On Stockholm Syndrome in the Medical Community: A Conversation with Doctor Ken Rictor

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When Dr. Rictor announced to his patients that he would no longer be a provider for the insurance industry, the reactions varied--but none of them were good. “You would have thought I stole the security blanket away from Linus in the Peanuts comic strip,” he recalls. Pervasive looks of fear, anger and

bewilderment proved it unlikely that any of his patients would be willing to try something new. Any potential curiosity about the Direct Primary Care model was squelched by a nearly universal desperation to know the answer to a single question: “What are we supposed to do without insurance?”

After witnessing the degree to which uncertainty plagued patients who were considering modifying their insurance to join his practice, it dawned on Dr. Rictor that the majority of his patient population was suffering from something comparable to Stockholm Syndrome. Stockholm Syndrome, sometimes called capture bonding, refers to the psychological phenomenon seen in hostages who begin expressing empathy for, or positive feelings towards their captors, sometimes to such an extent that they will defend and identify with them. In this case, patients maintain that they simply cannot abandon their current insurance policies because they have been misled to believe not only in the affordability and efficiency of their captor-- the healthcare system--but also in its exceptionality. Consequently, when they are presented with another option, they are incapable of seeing it as a viable solution.

How We Got Here

“There was a time in our healthcare system’s history when insurance was only available for big ticket items like surgery, hospitalization, and trips to the ER,” Dr. Rictor explains. “During that period, patients had no fear of going into their doctor’s office with a wallet or checkbook in hand, ready to pay their doctor out of pocket for quality treatment.” Dr. Rictor notes that the shift from that system to our current one mirrors the eventual conflation of the word health insurance with health care. “There’s actually a conventional definitional difference between healthcare and health care,” he says. “Health care is what a doctor provides for the patient. Healthcare refers to the industry that facilitates that care.” Even people working in these industries--like doctors and government agency employees--fail to recognize the distinction between the two, and, as a result,

much of the information we have on the current system ends up being misinformation. “Not having health insurance is often mistakenly interpreted as not having health care. We were told during the debate for the Affordable Care Act that thirty-one million American were without health care, but it might have been that thirty-one million Americans just did not have healthcare--meaning they just did not have health insurance.”

Where We Are Now

The healthcare industry accounts for almost twenty-percent of the United State’s GNP--a whopping three trillion dollars and close to $10,000 per person. Of that amount, twenty-five percent goes toward non-medical care like insurance profit, liability, government payments, and consumer services. These statistics clearly illustrate how inefficient and ineffective the current healthcare model has become, but there’s one in particular that Dr. Rictor thinks best demonstrates the foolishness of sticking with the status quo. “In one of my lectures, I used a statistic that proves that the U.S. spends fifty percent more on medical costs than the next industrialized country, yet is ranked number thirteen in quality of care. Imagine that you’re going to go out and buy a vehicle at a car dealership and the sales guy takes you out to the lot and say, “Here, let me show you our cars. These cars cost fifty percent more than the next most expensive car that is sold in the United States and you know what? We’re ranked thirteenth in quality for our cars.’ I would imagine most people would say, ‘You’re crazy. There’s no way I’m going to buy something that ranks thirteenth for that price.’ Yet, we do it every single time we pay our health insurance premium.”

Dr. Rictor is not surprised that our healthcare system ranks so low, but he’s baffled that patients keep paying into it anyways. “We pay into a system that only pays for ‘qualified’ conditions that meet the ever-changing rules of reimbursement, a system that prohibits preventative tests in a risk population because it makes more off of life-limiting diseases than health creation.” He sees Direct Primary Care as most logical and straightforward

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solution to providing care and reducing overall cost, but knows first-hand that the task of getting patients and doctors to make the transition is made nearly impossible by this wide-spread Stockholm Syndrome. “When DPC extends a hand of rescue to a patient or to a business or to a physician, they just respond by recommitting to their health insurance. We are so afraid of change that we have embraced a broken system.”

How We Get Out

Understanding Where Patients Get Stuck

Addressing patient resistance requires a deeper understanding of where that resistance comes from and how it manifests. During the educational sessions he held on Direct Primary Care, Dr. Rictor identified four primary patient responses his new model. “A small percentage got it right away and had no questions. They saw our company for what it was, they liked the idea of it, and they were instantly on board”. Unfortunately, the groups who were not so keen on the idea comprised the majority.

Some were saddened by the switch. “They felt like they could not make that financial commitment to us, but still wanted to keep me as a doctor. They could not make the connection that this would end up costing them less money because they were in situation where they were paying little to no deductible. That out of pocket expense ruined the possibility of any further consideration of DPC from the get-go.” Dr. Rictor understands this response as a result of a misunderstanding of how health insurance is priced. “Patients that didn’t have a lot of out of pocket expense but had a huge pay expense thought that they were getting discounted insurance. If you saw someone that didn't have a lot taken out of their pay and they were asked to pay more out of pocket, they would tell you that they had a lousy insurance. In actuality, patients that never see that money coming out of their paychecks tend to think they have a really good system going, when really they’re being ripped off.”

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The third group's resistance was born out of confusion--a reaction that Dr. Rictor found much more conducive to changing minds. "Because I was already giving a high standard of care in my fee-for-service practice, some saw the change as nonsensical. They would ask, 'Why do I have to pay for something I was already getting? What's my benefit?' And my answer to that was, "Well, this allows us to continue to give you what you were used to getting and continue at the high standard of care that you're accustomed to.'" Once that confusion was cleared up, these patients typically expressed an interest in learning more.

The last group Dr. Rictor identified expressed anger and resentment at the change, and sought no further education on Direct Primary Care. "But even from the pool of people who left the practice, there have been a bunch that have come back. They said they couldn't get the same type of care that I was providing for them anywhere else. Those bad experiences helped them realize that there was a value to what I was doing, and that an affordable monthly membership was reasonable to get that care."

Dr. Rictor believes that getting patients on board with the membership-based model requires revealing the value of quality health care. "If something is important to you, you're going to find value in it. I've used this example so many different times: I'm not a hunter at all, but somebody who is a hunter doesn't have any problem dropping two or three thousand dollars for a gun. For me, twenty dollars for a gun would be too much because I wouldn't use it. Does that make that worthless? Of course not. So when somebody says to me, 'I don't want your product', I don't view it as 'Your product isn't valuable'--I view it as 'I don't find the value in it.' To coax people out of their Stockholm Syndrome around the insurance based model, we're going to have to find a way to get them to see the value in DPC."

Encouraging Doctors to Make the Leap

Dr. Rictor speaks from experience when he says that this

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syndrome affects doctors just as much as it affects patients. In our interview, he described the difficulty of making the switch. “I hung onto the system because I thought it was what we were supposed to do. I thought it was *the* system, and there was no alternative. But when I started asking questions about why I was spending more time on insurance billing than I was on patients, I realized I needed to make a change.”

While he recognizes the risk associated with starting a Direct Primary Care practice, Dr. Rictor hopes doctors will reevaluate their situation. “Really ask yourself: ‘Am I working for myself or am I working for the insurance company? Am I able to do what I feel is best for my patient’s care or am I doing what I’m doing just so I can get paid or please my employer?’ If you’re not comfortable with those answers, then you need to ask yourself, ‘Do I have Stockholm Syndrome?’” In most cases, Dr. Rictor expects the answer will be yes.

Dr. Rictor believes strongly that these physicians shouldn’t let their fear bring them to a standstill. “There’s something that was told to us in medical school that still resonates with me deeply. One of our professors said: ‘You have to understand that being a doctor isn’t something that you do, it’s something that you are.’ So when you take a doctor and pull them out of care issues, they don’t stop being doctors, they just stop practicing medicine”. Revealing the value in Direct Primary Care may be the first step in getting doctors back to practicing medicine--and practicing it on their own terms.

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