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The Moral Crisis of America's Doctors

The corporatization of health care has changed the practice of medicine, causing many physicians to feel alienated from their work.

By Eyal Press

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Some years ago, a psychiatrist named Wendy Dean read an article about a physician who died by suicide. Such deaths were distressingly common, she discovered. The suicide rate among doctors appeared to be even higher than the rate among active military members, a notion that startled Dean, who was then working as an administrator at a U.S. Army medical research center in Maryland. Dean started asking the physicians she knew how they felt about their jobs, and many of them confided that they were struggling. Some complained that they didn't have enough time to talk to their patients because they were too busy filling out electronic medical records. Others bemoaned having to fight with insurers about whether a person with a serious illness would be preapproved for medication. The doctors Dean surveyed were deeply committed to the medical profession. But many of them were frustrated and unhappy, she sensed, not because they were burned out from working too hard but because the health care system made it so difficult to care for their patients.

In July 2018, Dean published an essay with Simon G. Talbot, a plastic and reconstructive surgeon, that argued that many physicians were suffering from a condition known as moral injury. Military psychiatrists use the term to describe an emotional wound sustained when, in the course of fulfilling their duties, soldiers witnessed or committed acts — raiding a home, killing a noncombatant — that transgressed their core values. Doctors on the front lines of America's profit-driven health care system were also susceptible to such wounds, Dean and Talbot submitted, as the demands of administrators, hospital executives and insurers forced them to stray from the ethical principles that were supposed to govern their profession. The pull of these forces left many doctors anguished and distraught, caught between the Hippocratic oath and "the realities of making a profit from people at their sickest and most vulnerable."

The article was published on Stat, a medical-news website with a modest readership. To Dean's surprise, it quickly went viral. Doctors and nurses started reaching out to Dean to tell her how much the article spoke to them. "It went everywhere," Dean told me when I visited her last March in Carlisle, Pa., where she now lives. By the time we met, the distress among medical professionals had reached alarming levels: One survey found that nearly one in five health care workers had quit their job since the start of the pandemic and that an additional 31 percent had considered leaving. Professional organizations like National Nurses United, the largest group of registered nurses in the country, had begun referring to "moral injury" and "moral distress" in pamphlets and news releases. Mona Masood, a psychiatrist who established a support line for doctors shortly after the pandemic began, recalls being struck by how clinicians reacted when she mentioned the term. "I remember all these physicians were like, Wow, that is what I was looking for," she says. "This is it."

Dean's essay caught my eye, too, because I spent much of the previous few years reporting on moral injury, interviewing workers in menial occupations whose jobs were ethically compromising. I spoke to prison guards who patrolled the wards of violent penitentiaries, undocumented immigrants who toiled on the "kill floors" of industrial slaughterhouses and roustabouts who worked on offshore rigs in the fossil-fuel industry. Many of these workers were hesitant to talk or be identified, knowing how easily they could be replaced by someone else. Compared with them, physicians were privileged, earning six-figure salaries and doing prestigious jobs that spared them from the drudgery endured by so many other members of the labor force, including nurses and custodial workers in the health care industry. But in recent years, despite the esteem associated with their profession, many physicians have found themselves subjected to practices more commonly associated with manual laborers in auto plants and Amazon warehouses, like having their productivity tracked on an hourly basis and being pressured by management to work faster.

Because doctors are highly skilled professionals who are not so easy to replace, I assumed that they would not be as reluctant to discuss the distressing conditions at their jobs as the low-wage workers I'd interviewed. But the physicians I contacted were afraid to talk openly. "I have since reconsidered this and do not feel this is something I can do right now," one doctor wrote to me. Another texted, "Will need to be anon." Some sources I tried to reach had signed nondisclosure agreements that prohibited them from speaking to the media without permission. Others worried they could be disciplined or fired if they angered their employers, a concern that seems particularly well founded in the growing swath of the health care system that has been taken over by private-equity firms. In March 2020, an emergency-room doctor named Ming Lin was removed from the rotation at his hospital after airing concerns about its Covid-19 safety protocols. Lin worked at St. Joseph Medical Center, in Bellingham, Wash. — but his actual employer was TeamHealth, a company owned by the Blackstone Group.

E.R. doctors have found themselves at the forefront of these trends as more and more hospitals have outsourced the staffing in emergency departments in order to cut costs. A 2013 study by Robert McNamara, the chairman of the emergency-medicine department at Temple University in Philadelphia, found that 62 percent of emergency physicians in the United States could be fired without due process. Nearly 20 percent of the 389 E.R. doctors surveyed said they had been threatened for raising quality-of-care concerns, and pressured to make decisions based on financial considerations that could be detrimental to the people in their care, like being pushed to discharge Medicare

and Medicaid patients or being encouraged to order more testing than necessary. In another study, more than 70 percent of emergency physicians agreed that the corporatization of their field has had a negative or strongly negative impact on the quality of care and on their own job satisfaction.

There are, of course, plenty of doctors who like what they do and feel no need to speak out. Clinicians in high-paying specialties like orthopedics and plastic surgery "are doing just fine, thank you," one physician I know joked. But more and more doctors are coming to believe that the pandemic merely worsened the strain on a health care system that was already failing because it prioritizes profits over patient care. They are noticing how the emphasis on the bottom line routinely puts them in moral binds, and young doctors in particular are contemplating how to resist. Some are mulling whether the sacrifices — and compromises — are even worth it. "I think a lot of doctors are feeling like something is troubling them, something deep in their core that they committed themselves to," Dean says. She notes that the term moral injury was originally coined by the psychiatrist Jonathan Shay to describe the wound that forms when a person's sense of what is right is betrayed by leaders in high-stakes situations. "Not only are clinicians feeling betrayed by their leadership," she says, "but when they allow these barriers to get in the way, they are part of the betrayal. They're the instruments of betrayal."

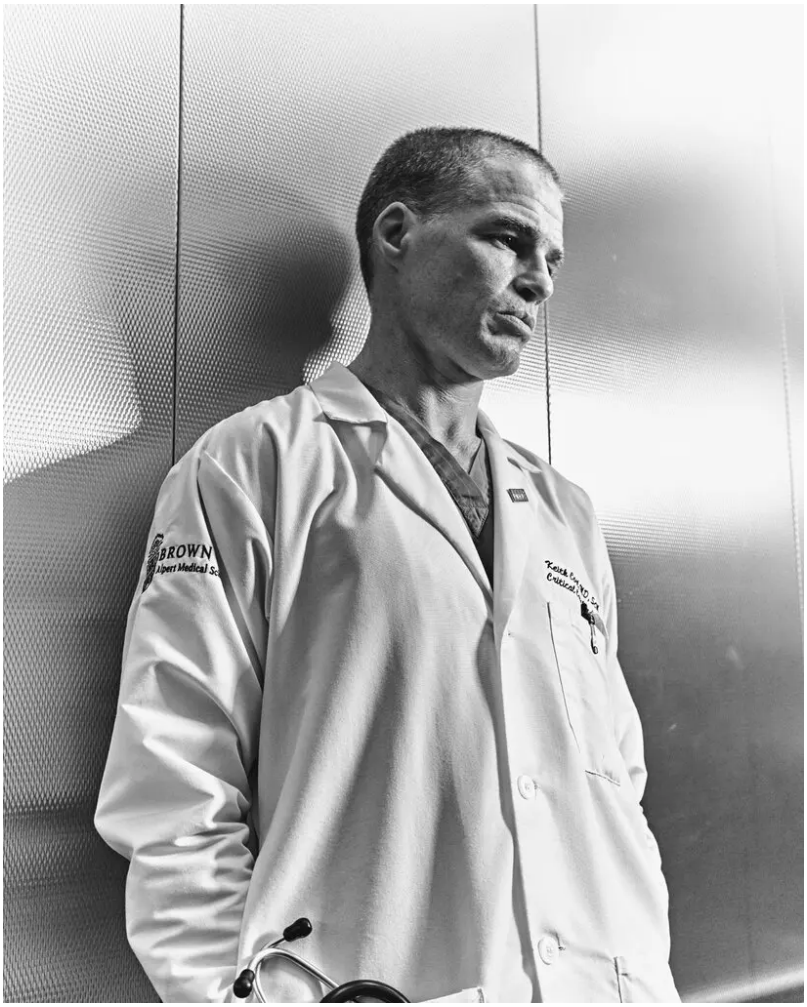
Not long ago, I spoke to an emergency physician, whom I'll call A., about her experience. (She did not want her name used, explaining that she knew several doctors who had been fired for voicing concerns about unsatisfactory working conditions or patient-safety issues.) A soft-spoken woman with a gentle manner, A. referred to the emergency room as a "sacred space," a place she loved working because of the profound impact she could have on patients' lives, even those who weren't going to pull through. During her training, a patient with a terminal condition somberly informed her that his daughter couldn't make it to the hospital to be with him in his final hours. A. promised the patient that he wouldn't die alone and then held his hand until he passed away. Interactions like that one would not be possible today, she told me, because of the new emphasis on speed, efficiency and relative value units (R.V.U.), a metric used to measure physician reimbursement that some feel rewards doctors for doing tests and procedures and discourages them from spending too much time on less remunerative functions, like listening and talking to patients. "It's all about R.V.U.s and going faster," she said of the ethos that permeated the practice where she'd been working. "Your door-to-doctor time, your room-to-doctor time, your time from initial evaluation to discharge."

Appeasing her peers and superiors without breaching her values became increasingly difficult for A. On one occasion, a frail, elderly woman came into the E.R. because she was unable to walk on her own. A nurse case manager determined that the woman should be discharged because she didn't have a specific diagnosis to explain her condition and Medicare wouldn't cover her stay, even though she lived alone and couldn't get out of a chair to eat or go to the bathroom. A. cried with the woman and tried to comfort her. Then she pleaded with the hospitalist on duty to admit her. A.'s appeal was successful, but afterward, she wondered, What are we being asked to do? When we spoke, A. had taken a leave from work and was unsure if she would ever go back, because of how depleted she felt. "It's all about the almighty dollar and all about productivity," she said, "which is obviously not why most of us sign up to do the job."

That's not always clear to patients, many of whom naturally assume that their doctors are the ones who decide how much time to spend with them and what to charge them for care. "Doctors are increasingly the scapegoats of systemic problems within the health care system," Masood says, "because the patient is not seeing the insurance company that denied them the procedure, they're not seeing the electronic medical records that are taking up all of our time. They're just seeing the doctor who can only spend 10 minutes with them in the room, or the doctor who says, 'I can't get you this medication, because it costs $500 a month.' And what ends up happening is we internalize that feeling."

I spoke to a rheumatologist named Diana Girnita, who found this cycle deeply distressing. Originally from Romania, Girnita came to the United States to do a postdoc at Harvard and was dazzled by the quality of the training she received. Then she began practicing and hearing patients complain about the exorbitant bills they were sent for routine labs and medications. One patient came to her in tears after being billed $7,000 for an IV infusion, for which the patient held her responsible. "They have to blame someone, and we are the interface of the system," she said. "They think we are the greedy ones." Fed up, Girnita eventually left the practice.

Some doctors acknowledged that the pressures of the system had occasionally led them to betray the oaths they took to their patients. Among the physicians I spoke to about this, a 45-year-old critical-care specialist named Keith Corl stood out. Raised in a working-class town in upstate New York, Corl was an idealist who quit a lucrative job in finance in his early 20s because he wanted to do something that would benefit people. During medical school, he felt inspired watching doctors in the E.R. and I.C.U. stretch themselves to the breaking point to treat whoever happened to pass through the doors on a given night. "I want to do that," he decided instantly. And he did, spending nearly two decades working long shifts as an emergency physician in an array of hospitals, in cities from Providence to Las Vegas to Sacramento, where he now lives. Like many E.R. physicians, Corl viewed his job as a calling. But over time, his idealism gave way to disillusionment, as he struggled to provide patients with the type of care he'd been trained to deliver. "Every day, you deal with somebody who couldn't get some test or some treatment they needed because they didn't have insurance," he said. "Every day, you're reminded how savage the system is."



After nearly two decades working in emergency rooms around the country, Corl's idealism gave way to disillusionment as he struggled to provide patients with the type of care he'd been trained to deliver. Balazs Gardi for The New York Times

Corl was particularly haunted by something that happened in his late 30s, when he was working in the emergency room of a hospital in Pawtucket, R.I. It was a frigid winter night, so cold you could see your breath. The hospital was busy. When Corl arrived for his shift, all of the facility's E.R. beds were filled. Corl was especially concerned about an elderly woman with pneumonia who he feared might be slipping into sepsis, an extreme, potentially fatal immune response to infection. As Corl was monitoring her, a call came in from an ambulance, informing the E.R. staff that another patient would soon be arriving, a woman with severe mental health problems. The patient was familiar to Corl — she was a frequent presence in the emergency room. He knew that she had bipolar disorder. He also knew that she could be a handful. On a previous visit to the hospital, she detached the bed rails on her stretcher and fell to the floor, injuring a nurse.

In a hospital that was adequately staffed, managing such a situation while keeping tabs on all the other patients might not have been a problem. But Corl was the sole doctor in the emergency room that night; he understood this to be in part a result of cost-cutting measures (the hospital has since closed). After the ambulance arrived, he and a nurse began talking with the incoming patient to gauge whether she was suicidal. They determined she was not. But she was combative, arguing with the nurse in an increasingly aggressive tone. As the argument grew more heated, Corl began to fear that if he and the nurse focused too much of their attention on her, other patients would suffer needlessly and that the woman at risk of septic shock might die.

Corl decided he could not let that happen. Exchanging glances, he and the nurse unplugged the patient from the monitor, wheeled her stretcher down the hall, and pushed it out of the hospital. The blast of cold air when the door swung open caused Corl to shudder. A nurse called the police to come pick the patient up. (It turned out that she had an outstanding warrant and was arrested.) Later, after he returned to the E.R., Corl could not stop thinking about what he'd done, imagining how the medical-school version of himself would have judged his conduct. "He would have been horrified."

Concerns about the corporate takeover of America's medical system are hardly new. More than half a century ago, the writers Barbara and John Ehrenreich assailed the power of pharmaceutical companies and other large corporations in what they termed the "medical-industrial complex," which, as the phrase suggests, was anything but a charitable enterprise. In the decades that followed, the official bodies of the medical profession seemed untroubled by this. To the contrary, the American Medical Association consistently opposed efforts to broaden access to health care after World War II, undertaking aggressive lobbying campaigns against proposals for a single-payer public system, which it saw as a threat to physicians' autonomy.

But as the sociologist Paul Starr noted in "The Social Transformation of American Medicine," physicians earned the public's trust and derived much of their authority because they were perceived to be "above the market and pure commercialism." And in fields like emergency medicine, an ethos of service and self-sacrifice prevailed. At academic training programs, Robert McNamara told me, students were taught that the needs of patients should always come first, and that doctors should never allow financial interests to interfere with how they did their jobs. Many of these programs were based in inner-city hospitals whose emergency rooms were often filled with indigent patients. Caring for people regardless of their financial means was both a legal obligation — codified in the Emergency Medical Treatment and Labor Act, a federal law passed in 1986 — and, in programs like the one McNamara ran at Temple, a point of pride. But he acknowledged that over time, these values increasingly clashed with the reality that residents encountered once they entered the work force. "We're training people to put the patient first," he says, "and they're running into a buzz saw."

Throughout the medical system, the insistence on revenue and profits has accelerated. This can be seen in the shuttering of pediatric units at many hospitals and regional medical centers, in part because treating children is less lucrative than treating adults, who order more elective surgeries and are less likely to be on Medicaid. It can be seen in emergency rooms that were understaffed because of budgetary constraints long before the pandemic began. And it can be seen in the push by multibillion-dollar companies like CVS and Walmart to buy or invest in primary-care practices, a rapidly consolidating field attractive to investors because many of the patients who seek such care are enrolled in the Medicare Advantage program, which pays out $400 billion to insurers annually. Over the past decade, meanwhile, private-equity investment in the health care industry has surged, a wave of acquisitions that has swept up physician practices, hospitals, outpatient clinics, home health agencies. McNamara estimates that the staffing in 30 percent of all emergency rooms is now overseen by private-equity-owned firms. Once in charge, these companies "start squeezing the doctors to see more patients per hour, cutting staff," he says.

As the focus on revenue and the adoption of business metrics has grown more pervasive, young people embarking on careers in medicine are beginning to wonder if they are the beneficiaries of capitalism or just another exploited class. In 2021, the average medical student graduated with more than $200,000 in debt. In the past, one privilege conferred on physicians who made these sacrifices was the freedom to control their working conditions in independent practices. But today, 70 percent of doctors work as salaried employees of large hospital systems or corporate entities, taking orders from administrators and executives who do not always share their values or priorities.

Philip Sossenheimer, a 30-year-old medical resident at Stanford, told me that these changes had begun to precipitate a shift in self-perception among doctors. In the past, physicians "didn't really see themselves as laborers," he notes. "They viewed themselves as business owners or scientists, as a class above working people." Sossenheimer feels that it is different for his generation, because younger doctors realize that they will have far less control over their working conditions than their elders did — that the prestige of their profession won't spare them from the degradation experienced by workers in other sectors of the economy. "For our generation, millennials and below, our feeling is that there is a big power imbalance between employers and workers," he says.

Last May, the medical residents at Stanford voted to form a union by a tally of 835 to 214, a campaign Sossenheimer enthusiastically supported. "We've seen a boom in unionization in many other industries," he told me, "and we realize it can level the power dynamics, not just for other workers but within medicine." One thing that drove this home to him was seeing the nurses at Stanford, who belong to a union, go on strike to advocate for safer staffing and better working conditions. Their outspokenness stood in striking contrast to the silence of residents, who risked being singled out and disciplined if they dared to say anything that might attract the notice of the administration or their superiors. "That's a big reason that unionization is so important," he says.

The Stanford example has inspired medical residents elsewhere. Not long ago, I spoke with a group of residents in New York City who were thinking about unionizing, on the condition that I not disclose their identities or institutional affiliations. Although the medical profession has been slow to diversify, the residents came from strikingly varied backgrounds. Few grew up in wealthy families, judging by the number of hands that went up when I asked if they'd taken on debt to finish medical school. "Anyone here *not* take on debt?" said a woman sitting on the carpet in the living room where we gathered, prompting several people to laugh.

Having a union, one resident explained, would enable the group to demand better working conditions without having to worry about getting in trouble with their superiors or losing fellowship opportunities. They would be able to advocate for patients rather than apologizing to them for practices they considered shameful, another added. When I asked what they meant by shameful, I learned that a number of the residents had trained at a hospital that served an extremely poor community with a limited number of I.C.U. beds — beds that during the pandemic were sometimes given to wealthy "V.I.P." patients from other states while sicker patients from the surrounding neighborhood languished on the general floor.

Forming unions is just one way that patient advocates are finding to push back against such inequities. Critics of private equity's growing role in the health care system are also closely watching a California lawsuit that could have a major impact. In December 2021, the American Academy of Emergency Medicine Physician Group (A.A.E.M.P.G.), part of an association of doctors, residents and medical students, filed a lawsuit accusing Envision Healthcare, a private-equity-backed provider, of violating a California statute that prohibits nonmedical corporations from controlling the delivery of health services. Private-equity firms often circumvent these restrictions by transferring ownership, on paper, to doctors, even as the companies retain control over everything, including the terms of the physicians' employment and the rates that patients are charged for care, according to the lawsuit. A.A.E.M.P.G.'s aim in bringing the suit is not to punish one company but rather to prohibit such arrangements altogether. "We're not asking them to pay money, and we will not accept being paid to drop the case," David Millstein, a lawyer for the A.A.E.M.P.G. has said of the suit. "We are simply asking the court to ban this practice model." In May 2022, a judge rejected Envision's motion to dismiss the case, raising hopes that such a ban may take effect.

Until the system changes, some doctors are finding ways to opt out. I spoke to several physicians who have started direct-care practices, in which patients pay a modest monthly fee to see doctors who can offer them more personalized out-of-network care, without having to answer to administrators or insurers. Diana Girnita, the rheumatologist who became disillusioned by the astronomical bills her patients kept receiving, started a direct-care practice in her specialty in 2020. One afternoon not long ago, I sat in on a virtual appointment she had with a patient who wished to remain anonymous, a 32-year-old veteran with an athletic build who began to experience severe joint pain several months earlier. He asked his primary-care physician for a referral to see a rheumatologist after a blood test showed a high level of antinuclear antibodies (ANAs), which can be a sign of an autoimmune disorder. He called every doctor's office he could find within a 100-mile radius of his house, but none could schedule him for months. His wife then stumbled upon Girnita's name online and called her office, and he got a virtual appointment the next day.

Diana Girnita, a rheumatologist who was distressed by the astronomical bills her patients kept receiving and started a direct-care practice. Emily Monforte for The New York Times

The meeting I sat in on was a follow-up appointment. When it began, Girnita relayed some good news, telling him that his ANA level had fallen and that his lab results indicated he did not have an autoimmune disease. The patient was visibly relieved, though he was still experiencing persistent pain in his wrist. Girnita advised him to get an MRI, which she said she could order for $800 — a fraction of the amount that hospitals typically charged. One advantage of the direct-care model was that physicians negotiated with labs and imaging centers for tests and services, Girnita told me, bypassing the corporate middlemen (insurers, pharmacy-benefit managers) that drove up health care costs.

When he went to medical appointments in the past, Girnita's patient told me later, the doctors he saw were often brusque. "They come in, tell you the medicine you're going to take and that's it," he said. His first appointment with Girnita lasted an hour, the minimum amount of time she allotted to all patients in their initial consultations. During the follow-up appointment I observed, Girnita spent half an hour answering his questions; she never cut him off and did not seem rushed or harried. At the end of the appointment, he thanked her profusely, in a way that made it clear he was not accustomed to such treatment. It was a novel experience not only for the patient but also for Girnita, who told me that, in the past, she often had to squeeze appointments into seven-minute time slots. Before starting her direct specialty-care practice, she added, she spent so many hours doing bureaucratic work that she barely had time to see her family, much less her patients. "The direct-care model is designed to rebuild trust," she said, "and to re-establish a normal relationship between physicians and patients."

Of course, the model is far from a panacea: Many doctors struggle to attract enough patients to make a living, which is a problem for specialists like Girnita, who rely on referrals from primary-care doctors. Girnita told me she understood why some doctors were choosing to leave the profession altogether. Two physicians she knew had switched careers recently, an impulse she fears will overcome more and more of her peers in the years to come, especially those who chose to become doctors for altruistic reasons. "They didn't quit because they don't like medicine," she said. "They were both wonderful physicians."

And even running direct-care practices, doctors cannot fully escape the frustrations and injustices of the health care system. A few months earlier, Girnita told me, a patient came to her after having a severe allergic reaction to an ulcer medication that his insurer had switched him onto because it no longer covered the drug he'd been taking. Girnita told me she had called her patient's insurer every week as his condition deteriorated. When she finally got through, she was told they needed 30 days to process the appeal. Girnita was livid. "They are literally putting this patient in danger — it is sick," she said. "This is sick medical care."

Eyal Press is a journalist and sociologist in New York. He is the author of, most recently, "Dirty Work," about the morally troubling jobs that society tacitly condones.
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