MD Life

February 2026

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The Hidden Costs of the Physician Non-Clinical Career Transition

Carlos N. Hernandez-Torres, MD

I entered medicine believing (perhaps naïvely) that experience mattered. Triple board certification, years of clinical practice across three specialties, and working in New York City felt like assets that would translate beyond the bedside. Like many burned-out physicians, I assumed that transitioning into a non-clinical role would be difficult, but not absurdly so.

I was wrong. Over several years, I applied to what felt like thousands of positions in pharmaceutical companies, utilization management, medical writing, content creation, consulting, and informatics, roles that routinely listed “clinical expertise preferred” or “physician background valued.” What I encountered instead was fierce gatekeeping and a level of dismissal that was both surprising and demoralizing. Rejections came quickly, if they came at all. Interviews often ended with vague references to “fit” or “lack of business experience.” Many applications disappeared into silence.

What was harder to ignore was how selectively these barriers seemed to apply.

Time and again, I discovered that people thriving in these same non-clinical roles had never completed residency, had left training early, or had no formal medical education at all. Some were earning six- or seven-figure incomes. Meanwhile, fully trained physicians were being told they were unqualified or needed additional certifications just to be considered. At some point, the question became unavoidable: When did completing medical training become a disadvantage?

The physician “escape industry”

As the rejections accumulated, I was introduced to what has quietly become a thriving market: the physician non-clinical transition industry.

This ecosystem includes paid coaching programs, expensive courses, exclusive boards, and memberships promising to “unlock” non-clinical careers. These offerings are marketed almost exclusively to burned-out physicians, often with testimonials, income claims, and carefully curated success stories. Fees commonly range from several thousand dollars to well into five figures.

In my own case, one such non-clinical career course ultimately revealed itself to be something else entirely: a program teaching physicians how to sell non-clinical career courses to other physicians.

At that point, the pattern was hard to miss. Physicians (already exhausted and disillusioned) are often asked to pay for permission to leave a system that has extracted years of underpaid labor. The irony is difficult to ignore. Many legitimate non-clinical roles do not require paid coaching, proprietary certifications, or membership in exclusive boards. Yet physicians are repeatedly told they must “rebrand” themselves, while others enter these spaces with far fewer credentials and little resistance.

Gatekeeping without transparency

Non-clinical medicine is frequently described as a meritocracy driven by transferable skills. In practice, access often depends on informal networks, nepotism, and proximity to power rather than demonstrated expertise. For physicians from underrepresented backgrounds, these barriers can be compounded by bias. Research has consistently shown racial and ethnic disparities in hiring, promotion, and leadership across medicine and the life sciences industry. These inequities do not disappear when physicians leave clinical practice; they often become less visible and harder to challenge.

What makes this particularly frustrating is the lack of transparency. Physicians are told they lack business acumen, communication skills, or industry knowledge, often by individuals whose primary qualification is having exited clinical medicine earlier. The criteria shift constantly, and the bar is raised selectively.

Meanwhile, the market tells a different story. Pharmaceutical companies, health care startups, and consulting firms regularly emphasize the importance of credibility, domain expertise, and regulatory literacy, skills physicians already possess. Yet practicing physicians are frequently treated as if their training counts only as a liability.

An inversion of value

There is something deeply unsettling about a system in which physicians who complete residency are told they need permission (and payment) to leave, while those who never practiced clinically often face no such scrutiny. This is not an argument against non-physicians succeeding in health-adjacent industries, nor is it an indictment of physicians who leave training early. People find viable paths where they can.

But it is worth examining why those who endure the most demanding training pipeline are often required to justify their worth most aggressively afterward. Physician burnout and moral injury are well documented. Less discussed is how this vulnerability has created fertile ground for industries that profit from selling escape routes, sometimes without delivering meaningful access or outcomes.

A more honest conversation

Non-clinical careers for physicians are real. Physicians work successfully in utilization management, pharmaceuticals, policy, informatics, writing, and leadership roles every day. But the path into these roles is far less commodified than the transition industry suggests. Most physicians who successfully move into non-clinical work do so through networking, mentorship, lateral moves, and persistence, not expensive courses or paid boards. They talk to people already doing the work. They learn on the job. They translate existing skills rather than purchasing new identities.

Physicians deserve transparency, not exploitation. They deserve honest conversations about what non-clinical work actually entails, what barriers truly exist, and which ones are artificially maintained.

Burnout does not mean gullibility. Wanting out does not mean a physician should have to pay yet another toll.

Carlos N. Hernandez-Torres is a family medicine and addiction medicine physician.

The 30-Minute Phone Cleanup That Recovers 75 GB and Makes Everything Faster

By Kim Komado

Storage Almost Full. If you've seen that warning, you're not alone.

Nearly half of all phone users hit that wall every single year. And one in 10? They see it every day. Before you delete your favorite memories or hand Apple or Google another $3 a month, hear me out.

Your phone is stuffed with junk you never asked for. I showed my friend Mark, who freed up 47 GB in 28 minutes. It only cost him one glass of wine.

Now, let me walk you through five steps to take back your space.

📸 Delete duplicate photos (10-20 GB)

Your phone saves multiple copies of every photo you edit. Burst mode photos stack up. Screenshots linger.

iPhone: Open **Photos** > **Collections** > scroll down to **Utilities** and tap **Duplicates**. Your phone already found them for you. Tap **Merge**, then **Merge items**. Most people find thousands of duplicates hiding in there. That's 10-20 GB back, easy.

Android: Use **Files by Google**. Tap the **Menu** (three lines) > **Clean** > **Duplicate files**. Select what you want to delete, then **Move to Trash**. Done.

🗑️ Clear app caches (5-15 GB)

Apps store temporary files that clog your phone. Facebook, Instagram, TikTok can each free 500 MB to 3 GB.

iPhone: Delete and reinstall apps you use daily. Your login stays saved, cache is gone.

Android: Go to **Settings** > **Apps** > [App name] > **Storage** > **Clear cache**.

💬 Delete old messages (3-10 GB)

Your text messages store years of photos and videos.

iPhone: Settings > **Apps** > **Messages** > **Keep Messages** > Change to **1 Year**.
Also: **Settings** > **General** > **iPhone Storage** > **Messages** > **Review Large Attachments**. Delete old videos.

Android: Google Messages doesn't have an auto-delete setting. But if your phone uses the Samsung Messages app, tap the three dots for **Settings** > **More settings** > toggle on **Delete old messages**.

📂 **Clear downloads (5-10 GB)**

iPhone: Files app > **Browse** > **Downloads** folder. Delete everything you don't need.
Then **Settings** > **Apps** > **Safari** > scroll down to **Clear History and Website Data**.

Android: Open **Files by Google** > **Menu** (three lines) > **Clean** > **Select files**. Delete old PDFs and videos.

🧩 **Offload unused apps (10-20 GB)**

iPhone: Settings > **Apps** > **App Store** > toggle on **Offload Unused Apps**. Your phone auto-deletes apps you don't use but keeps the data.

Android: Settings > **Apps** > three dots or filter/sort icon > sort by **Last used**. Uninstall anything you haven't opened in months.

Total recovered: 30-75 GB in 30 minutes. Your phone will feel brand new. Do this every three months, and you'll never run out of space.

Phew, that was a lot. But give yourself a pat on the back. You did it!

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Extensive Team Resources
Boutique Firm Attention

The Atlas Team of Wealth Enhancement are Fee-Only Financial Planners who specialize in the financial challenges that medical professionals encounter. What makes the Atlas Team unique (besides our level of education, which is among the highest in the profession) is our investment approach based on academic research that aims to create efficient portfolios with less risk, for a given level of return. Each advisor on the Atlas Team is a Certified Financial Planner professional, and they maintain advanced financial degrees and certifications. The MD Life team has decided to ask the Atlas Team some candid questions about their process and how they can benefit from hiring a professional wealth manager.

Q1: How is your investment philosophy different than other firms?

Atlas Team: We find that many advisory firms may employ a simple and traditional 60/40 asset allocation (60% large cap stocks, 40% bonds) approach to investments. They seem to ignore the last 60 years of research and mathematical advancements made in creating well diversified portfolio models. Their approach is archaic, in the 1950's mathematics and science were employed by Dr. Harry Markowitz (PhD, mathematics) to develop a theory based on statistics to devise (efficient) portfolios; those that had the least risk for a given level of return. Dr. Markowitz was awarded the Noble Prize in 1990 for his approach known as Modern Portfolio Theory (which founded the concept of diversification by combining uncorrelated assets in a mathematically determined approach to enhance risk adjusted returns). Over the last 30-40 years advancements have been made in mathematics behind the theory, we adopted those advancements; one of the partners here has a uniquely strong background in mathematics. In fact, we have proprietary software used to create our clients' model allocations. When you apply an advanced mathematical version of Dr. Markowitz's work and look at the

evidence-based data, portfolios that are optimized properly are less volatile meaning they are less sensitive to market declines, enabling them to recover more quickly and compound faster - ending in higher terminal wealth.

This raises an interesting question; how come it seems most advisors do not create allocations based on the latest advancements in this area?

Q2: What value can I expect from working with a medical doctor focused financial planner?

Atlas Team: The value we can provide for our clients can often be many multiples higher than the fee that we charge.

For example, we had one couple who recently decided to engage our services. This couple had a 14-year age gap and the husband just retired from the university hospital, and because he delayed his retirement past age 73, he had to start taking out his required minimum distributions from his 401(a) and 403(b) plans.

The Insurance company that acts as custodian and administers his retirement plan calculated his required minimum distributions ("RMDs"). After reviewing their recommendation, we determined that they used the least favorable calculation option which resulted in an annual required minimum distribution of close to $150,000 a year. The couple did not need this much income since they had many other sources of recurring ordinary income, so much of the withdrawal (after tax) would have ended up in their taxable account to be reinvested. This outsized withdrawal taxed as ordinary income may also have forced them into the highest marginal tax bracket (37%). The insurance company seemingly ignored the age gap between the spouses and the more favorable distribution calculation allowed under IRS rules. Using that rule their withdrawal required under the law was much lower which resulted in over $7,000 of annual federal and state tax savings. This more than covered our fee.

Q3: What is your process for creating a robust retirement plan?

Every medical professional's retirement should start with a complete financial analysis of their current circumstance and your life goals. We find that many people use free online retirement calculators available on many web sites. These use very simple assumptions; thus, they can be very inaccurate. Scenarios that include lumpy expenses such as car purchases, college expenses and wedding gifts for children are difficult to include in the assumptions. They also may only use straight line assumptions for investment return instead of a more robust statistical analysis with thousands of trials.

Our approach is extremely detailed and nuanced. We spend much time identifying your goals (more on that later) and helping you assemble a detailed picture of your current circumstance. We run through multiple detailed scenarios; we stress test the analysis to properly model bear markets etc. We incorporate detailed tax projections since taxes can have a dramatic impact on your plans. None of that can be properly modeled with the simple calculators.

Incorporating a robust modeling process that includes thousands of statistical trials provides much more insight into your ability to meet your future goals for retirement and other goals with more certainty. Planning for the certainty of uncertainty is an important part of the process. We help answer such concerns as what happens if I am disabled, what happens to my family if I die prematurely etc. We also consider risks to your plans including liability from a lawsuit.

This analysis should be considered an ongoing event not a one-time exercise, tax laws change, the economy changes, jobs and careers change etc. Revising and revisiting this work on a frequent basis makes it more robust and increases the odds you can have the lifestyle you desire

Q4: How do you align my values with my goals?

We are advocates of the values card exercise. In that exercise you start out with a playing card type set of 50 or so cards and over the space of a few minutes or even half an hour you whittle those cards down to your top 5 values. Then we help translate those values into your desired goals and then actions that will help you meet those goals using something called the alignment model. This exercise is extremely useful:

1. It clarifies what truly matters (and what doesn't).

Most people say they value *family, health, security, success*… but when they sort cards and must choose top 5, it forces real prioritization.
This quickly reveals:

- Core motivations
- Hidden conflicts (e.g., "freedom" vs. "stability")
- Values they *think* they hold vs. what shows up in choices

This clarity is extremely helpful in both life decisions and money decisions.

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2. It improves decision-making

Once someone knows their top values, questions like:

- *"Should I buy this?"*
- *"Should I retire now?"*
- *"Should I change jobs?"*
- *"Should we spend more on travel or save more?"*

…become much easier.

A decision aligned with values feels right and usually leads to better follow-through.

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3. It reduces stress and conflict — especially between spouses or partners

For couples, comparing values often uncovers:

- Why they save/spend differently
- Why certain choices cause tension
- What goals feel "urgent" to one person and not the other

It also improves communication because they can talk about values, not just money.

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4. From our view It strengthens the financial planning process

It Encourages Values-based planning:

- boosts client engagement
- increases trust and emotional connection
- guides goal setting
- makes tradeoffs easier to explain
- increases commitment to long-term plans

When clients see their plan as an extension of their values, they stick to it.

5. It uncovers goals perhaps you could not clearly articulate before

People often reveal things like:

- “I want more flexibility at work.”
- “I want to help my parents more.”
- “I want to feel less stressed.”
- “I want adventure in retirement.”

Many of these never come up in a standard fact-finding meeting.

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6. It's simple, engaging, and fast

A values card sort usually takes 10–15 minutes but often leads to 30–60 minutes of deeper conversation.
It works for:

- Individuals
- Couples
- Families
- Retirement planning
- Career transitions
- Financial independence planning

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7. It improves behavioral outcomes

Clients who understand *why* they're doing something are much more likely to:

- stay invested
- follow cash-flow strategies
- save more
- reduce impulsive decisions
- remain calm during volatility

Values = emotional anchors.

If you would like to see more of our valuable insights and educational videos, please scan the first QR code below to visit our YouTube channel, "It's Your Smarter Money." Please email scraffen@wealthenhancement.com if you would like to attend our upcoming webinar, **"Advanced Financial Planning for Medical Doctors: Atlas Team Philosophy and Office Hours." on February 18th (Wednesday) at 12 noon-12:30PM.**

About the authors:

Greg Giardino, CFP®, CPWA®, is a Fee-Only Fiduciary Certified Financial Planner, and Certified Private Wealth Advisor Consultant. Greg specializes in counseling high-net-worth MDs and academics. Greg's accolades include being named InvestmentNews' Rising Stars | Best Wealth Managers and Advisors under 40 in the USA for 2025 and on NJBIZ's 2025 40 under 40 list. You can reach him at ggiardino@wealthenhancement.com.

Greg Giardino was named among Investment News Rising Stars "Best Wealth Managers and Advisors Under 40 in the USA', announced October 2025 for the time period October 2025-October 2026. Greg Giardino was named among NJBIZ's 2025 "Forty Under 40" honorees, announced September 16, 2025 for the time period October 2024 – September 2025.

Stephen C. Craffen, BE, MBA, MS, CFA, CFP®, ChFC, CLU, BFA, is a Fee-Only Fiduciary Certified Financial Planner, and former Chair of the National Board (2018-2019) of the National Association of Fee-Only Advisors (NAPFA). He was named Thought Leader of the Year for 2024 by ThinkAdvisor. Steve specializes in working with high-net worth professionals. You can reach him at scraffen@wealthenhancement.com.

Stephen Craffen was named among ThinkAdvisor's 'Though Lead of the Year for 2025" announced December 12, 2024 for the time period January 2024 through December 2024.

2025-8263

Baked Sausage and Peppers

Thefoodiephysician.com

Juicy turkey sausage, sweet bell peppers, and onions roasted to perfection – this Baked Sausage and Peppers dish is comfort food made easy. It's simple, flavorful, and perfect for busy weeknights or game-day spreads!

Prep Time 15minutes mins

Cook Time 30minutes mins

Total Time 45minutes mins

Course: Main Course

Cuisine: American, Italian

Servings: 5

Calories: 257kcal

Author: Dr. Sonali Ruder

Equipment

- Sheet pan

Ingredients

- 3 bell peppers- red, yellow or orange, sliced
- 1 large yellow or red onion, sliced
- 2 tablespoons olive oil
- 2 teaspoons red wine vinegar
- 3 cloves garlic, minced
- ½ teaspoon dried oregano
- ½ teaspoon dried basil
- ½ teaspoon kosher salt

- ¼ teaspoon black pepper
- ¼ teaspoon red pepper flakes (optional)
- 20 oz spicy or sweet turkey sausage (5 links)

Instructions

1. Preheat oven to 425°F

2. Place the sliced bell peppers and onions on a large sheet pan. Drizzle with olive oil and vinegar. Sprinkle the garlic, oregano, basil, salt, pepper, and red pepper flakes on top. Toss to combine well.

3. Spread the veggies out in a single layer on the pan and nestle the sausages between them. You can use two sheet pans if needed. You don't want to the vegetables to be too crowded.

4. Bake in the oven for 15 minutes. Then, toss the vegetables and flip the sausages. Return the pan to the oven and cook another 15-20 minutes until the vegetables are tender and caramelized and sausages are cooked through to an internal temperature of 165°F as measured by a meat thermometer. Serve.

Notes

- Spread the veggies out in a single layer so they caramelize instead of getting steamed. It's okay if it takes more than one sheet pan.
- Keep a close watch on the vegetables. If they are browning too much, you can turn the heat down a little. I also recommend stirring the vegetables when you flip the sausages so they don't stick to the pan.
- Make sure the sausage cooks evenly on both sides by flipping them halfway through cooking. Use a meat thermometer to be sure that it is cooked to an internal temperature of 165°F.

Here are some ideas on how to serve this dish:

- **On a Bun:** Make a sub by filling hot dog buns or hoagie rolls with the sausage and peppers. You can top it with some shaved parmesan cheese, and warm in the oven before serving.
- **With Pasta:** Pair your favorite pasta and marinara sauce with baked sausage and peppers for a crowd-pleasing dinner.
- **With Rice or Potatoes:** Serve with cooked rice or mashed potatoes. You can go with cauliflower rice for a low-carb option

Nutrition

Serving: 1 sausage + veggies | Calories: 257kcal | Carbohydrates: 8g | Protein: 22g | Fat: 15g | Saturated Fat: 3g | Polyunsaturated Fat: 3g | Monounsaturated Fat: 7g | Trans Fat: 0.4g | Cholesterol: 85mg | Sodium: 911mg | Potassium: 496mg | Fiber: 2g | Sugar: 4g | Vitamin A: 2356IU | Vitamin C: 96mg | Calcium: 41mg | Iron: 2mg

U.S. Opioid Policy History: How Politics Replaced Science in Pain Care

Richard A. Lawhern, PhD & Stephen E. Nadeau, MD

Based on our combined experience of over 70 years in patient advocacy, pain management, and behavioral neurology, we are convinced that U.S. public perception and public policy on treatment of pain have been driven almost entirely by sociopolitical and legal factors. Seldom in recent years has policy been significantly influenced by science.

The U.S. enjoyed a brief period of scientifically enlightened policy in the late 1990s through 2008. A large number of patients almost certainly benefited from more available pain treatment employing opioid analgesics. However, tragically, patients treated with opioids were soon to become "legacy patients," prime targets for involuntary opioid tapering. University medical centers might have provided a scientifically based countervailing force to the various nonscientific influences through much more extensive education of students and residents on pain management. By and large, they failed to do so.

Beginning around the year 2000, corrupt physicians collaborated with corrupt pharmacists to create pill mills. A 5-minute visit with a "clinician" could net someone a prescription for 1,000 pharmaceutical grade oxycodone 30 mg tabs, which could then be promptly filled. National drug distributors such as McKesson, AmerisourceBergen, and Cardinal Health, strongly supported the pill mills. Pharmaceutical companies, most notably Mallinckrodt, provided volume discounts to the distributors. A tsunami of opioids flooded the country and vulnerable populations evolved to become the heart of the modern phase of the opioid crisis.

The decade from 2000 to 2010 was thus dominated by business corruption.

In response, the DEA began prosecuting pill mills. However, the reason for DEA actions was not transparent; many (eventually most) pharmacists became fearful that dispensing opioids in any quantity would put them at risk. Thus from 2008 to the present, a "pharmacy shuffle" emerged: Patients who had an opioid prescription issued by a clinician (even one with excellent credentials) could not find a pharmacist who would fill it.

This can be called the "panic phase" of the American opioid crisis. Well-intended pharmacists revealed that, after all, they are human beings, afraid for their own livelihoods.

Pill mills were shut down by the states between 2010 and 2012, mainly by strengthening Prescription Drug Monitoring Programs (PDMPs) and making PDMPs universal and ultimately highly interlinked between states. Closing of the pill mills should have ended debate about public policy bearing on opioid treatment of pain. The big problem had been solved.

The rise of illicit opioids and political influence

However, two other dynamics were percolating.

The first dynamic was driven by the entrance (around 2007) of Mexican drug cartels selling high purity, cheap heroin to addicts who suddenly had been denied an opioid supply or couldn't afford the rising costs of pharmaceutical grade opioids. Several years later, Mexican cartels were joined by Chinese entrepreneurs selling illicit fentanyl. These two sources of opioids continue to dominate the illicit drug market.

The second dynamic was driven by a group of anti-opioid zealots led by Andrew Kolodny: "Physicians for Responsible Opioid Prescribing (PROP)." Dr. Kolodny proved to be a very skillful schmoozer. He leveraged his friendship with Tom Friedan, then Director of CDC, to arrange for major PROP representation on the advisory board supervising the development of 2016 CDC opioid guidelines. The result was a guideline that was based purely on belief and devoid of science, and one that ignored even the CDC's own data.

This can be seen as the launch of "the political phase" in clinical management of pain. The enormous gravitas of the CDC (ill-deserved since the firing of its last independent director, David Sencer, in 1977) provided the basis for capturing the VA, the FDA, the DEA, pharmacists, health insurance companies, and state governments in a form of anti-opioid hysteria.

This is the mature political phase of our opioid crisis. U.S. public health policies on pain management are now dominated by it.

Well before 2016 CDC guidelines on pain management were published, health care providers became aware of the guidelines; their attorneys quickly perceived a potential new source of liability. If a patient died of anything and happened to be taking opioids and opioid dosage was not compliant with the CDC guideline, the family could potentially sue for wrongful death. So began the legal phase of the pain treatment crisis. This is where the rubber really meets the road. A health care provider can rescind a clinician's clinical privileges in a heartbeat.

Buprenorphine and the science gap

The rise of buprenorphine (usually prescribed as buprenorphine 8 mg/naloxone 2 mg (Suboxone) up to 3x daily) represents only the latest non-scientific wrinkle in the ongoing crisis. It appears that "Bupe" has become a favorite with clinicians because it is viewed as a safe harbor. They can treat pain but are highly unlikely to have their clinical privileges threatened or to incur DEA scrutiny.

One could call this "the sociological sub-phase."

But what about the science? There is robust science supporting the use of buprenorphine (and methadone) as an adjunct in the rehabilitation of addiction. However, the science bearing upon efficacy for treating chronic pain, safety, and most importantly, dosing, is far less robust. Higher doses have been tested, mainly in European studies. They provide some evidence that higher doses may be more effective in pain control, but are also more fraught with side effects. We have long known from studies of other opioids that due to genetic factors, there is enormous inter-individual variability in side effects caused by any given opioid.

The overwhelming likelihood is that buprenorphine has more similarities to other opioids than differences. Doses required to control pain vary enormously. Some patients will achieve adequate pain control when provided the standard Suboxone regimen. Clinicians see plenty of others who tell us that the drug "takes the edge off" or that "it is better than nothing."

We have long known that opioid dosage required to achieve pain control may vary by a factor of as much as 15. A substantial quantity of this variability can be accounted for by genetically mediated differences in enzymes of the hepatic P450 system. There is also strong reason to suspect that there are substantial inter-individual differences in central nervous system signal transduction when an opioid binds to a receptor.

It is also clear that suffering, which represents a pattern of neural activity in the orbitofrontal-limbic system of the brain, is the major factor that drives patient experience of pain and patient perception of pain control. There may be a substantial disconnect between pain signal and suffering. There is little published science that bears upon this.

As an opioid, buprenorphine has pharmacodynamic effects: Patients experience withdrawal symptoms if the drug is tapered too precipitously. Clinicians have been taught about pharmacodynamics during medical school as far back as the 1970s. Unfortunately, many clinicians (most notably the authors of DSM-5), display confusion about the difference between pharmacodynamics effects and addiction, often conflating the two. The mechanisms underlying the two phenomena are vastly different.

Thus, it seems fair to conclude that current buprenorphine practice, like opioid prescribing over the past 25 years, is not driven by science. Inadequate clinician training, corrupt business, fear, zealotry, political chicanery, health provider concern over legal liability, political institutional dynamics, and clinician and pharmacist sociology, coupled with the psychosocial/economic factors that drive people to addiction to illicit opioids, define current public health opioid policy. But science? Sorry but no.

Richard A. Lawhern is a nationally recognized health care educator and patient advocate who has spent nearly three decades researching pain management and addiction policy. His extensive body of work, including over 300 published papers and interviews, reflects a deep critique of U.S. health care agencies and their approaches to chronic pain treatment. Now retired from formal academic and hospital affiliations, Richard continues to engage with professional and public audiences through platforms such as LinkedIn, Facebook, and his contributions to KevinMD. His advocacy extends to online communities like Protect People in Pain, where he works to elevate the voices of patients navigating restrictive opioid policies. Among his many publications is a guideline on opioid use for chronic non-cancer pain, reflecting his commitment to evidence-based reform in pain medicine.

Stephen E. Nadeau is a behavioral neurologist.

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The Letter

A man was passing by his teenage son's bedroom and was astonished to see the bed was nicely made and everything was picked up.

Then he noticed an envelope propped up prominently on the pillow, addressed to, 'Dad'.

With the worst premonition he opened the envelope and read the letter.

"Dear Dad , It is with great regret and sorrow that I'm writing you. I had to elope with my new girlfriend because I wanted to avoid a scene with Mom and you. I've been finding real passion with Stacy. She is so nice, but I knew you wouldn't approve of her because of her piercings and tattoos, her tight motorcycle clothes and because she's much older than I am.

But it's not only the passion, Dad. She's pregnant. Stacy said we'll be very happy. She owns a trailer in the woods and has a stack of firewood for the whole winter. We share a dream of having many more children. Stacy opened my eyes to the fact that marijuana doesn't really hurt anyone. We'll be growing it for ourselves and trading it with the other people in the commune for all the cocaine and ecstasy we want.

Don't worry Dad, I'm almost 18 and I know how to take care of myself. Someday, I'm sure we'll be back to visit so you can get to know your grandchildren.

Love, your son, Joshua.

P.S. Dad, none of the above is true. I'm over at Jason's house. I just wanted to remind you that there are worse things in life than the report card that's on the kitchen table. Call when it's safe for me to come home."

Medicine Changed Me by Subtraction: A Physician's Evolution

Justin Sterett, MD

I used to think medicine would change me by adding things. Knowledge. Confidence. Authority. Certainty. I assumed growth would look like accumulation, more skills, more answers, more control. What actually happened was the opposite. Medicine changed me by subtraction.

When I started writing as a medical student, everything felt sharp and exposed. The hospital was loud, inefficient, and often cruel in ways no one named out loud. I wrote about scut work, hierarchy, exhaustion, and the quiet violence of bureaucracy because those were the things that felt most real. I was idealistic, but already skeptical. I still believed competence mattered, that suffering deserved dignity, and that good intentions could survive bad systems if you were just honest enough. I also believed that if you worked hard and cared deeply, the system would eventually meet you halfway. That belief did not survive intact.

Adaptation and detachment

Over time, I learned that medicine rewards endurance more than insight. It tolerates moral clarity only if it stays polite and quiet. I watched good people become smaller versions of themselves in order to function. We enter medical school believing the patient's story matters. We leave training being taught to interrupt them after 11 seconds of talking. No one frames this as teaching you to stop listening. But that is what it is. I learned, like many do, how emotional detachment can masquerade as professionalism. At first, that detachment felt like a loss. Later, I understood it as an adaptation. You cannot absorb everything and survive. But you also cannot turn off everything without losing something essential.

What changed most was not how I practiced medicine, but how I understood my role within it. I stopped believing that being a good doctor meant being endlessly available, endlessly agreeable, or endlessly resilient. I stopped confusing self-sacrifice with virtue. I became less interested in being seen as caring and more interested in whether care actually happened. That shift was uncomfortable. It stripped away a lot of external validation. It also made me more honest.

The clarity of constraints

Working in correctional medicine, military medicine, and low resource environments accelerated this evolution. These are places where systems are bare, incentives are obvious, and outcomes are hard to spin. I have examined wrist nerve injuries from days in four-point restraints (inmates in physical revolt against solitary confinement) then returned to my note to adjust their antidepressants. You see quickly what matters and what does not. You learn that documentation does not equal care, that protocols do not equal judgment, and an algorithm optimizes for whatever its designers told it to value.

You also learn that dignity is not a feeling. It is something you actively protect, especially when no one is watching. Protecting it sometimes means quiet institutional disloyalty: explaining a grievance process to someone living in 110-degree heat, naming years-long delay in care as neglect, refusing to order meds for a death sentence, saying out loud what the chart won't. The system does not reward this.

I no longer write from the posture of outrage. Not because the problems have softened, but because outrage burns hot and brief. What replaced it is something quieter and heavier: Responsibility. I care less about exposing broken systems and more about building or shaping things that reduce harm, even imperfectly. I am more cautious with certainty. More comfortable with limits. More willing to say no.

If there is humility in this evolution, it comes from recognizing how little control any individual truly has, and how much influence still exists within constraints. If there is insight, it is this: Medicine is not redeemed by idealism alone, nor destroyed by cynicism. It is shaped, slowly and unevenly, by people who decide what they will and will not participate in.

I am no longer looking for medicine to define my purpose. I am trying to be useful within it without being consumed by it. That may not be the arc I imagined early on, but it is the one that feels honest now. And honesty, it turns out, is harder to maintain than hope.

Justin Sterett is a correctional physician and a flight surgeon.

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Brain Food for February 2026

By Shane Parrish

Tiny Thoughts

Your greatest competition is yourself.

**

You can't outperform your attitude.

What you believe about the work shows up in how you do the work, and how you do the work determines your results.

Fix the attitude first. Everything else follows.

***

The more ambitious you are, the easier it is to fall into this trap. You hand someone a project and think, "I would have stayed late every night for this." When they leave at 5, you feel betrayed.

But here's the thing: you are unusual. Most people aren't like you. That's not a flaw in them. It's what makes you different.

Once you stop expecting others to be you, the frustration disappears.

****

What looks like success is often just patience.

**

Mastery is the revenge of the patient on the privileged.

***

Most people self-sabotage with self-defeating attitudes and behaviors long before anyone stops them.

Insights

The Dalai Lama on being honest:

"If you are honest, truthful, and transparent, people trust you. If people trust you, you have no grounds for fear, suspicion, or jealousy."

**

Steve Jobs on living:

"Your time is limited, so don't waste it living someone else's life... have the courage to follow your heart and intuition... Remembering that I'll be dead soon is the most important tool I've ever encountered to help me make the big choices in life."

***

Michelle McMahon on standing up for yourself:

"If you're in a situation of conflict ... you can't hold yourself responsible for their feelings. Regardless of how they handle the situation, you need to speak your truth. You need to do it in a respectful way, and then walk away knowing that you stood up for yourself."

French aviator Antoine de Saint-Exupéry on engineering excellence:

"A designer knows he has achieved perfection not when there is nothing left to add, but when there is nothing left to take away."

**

Bruce Lee on focusing on the outcome:

"The great mistake is to anticipate the outcome of the engagement; you ought not to be thinking of whether it ends in victory or in defeat."

***

Performance Coach Greg Harden on what it means to be assertive:

"Being assertive means being able to have your needs met while still interacting with great sensitivity to those around you.

+ It means valuing yourself—valuing your own life, your own goals, your own precious time here on this earth—while at the same time valuing others.
+ It means recognizing that you have a God-given right to pursue happiness and every other good and worthy thing in life. And that you don't have to put anyone else down to lift yourself up.
+ It means standing up for what you believe in and expressing your own feelings and opinions in a direct and appropriate way.
+ It means taking responsibility for your actions, recognizing your achievements, owning your mistakes.
+ It means knowing that for you to win doesn't have to mean that someone else must lose. It means always being honest, within respectful bounds.
+ It means protecting yourself and not allowing others to violate your rights or infringe on your happiness or peace of mind.
+ It means being less concerned about what others think of you and more concerned with who you aspire to be. Being assertive is all about giving yourself the four A's ... Self-attention, self-affection, self-approval, and self-acceptance. In other words, self-love."

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AI In Medicine: Why It Won’t Replace Doctors but Will Redefine Them

Tod Stillson, MD

I have spent my career practicing medicine in the real world: caring for patients, managing uncertainty, and making decisions where the stakes are personal and immediate. In recent years, I have also spent considerable time designing and deploying medical software that uses artificial intelligence in live clinical environments. Together, these experiences have reshaped how I think about the future of our profession.

That combination of experiences has led me to a firm conclusion: Artificial intelligence will not replace doctors, but it will redefine us.

The conversation around AI in medicine is often framed in extremes. Either AI is portrayed as an existential threat to the profession, or it is hailed as a technological savior that will finally fix everything medicine has failed to solve. Both narratives miss the point. The real issue is not whether AI can replace physicians. The real issue is whether we are willing to confront the limits of how modern medicine is currently practiced, and whether we are prepared to redesign systems that have quietly depended on human endurance rather than sound engineering.

Medicine has outgrown human cognitive limits

Modern clinical practice asks physicians to do too much, too fast, with too little margin for error. We synthesize complex histories under time pressure. We document while thinking. We triage while multitasking. We practice inside fragmented systems with incomplete data, constant interruptions, and competing incentives. When errors occur, the response is often moral rather than structural. We are told to be more careful, more resilient, more vigilant. Rarely do we acknowledge the obvious truth: Many health care systems are built in ways that exceed human cognitive limits. Medical error remains a leading cause of serious harm. This is not because physicians are careless or inadequately trained. It is because we are being asked to perform tasks that are better handled, or at least supported, by well-designed systems.

AI happens to be exceptionally good at certain things humans struggle to do reliably at scale: consistent application of evidence-based protocols, structured history gathering without fatigue, pattern recognition across large datasets, and reduction of variability in repetitive, low-acuity decisions. Ignoring those capabilities does not protect medicine. It perpetuates preventable harm.

The false fear of replacement

Much of the anxiety surrounding AI stems from a fear of replacement. That fear is understandable. Physicians have watched their autonomy erode for decades as administrative burdens have grown and

clinical judgment has been second-guessed by nonclinical systems. Against that backdrop, skepticism toward new technology is not technophobia; it is self-preservation.

But replacement is the wrong frame.

AI does not assume moral responsibility. It does not build trust. It does not sit with uncertainty or bear witness to suffering. These are not secondary features of medicine. They are foundational. What AI can do is reduce the cognitive noise that interferes with those human functions. It can take on tasks that drain attention without adding meaning. It can create consistency where variability introduces risk. It can surface information in ways that support judgment rather than overwhelm it. The real danger is not that AI will replace physicians. The danger is that poorly designed AI will replace relationships, obscure accountability, and optimize care for efficiency instead of outcomes.

Medical error is a system failure, not a moral one

One of the most important lessons from working with AI in real clinical environments is this: Errors are rarely the result of individual negligence. They are the predictable outcome of system design. When aviation faced unacceptably high accident rates, the solution was not to tell pilots to try harder. It was to redesign cockpits, checklists, workflows, and feedback systems around known human limitations.

Health care has been slower to adopt this mindset. We still tolerate systems that rely on memory under stress, undocumented workarounds, and heroic multitasking. We accept error as tragic but inevitable.

AI offers an opportunity to change that. Not by removing humans from care, but by building systems that assume humans will err and are designed accordingly. Used responsibly, AI can standardize what should be standard, flag what should not be missed, and create space for clinicians to focus on what requires judgment rather than recall.

Burnout is a signal, not a personal failure

Physician burnout is often framed as an individual resilience problem. In reality, it is a system signal. Burnout reflects cognitive overload, moral distress, and loss of professional meaning. It tells us that the way we have structured modern medical work is incompatible with sustainable human performance. When clinicians worry that AI is being used to train their replacements, they are responding not just to technology, but to a long history of being treated as interchangeable labor rather than trusted professionals.

Any attempt to deploy AI in health care that ignores this context is destined to fail. AI adoption that respects physician expertise, preserves accountability, and reduces unnecessary burden can restore time, clarity, and professional satisfaction. AI adoption that prioritizes cost reduction over care will accelerate disengagement and mistrust.

Human accountability and machine precision

In every responsible medical AI system I have worked with, one principle remains non-negotiable:

AI can assist.
AI can structure.

AI can inform.
But AI does not practice medicine.

Clinical care should begin with structured, evidence-based data collection. It should apply protocols consistently. It should escalate risk intelligently. And it should end with a licensed physician making the final clinical decision and assuming responsibility for that decision. This is not about speed for its own sake. It is about precision, access, and accountability. When thoughtfully designed, asynchronous and technology-enabled care can expand access and reduce friction without sacrificing quality in appropriate clinical scenarios. The determining factor is not whether AI is present, but whether responsibility remains clear and human judgment remains central.

The choice before us

Artificial intelligence will continue to advance. That is not in question. The question is whether physicians will help shape how it is integrated into care, or whether we will allow others, often far removed from the bedside, to define it for us. If AI is deployed primarily to reduce costs without preserving accountability, patients will suffer. If it is used to replace clinicians rather than support them, trust will erode. But if it is designed transparently, governed responsibly, and led by physicians who understand both medicine and technology, it can make care safer, more humane, and more sustainable.

AI will not decide the future of medicine. We will.

And the real decision before us is not whether to embrace AI or resist it, but whether we are willing to build systems that honor the complexity of medicine while acknowledging the limits of being human.

Tod Stillson is a board-certified family physician, medical device inventor, and health care entrepreneur focused on redesigning how care is delivered in the digital age. He is the founder and CEO of ChatRx, a national asynchronous telemedicine company providing safe, efficient, direct-to-consumer care for common acute conditions. Through ChatRx, Dr. Stillson developed an FDA-listed software medical device that combines structured clinical pathways with AI-supported decision tools to preserve physician judgment while reducing friction for patients.

Dr. Stillson holds an academic affiliation with the Indiana University School of Medicine and a hospital affiliation with McPherson Center for Health. After nearly three decades practicing rural family medicine, he shifted from traditional employment to building physician-led digital systems that expand access, efficiency, and professional autonomy.

He is the author of Doctor Incorporated: Stop the Insanity of Traditional Employment and Preserve Your Professional Autonomy and has published more than 400 essays on physician entrepreneurship, micro-business, digital health, and the future of medical practice. He contributes nationally to conversations on AI-enabled care delivery and physician leadership in digital transformation.

Dr. Stillson shares ongoing insights on LinkedIn, Facebook, Instagram, and YouTube.

Totally Relaxing Wellness Retreats Around the World

Here's where to go for creekside massages, stress-management sessions, and so much more.

By Cassie Shortsleeve

Swimming pool with view of the ocean at 1 Hotel Hanalei Bay.Image: Management/Tripadvisor

If I've learned anything reporting about health for 15 years, it's that wellness lives inside spas and thoughtfully designed programs meant to ease your body and mind... but it lives many other places, too. Sometimes wellness is finding stillness in unexpected spots—the best massage of my life happened at the Ritz-Carlton, South Beach. I've even found wellness moments floating along a lazy river at the Four Seasons Resort Orlando, amidst the chaos of Disney, and during a cozy staycation at the 14-room Beacon Hill Hotel (no spa here).

To me, wellness is a mix of how a destination makes you feel and what it invites you to do (or *not* do). These seven destinations offer all of that (and more), in very different ways.

Sedona, Arizona

Best for: Outdoor adventure by day and night

Where to stay:

- **L'Auberge de Sedona:** The draws here are the resort's unfettered access to nature and its top-notch location (the property sits in Sedona's city center at the banks of Oak Creek Canyon). Wellness is built into the very fabric of the resort, which has a spa offering creekside massages, stargazing, and a "blending bar" where you can create your own essential oils and scrubs.
- **Mii Amo:** This serene retreat is set within one of Sedona's well-known energy vortexes. It also provides access to some of the area's most unique outdoor experiences, including full-moon hikes offered through the nearby Trail House at Enchantment Resort.

What to do beyond the resorts: You can't go to Sedona without hiking popular spots like Devil's Bridge, where you can walk to the iconic sandstone arch, or Cathedral Rock, which has panoramic views of the desert, buttes, and Oak Creek. Pink Jeep Tours will take you around the city or further on to the Grand Canyon. Book a table at Elote for award-winning Mexican (plus cocktails and mocktails).

Tuscany, Italy

Best for: Food- and wine-inspired wellness

Pasta at Terme di Saturnia, Tuscany.Image: Management/Tripadvisor

Where to stay:

- **Castel Monastero:** Located near Siena, this resort pairs medieval history with modern wellness (think: a massage and a candle-lit dinner after a day exploring wineries). The spa, which has a soaking saltwater pool, also offers day passes, and the property is home to the Michelin-starred Contrada.
- **Terme di Saturnia:** The highlights are the spa and golf retreat built around thermal hot springs, where mineral-rich waters flow through a series of pools known for their soothing and skin-

nourishing properties. Medical-wellness consultations and mud treatments are on the menu, or you can play 18 holes of golf overlooking the Maremma countryside.

What to do beyond the resorts: Relaxation comes in all forms here. Slow the pace even more with a winery tour through Chianti (you can also go by bike), learn how to make pasta and tiramisu at a popular Siena restaurant, or visit the thermal pools and waterfall at Saturnia.

The Berkshires, Massachusetts

Best for: Four seasons of wellness

Indoor fire pit at Miraval Berkshires, Massachusetts.Image: Management/Tripadvisor

Where to stay:

- **Miraval Berkshires Resort and Spa:** This all-inclusive wellness retreat in Lenox has hundreds of weekly classes—aerial yoga, meditation, culinary workshops, and more. You can also hike the nearby trails, relax in the spa's quiet rooms or indoor-outdoor pool, and join activities designed to support mindfulness and restoration (think: beekeeping and eco-printing with plants).
- **Canyon Ranch Lenox:** One of the most comprehensive wellness resorts in the U.S., Canyon Ranch's Massachusetts outpost pairs physician-led consultations with fitness classes, nutrition and cooking sessions, and spa therapies. Programming spans everything from sleep optimization to stress management, and it's all set within a historic estate surrounded by woods.

What to do beyond the resorts: Spend a morning hiking to the summit of Monument Mountain for sweeping views of the valley, then get on the water with a guided paddle with Berkshire Canoe Tours. Art lovers can explore the contemporary installations at MASS MoCA or visit the iconic Norman Rockwell Museum in Stockbridge. In summer, don't miss an outdoor concert at Tanglewood, the Boston Symphony Orchestra's beloved seasonal home.

Hawaii

Best for: Big waves and big-time relaxation

Where to stay:

- **1 Hotel Hanalei Bay, Kauai:** Located on the island's North Shore, the resort has near-perfect views of the bay and Kauai's lush mountains. Steeped in sustainability and conservation, experiences here include food and farm tours and reef-focused talks. Spa treatments incorporate locally sourced plants and ancient Hawaiian healing rituals. And if paddling the bay itself isn't enough, the spa has an ocean float room for deep relaxation.
- **Sensei Lanai, A Four Seasons Resort:** You'll get a more structured approach to wellness here, and the unbelievably quiet surroundings make it a private sanctuary for rest and recalibration. Join personalized programs that include one-on-one consultations, strength and mobility assessments, guided thermal experiences, and nourishing, veggie-forward meals by Nobu.
- **The Ritz-Carlton Oahu, Turtle Bay:** Not far from the Banzai Pipeline wave, this is a surfer's paradise. But don't expect it to be all adrenaline, all the time. The resort owns nearby Kuilima Farm, where many of the restaurants' ingredients are grown (and where you can join guided tours). At the oceanfront spa, book a treatment in an open-air bungalow or garden room, or join a full moon crystal yoga class by night.

What to do beyond the resorts: If you visit Kauai, explore the island's dramatic coastline on a Nā Pali Coast snorkel boat tour or hike part of the legendary Kalalau Trail for sweeping views of the coast. Head to Lanai for the Keahiakawelo (Garden of the Gods) rock formations or hike the quiet and rugged Sweetheart Rock. Those heading to Oahu: book a surf lesson, visit the cliffside Puʻu O Mahuka Heiau for panoramic views, or take a guided horseback ride through the famous landscapes of Kualoa Ranch.

Iceland

Best for: Cold-weather wellness

Where to stay:

- **Retreat at Blue Lagoon:** Built on a dramatic lava field, this stay features suites with private geothermal lagoons and a subterranean spa offering full-body silica wraps and in-water massages. There are also steam caves and cold- and hot-water therapy pools, all powered by geothermal energy.
- **Ion Adventure Hotel:** Perched near Mount Hengill and just a short drive from the UNESCO-listed Þingvellir National Park, Ion is all about getting as close to nature as possible—a dip in its geothermal pool is downright healing.
- **Hotel Ranga:** This is the perfect stay if you're chasing the sky in southern Iceland. Cozy rooms are a given, but the on-site observatory and hot tubs are the best viewing spot for the northern lights.

What to do beyond the resorts: Plan a soak (weather and geology permitting) in the iconic Blue Lagoon—since the property sits in a seismically active area, stay up to date with changes in openings. Snorkel Silfra, a glacier-fed rift between two continents, with hot chocolate waiting afterward, or explore even more hot springs. Secret Lagoon is Iceland's oldest, and Hvammsvik is surrounded by black sand beaches. And of course, set out with a small group to seek the aurora borealis if you're visiting during the winter months.

Bali, Indonesia

Best for: A traditional retreat

Where to stay:

- **COMO Shambhala Estate:** This is one of Bali's most iconic wellness retreats. You'll be paired with expert practitioners who design personalized programs around fitness, nutrition, Ayurvedic therapies, and stress reduction. Join morning yoga overlooking the Ayung River, stretch in a state-of-the-art pilates studio, or enjoy Indonesian cuisine at the estate's open-air restaurant.
- **Fivelements Retreat Bali:** A ritual-centered, plant-based retreat (the vegan eats are a highlight), you can expect healing ceremonies, water blessings, meditation sessions, and award-winning Balinese therapies.

What to do beyond the resorts: Round off your wellness trip in nature by visiting the nearby UNESCO World Heritage Site, Tegalalang Rice Terraces, on a bike tour of Ubud. Join a small-group sunrise trek up Mount Batur, wander Ubud's artisan markets, or take a Balinese cooking class with a morning at the market. For a coastal moment, book an evening at the Uluwatu Kecak Fire Dance at sunset.

Alps, Switzerland

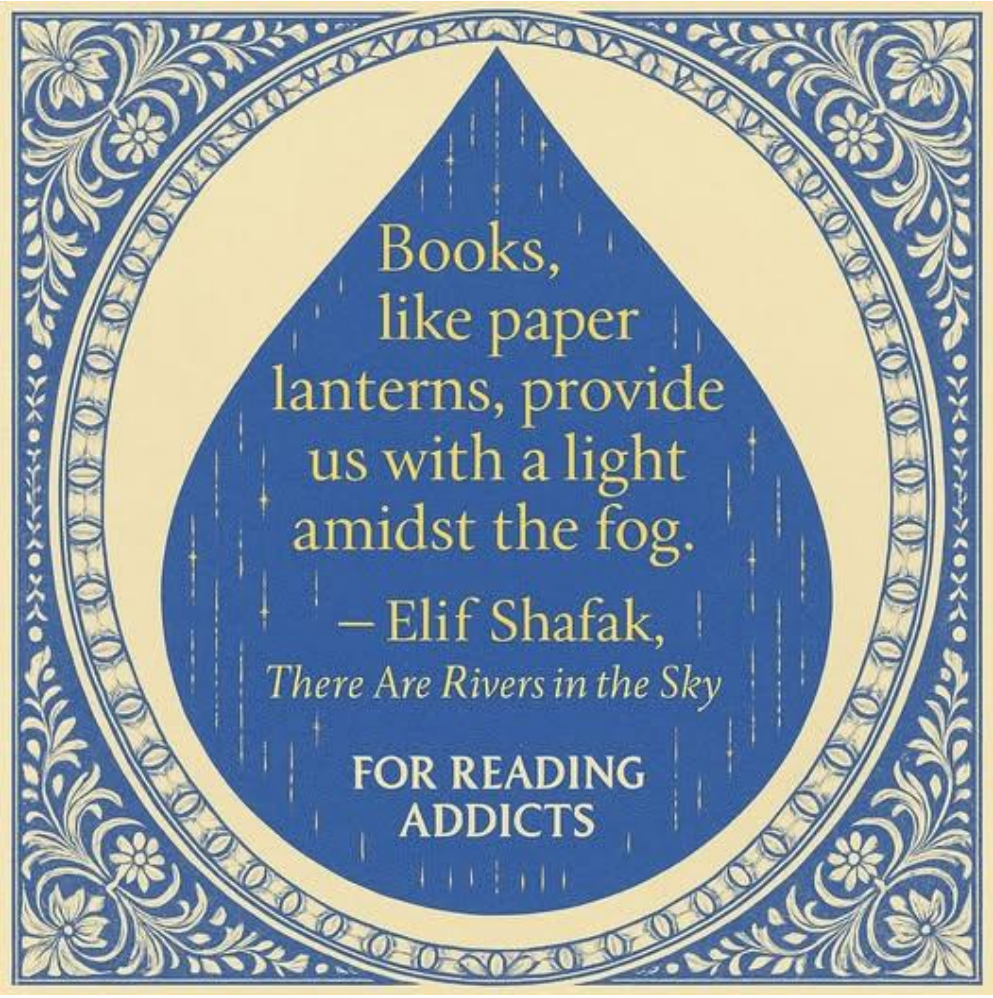
Best for: Mountainside medical wellness

Treatment room at Burgenstock Hotel and Alpine Spa.Image: Management/Tripadvisor

Where to stay:

- **Grand Resort Bad Ragaz:** Located at the base of the Eastern Alps, this property is built around the famed Tamina Gorge thermal spring, where quiet garden lounges and walking paths surround the grounds. A five-star resort, it's also home to one of the best healthcare facilities in Europe, offering sleep medicine, nutrition therapy, longevity-focused treatments, and more.
- **Bürgenstock Hotel & Alpine Spa:** There are three spas here, multiple pools, a salt grotto, relaxation rooms, and programming that includes "hydrothermal journeys." Light-filled treatment rooms overlook the forest and lake, and you can stretch your legs paths that wind along the surrounding cliffs.
- **Chenot Palace Weggis:** Across the lake from Bürgenstock in Weggis, this spot offers a science-backed wellness program with everything from energetic detoxes to cellular repair therapies that people travel from around the globe to take part in.

What to do beyond the resorts: Ascend into the mountains on the gondola or cogwheel railway to the summit of Mount Pilatus for sweeping ridge walks and alpine air, or book a guided alpine hike to get some movement in throughout. In Lucerne, explore the covered bridges, promenades, and markets of the Old Town or take in your surroundings by the water and enjoy a scenic boat cruise on the lake.



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Women In Health Care Leadership: Navigating Competition and Mentorship

Sarah White, APRN

In recent years, medicine has become more open about burnout, workforce shortages, and the challenges facing women in health care leadership. We write about mentorship programs, leadership pipelines, and the need to bring more women into ownership and executive roles. We celebrate women who build clinics, lead departments, and create space for others to rise.

What we talk about far less is what happens when women actually meet each other in positions of power.

I came into aesthetic medicine during a period when female ownership and leadership were being widely praised as signs of progress. I learned under a woman who had built something formidable, a business, a reputation, a presence in her community. I admired what she had created, and I believed, perhaps naively, that success among women in medicine was not a zero-sum game.

Life, as it often does, complicated that belief.

A family medical crisis forced me to rethink where and how I could work. The practical realities of caregiving, commuting, and sustaining a household made proximity and flexibility more than preferences; they became necessities. Like many clinicians, I began exploring how to continue practicing closer to home, in a way that would allow me to remain present both professionally and personally.

That is when I encountered the less-discussed side of professional “competition” in medicine.

Fairness in a care-based profession

Across health care, noncompete agreements and restrictive contracts are increasingly part of the conversation. National news outlets and professional blogs have covered debates about whether these clauses protect businesses or limit workforce mobility and free markets. Some states have moved to restrict them. Federal agencies have proposed rules to curb their use. The underlying question is not just legal; it is cultural: What does fairness look like in a profession built on care?

Healthy competition can drive innovation, higher standards, and better patient experiences. But not all competition is healthy.

There is a difference between protecting what you have built and preventing someone else from building at all.

What often gets lost in these discussions is who is most affected. Women in medicine still carry a disproportionate share of caregiving responsibilities, for children, partners, and aging family members. They are more likely to seek work that fits into complex lives rather than lives that fit neatly into rigid professional structures. When professional mobility is constrained, it is not just a career that feels smaller. A life does.

After opening my own practice, I had the experience of hiring a nurse who stayed briefly before deciding to pursue her own path. I understood the uncertainty of standing at that threshold, the mix of fear, ambition, and hope that comes with trying to build something new. I chose to support her, because I remembered what it felt like to need space rather than resistance.

That moment clarified something for me: Power is not just about what we are allowed to enforce. It is about what we choose to encourage.

Defining power through support

Much has been written, in professional forums, local business reporting, and national health policy discussions, about the "pipeline problem" for women in medicine. How do we get more women into leadership? How do we get more women to own practices, lead departments, and shape the future of care?

The harder, quieter question is what happens after they get there.

Solidarity is easy to praise in theory. It is much harder to practice when interests overlap, markets tighten, or success feels scarce.

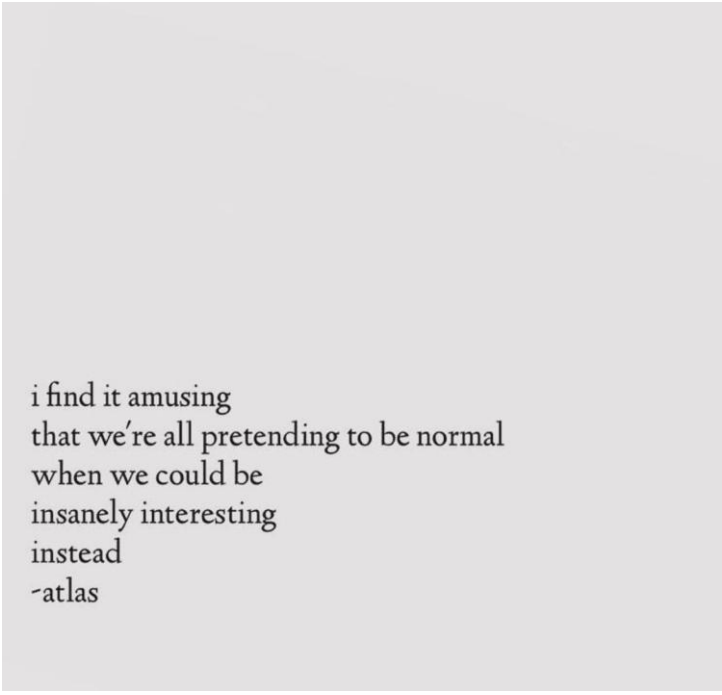
Non-competes, contracts, and legal frameworks will always have a place in business. But medicine is not only a business. It is a profession that asks for trust, empathy, and moral leadership, not just from clinicians toward patients, but from leaders toward each other.

We can make room for excellence without exclusion. We can believe in standards without building walls. We can protect what we have built without forgetting what it took to build it in the first place.

Medicine has always made room for ambition, innovation, and progress. It should also make room for generosity, especially among those who understand how steep the climb can be. The future of women in medicine will not be measured only by...

Sarah White is a nurse practitioner, small business owner, and premedical student based in Virginia. With a background in clinical practice and caregiving, she brings a unique perspective to the intersection of medicine, family life, and community service. She volunteers with the Medical Reserve Corps and is preparing to apply to medical school in 2026.

Sarah is also the founder of two growing ventures: Wrinkle Relaxer, where she specializes in aesthetic treatments, and Bardot Boutique Aesthetics, a space for curated beauty and wellness services.



The 2026 Grand Entrance: Why Oversized Pivot Doors are the Ultimate Architectural Power Move

First impressions in luxury real estate have always mattered, but in 2026, the conversation around entry doors has evolved into something approaching obsession among design-forward homeowners. The shift toward monumental entry doors that blur the line between functional necessity and sculptural statement represents more than aesthetic preference. It signals a fundamental reimagining of how architecture announces presence, establishes hierarchy, and commands attention before guests even cross the threshold. Think of traditional hinged doors as polite handshakes, pleasant enough but forgettable. Pivot doors, particularly those scaled to dramatic proportions, are the architectural equivalent of arriving by helicopter.

The pivot door revolution didn't emerge from nowhere. It represents the convergence of engineering advancements, material innovation, and a cultural moment where subtlety feels timid rather than sophisticated. Contemporary luxury demands boldness executed with precision, and oversized pivot entry systems deliver exactly this combination. Custom entry door design ideas that boost curb appeal have evolved beyond traditional parameters into territory where doors function as defining architectural elements. The broader context reveals windows and doors as design elements that transform houses into homes through their capacity to establish visual language and spatial experience simultaneously.

The Engineering Marvel Behind the Statement

Pivot doors operate on an entirely different mechanical principle than conventional hinged systems. Rather than mounting on side jambs, they rotate on a central or offset pivot point, allowing dramatically larger panels without the weight limitations that constrain traditional installations. This engineering breakthrough enables doors reaching 12, 14, even 16 feet in height while maintaining effortless operation.

The physics are elegant. Pivot systems distribute weight vertically through floor-mounted bearings rather than side-mounted hinges, eliminating the structural stress that makes oversized hinged doors prone to

sagging and operational failure. Premium pivot hardware now incorporates damping systems that control swing speed regardless of how forcefully someone pushes, preventing the awkward slam that would otherwise accompany such substantial mass.

Material Choices That Define Presence

Contemporary pivot doors showcase materials that would be structurally impossible in hinged configurations. Bronze panels aged to rich patina command attention while developing character over decades. Blackened steel frames surrounding expansive glass create minimalist drama that feels simultaneously industrial and refined. Solid wood slabs approaching four inches thick deliver gravitas that lighter constructions simply cannot match.

Glass selection alone represents an essay in luxury materials. Low-iron glass eliminates the green tint visible in standard glazing, providing clarity that makes transparency genuinely transparent. Fluted or ribbed glass obscures views while transmitting light in patterns that transform throughout the day. Integrated LED systems embedded between glass layers create illuminated entries that glow like architectural lanterns after dark.

The Spatial Experience of Grand Scale

Walking through a 12-foot pivot door fundamentally differs from entering through standard residential doors. The sheer volume of space moving as the panel rotates creates visceral impact that guests register subconsciously before forming conscious impressions. This somatic experience, the physical sensation of substantial architecture responding to human touch, establishes tone more effectively than any decorative detail.

The threshold transition becomes ceremony rather than mere passage. Traditional doors create distinct boundaries between exterior and interior. Oversized pivots, particularly those incorporating extensive glazing, establish permeability that makes the distinction less binary. Interiors begin extending outward through visual connection while exteriors project inward through scale relationships that redefine spatial expectations.

Integration With Contemporary Architecture

Pivot door installations demand architectural context that supports rather than overwhelms the statement. Double-height entry volumes provide the vertical space necessary for these systems to read coherently. Floor-to-ceiling glass flanking pivot panels amplifies their impact while flooding interiors with natural light. Minimalist material palettes ensure the entry remains focal rather than competing with excessive detail.

Site relationships matter enormously. Long approach sequences build anticipation that grand entries then satisfy. Immediate street visibility diminishes impact, making the reveal feel premature rather than earned. Strategic landscaping that partially screens entries until final approach creates the mystery that makes drama effective rather than merely obvious.

The Investment Calculus

Premium pivot door systems represent substantial financial commitments, typically ranging from $25,000 to $150,000 depending on size, materials, and hardware specifications. Custom designs incorporating rare woods, architectural bronze, or complex glass assemblies easily exceed these ranges. The investment becomes justified through multiple vectors simultaneously.

Property differentiation in luxury markets increasingly depends on distinctive architectural gestures that separate listings from otherwise comparable properties. Oversized pivot entries provide exactly this differentiation, creating memorable first impressions that influence buying decisions at subconscious levels. Market data consistently shows properties with architectural distinction commanding premiums that dwarf upgrade costs.

Maintenance and Longevity Considerations

Quality pivot systems, properly specified and installed, deliver decades of reliable operation with minimal intervention. Annual lubrication of pivot bearings and periodic adjustment of damping mechanisms constitute the primary maintenance requirements. This durability contrasts sharply with problematic hinged doors where weight and use create chronic alignment issues.

Weather sealing deserves particular attention. Pivot doors, lacking the continuous compression seals possible with hinged systems, require sophisticated multi-point magnetic or compression gaskets to maintain thermal performance. Premium manufacturers have solved these challenges, achieving thermal ratings comparable to conventional doors while maintaining the clean aesthetics that make pivot installations compelling.

The Cultural Statement

Choosing oversized pivot doors signals values beyond mere affluence. It demonstrates appreciation for architecture as art form, willingness to prioritize experiential quality over conventional approaches, and confidence to make statements that some might consider excessive. In an era when discretion often reads as timidity, these entries announce presence without apology.

The best installations balance drama with restraint, letting extraordinary scale and exquisite materials speak without resorting to decorative embellishment. This restraint paradoxically amplifies impact, creating moments where architecture achieves the spare elegance that characterizes genuine luxury. Oversized pivot doors don't merely provide entry. They establish territory, command respect, and transform the simple act of arriving home into an experience worthy of the architectural investment it represents.

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