July 2, 2020

Minnesota Board of Medical Practice

I am aware that under Minnesota law, the Board of Medical Practice has an obligation to make inquiries into complaints and reports of alleged violations of the Minnesota Medical Practice Act. I received your request for information, and pertinent documents and videos necessary for the board to address these allegations are attached.

I would like to begin by stating that as a physician who has practiced medicine in Minnesota for nearly forty years, and as an outspoken physician legislator in Minnesota, I believe the stated complaints and allegations in your letter are derived from politically motivated persons, but I respect your committee's responsibilities to conduct appropriate due diligence. Your correspondence referenced concerns regarding public statements, and I found it noteworthy that your concerns did not involve any actual patient care issues or complaints.

I want to make it very clear that because I was the chief senate author of the two major legislative health care policy bills over the last two years (Pharmacy Benefit Manager licensure and regulation; Insulin safety net program), and because I am vice-chair of the Senate Health and Human Services Committee, I certainly have been in the crosshairs of many politically energized people.

During the COVID-19 pandemic I have been both critical and complimentary of various actions by the Center for Disease Control (CDC), the Minnesota Department of Health, and the State of Minnesota. I take my role as one of the few physician-legislators in the State of Minnesota very seriously, and I firmly believe that I have an obligation to my patients, constituents, and all Minnesotans to use my medical expertise and senate experience to further an understanding of the pandemic situation by "connecting the dots" for citizens and patients who choose to consider a perspective other than what mainstream legacy news sources might choose to provide.

While serving as a legislator, I have been criticized and abused via social media, e-mail, voicemails and phone calls. Death threats have become for my wife and I an occasional "fact of life." Some of the same folks who exuberantly applauded my candid and nonpartisan communication efforts in February of 2020 regarding an insulin safety net program are the same people who now express disdain and ridicule for my "maverick" willingness to "go against the grain" regarding the current COVID-19 conventional media narratives. I have thought long and hard about what potential legal remedies might be available to me when I encounter blatant efforts to slander and harass me for expressing thoughts which don't match up with the "current" perspective.

For months now, people I have never met, never spoken to, and never treated medically have threatened to "report" me to various agencies and boards in an effort to stop me from applying what I believe to be appropriate medical and scientific scrutiny to the current events, treatments, and responses to COVID-19. I view the current allegations you are inquiring about as possible attempts by those who wish to discourage me from voicing alternative or contrarian points of view which may call into question certain governmental actions.

In the last few months, I have made hundreds of statements and comments on the floor of the Minnesota Senate, in various committee meetings, and in local and regional meetings. I have participated in local, national, and international television and radio shows to discuss the current COVID-19 circumstances. I

have said, "YES," to virtually any request I could accommodate because I believe that is my job as an elected official. To my dismay I have been chastised for not knowing in advance if a hosting media event was conservative or liberal regarding biases – I never thought it should matter. It has become more than clear to me that the American political scene has truly become "blood sport." Virtually all my public statements, comments, and opinions are available via YouTube, Facebook, Twitter, as well as various news and media outlets.

In responding to the two allegations outlined in your letter dated June 22, 2020, my intention is to respond in my own words and also provide attachments to help reveal the rationale informing my perspectives. I do believe these allegations evolved from an emotional and changing intersection of healthcare, public policy, and partisan politics such that information shared two months ago may no longer represent current perspectives. I have found in my last four years of serving in the Minnesota Senate that when people disagree with me politically, there is almost no telling what type of action or retaliation may occur.

Allegation #1. It is alleged that you were "spreading misinformation [regarding COVID-19] on a regional tv station [i.e. KXJB-TV], "claiming that the Minnesota Department of Health instructed providers to list COVID-19 as the cause of death on death certificates regardless of whether a patient died of COVID-19.

Response:

An allegation of "spreading misinformation" is nebulous and quite broad.

I did not claim that the Minnesota Department of Health (MDH) instructed providers to list COVID-19 as the cause of death regardless of whether a patient died of COVID-19.

But the fact of the matter is that on April 3, 2020 the Minnesota Department of Health emailed information to medical certifiers involved with cause of death certification responsibilities which did advise "physicians, physician assistants, and advanced practice registered nurses who certify deaths to … report Coronavirus Disease 2019 or COVID-19 on death certificates for all decedents where the disease caused, is assumed to have caused, or contributed, to death." (ATTACHMENT 1_MDH_4.3.20_initial email)

The language in this email contradicts CDC instructions which state that "significant conditions contributing to death" should not be assumed to be the CAUSE OF DEATH, but rather listed in Part II of the death certificate as a contributing condition. The CDC manual for completing death certificates specifically provides instructions that the UNDERLYING CAUSE OF DEATH (UCOD) should be "defined as the disease or injury that initiated the train of morbid events leading directly to death." For example, a patient placed in hospice care with end-stage heart failure or cancer who is rapidly approaching death but in the last 24 hours of life is identified as having a positive COVID-19 test or exposure should have the UCOD determined to be the underlying problem which prompted the initiation of hospice care. Any other determination – such as COVID-19 per the advice in the April 3 email from MDH – contradicts CDC manuals, standard physician practices regarding the establishment of a causation sequence with the UCOD identified as the initiating event leading to the patient's demise, and Minnesota's own death certification instructions compiled by coroners and medical examiners. (ATTACHMENT 2_CDC Manual_pgs. 9-11; full manual available at: https://www.cdc.gov/nchs/data/misc/hb_cod.pdf)

Another example would be the following: an HIV patient develops AIDS, then contracts overwhelming Pneumocystis pneumonia, then decides to utilize supportive care hospice services. In the last days of his life he develops a taste disturbance and PCR test for COVID-19 is positive. The appropriate UNDERLYING CAUSE OF DEATH (UCOD) is NOT COVID-19 but rather HIV leading to AIDS leading to Pneumocystis pneumonia with COVID-19 possibly involved in the sequence of death as the immediate cause. If the physician believed that COVID-19 did not play a role as the immediate cause of death, she/he could place it in Part II as a contributing condition. It is critical to understand that the UCOD is placed on the bottom line of Part I of the death certificate and is considered the cause of death when tallying causes of death and prevalence of various diseases.

The triggering MDH email stated that COVID-19 should be reported for all decedents where COVID19 caused, is assumed to have caused, or contributed, to death. It also linked certifiers to a CDC seven-page document which on page 3 states that it is acceptable to report COVID-19 as the cause of death without laboratory confirmation if the circumstances are ”within a reasonable degree of certainty.” (ATTACHMENT 3_CDC_4.3.20_Guidance for Certifying Deaths Due to Coronavirus Disease 2019)

But unfortunately, the CDC reporting guidance went on to declare that in cases where a definite diagnosis of COVID-19 could not be made, but was suspected or likely, it was declared acceptable to report COVID-19 on a death certificate as “probable” or “presumed.” This contradicted the following: (i) CDC’s own instruction manual for physician completion of death certificates, (ii) standard medical procedures, (iii) WHO coding recommendations, and (iv) Minnesota death certification manual. (ATTACHMENT 4_MN Death Certificate Manual_pgs 48, 60-63; full manual available at: https://www.health.state.mn.us/people/ vitalrecords/physician-me/docs/capcodbook.pdf)

Frankly the MDH email allowing or even encouraging the use of COVID-19 as a cause of death in the instance of being merely a contributing element was astounding to many physicians including myself – the initiating disease in the train of events leading to death has long been the basis for data and statistical compilation so as to inform public health policy, legislation, and even funding for disease control initiatives.

Both the MDH email and the CDC reporting guidance packet contributed to confusion. The CDC guidance packet was interpreted by many that if COVID-19 played a possible role in the death of a patient, this was enough to identify it as a cause of death. This led to remarkable situations in which no testing was done or even considered but death certificates still called out COVID-19 as the UCOD. The CDC guidance packet did indicate that, where possible, laboratory testing should be done through local health authorities. This “soft” recommendation opened the door for uncertainty and misunderstanding which unfortunately had subsequent impact throughout the world simply because a COVID-19 death was not held to the standard of being involved in the sequential train of causation leading to a patient’s death.

I was disturbed by the guidance MDH and CDC promulgated and asserted publicly that the sequence-of-causation protocol traditionally used in determining the all-important UNDERLYING CAUSE OF DEATH (UCOD) was being undermined by the Minnesota Department of Health’s invitation to establish COVID-19 as the UCOD regardless of whether or not a laboratory test confirmed the diagnosis of COVID-19 or regardless of the fact that such a test was even considered by a physician. I was alarmed that the nature of the April 3 MDH email seemed to “coach physicians” to complete death certificates in a manner outside standard practices and protocols. I believe that MDH potentially compromised the integrity of death certificate data by inviting the inclusion of “assumed” or “contributed” as a basis to code a death certificate as COVID-19 for the UCOD. I believe this represented a significant and noteworthy change

regarding the recommended practice for death certification which could easily reduce the number of deaths related to heart disease, cancer, stroke, emphysema, etc. in favor of exaggerating the COVID-19 death counts. With this less rigorous process for determining COVID-19 as the UCOD, even annual influenza patient counts would, at some level, be altered since the annual flu outbreak was still in process. (ATTACHMENT 5_AAFP_Editorial on Death Certificates)

I believe the origin of this allegation relates to an interview I participated in on April 7, 2020. I encourage you to watch the seven minute video (LINK BELOW) and would ask in advance that you be mindful of the difference linguistically between the words, "instructed" and "coached."

https://www.powerlineblog.com/archives/2020/04/how-honest-is-the-covid-fatality-count.php

As part of a response to any health crisis or pandemic, clear and verifiable information is key to addressing the situation, preparing a response, implementing preventative measures when possible, and providing treatment to the afflicted. All over Minnesota, the nation, and the world, there has been ongoing discussion related to how COVID-19 deaths are being reported. This is not misinformation; this is fact. (ATTACHMENTS 6,7,and 8_ Pennsylvania, Denver, New York)

In April of this year, the Illinois Director of Public Health, Dr. Ngozi Ezike stated the following:

> *"I just want to be clear in terms of the definition of people dying of COVID. The case definition is very simplistic. It means at the time of death it was a COVID positive diagnosis. So that means if you were in hospice and had already been given a few weeks to live, and then you also were found to have COVID, that would be counted as a COVID death. It means technically even if you died of a clear alternate cause, but you had COVID at the same time, it's still listed as a COVID death. So, everyone who's listed as a COVID death doesn't mean that that was the cause of the death, but they had COVID at the time of the death."*

Dr. Deborah Birx, part of the White House medical team, made the famous statement which has become nearly memorialized:

> *"If someone dies with COVID-19, we are counting that as a COVID-19 death."*

Her outlandish presumption that - no one died WITH COVID-19, rather they died FROM it - was "gas on the fire," and people around the world were quickly outraged. Any information, guidance, or publication which had the potential to skew, camouflage, or muddy the waters regarding an actual cause of death needed to be intensely scrutinized, in part because the recorded data in 2020 would shape future public policies which would have immense and lasting impact with potentially devastating unintended consequences.

In today's world of instant communication, any action taken by a governmental body or agency which does not provide clear, concise, and trustworthy information to the general public does nothing to further the public trust, and harms the reputation of such body or agency.

In summary the Minnesota Department of Health distributed instruction and guidance to providers to report COVID-19 on death certificates without precisely distinguishing between causation or correlation

or contribution to the UCOD. I have completed hundreds of death certificates over the last 40 years, and I vehemently disagree with this advice because it is absolutely contrary to past standard practice, created havoc and perverse incentives, and undermined quality data collection. New York, Pennsylvania, California, and many other states chose different paths to determine how to count COVID-19 deaths and each has undergone public scrutiny regarding such decisions.

The issue of laboratory confirmed cases not being segregated from presumed cases presents huge challenges which will require some level of uniformity in coding. (ATTACHMENT 9_COVID-19_ICD-10 Official Guidelines, specifically Chapter 1 (g)(1)(a), paragraph 3)

The notion that a contributing acute viral condition or test result could casually be inserted in place of a chronic progressive life-draining medical problem - such as cancer or heart failure - which was clearly the initiating condition sapping a patient's lifeblood to the point where death was closing in seemed ludicrous. I announced my concern publicly that the confounding communications by MDH and the CDC were problematic – but this assertion was not saying that MDH was "instructing providers to list COVID-19 as the cause of death regardless of whether a patient died of COVID-19." Rather I expressed piercing alarms that public agencies were unilaterally moving in a dangerous direction that would potentially undermine the public trust just when policymakers needed that trust more than ever if citizens were to be expected to comply with earthshaking public policy decisions. The angst caused by such challenging considerations took root throughout the country, and Americans in every state have proven that they are worthy participants in this crucial conversation regarding the determination of death counts which will obviously impact on case fatality rates, comparisons with influenza epidemics, and state and federal funding decisions to help all Americans get through this crisis.

I hope every physician in Minnesota shares my concern that a paradigm shift in establishing the UCOD has taken place if the cause of death can now be established without regard for a precise sequence of causation or even ordering a simple lab test to bring science into the realm of determining the real cause of death. At the very least there should have been a conversation about this approach, but this did not occur. I reached out to dozens of physicians experienced in the completion of death certificates, and found no disagreement with my concerns. I suspect many physicians lacking ongoing experience with death certificate completion might see my concerns as more esoteric than real. I cannot fix that.

I protested what I perceived to be a counterproductive paradigm shift regarding death certificate completion, but I was gratified to see MDH and CDC distribute clarifying language to remedy the problem. MDH sent out two additional communications in the following weeks to clarify what had become very murky and also announced that it would count only laboratory test confirmed COVID-19 deaths in their tabulations and would sequester death certificates listing COVID-19 without laboratory confirmed tests until further research could be done (these fatalities are now identified with an asterisk on the MDH dashboard.) Numerous states reduced their official death counts in response to the national public outcry and debate regarding questionable cause of death determinations.

On April 9, I received an email from MDH containing clarifying guidance from the Office of Vital Records calling for accuracy, clarity, and confirmation of COVID-19 deaths. This April 9 guidance also reiterated that the UNDERLYING CAUSE OF DEATH meant "the disease or injury which initiated the train of morbid events leading directly to death." It did not allow for a contributing condition to be the UCOD. (ATTACHMENT 10 and 11_MDH Final Guidance_4.9.20_AND_MDH Certifying Deaths Due to COVID-19_4.9.20)

On May 7, I received an additional MDH email with a link to video guidance for certifying COVID-19 deaths released by the National Center for Health Statistics (NCHS), and this video emphasized the need for the UCOD to represent best clinical judgement in identifying the most logical sequence of causation resulting in death. (ATTACHMENT 12_Video Guidance_5.7.20)

I did not claim that MDH instructed providers to list COVID-19 as the cause of death on death certificates regardless of whether a patient died of COVID-19. Rather I raised some questions:

- Should we be diagnosing COVID-19 in the absence of a laboratory confirmed test of COVID-19?
- If a laboratory confirmed test of COVID-19 is not obtained in a patient who dies, should death certificates be allowed to declare the UNDERLYING CAUSE OF DEATH as COVID-19? If so, in what circumstances?
- Does it matter if testing capability is readily available but not utilized in making the diagnosis of COVID-19? If the patient dies, does this change the diagnostic threshold?

Allegation #2. It is alleged that you also provided "reckless advice [regarding COVID-19] over social media," stating that COVID-19 "is nothing more than the flu."

Response:

Over the last few months, in my role as a citizen-physician-legislator, I have made numerous statements and comments in video clips, on the floor of the Minnesota Senate, in various committee meetings, and in local and regional meetings. I have made numerous appearances on local, national, and international television and radio shows. I cannot possibly respond with precision to an allegation that I have provided "reckless advice over social media," as such an allegation is overly broad, and no specific instance of any such "reckless advice" is provided. Further, what someone who disagrees with a viewpoint I have expressed may deem "reckless advice," another may deem quite sensible.

In regard to a statement that COVID-19 is "nothing more than a flu," I have stated that the underlying COVID-19 virus has many similarities to other viruses: it is similar to the 2002 SARS Corona epidemic in regards to physiologic systems involved; it is similar to influenza viruses in that it is a single-stranded respiratory RNA virus with presenting symptoms of fever, cough, shortness of breath, malaise, headaches, muscle aches and GI disturbances. All three of these viruses – Covid-19, SARS, influenza - can kill thousands of people during an outbreak. I have provided specific contextual comparisons between influenza outbreaks and COVID-19 in regard to mortality, testing, latency and incubation periods, modelling uses and shortcomings, treatment protocols, and the unique 'attack mode' every virus has the potential to exhibit. Certainly, COVID-19 viruses are far more comparable to influenza viruses than to herpes viruses, Ebola viruses, or gastroenteritis viruses. .

The CDC reported the following on June 14, 2020:

> *"COVID-19 can look different in different people. For many people, being sick with COVID-19 would be a little bit like having the flu. People can get a fever, cough, or have a hard time taking deep breaths. Most people who have gotten COVID-19 have not gotten very sick. Only a small group of people who get it have had more serious problems."*

Dr. Anthony Fauci stated in a New England Journal of Medicine Editorial on March 26, 2020:

> *"This suggests that the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza (which has a case fatality rate of approximately 0.1%) …"*

(ATTACHMENT 13_New England Journal of Medicine – COVID-19-Nagivating the Uncharted).

Dr. Michael Osterholm told Beret Leone of Fox 47 Duluth News on March 14, 2020:

> *"Deadly strains of Influenza or the flu have been around for centuries. The flu has become a pandemic more than once and killed millions of people. It still exists today, but modern health experts are discussing what would happen if a new influenza virus showed up today, in world of 8-billion people. Unfortunately, we now have on our hands, but it's caused by a coronavirus which is acting very much like influenza."*

(ATTACHMENT 14_National Infectious Disease Expert Talks COVID-19 in Duluth)

I have compared and opined on case fatality rates, incidence, and death totals between COVID-19 and influenza, which I believe to be eminently reasonable. I have called into question certain reporting metrics which fail to take into account the context of a given perspective, e.g. in 2018 influenza was reported to have caused ~80,000 deaths in the U.S. and the 1918 pandemic caused possibly 50 million deaths worldwide, albeit without the benefit of antibiotics. I have utilized numerous resources - MDH, DHS, CIDRAP, IHME – to inform my opinions. I have interviewed world experts on epidemiology and participated in BBC news programs, Tony Robbins podcasts (with an expert panel featuring world renowned authorities including a Nobel laureate).

I have commented on whether past treatments used for influenza syndromes (as well as other viruses/illnesses) could be beneficial in dealing with COVID-19. Most importantly I have shared with thousands of people through many platforms that a contextual understanding of the similarities and differences between COVID-19 and influenza is one of the most pertinent comprehensions Americans can strive for. I have tried to convey a message centering on scientifically established facts and teachings, personal responsibility, and hopefulness.

I do not recall ever saying specifically that COVID-19 "is nothing more than the flu." Please direct me to a specific source if you have information to the contrary. (Worldwide there are hundreds of media articles and videos which include comments I have made over the last four months, many without my awareness or permission.)

I do realize that some of my words have been taken out of context and used to fuel perspectives I do not share. In this world of social media, I do not know how to prevent this. I have erected increased safety and privacy guardrails on my social media pages. I have restricted others from posting and tagging on my pages. I have limited administrator access to my platforms. I have recruited numerous persons to scan media and promptly report any concerns to me.

As a Senator receiving thousands of inputs every week, I have diligently reached out to many detractors inviting conversation – some have accepted, most have not. Clearly politics and COVID-19 have become incredibly intertwined and dramatically divisive. For an outspoken and often skeptical physician legislator such as I am, the full exercising of freedom of speech has pushed me into a realm I previously have not explored. Rest assured, I am immensely frustrated by some of the antics that go on in social media, but I

have had to come to the unhappy conclusion that when the worlds of politics intersects with health care, selective use of news sources leads to amazing distortion, division, and discord.

These are critical times. These are hard times. More folks have died alone in long term care facilities than at any other time in my medical career. There will be a new normal emerging and it is still evolving. The resources physicians and patients depend on have become unnecessarily political. I am angry that my patients suffered, often unnecessarily. But I must say that your request for information has helped me process what has gone before us, and I am reinvigorated to do my part in helping Minnesota move through this dramatically difficult and bizarre time with grace and dignity and kindness to others.

Both of the allegations in question are false. Certainly, I might have been able to do some things differently to prevent the misuse of my words on social media sites of which I had never heard of. However, I know of no sure-fire way to do this, and daily I see message content from leaders in education, ministers, doctors, and politicians twisted and turned into something not in any way resembling original intent. Understanding this reality and ruminating on this lesson will be useful for me in the future.

I thank you for doing the work you do as I respectfully submit this response with attachments.

Senator Scott Jensen, M.D.