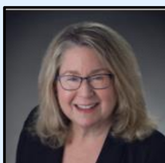
I DON'T THINK WE HAVE TO STAY STUCK

Interview with Gabe Charbonneau, M.D.

By Eve Shapiro February 4, 2025

Gabe Charbonneau, M.D. (GC), co-founder of Medicine Forward and creator of the #FightBurnout movement on social media, is a primary care physician in rural Stevensville, Montana.



Eve Shapiro (ES) interviewed Dr. Charbonneau on January 21, 2025, to discuss the challenges to primary care practice, the business of medicine, and hope for the future of primary care.

This interview has been edited for length and clarity.

ES: What are the greatest challenges you and your colleagues face in your primary care practice? How do you work to overcome them?

GC: There's a long list of challenges. One of the greatest challenges in rural primary care is that it can be hard to recruit and retain great clinicians who want to stay in the community and who aren't burned out from the jobs we currently have to offer.

ES: Is this because you're in a rural area or is this something practices everywhere face?

GC: It's a little of both. The burnout factor is everywhere. Burnout is incredibly common in lots of places. I would argue that depending on your situation, rural communities can be a little protective when it comes to burnout. In my own experience, having worked in both urban and rural settings, there is a much greater sense of meaningfulness in rural work: it matters a lot more that you are there to practice. When I worked in the city, there were so many other family physicians that I felt if I wasn't there, it wouldn't have made much difference. Having a sense that your work matters is a protective factor, at least for me.

ES: What can members of your community, including local elected officials, companies, groups, and individuals do to help you overcome the challenges you face in primary care practice?

GC: To address the challenges of recruiting and burnout, elected officials and others could speak up for the need for sustainable jobs in primary care. So many people are realizing that there aren't sustainable jobs. That speaks to the burnout problem. Doctors are leaving practice, they don't have enough time to spend with their patients, and they are overwhelmed with the administrative burdens.
The public could speak to their representatives and senators about their own experience as a patient and say "I wish I had more time with my doctor, and I wish their time with me was valued." I'd like to believe that if there were a movement of enough people saying that repeatedly, then it would get someone's attention.

To elected officials, I would say when you're looking at different policies and there ever is an opportunity to do things that give doctors more time or more support, it would be good to support those initiatives.

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ES: What can you say about Medicine Forward and the work you're doing to improve the experience of primary care for physicians and patients?

GC: There are a few things. I'll talk a little bit about my own experience. I have a background of being involved in leadership in our healthcare organization, and that contributed to my sense of burnout, in part because meetings felt like they were totally driven by business interests. Meetings started out as conversations among physician colleagues and one administrator, and we would talk about problems and challenges and what we could do about them. I thought those meetings were productive.

At some point, the administrator was tired of having to repeat what was said to other administrative colleagues, so decided the meetings should change. All of a sudden, we went from six or seven doctors and one or two administrators to a meeting of 20 people, and almost all of them were administrators. And when that happened—you can imagine what kinds of conversations those were—we couldn't really get anything done. The meetings went from thoughtful conversation and dialogue to, "Here's how we're going to get paid, we want you to be on board with this, and we want you to go back to your clinic and get your colleagues on board with how we're going to get paid."

Essentially, that was such a huge problem for me that I quit that role, and that was a big part of my inspiration for being part of a group like Medicine Forward. In that setting, I had no say, and I felt used. Medicine Forward is a group of people who really care about making things better and asking questions like, "What can we do to improve things at the systemic level? And at the individual level?"

ES: Is Medicine Forward planning community collaborations?

GC: Not so much in local, rural communities yet. We tend to do more collaborations with people whose communities share an interest in medicine. For example, we held an event in collaboration with the Burnout Symposium in New York, so it was a community of people who are passionate about improving burnout. Then we got others together who were interested in that, but it wasn't a local or rural effort. It was sort of the opposite of rural.

ES: Do you see any potential for community collaboration?

GC: Yes. We're excited that we're starting a new model that we're working on right now. It's called the Team of Teams framework. The idea is that within the umbrella of Medicine Forward, anyone who is a member can start a team to do something positive that they think is important. And they can recruit other people within Medicine Forward to join that effort and use our infrastructure and potentially our resources to do something. For example, there could be someone like me in rural practice who decides, "I want to do something about burnout in primary care in rural communities with a Team of Teams." And I could look for other rural physicians or people who are passionate about that to get involved.

We're developing a framework that helps facilitate some initial set-up and conversation and see how that can tap into the larger organization—whether that means advocacy or support for each other or whatever it is that people want to do. So, yes, there is potential for that. It would just require someone who's passionate about it, and that they want to help find others to get something started.

ES: What do you think about the physician strike in Philadelphia, and the doctors' and nurses' strike in Oregon? I'm thinking back to Eric Topol's 2019 article in the New Yorker that laid the foundation for Medicine Forward, "Why Doctors Should Organize."

GC: I have really mixed feelings about it. So many of us feel we have no power. Historically, we're an ideal group to manipulate and take advantage of because of the Hippocratic Oath. And then you put us in this setting of the business of medicine, and the business can tell us what to do, and we really have no voice.

I'm not surprised because I've known for a long time that the pressure has been building with dissatisfaction and people feeling they aren't being heard—and they aren't being heard about really important things, like not having enough staff, and not having enough time to spend with patients, and being expected to do more with less, again and again and again.

I know that every one of those doctors who is on strike, and probably nurses and anyone else, too, has to be very conflicted that in the name of sticking up for what they believe is right, they have to walk out on providing care to patients. That makes me sad. I can't imagine that anyone takes that decision lightly. There's no one I know who would be able to do that without having some internal struggle. And the fact that it's gotten to the point where people are willing to strike for these issues tells me that it's a really, really big deal.

ES: What else would you like me to know?

GC: I strongly believe if we're going to get healthcare right, we need to have a strong primary care system with a lot of primary care doctors—more than we have. We need to

have good jobs for those primary care doctors where they're not feeling discouraged or burned out. They need to feel that their work is doable and they get fulfillment from it. It can be hard work, but primary care doctors overall need to be fulfilled and not run into the ground every day they show up for work.

There's a conflict when so many of the primary care organizations are owned by hospitals that make money primarily by doing expensive things to people, like doing surgery or having expensive hospital stays. That's hospitals' bread and butter, it's how they make money. But in primary care, the goal is to help people be healthy. And often that should be less about doing things to people and more about spending time with people in conversation and really getting at the root of what their problems are and working together over time. This whole paradigm of primary care being owned by hospitals and having economics be the driver doesn't make any sense at all. I believe that a robust primary care system is important if we want to have a better healthcare system. But I also think we have to completely reimagine the incentives that are driving things if we want that to work.

ES: Isn't that the norm now, where hospitals are buying up practices?

GC: Yes, it's so, so common. Private practices are always getting gobbled up by big systems. A large part of it is that primary care practice has become so complex, and there are so many administrative burdens involved in running a practice.

Other than the direct primary care movement, in which patients pay their doctor or practice a flat annual or monthly fee for a broad range of primary care and administrative services, the vast majority of physicians are employed by large hospital systems whose incentives are very different, for the most part, from prevention.

I think many of the people who are choosing to go with the direct primary care model will say it's because they can spend more time with patients. And because generally those working in direct primary care don't take insurance, everything they do can be based fully on what's best for the patient. So, ideally, they should be able to focus more on prevention than intervention.

ES: What would you suggest as the solution to all the problems you've raised?

GC: The solution I'm currently interested in is a start-up company in rural Oregon called Orchid Health. In June I'm stepping down from Medicine Forward and will be working with Orchid Health, which now has six clinics. Orchid Health does try to answer the questions about how to take care of your healthcare workforce and make them a real priority, how to give people a voice in how they're working so they can take great care of patients, and how to do it in some kind of financially sustainable way. All of those things are a huge part of Orchid. I think this is a model that can work beyond rural Oregon, and I would like to be part of seeing if that can be expanded.

There are a lot of good people inside of our healthcare system. There are a lot of really fine humans who want to be good doctors and nurses, and every other kind of job you can imagine inside of healthcare. They really are kind and compassionate, smart, hard-working people—and the disconnect between this reality and how stuck we are is part of what bothers me so much. We have to find a way to get to a better future that brings people

together and empowers people to do the work that is very meaningful to a lot of us. It doesn't have to be so upside down. That's what I'd like you to know. There are a lot of really good people, and I don't think we have to stay stuck.

As a medical writer, **Eve Shapiro** is keenly interested in the forces that promote, diminish, and destroy joy in practice for doctors—the same forces that directly affect the health of patients, families, and communities. Her current focus is true stories of community and connection that start small and grow into social movements to improve people's health, social circumstances, and emotional wellbeing. Her most recent book is *Joy in Medicine? What 100 Healthcare Professionals Have to Say about Job Satisfaction, Dissatisfaction, Burnout, and Joy* (Taylor & Francis). http://www.eveshapiromedicalwriter.com.