Dr. Shannon Dowler on Rural Life, Resilience & Redefining Family Medicine Transcript

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Podcast Introduction and Guest Welcome

Welcome to the Doctors Making a Difference podcast, where we help physicians to be empowered with the tools they need to successful in medicine, in finance, and in life.

Join us as we highlight doctors and other professionals around the world who are making a difference. I would like to welcome Dr. Shannon Dowler today.

She's taken the time to meet with us and be a part of the podcast. Dr, Shannon, she's given me permission to use her first name. is a family doctor. She's worked in North Carolina for a lot of years and she serves as a member of the board of directors for the American Academy of Family Physicians.

she's done lots of stuff and I'm excited to catch up with Shannon today and kind of hear it. So would you mind talking to us a little bit about who you are and what you do?

Absolutely. Thanks for having me. I'm excited to talk about all the fun things that we get to do as family doctors and sort of some of the circuitous paths our careers can take as well, sometimes in family medicine.

So I was born and raised a North Carolina girl. a farm on the side of a mountain in the middle of nowhere. I've got more cows as neighbors than people and we love it very much.

And we started, you know, accumulating animals. When my kids went to college, I decided to fill the nest with other species. So I have had a long and exciting career.

That's been sort of one of the things I love about family medicine is it can be such a choose your own adventure career and some people like have the thing they want to do and they know what they wanna do.

They just do that thing for their whole career, and then others of us like to mix it up and change periodically. So I've done a variety of things in my career with a focus though on leadership underserved care.

Oh, did with all that flooding last year, Did you get affected by that and you're part of the state? Yeah. Helene was rough. We were lucky on our property.

You know, a dozen trees or so, nothing bad. Got, you know a gazillion trees, but we didn't have power for several weeks and without power you can't run the well, so we don't water unless we could get gas to run Gas was really hard to get for the first two weeks.

Shannon Dowler's Background and Family Medicine Path

So it was a challenging time, but there were certainly a lot of people that were far more impacted than us. We set up a relief station and accepted donations from around the country.

People just show up with an 18-wheeler loaded with stuff from their church. And then it would turn our entire stock of donated goods would turnover sometimes twice in a day as different people stopped to take things back to their neighbors and their parents and other folks who didn't have resources for that period of time.

Well, I'm glad you were able to help. I know that was just a horrible, tragic situation. One of my practice partners in Idaho is from North Carolina. She made a journey back there during that time to provide some relief work as a physician and it was overwhelming.

And she had talked about how family members were just kind of stranded and didn't have access to food or water or the basics and its mountainous terrain, pretty challenging time.

So anyway, neat that you're able help as much as you could in a challenging like that. Yeah. And we actually had a couple of family docs like fly across the country and stay with me.

One of the docs from Ohio filled up a pickup truck with generators and winter coats and all sorts of things and brought it. So it was really, the outpouring from around the county was impressive.

Yeah, I've understood it's probably going to take quite a few years to rebuild some of that infrastructure that was damaged. Huge storm and major, major flooding.

So I want to ask you a little bit about your background. Why did you choose family medicine? You know, you were young, aspiring medical student, and now you're very passionate about what you do.

You're involved in, like you say, your, try a lot of different things that you can do as a family doctor. How did your choose? Family medicine back in the day when you are making that choice.

Yeah, so I always thought I was going to be a veterinarian. From the time Iwas like 13, I had to go down to the DSS office and get a worker's permit. So I could work at the vet hospital about a mile.

I'd ride my bike to work on the weekends at six in the morning and muck out the cages and stuff. And I thought it was gonna be at vet. Then in undergraduate, and I think I became more socially aware during that time as a lot of college students are.

I started kind of leaning more into social justice issues and thinking about all the people that didn't have access to healthcare and started questioning whether it would be, my contribution to the world would better if I took care of people.

So I did a couple rotations at the local hospital and with a local pediatrician and I was hooked. I like, oh no, I'm going to have to go into medicine.

And I clear that family medicine was going be the thing because I wanted to be able to take care everybody. just a tremendous amount, the breadth and scope of it, is if I wanted to live rural, which at that point in time, that was totally my plan.

I could do everything, or if ended up wanting to hone in and do something more specific, I can do that. And I really appreciated that, and also it was a career where I knew that I would give back in underserved care, there was this infrastructure of opportunities for physicians who really felt strongly about underserve care.

So that's when I decided, probably senior year in college, family medicine was going to be the path. So even before entering medical school, is that right?

Even before that, you knew that was the direction you were headed. That was my direction. And like many of us in medical schools, like every rotation I would be like, no, I'm going to be a surgeon.

No, i'm gonna be an OBGYN. I am going be pediatrician, because I loved all of them so much. Then at the end of the day, it kind of came back to, well, if I love them all so then I probably need to stick with family medicine.

So I have the opportunity to do all the things that I might want to in my career. Yeah, I'm much the same. And you know, when I talk to our family medicine colleagues, everybody's like, well, they love surgery and I love pediatrics and whatever it may be.

Once you find all that stuff, that's about the only one where you get broad training and then your career actually does involve that. For those who are listening who don't practice in it, it is such a unique thing.

My day can start with delivering a baby. and then directly to the nursing home to take care of somebody who's on hospice care and the inpatient side. And then we're in clinic doing well-child checks or somebody there with hypertension.

Then at the end of the clinic, you're maybe back overseeing another sick hospital patient. I remember the first time I saw it as a medical student rotating with one of physicians in a rural area.

It was like, wow, this guy. He was covering the ER at that same time and I was fascinated by it. I had the same exact experience. Yeah, I saw this, you know, rural practice where she was covering the emergency room, someone came in labor, she had to deal with that.

Then she has to go do a c-section. And then, it was just like all of it. It was so impressive to me. Yeah. So, and so I've lived that life. I'd been in the same area for 14 years and I loved it.

And I have done all those things. When people ask me about it, I say, "I love my job." I really do.

Rural Practice, Flood Relief, and Career Balance

It's so cool. I get to do all these things and enjoy being right in middle of people's healthcare. Often I'm the one helping to make the diagnosis and if we need specialist referrals, we're kind of coordinating it and i do love what I do on the other hand, i get do everything but i have to everything.

That's the challenge. Sometimes you're like, well, you were on call and everybody else is out of town. So you have to do all that too. It's hard to find the balance on that.

You've worked in this for a number of years. How did you find a balance during that part of your life when you kind of doing all those things? You know, I don't know that I've ever actually achieved balance every time I thought I would start working.

The way I felt that balance happened, particularly when my children were younger, is I just work part time, and then I'll have the balance. Well, that doesn't work for me.

So I will just end up volunteering an extra 20 hours or 30 hours. Suddenly, i was working just as many hours, but I was only getting paid for a fraction of it.

And so that gets taken me to my 50s to understand that this is me and so now what I do is like carve out time. I platform in my way where my goats are, where I do goat yoga and meditation.

I've taken myself to several meditation retreats. So I really taught myself how to simmer down and settle down. Which I need to, especially after my last five years as the chief medical officer of our state Medicaid program, which was a really kind of super crazy time with COVID and other things.

So I found that and then I love the animals. So like going back to that, you know, saying I'd always thought I would be a veterinarian. And I've got a ton of animals and they give me joy.

I was just dealing with deworming goats after an unfortunate discovery in one of my goat's bottoms the other day. So I'm learning how to do the animal medicine at the same time.

I don't know, that gives me joy. And I am creative, so I've done a bunch of rap videos, and I wrote a book telling stories. Tapping into my creative energy is actually one thing that is good for my balance.

Well, and there's kind of this idea that maybe the idea of perfect balance is a myth, really, that most of us have to just say, when I'm doing this, I am all the way in, both feet, all of the into what I was doing.

And then when doing the next thing, or when home with my family, I wanna be all the way there. And when I'm on a

hike with the kids or out in the mountains or doing that, I can't try to be split and it's really hard to achieve.

When I think about my job, but sometimes there's too much of it. It's a challenge to try and fine tune that. I certainly don't claim to have it figured out, especially those who've worked in kind of a rural area with maybe limited resources and only a certain number of other doctors that can do your skillset.

We all have to kind of reflect on that and find those other parts of our life that light us up. Absolutely. And I think we named our, you hit on it, like jumping into things with both feet.

We actually named out property up here in the mountains, Feet First Farm and Forge. Feat First, as my husband said, the only way I'm leaving this place is feet first in a hearse.

He is here for the duration. Then he said and for you, feet-first is you jump into everything. You go fully in when you go into it. I think that's right.

And if that is your style and what gives you joy, then that great. But finding those ways to carve it out, you know, your idea of when I'm with the kids, I am with kids and when i'm on the hike, i am on hike.

You know as much as you can protect those spaces and make sort of sacred spaces in your life. We'll talk for just a minute about, you've not only practiced family medicine in a variety of different settings, we've done some administrative time, more of a rural practice, a lot of things.

I'm a family doctor, so I feel like I have a pretty good understanding of what family doctors do and the importance of family medicines, but you have seen it on a national level and seen a lots of iterations of it.

the kind of the future of family medicine and why it's important. Because like, I think it is important, but I get so busy in my job every day, sometimes I stop, and I don't stop and think about it.

But I'm interested in your vantage point. Why, why primary care matters? I mean, it think, It is the most important specialty for the health of a population.

And I that is, you know, family, medicine gets slept on a little bit. So sometimes people don t always acknowledge how critical it i, but the fact is If we want to keep our communities healthy, you have to have a robust primary care infrastructure.

And particularly when you live in a rural community, You're not going to attract every different age group primary-care provider to carve out those areas and provide care.

It just doesn't happen. This country is a very rural country. So while in the urban centers you might be able to the right number of internists and pediatricians and geriatricians, that doesn' happen in rural America.

If you're honest, our safety net providers are most effective when they're primary care family physicians because they can do that. They've got that breadth of practice, scope of practise.

Even if they don't want to do deliveries, they could do shared prenatal care. But they've the ability to show up and do what needs to be done. And as we look at our healthcare costs and you look our our health care outcomes, countries that invest in primary here have better outcomes and lower costs.

Unfortunately, that is not the United States. So why am I hopeful? Well, I'm hopeful because I do think there are actually lawmakers sorting this out and figuring out how critically important that family medicine is to the success, the long term success both financially and from a health perspective of our country.

and figuring out how we pull the levers just right. So we're not penalizing our specialty colleagues. We need them, right? There are times when we absolutely want someone to come in and do the cath.

I don't want to do that. That would end badly for everybody. How do we honor our colleagues in medicine, but also raise up family medicine where they need to be?

That's a challenge because every type of medicine and every kind of doctor is needed. The system needs people in every single one of those. And it is kind challenge.

And unfortunate thing, but I remember in medical school, I was doing a subspecialty rotation my fourth year. And I. One of the subs specials sat me down during lunch.

And he spent 40 minutes telling me that I was ruining my life, wasting my live by choosing family medicine. 40 Minutes from a respected attending physician.

I mean, it really gave me pause. And it's not that, you know, I had chosen at that point to I wanted to practice in a rural place. It was pretty well set on that path.

But I thought that was interesting in an academic medical center from the vantage point of this specialist colleague. I was wasting my education. Why was I doing something so foolish, going to be paid so little and work so hard?

Some of that is true. Family doctors aren't paid as much as specialists and you do work hard. I'm hopeful like you that we can try to leave medicine better than we found it.

And I am curious, what are the ways that you would, how do you see it going forward? How do we help our country? Because part of it is trying to get politicians aligned with the needs of the country.

And part of it is our medical institutions valuing saying that we still need to be on the, you know, this foundation of this core of good primary care doctors.

So I'm curious your thoughts on that. Well, I think we have to keep showing up. And I. That happens in a variety of ways. so, kind of wearing my family physician on.

The board of our big national specialty organization. It's critical that people are members of. Our Academy because. that membership one builds resiliency.

There's a lot of infrastructure and benefits that you get from it. But it also allows us to have a stronger voice in DC and have more powerful influence on politics and payment and how things happen.

How do we reduce administrative burdens so we're not the administrative is not killing everybody. And like there's really important work to be done, but there is power in numbers.

So that piece is really I think important for us moving forward and then also honoring that not everybody wants to do family medicine the same way. And that is okay.

We have employed physicians, we have independent physicians and we've got folks that do full scope, everything, including out West people doing surgeries to people on the East coast where that's less likely to happen and people might have more of a specialty.

So like my clinical time has gotten increasingly narrow in the sexual health space because as my administrative roles got bigger and bigger, I didn't feel like I could keep up with everything and do as good a job as some of my colleagues.

And so I wanted to really hone in one area to feel I was the best doctor I can be.

Why Primary Care and Family Medicine Matter

In those hours I got to be in clinic. That's okay too. Some of our colleagues are doing emergency medicine or

urgent care or nursing home or hospice. There are so many different ways that we can touch the healthcare system.

I think this openness, being open to letting your career iterate and that your life changes your situation changes, your needs change, and that's kind of the beauty of this specialty, right?

You can move along with it. And so we need everybody. We need the folks that are doing the administrative work. You know, that're at the health system helping drive quality and outcomes in a way that is really thoughtful about their colleagues in the clinic.

and we the need folks in rural, middle of nowhere, taking care of everybody that walks in door. Everybody's got an important part of Yeah. What would you say to a medical student who's having that conversation with lunch in 2025, where somebody's trying to talk them out of it?

Not because everybody should be a family doctor, but if someone who says, look, I have this broad interest. I want to do this. Like kind of think I wanna be in a rural area.

Kind of like all of the aspects of medicine. But I've got someone, who is kind talking it down and saying, hey, this is a waste of your time. Well, what would say that student?

I would say that you're not alone. That happened to every single one of us in our training. I don't know a family doctor that did not have this experience.

had a surgeon who was mentoring me, like super mentoring and then at the end of the rotation asked me if I was going to match in surgery. And I said, Nope, I think I'm going do family medicine.

The whole next year of my medical school, he would not make eye contact with me. He would speak to me every one has had this And I think you just have to let it wash off.

That's someone's perspective and opinion. And the fact is family medicine in many ways is the hardest specialty. You've got to know something about everything.

you've gotta know what sick looks like and when you need help. I thinks it takes the most academic rigor of any specialty, my bias. For people to feel confident in their decisions and go after what they know they need.

And also, I think recognizing that this specialty does have so many different avenues and pathways that you can follow if you decide you want to go into public health or you wanna go in to public policy or, you wanted go do mission work in another country.

Like it sets you up to do anything you do. Yeah. Well, and I've, Shannon, have been privileged to all those things. I work at a place where we get to surgeries and I've done lots of mission work and i've been able to take care of patients in every setting possible and and.

I really love it I wouldn't do anything different when I go back i'm so thankful that I chose it it's not for everybody but i am thankful. That that was the career choice that i made and one other reflection is.

the idea that, oh, if you go into family medicine, you're going to be poor as dirt and never be able to pay off your loans and yada. That's not been my lived experience.

And most of my peers, when I talk to them, say, I have a fine income. I can add or subtract based on the hours I work. But the range of paid among the people in the same specialty varies more than the range of pay between specialists.

So I know family doctors that make $600,000 a year, and I knew family doctor that makes $100,00 a years. And it's a huge range. It depends on where you practice and what range things you do.

I think people can design it. Maybe some of those people that were downgrading it are saying, okay, they're only seeing one little version of family medicine.

They say, our colleagues are in a suburban practice only and only do a limited range of things. Maybe they're feeling like that was a limitation. But really, it's just that you need to fill all those gaps and be able to adapt to wherever your career takes you because every one of those places needs a physician for sure.

Absolutely. So another question I wanted to ask you about is, you know, policy, national policy regarding physician pay and Medicaid, especially in a recently Medicaid's come under a whole bunch of scrutiny or attack.

And it, sometimes people couch it as a political issue, but I don't really know that it's a a human issue. We have to be able to take care of our families, our communities.

And, you know, I'm not sure. It doesn't always have be Medicaid to answer all those needs. But when we just do a sudden drawback, it does seem like it's causing a lot of chaos.

I wondered what your comments are. You've been on the administrative side, on a patient advocacy side. What are your thoughts on that? I think we're in a really scary place as someone who really deeply believes in underserved care, but also recognizing that we have, the rural population is disproportionately positively impacted by Medicaid coverage.

So when you look around the country, rural has more benefit from Medicaid than urban. And so when we look at these cuts that happened in the, you know, some people call it the one big beautiful bill act.

Some people are pivoting to call an HR one. Now I understand there's a whole nother name getting derived for it. It essentially significantly reduces access to Medicaid for many, many people.

It makes it harder to stay on Medicaid with work requirements and things that have been proven. The evidence has proven that they're not actually effective and make a difference in the economy or the health of a state.

And it also has all sorts of other tentacles in ways that it's going to hurt people. I've actually already seen it start playing out. Most of us were thinking about, oh, these things don't go to effect until after the midterm elections, which, by the way, wasn't an accident.

So when you say it's not political, it was definitely partisan. And some of the things are already happening. So I just learned last week, I was in a meeting that the homeless population in North Carolina was able before to qualify for SNAP benefits, to get some food assistance when they were homeless.

They were exempted out of a rule where you can only get it for three months out 36 months. Because of that, OBBBA or HR1. that actually immediately they lost that benefit.

And so when they went to the grocery store to use their snap card, they found that it hadn't been reloaded. So the homeless population across North Carolina and many other states, is my understanding, because of that bill have now lost access to food resources.

It's not just healthcare, it's that overall health of the person. But I think the Medicaid impacts are significant. North Carolina, we were the most recent expansion state.

That was the last thing I did at Medicaid before I left. I got to lead some of the expansion work, which was, I mean, a lifetime high and privilege to see that happen, brought close to 700,000 people on the books that were in the gap that had fallen through the cracks.

And unfortunately, re-anticipate a lot of those are going to be lost. We in North might actually lose all of our expansion because of a unique trigger law we have in north Carolina.

But we also are gonna see in January the marketplace or the exchange people are losing their subsidies. So when you have that group of people where they're low income earners, but they are not so low, they qualify for Medicaid.

They're working, They are doing the thing, But they get the subsidy to help pay for their insurance. A lot of them are loosing that in January. And so what's gonna happen is they gonna fall off the books.

Medicaid, Coverage Gaps, and Policy Impacts

and as a result of that, the health plans are raising their rates dramatically starting in january. It's disproportionately again, impacting the rural populations and the plans in rural America.

We are gonna see even more people have to choose between making their car payments or paying for health insurance on the exchange and people are gonna fall out of coverage.

So I expect that we will continue to see ongoing impacts in a sort of slow but steady state over the next two years. You practice in a place where they didn't do the Medicaid expansion initially and the same thing in Idaho.

I noticed in that time, the biggest challenge is that the Affordable Care Act subsidies only extended down to a certain income level and there was a really big gap.

And when people talk about closing the gap, but there really wasn't in our rural area. If you weren't the poorest of the poor and you didn't quite make enough to meet a subsidy, there was a whole bunch of people that just had access to nothing.

We hear kind of buzzwords saying like, oh, we're going to make Medicaid the right size or we are going focus it just on pregnancy care or people with disabilities.

For sure we should cover that, but if you're gonna draw that back, it seems like you have to come up with something else, either increase the subsidies or the range of incomes that are covered by that.

You just have give people away. I've talked to hundreds of patients in my area that have had Medicaid or they haven't had it at different periods of their of Their life and almost every one of them said I would like to pay part of my own way.

I'd like I don't want a handout I'm not looking for that but I need a way forward and if the way Forward is I have to paid $2,000 a month for insurance or I Have no insurance at all.

That amount of money is too much But if they said it was graduated down to where I could afford it if it Was a hundred dollars a They would do it. And even our folks on Medicaid, who are the poorest of our population, still want to contribute.

Almost everybody wants to participate in that. I feel like sometimes they're characterized as people who were just freeloading off the system. There are a few for sure, but the very large majority of the ones I've come across, that's not, again, doesn't match my lived experience when I hear those talking points.

Do you hear anything like that? Yeah, I think it is a misperception and sort of an assumption that people are sitting at home eating bonbons, you know, so that they can be on Medicaid.

There's a real belief that the fact of the matter is, and the data proves out, this is the working population. This is particularly childless adults are working in our low income places.

They're in the tourism industry. So they're working as housekeepers in hotels or their doing food services, or the kind of jobs where they're small businesses, where the business is too small to be able to afford health insurance, because it's incredibly expensive for a small business to do that.

And so they are the people that get left out, to your point. The vast majority of them are working, and the data is actually really strong that says that having Medicaid increases your employment and strengthens the economy, but also that the children who benefit from having Medicare coverage as children actually go on to higher wage earners, and more powerful contributors to society if you measure it that way.

So there's just really good data that Medicaid works and that keeping people healthy and doing preventive care is less expensive for our system, right?

I'd much rather diagnose someone with DCIS than a stage four fungating breast cancer. The outcome is certainly very different for that woman as well, but the fact is our is moving away from that in a way that's really scary.

And I think particularly for folks that are in independent practice, that they're going to have to make really hard decisions about what your patient panel is going look like and who you can afford to take care of in your practice and how you're gonna make the business of your practices work if we keep cutting and cutting.

It is challenging because if you are at a place where most of the jobs offered offer insurance, And if that's what you're surrounded by, like, well, just then it's easy to say, we'll just go get a job with insurance.

but where I work and probably some of the places you've worked, like you just described, a lot of businesses are very small. They don't offer insurance.

The couldn't afford to, the business would fold if they had to offer that kind of thing. So it is kind unfortunate that our system is all built around employer-based insurance because it kind depends and you don' necessarily get to pick where you're born or where do you live.

Sometimes people can move, but I have a lotta people who say, they're told, well, why don"t you move to a different area and get a job? Your family's here.

You don't have a place to start. How would you afford housing? How did you even start that process? And we try to give people opportunities, try and encourage young people.

to seek education and a lot of them really do. They're wonderful, but there are many people who get dropped. And I guess I feel most bad about this because instead of offering people a way forward or a ways to make those ends meet, we just kind of drop it and say like, well, they'll figure it out.

I don't know. Again, back to my real life lived experiences says these are hardworking people. Have not observed very many that are eating bonbons. Like you said, that's just, very much the exception than the rule.

Yes, absolutely. How do we get those stories to our lawmakers? How did we help them understand that the rhetoric that they're sort of following along with isn't our experience as family docs on the ground?

And one great way to do that is to show up in DC. Actually, the AFP has a great meeting every June. It's the Family Medicine Advocacy Summit where family doctors from all over the country just elect to come to DC for a few days.

We all get sort of trained up on here are the big issues. And then they've scheduled you to have meetings with your legislators and you like congressmen and senators and people, you know, You go in groups, don't go by yourself, because that's overwhelming for some people.

I'm amazed every year about people that fly all the way in from Washington and Hawaii and Alaska to come do this and how powerful it is. But you can also do it at home.

You can do from your home or be an advocacy ambassador, which costs nothing. The Academy puts out alerts saying, hey, let your senator know this bill's coming and it's going to really help reduce your administrative overhead and you should send them a letter.

There's so many ways that family docs around the country can contribute and influence these decisions. And I think they really actually matter. I know that in those offices, they've got a bunch of interns that are doing tick marks for every letter they get for and against something.

It does actually influence the way people vote and as they make these policies. It's more important now than ever, I think, for family docs to talk one-on-one conversations with their local elected officials.

And even at the county level, it's going to be important because as these funding cuts come down, they're hurting states as well. That means the funding to the counties will be less.

The trickle-down effect of all this over the next two years is going be really painful for communities. Having those conversations now to strategize about, okay, how are we going prepare for this and how we're going ready for it so the least people the fewest number of people are negatively impacted.

Yeah, I've found it really beneficial just to stay in contact with our local legislators. In my district in Idaho, i've tried to make it a point to get to know every one of them.

It's not like they listen to everything I say, but when there's something that comes up I usually just send them a text or call and be like, hey, if you have any questions I just want to be a resource for you.

I'm happy to answer any And then the other thing I found helpful is I just kind of keep a little collection of stories and they're not made up stories.

Sometimes the patient doesn't have the ability to share that story themselves, but I can share the story and say, yeah, Mrs. Jones waited for months and months to come in because she had right up her quadrant pain.

And when she came in, she has a huge stone and she required a hospitalization for two weeks because And had she come in for an ultrasound and an outpatient visit, the gallbladder would have been removed and it would've been a simple, much cheaper procedure.

But now that same patient is now bankrupt and can never pay that debt back. It's a debt that she could never. Pay in her entire life with the income she has.

And now her health is in poor shape, and she can't afford follow-up care. So it was cheaper. Just those kind of stories that we come across again and again, if you kind keep a little reminder of those, that's the stories I feel like move the needle more when you're talking to people.

Say this is a person that lives in your legislative district. This is what happens because we don't have access to care, she works 40 hours a week. She would pay everything she could, but she cannot afford insurance on her own.

So you've got to find a way. And if she's recovering from sepsis, she is not going to be able to go back to work for six months, 30 years, if ever. Some people then are on disability for the rest of their lives after a terrible sebsis.

The cost downstream is so much more if we don't get involved upstream. I think those stories are really important and powerful. It was fascinating to me in Medicaid, when I was CMO of Medicaid.

There would be things that I wanted to cover. and our, you know, go through our fiscal analysis, folks, and they say, Ah, this is going to cost you much, we can't prioritize this now, like, there's no way we could do it.

But all it took was a senator, a state senator raising cane, because one of their constituents said, my Medicaid won't cover this for my child, they need it, well, suddenly, I could get things covered, so they're very influential.

On the even at the state level, but even down to your county level. So I do think those relationships are important and the stories are critically important.

Yeah. Perfect. You know, the other thing I think about is. We live in the wealthiest country in world. At least, you know, at least among the larger countries of the world, the United States has a tremendous amount of wealth.

You've done medical service work in other countries, as have I, and you realize just the vast difference in what people have. So when I look at where we spend our money and how we spent it, there's probably ways to tweak it and we should probably make it so that there is a way for everybody to contribute so they are paying into something where they don't feel like everybody else is just giving things to them.

Advocacy, Advice for Future Family Doctors, and Closing

But certainly we have the capacity to solve this problem. It just requires the willpower and the intelligence to kind of solve it. it's not a lack of resource.

To me, it seems like a Lack of coordination and motivation and political will to fix it I don't know if that's been your observation. That's what I observe.

I think it is true. And right now a lot of the rhetoric is around fraud, waste and abuse. In D. C. they're thinking about it as people sort of lying to get on Medicaid or people that are not supposed to be on medicaid getting on medicate.

But the way I see it from my lens as the prior CMO of Medicaid and as a family physician is I actually see a lot of waste in our health care system like real waste paying for things that aren't evidence based or doing surgeries that or not evidence.

Like there's just a opportunity, I think, for us as physicians to be part of the solution. So fraud, waste, and abuse probably is real. I don't think it's happening in the places that the folks in DC are thinking it is happening, but I do think its real, so how can we lean in and go to our Medicaid program and say, hey, notice that I'm getting patients that are having this procedure done a lot and actually the data is not good for this and there are alternate treatments that better or more effective.

How do we invest in the things that are preventive or non-procedural that help people get better? We have a role in that too, to sort of help ferret out the fraud, waste and abuse when we see it as healthcare providers.

And most of the time where everybody's just so busy and their heads down and doing all the work. But I think we could have role and helping find some savings in healthcare.

I totally agree. I applaud the efforts to remove fraud, waste and abuse. It's about how you do it and what things are actually wasted. But I know that taking Medicaid away from our little farming families that are working every year and trying to make ends meet, that's not really that efficient because now they don't have care.

And I was talking to a guy the other day who's got a large family and he said, you know, we work the same amount every on those busy summers when we're harvesting.

It's 100 hours a week. In some years, We don' qualify for Medicaid. We make plenty of money. we buy Affordable Care Act as sort of a plan and it works great for us.

And we work the same amount the next year and the crops don't come in as well and it doesn't rain enough or whatever. And suddenly your income is just a quarter of what it would have been, and there's no way you could afford it.

So it's not the amount of work that changed, but the number of incomes certainly changed. I know everybody likes to eat, so we're thankful for our farmers.

It's just one of those things where we need to be really careful not to just paint people with such a broad brush. There's a lot of nuance among the people that are on Medicaid.

not only worked in your own home state, but you've done some national advocacy on that through your work with the AAFP and I appreciate it. Absolutely.

Well, so Shannon, as we wrap up here, what are some advice, some final parting words and advice you would give to Again, to other doctors and medical students as they contemplate like family medicine, especially, you've been a kind of a champion of family and I would just, as you're thinking about that, what would you say to aspiring family doctors or people who are mentoring family?

I think helping this new generation of learners see that There are so many ways to do it. What I see, my kids are 22 and 24 and I them and their friends and how they're coming out into the world and it's a little different.

They don't want to be fixed into a mold necessarily. they want find their path and i just don' think there's better specialty to allow you to find the path you want and to honor the fact that your path might change.

My path has changed all over the place. I've gone from being a full time in the clinic doing full scope family medicine To being a CMO of a large FQHC, to being an executive in a health system, being the Cmo of Medicaid.

I've done all sorts of different things in my career and that is joyful for me. And there are plenty of people that want to live in rural, whatever state, name your state and re-embedded doing full-scope family medicine all the time, every day until they retire.

And then folks that just want to change, maybe they want start urban and move rural or they wanna do rural care but live in an urban setting. So just seeing that there's not one way to do it and that I really believe family medicine is the linchpin in our healthcare system and we're the most critical piece to it.

And so knowing that you're becoming part of a group of people who are pretty amazing. I mean, I know you've met a lot of family docs around the country as have I.

We're a pretty, amazing and cool group people. that you'll become part of this bigger thing and that your path can take you so many different ways. I think this new generation coming out really needs to see that.

And I don't think they're as hyper-focused on money making as prior generations have been probably, although they are very practical and coming up with this tremendous amount of debt is really meaningful in influencing their decisions.

So also thinking about how we can help people find loan repayment and debt assistance as they come out of their training programs will help us help them pursue that career if that's what they want.

That's wonderful. Thank you. How do people follow your work or follow along? I know you've been active on social media and have been involved in a lot of stuff.

Where would you people direct people so they can follow Yeah, so I have a website that I am terrible at keeping up, but it's ShannonDowlerMD.com, very easy.

When I wrote my book, my publisher said, you have to have website. So I'm like, fine, I'll do a web site. But it has actually been kind of fun. And so, and I will blog every now and then, But I try to update it with pictures and different activities and events and speaking engagements and other things, publications, podcasts.

I got to be on the New York Times daily podcast in July, which was a super cool experience. Oh, thank you. You can see my rap videos. They're linked to on there to my first country cover.

I'm not actually a country person, but I changed. Grandma got run over by a reindeer to, um, grandma got infected with a virus. That's a good one. Uh, so anyway, there's all sorts of interesting things out there next time you're bored and scrolling, But, you know, show up at the AFP meetings too.

A lot of them and love to meet people from around the country. Yeah. Well, Thank you so much for taking the time to do that. Keep in touch. And I really appreciate it.

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