At a recent lecture to students at Hershey Medical School, Ken Rictor displayed an image of the character Marcus Welby from the television series of the same name, and asked the audience to identify him. To Dr. Rictor's great surprise, no one could. Not a single person recognized the fictional physician nor had they heard of the popular television drama that centered on his private practice in Santa Monica. In Dr. Rictor's mind, Marcus Welby represented everything that primary care used to and should be; the fact that he was completely unknown to the next generation of doctors-to-be proved to Rictor that the figure of the family doctor had been wiped from our collective imagination.

The portrayal of the family doctor in *Marcus Welby, MD* is certainly far removed from the current realities of primary care. In the first episode, we see Dr. Welby at a local high school football scrimmage, but the opening dialogue makes it readily apparent that Dr. Welby isn't just the team medic. When a journalist walks by and asks why he isn't attending to his patients, Dr. Welby responds, "I delivered some of those boys Riley, and if they're good enough to finally make the city playoffs, I don't want them bent out of shape!" This interaction illustrates the extent of Dr. Welby's commitment to patient wellness across the lifespan, and reflects Dr. Rictor's own experiences early in his career. "When I was doing my residency in the late eighties, it was commonly understood that family doctors were to be involved in every aspect of care. We were trained to deliver babies, we were trained to help in surgery, and we were trained in providing both inpatient and outpatient care. We were able to be everything for everyone--no matter what age, no matter what person. We spent the time, and we made the investment, just like Dr. Welby."

Where Welby Got Lost

Dr. Rictor believes that the looming threat of malpractice suits, changes to reimbursements in the fee-for-service system, and the rise of urgent care facilities have all played a role in facilitating the shift to a more limited, efficiency-oriented primary care role over the past fifteen years. While the changes have been dramatic, they've also taken place slowly, making it difficult to ascertain the specific causes and conditions responsible for lessening family doctors' involvement in inpatient care. Dr. Rictor, however, is certain that these three factors were at play. "First, the malpractice climate made it financially infeasible to do obstetrics as a primary care physician. Delivering one baby would double the cost of the necessary insurance, meaning doctors would have to deliver one hundred babies every year just to break even. Then, new standards for reimbursement under the fee-for-service model forced providers to see more and more patients per day, just to keep their doors open. As patient populations increased, the capacity of doctors to give personalized care decreased, leading to a loss of one-on-one, face-to-face discussions about long-term health and wellness. The subsequent rise of minute clinics led patients to seek quick fixes for their health related problems, especially as wait times for appointments at family practices increased."

As a primary care physician who also moonlights at an urgent care center, Dr. Rictor has a unique perspective on how patients have understood and participated in recent changes to the medical landscape. "When people come in, I often ask, 'Why are you here? Why did you come to MedExpress?' The typical answer is something like: 'Well, I called my family doctor, but she can't get me in for the next two weeks', or 'I don't have a family doctor because I couldn't get one', or even, 'I went to the emergency room first, but I was going to have to wait three or four hours just to been seen.'" It quickly became clear to Dr. Rictor from these interactions that access and timeliness were being valued over the ability of the provider. "They don't look at the diplomas on the wall or the rankings of the institution; they just want to be seen by a kind, receptive person, and they're willing to go wherever they have to in order to find that."

Despite widespread desire for effective, accessible care, Dr. Rictor has witnessed a pervasive reluctance to embrace the one model that could guarantee it. "People have been relatively slow to adopt Direct Primary Care, despite the fact that it's incredibly

cost effective and benefits doctors and patients alike." Dr. Rictor suspects that part of this hesitance stems from a cultural shift. "It's difficult to recognize the value in something if you've never seen before. Because representations of the local family doctor aren't visible in the mainstream, people have forgotten what quality care looks like." In order to reverse this collective amnesia, the DPC movement seeks to reclaim the Marcus Welby ideal, pulling him out from the annals of history to prove that his style of care is just as relevant, possible, and promising now as it was then.

Pushing For DPC in a World Without Welby

Dr. Rictor thinks the growing cultural desire for instant gratification combined with powerful corporate interests in making medicine profitable has created an increasingly frustrating situation for doctors and patients trying to function within the hospital system. To illustrate the degree to which bureaucracy prevents good care, Dr. Rictor shares an example from a recent shift at urgent care. "A man with diabetes came in carrying some empty bottles of medicine, and asked for them to be refilled. I was somewhat confused because very rarely do people come into an urgent care center asking to have refills for chronic medications—especially not diabetes. I asked him if he had called his family doctor, and he said he had, but that they had refused to refill his meds until he came into the office. This made sense to me at first. I mean, under the fee-for-service model, they're always eager to make people pay the office visit charge, plus they're at less risk of a lawsuit if they see people to make sure they're getting the right medicine." As the patient went on to explain further difficulties, however, Dr. Rictor realized that something was clearly amiss. "He told them that his pills were going to run out in a week, but his doctor's office didn't have any available appointment slots for the next four weeks. He was willing to go into the office to get the medications, but they weren't willing to see him. They were literally going to let a diabetic go without his medicine in order to best follow the inefficient procedures and regulations that dictate that system." As these types of problems continued to drive people into the urgent care center, Dr. Rictor began to realize that these cases weren't the exceptions, but rather evidence of a widespread failure that had become the rule.

"The actions of this practice struck me as absolutely ridiculous, but they represent a larger pattern that's unique to the current moment. These kinds of problems didn't exist before. Marcus Welby and his staff weren't worried about the business and expediency of medicine; they were a tightknit community of people dedicated to providing quality care, not figuring out the most profitable way to code and bill visits." Dr. Rictor doesn't believe that physicians in 2015 are actively seeking careers that necessitate this style of work, which is part of the reason he advocates for better education about alternative medical models. "The reimbursement bureaucracy has created most of these issues. It forces doctors to bury their heads in a laptop during appointments, so they can click off the right boxes and bill enough information to get paid. Unfortunately, the majority of providers see it as a necessary evil. I think most people really are ready for a change—they just don't know that change is possible."

Lack of knowledge surrounding Direct Primary Care may pose the biggest threat to its viability as a mainstream medical model. In Dr. Rictor's opinion, better understanding leads to wider adoption, but, for that to happen, people need to be willing to learn. "In order to recognize potential solutions to this problem, everyone needs to understand what is causing it." In particular, Dr. Rictor wants people to see that the hassle of billing actually has a price tag. "As a Direct Primary Care practice, we were able to make a cash deal with a private imaging company that allowed us to get a MRI for $340. Under the not-for-profit hospital system, that same MRI was billed to the insurance companies for $3600. The cost difference was attributed to the tremendous expense of billing." As Dr. Rictor points out, the DPC model reduces costs by saving time, and vice-versa. "Implementing a simple, inexpensive billing platform that automatically draws out the monthly fees for private practices allows physicians and staff to refocus their attention on long-term patient health."

Last Lessons

Talking about the savings generated through Direct Primary Care has its limits as a strategy for increasing interest in the model. In the end, Dr. Rictor knows that money isn't the motivator for primary care physicians. "Doctors aren't moving to DPC because of financing. They're moving because they don't feel like doctors anymore. Most feel like they're claim adjusters working for an insurance company, and they're not finding value in what they do anymore. Many have missed being able to invest meaningful time and energy into their patients' wellbeing." In a way, Dr. Rictor sees the Direct Primary Care movement as a means of putting a little bit of Welby back into the medical landscape. "We've got a group of doctors who truly want to make dynamic change, who want to make a living providing quality care to patients they're committed to. I think that's the kind of doctor we're all looking for—doctors who want the satisfaction of taking care of others more than they want the financial perks of a participating in a broken system. I'll take that kind of doctor any day of the week."