

I'm Finally Practicing Medicine the Way It Should Be Done

**A new model of medicine lets doctors, not insurers,
decide on care.**



"I'M FINALLY GETTING TO BE THE KIND OF DOCTOR I'VE ALWAYS WANTED TO BE," WRITES CHARLOTTE GRINBERG. (PHOTO BY H. ARMSTRONG ROBERTS/CLASSICSTOCK/GETTY IMAGES)

By Charlotte Grinberg

In medical school, I planned to be a primary care doctor. I started residency at a Harvard teaching hospital, caring for patients that

included multigenerational Armenian and Irish families as well as students from nearby colleges. I quickly saw the reality of the primary care system: rushed, fragmented, impersonal, and often inaccessible. My patients arrived in the exam room frustrated after waiting over an hour, and their frustration was justified; I had to see so many people so quickly that I could barely keep track of their names.

For decades, insurance and health-system pressures have required doctors to see more patients in less time. Visits narrow to whatever symptom is in front of you, and the view of the whole person is forgotten. Physicians learn to signal that their time is scarce. Questions are hurried, at best. Patients, sensing or experiencing judgment or dismissal, grow quiet. Many end up avoiding anything but the most urgent medical visits altogether.

Primary care doctors are supposed to be medicine's first line of defense. A doctor familiar with your medical history can understand the entire state of your health, not just the problem you came in with. That influences whether you get preventive screening, early disease detection, and a thoughtful approach for further treatment. Yet most people spend almost no time thinking critically about choosing a primary care provider; they open the insurance directory and pick whoever is available. Their experience of primary care is often so negative that they can't see how it matters.

After my residency, I ended up specializing in end-of-life care as a hospice physician, and beginning-of-life care as a childbirth doula. These were fields centered on the patient relationship, and my experience solidified for me just how essential that relationship was.

This year, though, I started my own primary care practice. After years at the bedside as a hospice physician, I saw how deep patient distrust of the healthcare system could run. By the time they got to me, patients and their families were understandably angry about the fragmented care they had received. I was reminded how my goal had always been

to help people navigate their health with more meaning, continuity, and personalization—relationships nurtured over time, not rushed in the final days of life. I also wanted more autonomy over my time and my professional growth.

What made it logistically and economically possible was a recent transformation in primary care called “direct primary care” (DPC). I first learned about DPC from a physicians’ Facebook group in which doctors looked for ways to mitigate the burnout that came with brutal patient volumes. In the comments, the same advice kept popping up: “Look at DPC.”

DPC is a membership model: Patients pay the doctor’s practice directly (monthly, twice a year, or annually), not going through insurance, and in return get easier access, longer visits, and broader day-to-day care. Practices can do that because they don’t take on the cumbersome administrative work of billing insurance and don’t have to take on the 1,000-plus patients insurers expect. When I first stumbled on DPC, I thought it was probably just another healthcare acronym. In fact, it has turned out to be the first model I’ve seen that makes it possible to practice the kind of medicine I went to medical school to do.

For the first time in my entire medical career, I feel present for each patient.

From the outside, DPC can sound like a version of concierge medicine, which works by adding a large retainer fee on top of insurance. But the economics are almost the opposite. People pay a primary care membership fee for routine, predictable, relational care. They can pay for each service (labs, imaging, procedures) at cost and buy catastrophic insurance for rare, expensive events. That makes it possible to offer care that’s actually accessible to small-business

owners and people with high-deductible plans—people who are already paying out of pocket but getting very little for it.

DPC clinics often help patients get cash prices on medical services—and those prices can be dramatically lower than what people pay using “good” insurance. I was shocked when I learned that the basic blood work a doctor orders at an annual visit—which carry “list prices” adding up to \$300 to \$400 or more—can cost about \$30 when you negotiate cash-based prices with Quest and Labcorp. A cash-based chest X-ray can cost around \$90. In my experience, DPC doctors know how to compare costs and insist on real-world prices for their patients instead of the inflated numbers that appear on an insurance explanation of benefits.

Two key policy shifts that will arrive next year could make 2026 the year DPC goes mainstream. Thanks to new legislation, DPC fees (up to \$150 a month for an individual and \$300 a month for a family) can be treated as a Health Savings Account (HSA)-qualified medical expense starting in January. Second, for Americans buying on the Affordable Care Act (ACA) marketplace but not getting tax credits (a category likely to grow dramatically if enhanced premium tax credits are not extended), new federal rules make it easier to pair a low-premium catastrophic plan with other coverage. If you’re one of those people, now is the time to look, since ACA open enrollment in most states runs until January 15.

Put together, that means more people can buy a catastrophic or high-deductible-style marketplace plan for the big stuff, use an HSA, and then spend pre-tax HSA dollars on their DPC membership. In other words, your insurance will become what “insurance” was meant to be: protection against life-ruining events. Otherwise, you pay only for the medical care you actually use, at cost. You’ll likely end up spending a fraction of what you would on premiums.

DPC is keeping doctors in the field who may otherwise have considered leaving medicine altogether. I can now listen, focus on prevention, and follow up properly. For the first time in my entire medical career, I feel present for each patient. When illness shows up—as it always does—patients get to spend the time they need with their doctor without being rushed, to ask questions without feeling like a burden, and to be seen again quickly.

Just this week, the daughter of a patient wrote to me, “My mom feels heard and understood for the first time in a very long time.” She had been referred to multiple specialists by an overwhelmed primary care provider who brusquely told her that her medical issues must stem from her depression. Encounters like that used to be possible only when I quietly defied the time constraints of traditional practice and kept everyone else waiting. Now I don’t have to worry about that trade-off. I’m finally getting to be the kind of doctor I’ve always wanted to be.

