Why Do Doctors Leave the National Health Service in Portugal? State of Play and Possible Solutions

Porque É que os Médicos Deixam o Serviço Nacional de Saúde em Portugal? Ponto da Situação e Possíveis Soluções

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Over the last 40 years, Portugal has established a solid healthcare system. Through the establishment of a public National Health Service (NHS), as well as medical career pathways and medical training schemes through an organized medical residency program, we have a system that has served, although with identified deficits, the ultimate purpose of providing a good quality medical assistance to the population.

Recently, many specialist physicians have left the NHS. If many did retire, many more are doctors at the peak of their knowledge and technical skills. They are those who would be the trainers and mentors of the new medical generation. They are those who, given the possibility of remaining in the comfort of the familiar environment in which they were trained, prefer to exchange it for uncertainty, opting for a path of adaptation and challenge, usually outside the NHS. Why do they leave? Why will they continue to leave? On a two-sided scale that balances job instability with less peer training, we have the salary, working conditions, and personal living conditions as the main, but not the only, reasons for Portuguese doctors to leave the NHS.[1-3]

It is known that the remuneration and working conditions of physicians are not the best and that they have not improved in a comparable (and fair) way to other professions. In fact, the medical profession is one of the few cases in the Organization for Economic Co-operation and Development (OECD) where remuneration has decreased in real terms in the last decade.[4] Therefore, is it surprising that doctors seek better working conditions?

There are several entities involved in the medical residency program that try to overcome the growing difficulties to increase the number of training posts. In a system with known deficits, this situation becomes possible by resorting to medical centers with partial training capacity, in places with identified structural deficits but with overspecialized activities that are themselves an appeal to the new generation. And this, resulting in the need for additional training, necessarily alters the training and work dynamics of resident physicians and of course the different departments.

Within the scope of the 2021 medical residency application scheme, while more training posts were made available, and even though there were more candidates than posts, 51 posts were unfilled and 24% of candidates did not choose any post. Most vacant posts were in or near the capital, Lisbon, which contradicts the idea that the unfilled posts are in the countryside, far from large urban centers.

Candidates at this stage are looking for placements that, primarily, ensure the quality of training within the scope of the chosen specialty and, secondarily, have prospects for continuing their professional activity within the expectations they have for their future.

Looking in particular at the unfilled training posts, we do not think that this situation is only because of local problems of the departments. There will surely be a reason for a similar tertiary university hospital next door to have all its posts filled to the detriment of another whose training positions remain to be chosen; or for older, less well-paid family health units in the countryside to have all training posts filled to the detriment of a new family health unit in Lisbon. In general, we feel that posts are not filled when the binomial quality of training *versus* cost of living (and therefore prospects as well) is simply not worth it.

Yes, there were already known difficulties in retaining new specialist physicians, but now there is also a difficulty in attracting resident physicians for various specialties.

Focusing on the current situation, we suggest the following solutions to address the current problems:

1) Specialty training posts with overall training capacity close to the limit:
   - Specific mandatory internships see their annual

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training capacity being insufficient due to its lack of technical and material resources.
- The different specialties face difficulties in human resources due to the increasing resignation of many senior physicians in search of better opportunities,[1] which further limits existing capacities.
- Partial posts (those that cannot offer full training) must be opened only after the training needs for completion of the residency program are obtained from other institutions. Overloading capacity because of a lack of central planning will not be good for anyone in the long term.
- The NHS's future human resource needs plan is not known. It is only by measuring that it is possible to manage and plan the training pathways of physicians in the best possible way.

2) Insufficient salary for the cost of living:
   - A position in a location with a higher cost of living is unaffordable on a physician's basic salary. It is also not sustainable for a physician who constantly works overtime (in many cases not adequately paid) but suffers much more wear and tear with consequent unavailability for other activities, as well as significant constraints for his/her personal life. Furthermore, the European Working Time Directive limits may not be respected in those cases.
   - Even the best trainers do not have the capacity to offer their residents all the essential training activities to ensure up-to-date medical training. Expensive courses are needed every year. The Portuguese Government has discouraged and limited industry funded medical education, while not fulfilling its role in the training of its professionals, which is, legally, its own inherent role. It is often physicians themselves, especially resident physicians, who invest in their training within their financial possibilities. The Portuguese Government seems to be increasingly discouraging medical specialization even though specialist care appears to be better and less expensive in the long term. On the other side, non-specialization can often be more profitable for non-specialized physicians because working contracts for emergency departments in both the private and public sector offer better remuneration when compared with the salaries of specialists and residents.

3) Protected time and quality standards for medical training:
   - There is no protected time for residents to study, integrate, reflect, and incorporate the knowledge that makes Medicine the complex science it is. We have 48 medical residency programs and only one (Family Medicine) allocates specific time for it in its training program. In addition to protected time, the existence of structured and instructive training is essential to improve the overall quality of training.[5]
   - The multiple cases of suicide, burnout,[6-8] and the use of psychotherapy and/or pharmacological therapies among residents may be justified by their working conditions.
   - There is often no protected time for trainers. The care burden and all the bureaucratic workload that falls on physicians greatly limit their training capacity, leading to less concern for those who end up doing it as an additional task on top of their clinical activity.
   - In short, protected time will allow a major improvement in the training activity and, consequently, in the future health care activity.

Medicine, in general, does not seem like a well-paid, prestigious, or appealing career anymore.

Medicine is serving as a wake-up call to the entire system, foreshadowing a potential large-scale problem concerning the future maintenance of a minimum number of specialist physicians and of medical trainers in the NHS.

Many doctors are leaving the NHS, the country, and, perhaps worse, Medicine.

Very soon, more than discussing the quality of healthcare, we may be discussing whether there is access to healthcare.

AUTHOR CONTRIBUTIONS

CM, JCR, MLL: Draft, conception, critical review and approval of the manuscript.

IGM: Conception, critical review and approval of the manuscript.

COMPETING INTERESTS

CM: Leadership or fiduciary role in Conselho Nacional do Médico Interno and Conselho Nacional do Internato Médico (Consultant Board of the Ordem dos Médicos).

IGM: Leadership or fiduciary role in Conselho Nacional do Médico Interno, Comissão Regional do Internato Médico da Zona Centro, Assembleia Geral da Secção Regional do Centro da Ordem dos Médicos and Gabinete de Formação Médica da Secção Regional do Centro da Ordem dos Médicos.

MLL: Leadership or fiduciary role in Comissão Regional do Internato Médico, Internato Médico de Medicina Geral e Familiar and Conselho Nacional do Internato Médico.

JCR: Leadership or fiduciary role in Conselho Nacional do Internato Médico, Comissão Regional Internato Médico do Centro.

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