panels, unresolved inbox burden, inconsistent follow-up structures and unstable staffing workflows while simultaneously adapting to new documentation systems, referral pathways, quality expectations and productivity demands. Nursing staff, schedulers, referral coordinators and clinical teams may repeatedly adapt to changing communication patterns and workflow preferences during ongoing turnover cycles.

Patients themselves may also experience repeated disruptions in continuity. Chronic disease management plans may change between clinicians. Preventive care gaps may persist despite multiple health care interactions. Subtle longitudinal changes in baseline functioning or psychosocial circumstances may become more difficult to recognize when contextual understanding repeatedly resets across turnover cycles. Although these disruptions may appear operationally small in isolation, their cumulative effects may significantly influence utilization patterns, escalation risk, patient trust and long-term operational stability.

Repeated recruitment cycles, onboarding instability, productivity disruption, turnover and fragmented continuity all carry major direct and indirect costs. Unstable continuity may contribute to preventable emergency department utilization, duplicative care, worsening chronic disease outcomes, lower quality performance and rising total cost of care.

From this perspective, workforce integration is not simply an educational issue or workforce sustainability initiative. It is core operational infrastructure. While operational challenges may vary for rural, metropolitan, independent and large integrated systems, many of the underlying problems are the same. Clinicians are often expected to function effectively despite inconsistent mentorship structures, fragmented developmental support and limited operational integration over time.

Effective health care delivery increasingly depends on clinicians' understanding not only clinical medicine, but also care coordination, disease management, utilization implications, quality metrics, documentation complexity and the broader operational realities influencing patient outcomes and organizational performance. Many clinicians, however, receive limited support in understanding how their day-to-day clinical decisions directly influence continuity, utilization, risk stratification and value-based care performance. Addressing these issues requires health care organizations to think differently about workforce capacity itself.

Moving Toward Durable Workforce Integration

Several practical approaches may help organizations strengthen workforce integration and long-term operational stability. Some of them include:

- Graduated onboarding structures aligned to clinician experience and complexity exposure rather than rigid productivity timelines.

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- Protected consultation access during early and transitional phases of practice.
- Longitudinal mentorship structures extending beyond initial onboarding periods.
- Alignment of panel complexity and responsibility with developmental readiness.
- Greater integration between workforce development initiatives, operational leadership and clinical practice realities.
- Expanded interdisciplinary support systems within primary care and value-based care environments.

Practical Barriers and Operational Realities

Barriers to improving workforce integration include organizations operating under substantial productivity pressure, staffing shortages, reimbursement constraints and administrative burdens that compete directly against the time and infrastructure that meaningful change requires. Protected mentorship time, graduated onboarding structures, interdisciplinary collaboration and developmental support may initially appear financially inefficient within environments heavily focused on immediate access and productivity demands.

The absence of these structures may, however, ultimately create forms of instability that are considerably more expensive over time. Repeated turnover, continuity disruption, onboarding strain, fragmented care coordination and operational instability may gradually erode workforce sustainability, patient continuity and value-based care performance across the organization itself.

It is important to understand that these approaches should not be viewed as secondary educational initiatives occurring adjacent to health care delivery. Increasingly, they may determine whether health care systems merely fill vacancies — or actually stabilize care delivery over time. A clinician entering practice does not immediately become a part of interchangeable operational infrastructure simply because a vacancy has been filled. Stable care delivery capacity depends on how effectively clinicians are integrated into increasingly complex care environments.

> Continuity is not simply relational. It is operational infrastructure.

Health care transformation depends not just on expanding workforce supply but also on how organizations become intentional about building the structures and programs required to sustain ongoing workforce stability, continuity of care and durable operational performance

Filling vacancies alone does not necessarily stabilize care delivery. Increasingly, health care organizations may need to recognize that continuity itself — for both patients and clinicians — is not simply a relational ideal or workforce preference. It represents one of the most important and under recognized forms of operational infrastructure within modern health care systems.

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and orthostasis, electrolyte disturbances, GI dysmotility, endocrine disruption, fertility changes and bone density loss. An important clinical nuance is that starvation and weight suppression themselves can generate psychiatric symptoms — irritability, cognitive slowing, heightened anxiety, obsessive thinking — so nutritional rehabilitation is not just "supportive," it is treatment. We typically address the eating disorder and comorbidities in parallel, while prioritizing immediate medical safety and stabilizing nutrition so psychotherapy and medication can be more effective. In short, eating disorders frequently co-occur with other psychiatric and medical conditions, and effective care treats both while prioritizing medical stability and nutrition.

The impact of GLP-1 receptor antagonists on eating disorder pathology is understudied, but this has not slowed them from accounting for 7% of all U.S. prescriptions. What should we know about this?

First, a terminology clarification: commonly used medications in this category (e.g., semaglutide, liraglutide, tirzepatide) are GLP-1 receptor agonists.

Their impact on eating disorder pathology and recovery is certainly understudied, so we need to approach them thoughtfully—especially for people with current or past eating disorders. By reducing hunger and increasing early satiety (and sometimes causing nausea or GI slowing), these agents can unintentionally reinforce dietary restriction urges and behaviors, intensify weight/shape preoccupation, or disrupt the structured nutrition plan that recovery requires. That concern is particularly relevant in anyone prone to restrictive eating as a component of their eating disorder. For those with a history of purging or laxative abuse, the fullness and GI slowing caused by these medications can reignite urges to resume those behaviors. For some individuals with binge-eating symptoms, early data and clinical experience suggest potential reductions in urges or episodes, but long-term outcomes (including relapse risk and effects on eating disorder cognitions) remain unclear. Best practice is careful screening, shared decision-making with goals beyond weight and close monitoring by an eating-disorder informed team. GLP-1 agonists are widely used, but in those with eating disorders, they require extremely careful screening and monitoring because they may complicate recovery or hasten a relapse.

What are some of the issues around eating disorders as they apply to individuals from diverse cultural or racial backgrounds?

Eating disorders occur across all racial, ethnic and cultural groups, but they are not recognized or treated equitably. Stereotypes about who "gets" an eating disorder contribute to under-screening and delayed diagnosis for people of color, men, older adults, LGBTQ+ individuals and people in larger bodies. Culture can also influence how symptoms are described: patients may emphasize GI distress, "health eating," strength/fitness or a desire to feel "clean" rather than using weight/shape language so clinicians must ask behaviorally specific questions and remain culturally curious. Structural barriers matter: insurance coverage, language access, transportation, time off work and experiences of discrimination or mistrust can shape engagement and retention in care. Weight stigma and racism can intersect to normalize or even praise restrictive behaviors, increasing risk while decreasing access to help. High-quality treatment requires culturally

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responsive assessment, attention to identity and context and practical support that reduce barriers to sustained, evidence-based care. The core illness of an eating disorder is often the same, but inequities, stigma and cultural context strongly influence who gets a diagnosis and who gets effective treatment.

What do you see in the future for eating disorder treatment?

I expect several advances, alongside a continued emphasis on the fundamentals of recovery. Clinically, we will likely see broader access through virtual and hybrid models, improved coordination between primary care and specialty programs, and more measurement-based care so teams can identify stalled progress early and adjust treatment promptly. We are also learning more about how to tailor evidence-based therapies — such as CBT, DBT and FBT — to different developmental stages, comorbidity patterns and social contexts, which may improve engagement and reduce dropout. I also anticipate that eating disorder treatment centers and specialists will expand their ability to effectively treat the most common comorbid psychiatric and medical illnesses as one method of promoting holistic, rather than fragmented care for the individual. On the research front, there is active exploration of adjunctive interventions (e.g., digital tools, virtual reality–supported exposures, medication trials and neuromodulation) for carefully selected patients, but these will likely complement, not replace, nutrition rehabilitation and psychotherapy. First and foremost, I anticipate stronger efforts to address weight stigma, improve culturally responsive care, and reduce inequities that delay diagnosis and limit access to higher levels of care. The future is likely to bring more accessible and personalized care, more comprehensive care for an individual's comorbid psychiatric and medical illnesses, more medication and medical intervention options, while keeping nutritional rehabilitation and psychotherapy at the core of effective treatment.

What are the most important things physicians should know about eating disorders?

Physicians should know, first, that eating disorders are common, potentially life-threatening, and treatable — and they occur at any weight, so appearance is not a reliable severity marker. Second, risk assessment matters: evaluate weight trajectory and rapid changes, orthostatic vitals, bradycardia, temperature, electrolytes (especially potassium, bicarbonate, phosphorus, magnesium), and consider ECG when indicated; significant medical instability can occur even with "normal" BMI. Third, ask directly and routinely about food restriction, binge eating, vomiting, laxative/diuretic misuse, diet pills, compulsive exercise, and ARFID-type avoidance; specific questions outperform vague ones. Fourth, intervene early: timely referral to an eating-disorder informed multidisciplinary team improves outcomes, and higher levels of care can be medically necessary and life-saving. Finally, language matters — avoid reinforcing diet culture or weight stigma, and emphasize recovery goals such as normalized nutrition, medical stability, improved cognition and restored functioning. Early identification, careful medical risk assessment, nonstigmatizing communication, and prompt referral to specialized care are the essentials physicians need to manage eating disorders well.

Brad Smith, MD, DFAPA, is the chief medical officer for The Emily Program. He is board-certified in adult and forensic psychiatry and is dedicated to advancing high-quality, patient-centered care for individuals with eating disorders.

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