Doctors are fleeing the medical field. Here's why.

ANNA GLADSTONE, DO | PHYSICIAN | AUGUST 10, 2020

The first day I started work as an attending physician in primary care medicine, I knew I had made a terrible mistake. This was not the heroic, selfless, service-oriented job or the romantic life "as seen on TV" I had imagined.

Riddled with heavy school debt, despite my best efforts to join debt relief programs, I had a frustrating job with nothing but red tape and hurdles to jump over. And I felt stuck. I was now $200K+ in the hole for this, so I felt financially committed.

In my mind, I know there are always options, but after such a huge investment, it would feel like an abandonment of my younger self if I were to walk away from medicine now, a betrayal of my wasted youth.

So here I am, five years in, still contemplating whether I should stay or go.

In medical school, it is taught the "gold standard" of care, the medicine regimen we should strive toward to best help our patients. However, this is rarely attainable. There are many reasons for this: patient preference or personal beliefs, financial or other barriers to care, but often it simply isn't covered by insurance.

It's no wonder that morbidity and mortality rates are so much higher in this country than comparable developed countries.

There is little time for the practice of medicine — there's only paperwork and red tape.

HMOs are ruining medicine.

A specific HMO — I will not identify it here, but its name has some relation to the color of the sky and a network — is the worst.

If you are a patient who needs a procedure, test, or referral, your primary care doctor's office has to authorize everything. This means, even though that doctor ordered the test, once you schedule the procedure, you must call that doctor's office back (yes, the one who ordered it), and they must then go through the process on the network website to approve the procedure.

Once it is approved, you can then go ahead, but if the insurance company does not think that this procedure is warranted, even with your doctor's recommendation, it will be denied, and the process starts from square one.

This is such a heavy burden on doctors' offices that many are contemplating dropping this network to alleviate the burden on their staff.

When working with HMO drug formularies, that often change quarterly if not monthly, a doctor finds it nearly impossible to get someone's disease — for example, asthma — under control. Big pharma and insurance companies are constantly in negotiations for the lowest-priced drug, and whatever drug is on contract for that quarter is the one that is covered by that patient's insurance.

Without proper notice to providers, enrollees, or pharmacists, a mainstay of asthma treatment — inhaled corticosteroids — will be switched to a similar drug but with different dosing and device delivery methods.

The asthma patient who finally had control of their disease will go to the pharmacy to pick up her medicine and find out it is no longer covered by her insurance.

What she often is not told by the pharmacist (maybe because the pharmacist lacks the time or the knowledge) is that a similar but different drug came under contract with the insurance company and so the doctor needs to write a new script. Thus, without being informed of these changes, the patient leaves the pharmacy empty-handed.

This back-and-forth between pharmacy and doctor's office often leads logically to patient frustration expressed as anger or distrust toward the pharmacist or the doctor's office staff, eroding confidence in these professionals' ability to do their jobs. This disruption in the patient-doctor relationship makes it all the more difficult to give patients that "gold standard" of care.

Now we are working through a global pandemic. If medicine were ever to be exciting, it would be now. But no.

During the most stressful time in a physician's life, due to fee for service medicine and cancellations of high-cost elective procedures, like knee replacements and other surgeries, many physicians' livelihoods are at stake.

Hiring has been put on hold in many systems, contracts are being re-negotiated, work hours are being cut drastically, and there is no end in sight to this anxious misery.

While some hospital administrators continue to make six and seven figures, doctors and other front line workers, enduring the most stressful challenge of their lifetime, are taking huge pay cuts. This is why fee-for-service medicine is so asinine.

When the world needs doctors more than ever, they are losing jobs and taking cuts.

Let's consider how this has worsened life for all of the people in this country who have lost their jobs due to COVID-19.

Furloughed employees, during a global pandemic, find themselves without work and without medical insurance because our fucked up system relies on employer-based health insurance. And when suddenly millions of folks need to apply for Medicaid and unemployment benefits, you can bet there is a backlog on the enrollment process. These systems were not built to see such a huge influx all at once. So during a pandemic, 30 million or more people in this country must fear getting sick from this virus and not having medical coverage.

The reason that people in the U.S. are so unwell and unhappy is also linked to the employer-based health insurance model. I have a patient whom I saw for the first time at a new practice.

Her ulcerative colitis was well controlled by her previous physicians and infusions; however, her insurance changed, and therefore, her network of physicians changed completely. She could no longer see the gastroenterologist who got her disease under control and had to wait six months to get her infusions approved and restarted.

This lapse in treatment caused a flare-up of the disease, and now she is having a difficult time getting it under control again. If she had been allowed to stay in the first practice, all of this would not be a problem.

This model has personally affected me, too. When my father was feeling burnt out and beat up by his employer, he was ready to quit. He got passed over for a promotion and had questions of ethics concerns about the management above him. He had drafted a letter of resignation and was ready to turn it into HR. He called my mom and told her, and she responded, "You mean my babies are going to be without health insurance?"

He stopped himself, staying in this job that he wanted to quit, put up with the parts he despised until retirement. Now I know that he could have made different choices, but that fear is always a part of every employment decision, making it that much more likely that people will stay in toxic work situations because of the “benefits.”

Don’t get me wrong — medicine is not all bad. I love the long-term relationships that I have with my patients. I love being able to guide them through life’s most beautiful — and toughest — times.

I had the most beautiful goodbye with a patient when I left my practice for a new job. She told me she attributed being alive today to my care for her. These moments of connection make medicine a calling and not a job. It has become less of a calling and more a set of boxes to tick off before you can start to do the real work of medicine.

The boxes are starting to become so cumbersome that they have taken some of the love and care out of it. How much more restricted can networks get before people realize we already have death panels dictating our lives? Something has to change.

Anna Gladstone is a family physician.

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