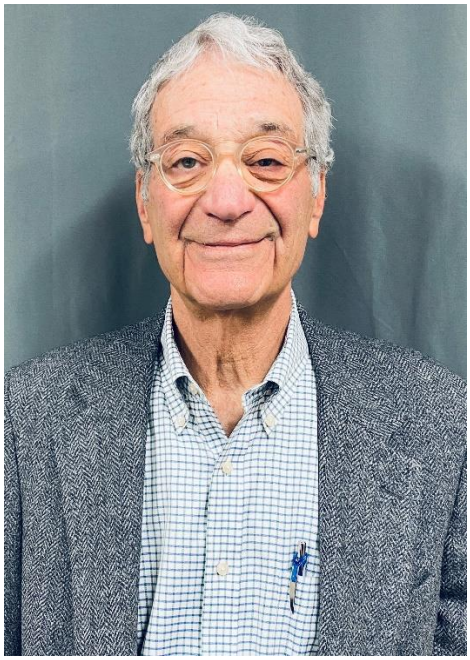

Dr. Michael Belzer: An Oral History

Role as Chief Medical Officer at HCMC and Changes in Medical Education and Supervision Over the Last 50 Years

at Hennepin County Medical Center

HENNEPIN MEDICAL HISTORY CENTER

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Hennepin Healthcare, Minneapolis, MN

Hennepin Medical History Center ORAL HISTORY PROJECT

Dr. Michael Belzer: An Oral History

Role as Chief Medical Officer at HCMC and Changes in Medical Education and Supervision Over the Last 50 Years

at Hennepin County Medical Center

Interviewed by Mary Ellen Bennett, RN

November 1, 2023

At Hennepin County Medical Center, Minneapolis, Minnesota

Edited and redacted by Mary Ellen Bennett and Michele Hagen

Coordinated by
Hennepin Medical History Center
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Direct quotations are based on recollection. The entire text has been edited for length and clarity. Portions of the text are redacted as noted due to privacy, confidentiality, or sensitivity of the content.

Mary Ellen Bennett: The following interview was conducted with Dr. Michael Belzer on behalf of the Hennepin Medical History Center for the History Center's oral history project. It took place November 1st, 2023, at Hennepin Healthcare. The interviewer is Mary Ellen Bennett. Dr. Belzer, thank you for coming in to speak with us today, to tell your story and the story of your career here at Hennepin County Medical Center. Can you tell us a little bit about your personal history, where you grew up, went to college and medical school, and what led you to practice at Hennepin County Medical Center?

Dr. Michael Belzer: Well, thank you. I grew up in southwest Minneapolis near Lake Harriet. My father was a physician. I went to Clara Barton grade school, Ramsey Junior High School, and graduated from Washburn High School. In my era, most of the high school students would stay in town rather than apply out-state for college. I did what my peer group did and ended up doing my undergraduate work at the University of Minnesota and went to medical school at the University of Minnesota.

What led me to practice, the Hennepin County Medical Center? My further training after attending medical school was to do an internal medicine residency at Chapel Hill, NC, for three years. And then because hematology and oncology are a subspecialty rather than a specialty, I trained in hematology oncology at UCLA from 1977 to 1980. The interesting piece of how I landed back at Hennepin, there are a number of reasons besides returning home, but when I was at the University of North Carolina, the patient population was largely underserved, indigent, and minority, and it was just a lot of fun for me to train there. It was a great program. There was something about this patient population that was really intriguing to me, as well as being something that I appreciated in terms of how fortunate I was to be able to grow up in a family that was able to receive healthcare. And then I went to UCLA. And doing my fellowship at UCLA was also very interesting because it was in tony West, Los Angeles. There were no indigent patients. Most of our, out of county, out of Los Angeles County, patients came from Iraq or Iran, or other countries seeking care at the tertiary care medical center. And through that work, and it was a great fellowship. I loved it. I learned a great deal. I just determined that for my personal preference, I really like dealing with underserved and indigent patients. It just was something that was a better fit for me. And once you finish your residency and fellowship and seek employment or a first job, Hennepin County Medical Center was a natural place for me to come because of the role that they serve and the patients that they take care of.

Bennett: And you started out in oncology here?

Belzer: I arrived at Hennepin County Medical Center in May of 1980 and I was recruited by the then, Hematology and Oncology Chair, a physician by the name of Charlie Moldow. Dr. Moldow was a hematology researcher. He wasn't really a trained medical oncologist, and he was very eager to get somebody to work in the faculty section in hematology-oncology that knew how to take care of cancer patients. And so yes, I started in 1980 as a hematologist-oncologist in a two-physician department, Dr. Moldow and me. And eventually we recruited several others to have a more robust, normal sized section. So yes, that's how I started out my training, loved it. We had a number of different locations for the oncology clinic and the oncology ward. Some of our younger faculty, were very interested in doing bone marrow transplants. So, we did that for a while. We were very involved with clinical trials, research for several cooperative oncology groups, which was something that academic medical centers should do, and was very important for the progress of our hematology oncology section.

Then in 1985-86, the physician practice group, called Hennepin Faculty Associates,[1] wanted to start an education office. The name that they gave it was Office of Academic Affairs. They were trying to quantitate research activity, quantitative educational activity, to be able to fairly distribute compensation to the physicians for non-revenue experiences, like research and education. In addition to that, we were charged with starting a Continuing Medical Education Program. One of my jobs was to work with the existing medical director, Dr. Dick Raile, for running the rotating residency that was called the transitional residency. So, from 1987 to 1990, I was head of the Office of Academic Affairs, working in education, and then Dr. Raile retired in 1990. At that time, I was just a kid, I was 39 years old, but I decided to throw my hat in the ring because he asked me to. And to make a long story short, even though it was a national search and I thought I was too young to be selected as the next, would have been the third ever, Medical Director at Hennepin County Medical Center, I was chosen to take the position. And so, I started that job in 1990 and I continued with it until I retired in 2016.

Bennett: You held the role of Chief Medical Officer at Hennepin for thirty years. Dr. Richard Raile held that role for the thirty years prior, so that is really continuity. What kept you here in the role for thirty years?

Belzer: It's a very good question. I think it's as simple as the commitment to the mission at Hennepin County Medical Center and the peer group, physicians, advanced practice providers, nursing staff, support personnel, that I worked with. Hennepin is just its own world. It's quite different from other hospitals. It's a classic safety net hospital. The mission to take care of all patients regardless of their ability to pay. And therefore, we had a large percentage of our patients who are underinsured, uninsured, on Medicaid, and have had difficult situations in their life. Those folks really need to have respectful healthcare delivered by healthcare professionals. And that was something that fit into my sweet spot. The adrenaline and energy of working at a Level 1 Trauma Center,[2] added to the excitement. And I think overall, in terms of the work that we were doing from 1980 to maybe the next couple decades with medical education, was really more of the capstone of what I enjoyed doing. With the training of physicians, training of advanced practice providers, integration with interdisciplinary health, with our nursing colleagues, and working with the rest of the organization to train the next generation of caregivers and support personnel for the state.

Bennett: What was the typical day like for you in your role as Chief Medical Officer? What kind of things did you have to deal with?

Belzer: Oh, that's a great question. So, when I started in 1990, which was my first year as Chief Medical Officer, the administrative oversight and the time it took to be a physician administrator was much, much, much less than when I retired in 2016. So, at that time, I was able to work about two thirds of my time clinical, being a hematologist-oncologist. One third of my time was spent with the Medical Executive Committee, the Quality Committee preparing for The Joint Commission accreditation visits,

[1] Hennepin Faculty Associates, HFA. Physicians practice group for HCMC that was started in 1982.
[2] Level 1 Trauma Center Certification was granted to Hennepin County Medical Center in 1989. This certification verifies the hospital meets all the requirements of the American College of Surgeons. More information can be found at: Verification, Review, and Consultation (VRC) Program | ACS (facs.org)

and dealing with the various issues where the hospital needed a physician to work with the other physicians in terms of aligned interests, medical programs, and so forth.

Throughout the next 30 years, because the world changed and administrative regulation oversight, the Libby Zion case,[3] where a young woman was unfortunately mishandled in a Medical Center, at a time when the residents were taking care of her and the faculty was minimally involved, we had to relook at how we were going to provide appropriate medical education oversight for our trainees. At the same time that they could be trained and learn how to make independent decisions. As time went on and I needed to spend more and more time in medical administration and I stopped practicing clinical medicine, probably around 2005.

And to answer your core question, my typical day would be to come into the office. There were a number of meetings I would have on most days from committees I've mentioned, the Medical Executive Committee, the Clinical Quality Committee, a number of Hennepin Faculty Associates (that was the practice group that represented the physicians), and do meeting preparation. A big part of the position that I personally enjoyed, because one of my core beliefs is that there's no role for disrespect in the Medical Center, is I would deal with a lot of physicians, trainees, and other members of the medical staff that had comportment or discipline issues. Typically, it would be disrespectful interaction with nurses, or health unit coordinators, or their colleagues. And that would take a lot of time for me to think about the right way to approach those issues and to deal with whatever medical staff issues came up. And then of course, there were the contracting aspects, where medical clinician input was needed. So, most of my day was spent either in meetings, meeting with individuals, working on strategic planning with the Hospital [leadership], or working closely with my colleagues and Hennepin Faculty Associates, with very little time to have any interaction with patients and hematology and oncology.

Bennett: With the onset of all the new regulations that came during your career, I'm sure that your position changed from the beginning to the end where you had to deal with many of the new regulations and all the things that came with them, trying to get people to comply with the regulations.

Belzer: Yeah, for sure. And in large part, when I was accepted into medical school, the key aspects that search committees were looking for, were kind of like the Marlboro Man. Marlboro was a cigarette that had an advertising campaign with a cowboy. And the point of it was, the lone individual, independent, strong, carving their own pathway. And that is what the cohort of physicians were recruited for, to get into medical school in my peer group. And as a result, they typically didn't like administrators telling them what they could or couldn't do or outlining what regulations and rules were in place. And I of course needed to do that because we would get accreditation visits that would determine whether or not we could bill Medicare and Medicaid or run education programs. And so, following the rules, was really very, very important. As time went on, the world realized a number of things, one we'll talk about later, about oversight of trainees in the Medical Center. But people began to understand that medical care was a team effort. [chuckles] It wasn't the captain of the ship physician running everything telling people what to do and not listening to what their colleagues were telling them. It's more like a pit crew in a motorized race in NASCAR, where everybody gets together and it's the teamwork that changes the tires quickly, that determines whether or not a race is won. So, when

[3] Libby Zion was an 18 year old who died in a hospital in 1984. Her death led to regulations that limited the number of hours that resident physicians can work in hospitals.

the team concept moved into healthcare, it really opened a different world on how physicians viewed advanced practice providers, nurses, and made my job quite a different job focusing on teamwork, interdisciplinary care, and those efforts. It was easier as people understood the teamwork concept, they were less averse to having Medical Center rules determine what they could and couldn't do in clinical settings.

Bennett: Well, I know we appreciated your support for many of the efforts when I worked in infection prevention here, especially hand hygiene.[4] That was a big challenge, but you said everybody had to do it and to come to you if there were any issues. We certainly appreciated that. And those again were regulations, but it was all for the common good.

Belzer: Yeah, those were known as 'Uncle Mick Talks.' Not only hand hygiene, but when our providers or trainees would get out of sorts and they'd get called to my office, it was, 'oh, you get to go to an Uncle Mick talk.'

Bennett: You stated that HCMC was a unique draw for socially conscious physicians as opposed to pure private practice physicians. Can you talk more about this?

Belzer: Yes. So, safety net hospitals,[5] of which Hennepin County Medical Center is a classic example of, typically have a portfolio of patients in clinical services that look very different from your other private hospitals, whether they're not-for-profit or for profit. So, for example, Hennepin County Medical Center in 1916 started a Social Services Department. Think about that, 1916. Recognizing the need of patients who had issues with family support, food, transportation, unsafe home situations, et cetera, et cetera. And I think that says really a lot about the Medical Center's commitment to caring for others. Our patient population, which I've mentioned several times, has a large number of underserved, uninsured, vulnerable, and disadvantaged patients. Physicians who want to take care of that patient population are just a little different.

For example, I'm sure when I left my fellowship, I could have been a successful private practice, hematologist-oncologist in Edina or Wayzata. And I'm sure I would have enjoyed it, but it was a very, very different job being in private practice, taking care of employed individuals, than working at Hennepin County Medical Center where it's a very different look at the world. Physicians at academic medical centers, especially county medical centers, made less money than in private practice. There was, and still is, a psychiatric emergency department, a burn center, the Coordinated Care Center,[6] our outpatient ICU where we take care of the toughest of the tough patients. To do that, you have to have a special interest and makeup to want to work at a medical center for less pay, loss of independence to a

[4] Hand Hygiene (hand washing or use of alcohol hand rubs) is recognized by healthcare regulatory and accreditation agencies as necessary for prevention of infections. Healthcare organizations are required to promote hand hygiene and provide evidence of healthcare worker compliance.
[5] Safety Net Hospitals provide healthcare for individuals regardless of their insurance status or ability to pay.
[6] Coordinated Care Center is described as an "ambulatory intensive care unit" designed for patients with complex health problems that result in frequent hospitalization. The clinic provides patient-centered, multidisciplinary, team-based care in an effort to reduce the impact of chronic illness on the lives of its clients. See journal article: Johnson P, Linzer M, Shippee N, Heegaard W, Webb F, Vickery KD. Development and Implementation of an Interdisciplinary Intensive Primary Care Clinic for High-Need, High-Cost Patients in a Safety Net Hospital. *Population Health Management*. April 2020; 23(2): 124-131.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7074919/

degree, and a very different patient population than going into private practice. And as a result, we ended up getting people who were very, very committed to social justice. It's important for them to be in service and professional to our patients, many of whom have not had anybody be nice to them in their career. And so, by virtue of what we do and how our organization was structured, we ended up with a much more liberal medical staff in terms of social justice, and my hunches is in politics as well.

Bennett: I always felt that too, that people would start to work here, and if they didn't fit in, if they didn't like the mission and the vision, that they would leave. And the people who stayed were more in tune to the mission and the vision like you just discussed.

Belzer: That's an excellent, excellent observation. I remember there was a short period of time when two of my oncology colleagues left to go to the University and I needed to step out of my Chief Medical Officer or Medical Director role and be the only oncologist. This was probably around 1998. I would have done almost anything to recruit somebody to help me out because I was doing all of the inpatient, all of the outpatient clinics, dealing with the interface between inpatient, outpatient, all the weekends. I just really wanted to get somebody to help do that work that was a good fit. And let me tell you, it wasn't easy finding people who would embrace the mission of Hennepin County Medical Center. Even though I would, you would think, have as a criterion, somebody that could talk and breathe to help out with the workload, that wasn't the case. So, it took me many, many months before I was able to recruit individuals whose makeup and philosophy and caring matched the needs of Hennepin County Medical Center.

Bennett: You also said that there were dramatic changes in medical education and supervision during your years here. Can you discuss that a bit?

Belzer: Yes. Looking back at medical training through the last century and maybe just focusing on my training, which would have been in the mid-70s. At that time, the training model was to take your least experienced professionals, interns, just out of medical school, and give them the most responsibility. And so, the classic training programs in teaching hospitals had the newly minted interns[7] at the forefront of taking care of patients, taking care of emergencies. And if they needed help, they would then ask the next person up on the training level, the first-year resident or second-year resident, for help. But of course, there was always that concern, if I ask for too much help, I'm going to be looked at as a wimp and I need to show my strength and my intelligence. And so, I'm sure a lot of interns, in a lot of hospitals, in a lot of states, really were taking care of things that they weren't fully comfortable to do.

And as I mentioned a little bit earlier, I guess it would have been in the 80s or possibly 70s, there was a very famous case of a journalist's daughter, Libby Zion, who died at an eastern Medical Center because of some complication of a medication or a misdiagnosis that wasn't recognized. And as they went back into the record and looked, it turned out that everybody thought there wasn't adequate supervision by the senior physician into the care of the individual. And then the world sort of woke up slowly over the next couple decades and said ‘boy, is this really a good idea to take your trainees and give them all of the responsibility and have attending physicians stand back and help educate, rather than taking care of the patients.’

[7] Intern – is a resident physician who is in their first year of practice.

So, for example, when I started in 1980, internal medicine rounds took place twice a week from 10 to 12 on Tuesday, Thursday. The rest of the time, the house staff, which were the residents and the interns, were doing all of the care unsupervised. And patient teaching rounds then were basically teaching rounds. The attendings weren't responsible for the patients, the Medical Center was. And many of the attendings weren't employees of the Medical Center. And as a result, you just had a care system that nobody logically would want to be taken care of in. It made sense, if you want to train physicians to be good at trauma, throw them into the fire. It wasn't fair for patients.

And as a result, over the next few decades, the role of interns and residents moved from a workforce or labor, to trainees, which was very, very important. And so, over that period of time, there was much, much, much, much more supervision by faculty required as well as they are doing it because they are now responsible for the patients. As a result, I think the care system is much safer, much better. Trainees, are trainees, and should be treated as such, rather than a low paid workforce to do the work of an attending physician. So, things changed dramatically over that period of time. And I think, for the good.

Bennett: I guess I from where I was sitting, I didn't realize that this big change was happening. But it was an evolution it sounds like, out of necessity. And it ended up to be much better for the patients and also much better for the residents, so that they weren't put into difficult situations as much as they were before.

Can you discuss the leadership structure and the medical leadership organizational changes over the years?

Belzer: Sure, sure. It's a complicated topic. I'll try to give you the Reader's Digest version of it. When I started in 1980, the physicians were employed by Hennepin County Medical Center but payrolled through the University of Minnesota. We were not Hennepin County Medical Center employees, but basically, we were subject to all the HR [Human Resources] rules of the hospital. It's just our paycheck came from the University.

In 1984, because of the nuances of the billing systems for Medicare and Medicaid, and then private insurance companies typically follow that, it was determined at Hennepin, along with most other academic medical centers that it was advantageous for physicians to form their own physician practice plan. In 1984, after a number of consultants came through, an organization called Hennepin Faculty Associates was formed. The leadership was Hennepin leadership, by our Hennepin physicians, Dr. Shapiro[8] and later Dr. Bubrick.[9] And the organization then contracted with the hospital for professional services, education, administrative services and so on. So, in 1984 they no longer were Hennepin County Medical Center employees, they were Hennepin Faculty employees. The relationship changed. The good news is that the medical staff was, and still is, very, very committed to Hennepin County Medical Center. I would say it's a very different circumstance than took place at the University of Minnesota with their physician practice plan called the University of Minnesota Physicians, UMP. Our physicians have always

[8] Fred Shapiro, MD was Chief of Nephrology at Hennepin County Medical Center. He was the founding president of Hennepin Faculty Associates, a founder of Renal Systems (now Minntech); and was a pioneer in the treatment of end-stage renal disease patients. He died in 2004.

[9] Melvin Bubrick, MD held roles as Chief of Surgery at Hennepin County Medical Center and President of Hennepin Faculty Associates.

valued Hennepin; they've been very loyal. The issues between the hospital and the medical staff, if there were any, well there were, always boiled down to money. It was never direction; it was never strategy. It was never who are we going to take care of. It was never should we have a trauma program. It was basically financial and that made it very difficult for my office to be able to conduct the work that we needed to do for regulatory and for accreditation visits. Because now the physicians no longer were hospital employees, they no longer technically reported to me or my Office. And they always had the ability to go, hey, 'we don't report to you, we have our own organization.' That was a small problem; that wasn't the big problem. But it made for a very different role for my job from being a leader with directional oversight responsibilities, to a negotiator trying to use my personal influence to get the other organization physicians to do what the hospital needed them to do.

For a variety of reasons, I think I have this right, in 2011, Hennepin Faculty Associates, integrated with Hennepin County Medical Center. The organization disappeared; the assets came to the Medical Center. The physicians and advanced practice providers who were Hennepin Faculty Associates, once again became Hennepin County Medical Center employees. And again, it made it easier for my office and our work with our own employees, in terms of the work that we needed to do to prepare for accreditation visits and to do the compliance work that we need to do with our own medical staff, being our employees. So, it was different. It was never a big problem, but it smoothed out the edges and probably made for a more efficient organization with everybody in the same employee pile, working with aligned incentives and working together to move their organization forward. Rather than this is your organization, not mine, you do what you want, which would take place occasionally.

Bennett: Maybe you said this, were you an HFA employee, during those years that HFA existed, or were you a Hennepin County Medical Center employee?

Belzer: I was an HFA employee. Only because, that's what I inherited from Dr. Raile and the County had a cap on compensation for County employees and if I was a Hennepin County Medical Center employee, I would have been a County employee. So, it just made things easier for the Medical Center to be able to, with their $60 million contract, to be able to pass my salary along to them. It wasn't symbolic of anything; it was just a convenience for payroll.

Bennett: Can you describe the culture at HCMC? By culture I mean how the staff interacted with each other, the interactions with your colleagues and other departments. You've talked about this a little bit that you thought it was special here. Can you talk a little bit more about your feelings on that and maybe some examples?

Belzer: The circumstance of having a physician group all co-located in the same building, essentially working in only one hospital, was a very different model from private practice. Let's go back to 1980. It's a little less unusual now that the number of employed physicians is increasing, just because of the way that medicine is being practiced. But, in those days, if you remember, your physician often would have their own office and their own practice. They would see patients in their office, go to whatever number of hospitals they had patients hospitalized in, maybe Fairview and Allina, and come back to their office in the afternoon, then go back to the hospital. There was very little chance for collegial interaction, except maybe in the doctor's dining room, or maybe in medical staff meetings, or maybe when there would be conferences around a certain patient.

So, the fact that we had 300 physicians and 300 advanced practice providers all co-located in the same building, with the same hospital, with the same patients, just made for a different and a unique environment. And it made for care conferences being much easier to set up. It made for lunchtime conversations, for 'how would you handle this patient' curbside consults, much, much easier.

And then when you take the energy of an adrenaline of what happens when you have major trauma. The bridge collapse, I guess would be a perfect example, where our training in the Incident Command System was able to mobilize, ten doctors, ten nurses, twenty medical staff in a room trying to coordinate the medical response for the bridge collapse. Clearing out operating rooms, doing all this work. Everybody was there. Everybody had aligned interest to make sure that this was the best possible medical care. And I'm not sure you could do that at other hospitals. So, I think it was just the co-location, the co-employment, the fact that Hennepin has this unusual mission. And then, just, I don't want to say tension and drama around the Medical Center. But there was a little bit of that, that made it a different type of environment where you tend to consult and embrace your colleagues rather than look at them as competition, for example.

Bennett: In the interviews that we've been doing, it's a common theme that people have said there's never a dull day here at Hennepin County Medical Center. Something interesting and lively is always happening.

Belzer: And very different from what you would hear or see at other hospitals.

Bennett: Do you have anything else that you would like to share regarding your work at Hennepin County Medical Center? Anything you forgot to mention or you think is important?

Belzer: No, I'd just like to thank you, Mary Ellen, for the opportunity to do the interview. I have a lot of great friends at Hennepin. Many of the physicians I worked with are retired. We have an organization called Hennepin Honorary Alumni, where we still get together and socialize and talk about philanthropic endeavors that we can undertake. But it was a very, very, very important part of my life, something I will always attach to myself, if somebody ever asks me to talk a little bit about my life. And I really miss Hennepin. It's a special place.

And I happen to be on the very optimistic side of how Hennepin's going to do in the future. My personal hunch is that we won't be a standalone, do all, medical center in 10 years. I assume we will find some partner to integrate with, and who embraces our missions, so we can have other campuses with other specialties, that will be able to balance the work that we do. I just think the medical environment is too tough to have us stand alone as a do all, full-service hospital, with our payer portfolio of the uninsured and underinsured. But I think that will be handled well and I'm very, very optimistic and very strong on the future of Hennepin County Medical Center. I think their leadership is excellent and I'm really enjoying sitting back and watching what Hennepin does moving forward.

Bennett: That's very nice to hear. Makes me optimistic then too. It's, I think, always been a struggle with money and management, but we do a good job here and we make a difference.

Belzer: And if you will remember in your career, we must have had dozens of financial crises, drawbacks. I can remember the year that Governor Pawlenty eliminated a program called General Assistance Medical Care, overnight, in the middle of the night. Which meant a $50 million loss to the Medical Center that we were unprepared for, didn't expect, and needed to cope with. And things like

that happen. But it's been one hundred and thirty-five years,[10] we're still here, the campus is expanding. We've been able to overcome all the obstacles, road blocks that have been thrown in front of us, and I assume that will continue to be the case.

Bennett: It's been a great honor to speak with you today, Dr. Belzer, about your amazing and long career here at Hennepin, you have guided the course of the Medical Center over many years with your strong leadership, and you have made countless contributions to its success. Your work has made a tremendous impact to Hennepin's mission, vision, and our patient care. On behalf of Hennepin Medical History Center, I want to thank you for your many years with Hennepin County Medical Center, your support of our History Center, and for sharing your story with us today.

Belzer: Thank you, Mary Ellen. It's been my pleasure.

[10] Hennepin County Medical Center started as City Hospital in 1887.

Biography for Michael B. Belzer, M.D.

Dr. Michael Belzer served as the Medical Director, Vice President for Medical Affairs, and Chief Medical Officer of Hennepin County Medical Center (HCMC) for over 27 years- from 1990 to 2016. HCMC is a 450-bed public safety net hospital and academic medical center located in urban Minneapolis, Minnesota. During that time, he also served as the Medical Director for Hennepin County's Community Health Department.

Dr. Belzer served as the Associate Dean of the University of Minnesota Medical School for more than 15 years and was the first member of the Medical School Dean's office to be located off the University of Minnesota Campus.

In October of 2014, he was awarded the prestigious, Charles Bolles Bolles-Rogers Award of the Twin Cities Medical Society for lifetime achievement in research and significant sustained contributions in medical leadership to the State of Minnesota. In 2015, Dr. Belzer was the recipient of The Harold S. Diehl Lifetime Achievement Award as well as the 2004 Distinguished Alumni Award from the University of Minnesota Medical School Alumni Association and Medical Foundation. He is the only alumnus to have received both awards from the University Medical School.

Additional awards include the Distinguished Teaching Award of the University of Minnesota's Medical Foundation, The University of Minnesota Medical School Outstanding Mentorship Award, and the HCMC Teacher of the Year.

Dr. Belzer is a Past Chair of the Metro Minnesota Council on Graduate Medical Education (MMCGME) which represents the leadership of the four major affiliated teaching hospitals of the University of Minnesota Medical School in the training of Medical Students and Medical Residents.

Dr. Belzer is a Past Chairman of the West Metro Medical Society (formerly known as Hennepin Medical Society) that represents over 4500 Physicians in the West Metropolitan Twin Cities Area. He has previously held positions of Chairman, President and President–elect of the Medical Society. Dr. Belzer served as the Chairman of MERC, a Minnesota Department of Health Committee that distributes approximately $60 million dollars per year for healthcare worker training.

For more than six years, Dr. Belzer served on the Executive Committee of America's Essential Hospitals, and was the Chair of the National Public Health and Hospital Research and Education Institute, the National Association of Public Hospitals Physician Leadership Advisory Committee, a board member of The West Metro Medical Association, Association of American Medical Colleges Chief Medical Officer Group, Hennepin Health System Foundation Executive Committee, Minnesota Visiting Nurse Agency and was the Board Chair of the Hospice of the Twin Cities -for six years

Dr. Belzer is currently the Chairman of the Board for Planned Parenthood North Central States.

Dr. Belzer has specialty and subspecialty board certification in Medical Oncology, Hematology, and Internal Medicine. Dr. Belzer is a Fellow in the American College of Physicians (FACP), a member of The American Society of Clinical Oncology, The American Society of Hematology and Alpha Omega Alpha National Medical Honor Society.

Dr. Belzer is married to Ellyn Wolfenson and they are proud parents of a family of eight adult children and a Goldendoodle named Wolfie.

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