Can the Family Physician Avoid Conflict of Interest in the Gatekeeper Role?

An Affirmative View

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The gatekeeper concept has appeared in health care delivery systems in recent years, partly in response to the rapid rise in health care costs. There are many variations in the concept, but in most systems, the gatekeeper is a primary care physician who both provides medical care and oversees medical expenditures from a pool of money (a capitation allowance) allotted to the physician in advance for the care of assigned enrollees in that physician's practice. That physician's practice then manages the capitation allowance and can retain a portion of any money remaining after care is delivered over a specified time, usually a year. The distribution of that surplus varies according to individual practices.

The gatekeeper role, as described in medical literature, may include coordination of medical care[1–4] and social services,[5] control of access to medical services,[2–5] patient advocacy,[4,6] evaluation of technology,[4,7] and to a lesser extent, serving as a broker, confidante, educator, risk manager, or researcher.[4] Not all observers are comfortable with the term *gatekeeper*, but much of the primary care literature supports the involvement of primary care physicians in the tasks attributed to the gatekeeper role. The gatekeeper may be required to juggle and balance roles while responding to the multiple forces in health care. These forces include patient needs, insurers' requirements, financial incentives, liability risks, and the physician's personal ethics. Responding to these forces creates potential dilemmas as the gatekeeper balances competing demands.

The purpose of this paper is (1) to demonstrate that such dilemmas arise throughout the health care system; (2) to describe some of the dilemmas primary care gatekeepers face in terms of the ethical principles of truth-telling, paternalism, beneficence, autonomy, and utility; and (3) to propose that such dilemmas can be mitigated by structural provisions and communication skills that reduce the potential for conflict of interest in the physician's role as a gatekeeper.

Examples of potential economic conflicts of interest appear throughout the health care system. Physicians determine when to order diagnostic tests, whether to certify disability, whether to treat patients on public assistance, whether to order one drug as opposed to another, and when to perform elective procedures. Physicians are being asked by their patients which insurance coverage the patients should choose. Physicians whose patients have an option to join either a fee-for-service insurance plan or a prepaid plan offered by their employer may be tempted to influence sicker patients to choose the fee-for-service plan because the high costs of the patient's care would be paid out of a capitation allowance managed by the primary care physician. New Medicare demonstration projects place physicians in the position of discussing capitation-based Medicare plans with potential enrollees.[8] Conflicts of interest may also exist in institutions where the services offered may not be the best available, but where physicians stand to gain by referring within that institution.

In the fee-for-service sector, the temptation to overtreat is itself a conflict of interest where physicians act as what Brody calls "positive gatekeepers"[9] by encouraging use of their own diagnostic and treatment facilities. Physicians have been criticized for investing in profit-making medical diagnostic and treatment centers to which they may refer or admit patients.[10] Critics have spoken out against the potential conflict of interest in such physician investments[11] and in the temptation to overcharge under retrospective reimbursement systems and deny access to public assistance patients.[12] Wennberg and Gittelsohn[13] have described marked variations in surgery rates among different

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communities, concluding that some of this variation arises from differing practice styles among physicians.

Many medical practitioners see themselves as purveyors of services billed to insurers or patients. For many years this service delivery occurred in a relatively unhindered market. Now, strains in the system are appearing and brakes are being applied to escalating costs. Ethical objections can be raised against almost any economic system, especially those in which resources are unequally distributed. Allocation, rationing, limitation, and managing are terms becoming common in discussions of health care delivery. As Emily Friedman puts it, "To debate whether 'rationing of service' might take place 'someday' in this country is to deny the obvious."[14]

Thus, many potential conflicts of interest exist throughout the health care system. If physicians can be trusted to maintain some integrity in the face of ubiquitous competing influences, it follows that physicians should also be able to cope with the potential conflict of interest in gatekeeper-based insurance plans. How then can primary care physicians cope with these complexities? Can the gatekeeping role be accomplished and still remain consistent with central ethical principles?

ETHICAL PRINCIPLES

In prepaid systems the gatekeeper role has been compared to that of a lawyer who serves simultaneously as an "advocate for his client and the judge in the case," a difficult ethical dilemma.[15] Many have supported the right of the patient to disclosure about the financial details of medical insurance in discussions between patient and physician. Many prepaid plans, however, discourage physicians from discussing these issues. Nor do many physicians openly discuss the opposite incentives in the fee-for-service sector, where, as patients generally realize, physicians make money by performing procedures on patients, and the patients must trust the physician that the procedures are necessary.

The trust placed in the physician with regard to the health of the public cannot be overemphasized. Medicine stands distinct from other professions because of the dependence and vulnerability of those medicine serves, who may, in cases of severe illness, depend for their survival on professionals who hold positions of power and moral authority. With that power comes trust by those served. Also with that power comes responsibility. Marsh[16] speaks of "covenant-fidelity, or promise keeping" and "fiduciary relationships" between physician and patient.

The role of doing good works for someone else can easily become a paternalistic relationship—not always in the patient's best interest. Pellegrino sees a unique responsibility for physicians in prospective payment systems, which challenge the physician's prime moral responsibility to act for his patient's good. He has expressed concerns about the potential effects of "procompetition" and medical corporatization on the physician-patient relationship.[18]

Since acting *for* a patient is implicit in the physician role, the physician-patient relationship is fraught with potential conflict of interest in any situation where the physician decides whether a service is indicated, whether the physician benefits by controlling access to certain services (as under prepaid health care) or by doing things for and to patients (as under traditional fee-for-service care). The patient's autonomy may conflict directly with the physician's autonomy. Asserting the primacy of the patient's autonomy may result in consequences ranging from harm to no effect to actual benefit, though a lack of medical benefit negates the purpose of the physician-patient interaction. Brett and McCullough[18] describe the result: "The enhanced expectations are sometimes unrealistic, thus creating grounds for disappointment or even conflict in the physician-patient encounter." They go on to describe reasons patients and physicians disagree: differing understanding of disease processes, differing commitment to individual as opposed to community benefit (as in the use of antibiotics for viral illness), patient concern that a common illness such as headache might arise from an uncommon cause such as tumor, and physician concerns that costly tests are unnecessary given certain medical probabilities. The authors maintain that economic factors should not interfere with clinical decision making but should be made a matter of public policy and that the patient should be allowed access to a test (such as a nonindicated computerized tomography) if the patient pays for it. Universalizing this view, however, could bankrupt an already stressed system. As a partial solution to the precarious balance between the individual and the community benefit, the concept has been proposed of an intermediary to arbitrate between physician and patient in difficult cases, taking cost-containment decisions away from the bedside and minimizing the potential for conflicts of interest.[19]

The conventional concept of utilitarianism implies the goal of achieving the greatest good for the greatest number. In health care delivery this concept is usually discussed in such terms as improved efficiency, effectiveness, continuity, coordination of care, quality assurance, and equitable distribution of resources. But the day-to-day delivery of health care in the individual office setting works differently. Says Lee,[20] "It has become so axiomatic in our time that the goal of health care is to serve the individual patient, not the community per se, that no one has sought to challenge this notion directly." Physicians deal with individual patients, governed in these one-on-one encounters by a sort of "act utilitarianism"; however, a type of "rule utilitarianism" assumes greater precedence when physicians contemplate the limitations imposed by the health care organization in which they work, or they face the dilemma of distributing a scarce resource.

Marsh,[16] in his essay dealing with the "duty to treat," focuses primarily on diagnosis-related groups (DRGs) and hospital care, but the discussion might pertain to capitation-based systems. He states: "Because of the increasing pressure to serve two masters, the physician today must not only be concerned with each patient's needs, but also the

hospital's needs in deciding what type and amount of medical care to deliver. As a consequence, the physician who desires to hold on to the traditional notions of the physician-patient relationship might very well find that this requires doing battle with windmills."

REDUCING POTENTIAL CONFLICTS OF INTEREST

Clearly, conforming to ethical and professional standards and acting as an effective allocator or gatekeeper is a difficult task. Some structural and communication-based adjustments may alleviate the pressures on physicians in the gatekeeper position.

1. Physicians and their office staffs should be honest about the requirements and limitations of insurance systems. Patients often expect the best—eye examinations every two years, successful infertility diagnosis and treatment regardless of cost, multiple specialty consultations, minor cosmetic surgery—when such benefits would raise premiums beyond the reach of most if applied to all those who request them. The financial philosophy, the strengths and limitations of the plan, the availability of the consultants should all be discussed. Such openness and honesty would reinforce the communication of truth about one important medical decision—the consequences of selecting a given type of insurance coverage.

2. One method of reducing the potential for financial conflict of interest on a given clinical question is to introduce intermediaries to make decisions outside the physician-patient dyad. Such intermediaries would, ideally, be physicians with expertise in the area of concern. Such intermediaries could reinforce the fiduciary role of the physician and the principles of paternalism, reviewing the case objectively, given the facts assembled by the primary care physician. A third-party "medical director" or utilization committee could assist in tracking certain types of cases on which future decisions can be based. Physicians should avoid, when possible, making allocation decisions on an individual patient level. As Friedman[14] says, "For physicians to appear to place fiscal incentives before clinical judgment is to invite further intrusions by third-party payers and others who are only too ready to drain the diminishing control of the medical profession over its own practice."

Medical care of proven benefit must be preserved, even if positive benefits are only apparent after many years (eg, cancer prevention). Prevention, patient education, mental health, and other services can quickly be considered luxuries in such systems, to the long-term detriment of the enrollees, the system, and ultimately society. Some capitation-based plans have placed mammography and immunizations, for example, in a separate pool distinct from the pool from which surplus payments are derived. In this way, the principle of paternalism is respected, as the physician facilitates health care that is in the best interest of the patient.

3. Physician skills in such integrative skills as data management, ability to assess performance, negotiating skills, weighing of risks and benefits, and communication skills will become essential in the practice of primary care in the future. It is as important to make a correct diagnosis and treat a condition in a timely manner as it is to stop fruitless interventions and explorations, defer elective procedures that are not medically necessary, or select a less-expensive but equally effective alternative. The importance of such skills is magnified when physicians are placed in the position of managing resource allocation for a group of patients assigned to an individual physician. Such skills will help physicians balance the competing demands of personal ethics, patients, insurers, purchasers, and the courts, and would serve to maximize patient autonomy where appropriate.

4. Physicians must become more involved in decision making on a broader scale, not just in the physician's office. In this way, physicians would incorporate the principles of utility into their medical decisions. Through medical teaching, professional societies, and medical committees physicians can become involved in assessing outcomes, efficacy, and medical necessity. Physicians must take an active interest in quality assurance efforts, in the formation of ethics committees, in the development of guidelines for cost-effective medical management and prevention, in the evaluation of new technology, in handling patient grievances, and in educational efforts directed toward both patients and physicians.

CONCLUSIONS

Given the rise of consumerism and the unflattering portraits of American medicine in the lay press, it is not surprising that physicians, especially those in primary care, have been asked to "keep the gate." Purchasers of health care, insurance plan payers, patients, and now, physicians in the gatekeeper role are being asked more frequently, "Is this really necessary?" Just as it has become commonplace to question advice that a car needs repairs or an appliance needs an expensive warranty, medicine has also come under scrutiny. Patients needing services often cannot see or understand what is being serviced. Often the health services are needed immediately and alternatives may not be available. Wide gaps may exist between what is suggested by a consultant or wanted by the patient and what is medically necessary. All of these factors contribute to the conclusion that physicians have great potential to help control health care costs. It is natural, then, that physicians should become central figures in the efforts to control costs.

Practicing medicine is not like fixing a broken transmission, however. It is a profession. Membership in a profes-

sion implies some degree of trust, decency, and commitment to standards of excellence, transcending protocols and financial incentives. The same professionalism that has fended off change in medical care over the years may minimize some of the dilemmas and potential conflicts of interest inherent in the gatekeeper-based system. How long physicians can hold onto an ethic based primarily on physician autonomy is in question. Many physicians see themselves as lone protectors on the frontiers of medicine, guarding their patients' health. Some physicians balk at efforts to evaluate the quality of care they deliver, to control their fees, to regulate their practice style and cash flow, because of pressures to meet their debt obligations, support their families, avoid legal liability, and maintain control. Physicians, like many Americans, like their independence, and also guard their "frontier." Meanwhile other forces infringe on the territory of traditional medical providers: consumer activism, governmental and employer intervention for the public good, the physician glut.

Many physicians would like to ignore the issue of allocation of limited resources. But, as Friedman[14] states, "The choice for American physicians seems clear. They can assert that their role as patient advocates makes it impossible for them to participate in rationing or resource allocation, leaving the field to other players who are not likely to hold patients in high ethical regard, or they can accept that rationing and resource allocation must continue to be the domain of physicians and that physicians must, even at this late date, learn how to do it right." Capitation-based systems utilizing the physician as gatekeeper are certainly not the only way to control costs. There are many others in force, and many others yet to emerge, in the precarious balance between quality and efficiency in medical care. Imperfect and difficult as the role is for physicians, the gatekeeper concept could, with appropriate safeguards and checks to minimize potential conflicts of interest, assist in the difficult process of allocating medical resources.

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An Opposing View

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Socrates: *Why, don't you know that saying of Phocylides, that a man should practice virtue when he has made enough to live on?*

Charmides: *I should have thought he might begin sooner.*

Plato, *Charmides*

My answer to the question that is the subject of this debate is unequivocally "No!" It is based on more than two years' experience as a gatekeeper in two health maintenance organizations (HMOs) for about 900 subscribers. I believe that the gatekeeper role is hopelessly conflicted, ethically unmanageable, clinically naive, professionally ungratifying, and historically unnatural for a family physician.

While I intend to argue these points vigorously, I want to enter two disclaimers. The first is to acknowledge that HMOs are in a state of rapid evolution, that all of them might not have the characteristics I abhor, and therefore

might not be appropriate targets for my arguments. The second is that, in criticizing the gatekeeper role, I am not necessarily defending indemnity insurance and fee-for-service medicine as less conflict-laden and morally superior. That might turn out to be true, but it is not what I am arguing.

On the other hand, I must assume that my experience as a gatekeeper is a fair sample of what other family physicians have experienced in similar roles. One of the two HMOs in which I participated is the largest in my state, and the other is one of the largest in the country. Not only that, the office in which I practiced is the largest provider of HMO services in my state. If these circumstances are not representative, my arguments will be idiosyncratic, but I am assuming that such is not the case.

Perhaps I should enter a third disclaimer. My arguments are not against all forms of managed care. Experts[1] are already predicting that HMOs, as we now know them, might disappear into new and improved forms. If this be true, it would be unfair to judge them negatively in advance. Managed care systems of the future will have to stand on their merits.

MY EXPERIENCES

On balance, gatekeeping has turned me and my patients into a gang of wheedlers and sharpies, each trying to outfox the other for petty privileges and paltry savings, both manipulating "the Plan" for bigger ticket items like year-end kickbacks, expensive elective medical procedures, and a better contract at the next renewal date. Meanwhile, the Plan, through its mysterious and anonymous policy boards, committees, and administrators, its subscriber service counselors and physician representatives, actually encourages such wheedling and succeeds, more often than not, in distracting us from itself by getting physicians and patients to play the game, "Let's you and him fight."

A case in point. A long-term patient, one whose relationship was established with me long before he became a subscriber and I a gatekeeper, became incensed with me when I refused to prescribe an expensive mouth rinse that his dentist recommended for prevention of "receding gums," a newly popular treatment in our area. The problem was that the Plan's dental rider did not cover prescriptions written by a dentist. The patient, who must be given credit for propriety, called a subscriber service counselor and was told that the rinse was not covered "unless you can get your personal physician to write the prescription." I refused on two grounds. First, I do not write prescriptions for agents with which I am not familiar and am not prepared to monitor. In this instance I would have had to write six prescriptions, one per month, because the Plan covers only one month's supply at a time. Moreover, the agent was not entirely without possible side effects and was not known to be effective. Second, I resented the clear subterfuge, suggested by the counselor, to circumvent the Plan's intent. If the Plan wished to pay for the treatment of incipient gum disease, why not honor a prescription that the dentist was qualified to write? Why should I have to become involved in this administrative problem at all? The patient and I were neatly triangulated into a conflict that threatened a long and otherwise satisfactory physician-patient relationship.

Another patient, a notorious wheedler, requested a referral to an out-of-Plan otologist in a distant city for a stapedectomy. I did so after she agreed to consult a competent, local, in-Plan otologist, whom she decided she did not like. The referral was approved by the medical director, but the rub came a few weeks later, after the stapedectomy, when she requested a local referral to a third otologist to perform her postoperative care, for an additional fee, of course. She was too busy, she said, to travel to another city for follow-up care, which would have been covered in the surgical fee. Again, I refused and lost a family in my practice.

With chagrin, I acknowledge the relative triviality of these examples. No great sums of money were at stake, and no important health risks lay in the balance. Moreover, in spite of my rationalizations, I have to recognize unflattering aspects of myself in these decisions to protect the Plan against the patients. I was correct without being right. In taking a stand against these minor exploitations, I did not even act in my own self-interest. But such is the nature of wheedling; it is demeaning to those who engage in it.

The larger problem is that these examples were not exceptional. Several similar encounters occurred each week, mostly around requests for referrals. Patients wanted to see dermatologists, orthopedists, allergists, otolaryngologists, psychologists, even chiropractors for minor, chronic problems that I felt competent to treat. It was difficult to say no to a referral, then shift into the role of a therapist. The conditions for successful treatment were undermined by the refusal, no matter how cleverly done. Sometimes the patients simply did not know that I could treat them, but mostly they wanted to continue a satisfactory relationship with another physician. Many requests for referral came by telephone, which was clearly against the rules, and were handled by the nurse, who incurred resentment by insisting that the patient had to see the physician before a referral could be given. Some of the requests were for retroactive referrals, also against the rules. Referral forms were "lost" in the mail or misplaced in the consultant's office, and urgent calls for another one interrupted our day. The nurse spent a good part of each day on the telephone about administrative issues arising from the gatekeeper role.

The collective impact of these negative encounters, though each in itself might have been minor, created a climate of suspicion, cynicism, readiness to fight, and a sense of being used that permeated my office in a way that I had not known before. In addition, there were problems between my office and the Plan—slow pay, inaccurate pay, infrequent and often uninterpretable reports, feeling unrepresented at policy-making levels, and, to this day, no payment from any of the pools for which we were eligible,

in spite of being considered a successful and profitable group. Each of these problems was addressed, promises were exacted, or ad hoc solutions were negotiated, but the whole experience was debilitating. One of the two HMO plans experienced huge financial losses nationally, reduced its local administrative personnel, and recently replaced its top two executives in an effort to restructure its operations. We stayed with the HMO plans because we became dependent upon them.

THE ROOTS OF CONFLICT

While some of my experiences can be chalked up to start-up problems and debugging new systems, most cannot. These experiences reflect deeper problems inherent in the theory and practice of a gatekeeper model of managed care, which I believe is inimical to family physicians' style and art, subverting their effectiveness and exposing them to unmanageable and undefined risks. I cannot imagine that, apart from defensive economic strategy, well-informed physicians or patients would choose a gatekeeper model of medical care on its noneconomic merits.

According to Hillman,[2] the risk for conflict of interest is increased when (1) the number of physicians sharing financial risk is small, (2) there are financial penalties beyond the withheld amounts, (3) outpatient laboratory tests are paid for from a primary care capitation fund, (4) the physician's income depends to a substantial extent on HMO enrollees, (5) the above factors are combined, and (6) the physician is also a shareholder in a for-profit HMO. Up to 40% of 302 responding HMOs in this study reported one or more of these characteristics, which suggests that there are serious built-in liabilities for even the most conscientious and well-motivated physicians.

InterStudy, an HMO-advocate organization founded by Paul Ellwood, conceded in a 1988 report[1] that the "competitive strategy" underlying HMO theory "has not fulfilled its original goals of cost containment, enhanced quality [of health care], and improved access to care." Such an admission of failure by HMO enthusiasts suggests that more is wrong with the idea and its implementation than can be explained by the personal flaws, misunderstandings, and habits of individual physicians and patients. Both groups are enmeshed in a flawed contractual arrangement, including gatekeeping, that neither can control without harm to the other.

Secrecy

Whether intentional or not, secrecy is one of the most egregious flaws in gatekeeping organizations, because secrecy lies very close to deception. It takes many forms and affects all groups and classes, those who know the secrets as well as those who do not. The investors, owners, and managers are anonymous, hidden in a maze of holding companies, subsidiaries, and partnerships, which only the tax laws can create, usually fronted by some euphonious name ending in the word *Care*. God only knows who the "big mules" are in these organizations and what are their relationships, motivations, commitments, and risks. This is normal operating procedure in American business, but its entry into health care is a novel development that was vigorously resisted by the medical profession for most of this century. It is ironic, to say the least, to observe how easily a profession that spilt blood over the evils of feesplitting could be swallowed up in corporate financial legerdemain. It is even more ironic that business should become entrusted with medicine at a time when corporate crime is almost daily news. Secrecy at the top of a hierarchy inevitably filters down to the most elementary transactions. Physicians in HMOs have very little idea whom they are working for, and patients know even less about the physicians' obligatons to their mysterious employers.

Then there is the "big lie" that the fundamental purpose of HMOs is to increase their subscribers' access to optimal medical care, including preventive care, when, in reality, HMOs aim to reduce and control utilization. This reality is the "actuarial secret," the hard-core calculation of utilization and expenditure that cannot be exceeded, a secret closely guarded and kept from physicians and subscribers alike. The problem is not that such a calculation exists, but that it is a secret that expected profit margins are kept hidden. All parties in an HMO have a legitimate interest in knowing its actuarial assumptions, the magnitude of profit it intends to make; and to my mind all parties should also know how those profits are to be distributed. I do not know this information about either of the HMOs in which I participated. The absence of such knowledge leads to much of the wrangling that occurs between physicians and patients. Purchasers tend to overestimate what the HMO can and will do, while providers, especially gatekeepers, tend to see every unusual expense as a threat to the fiscal viability of the plan.

Nowhere is the actuarial secret more problematic than in the differences between the advertising and marketing of HMOs and the details of their exclusions and limitations. Marketers sell their product with persuasion, hyperbole, and not a little obfuscation, but when delivery time comes, the marketers are long gone, and it falls to the gatekeeping physician to become the bearer of bad news. One of the plans in which I participated has three large pages of fine print detailing its exclusions and limitations in language that only experts can understand. Even then, there are enough contingencies and ambiguities to cross a rabbi's eyes. Benefits are described in glowing terms, implying that everything necessary will be covered with no fuss or bother, but the exceptions are a tangle of qualifying phrases: "when medically necessary," "prior approval of the medical director," "short-term therapy," "expected to show significant improvement," "when symptoms are severe," and "as determined by your personal physician."

My point in all this is to show that the gatekeeper's role is shrouded in secrecy of a type that is common to corporations but which in medical practice is a systemic liability

that undermines the full therapeutic potential of the physician-patient relationship.

Power

Whatever idealism attended the founding of the earliest HMOs in the interest of distributive justice, there can be no doubt now that they have evolved as instruments of social control. The entry of corporate capitalism into medical care brought with it hierarchical structures of power that are authoritarian, antidemocratic, and in some cases, repressive. As Starr[3] observed about the transformation of American medicine into a sovereign profession, the dream of reason did not take power into account. Both patients and physicians have lost power to corporate owners and managers, who are not necessarily better custodians of it. The power of choice has been exchanged for presumed economic advantage. Most of the decisions about which physicians and patients become conflicted are little decisions, because all the big decisions were made when the contracts were signed. It is paradoxical that this current evolution of managed health care should have occurred at a time when medicine was beginning to escape the evils of parentalism, and patients were beginning to become better informed and to take more responsibility for their health and medical care. The imposition of business structures of control is a setback to egalitarianism. No one is more aware of the power shifts than the gatekeepers, who must administer the new systems at the grassroots level. This is a blow, both to the autonomy of patients and the professional integrity of physicians. The power to keep a gate, any gate, is ultimately corrupting, both to the keepers and the users.

Ethical Responsibility

Gatekeeping entails the assumption of risk that far exceeds the scope of responsibilities the physician can be expected to undertake. There are promises that cannot be kept. One promise is to be responsible for overseeing all of another's medical care on a contractual basis. The medicolegal breadth and depth of this presumed function has yet to be plumbed. It is unrealistic to suppose that a family physician can sit in judgment on the appropriateness of subspecialty care. No one can do that. Family physicians cannot be the conscience for all of medicine, especially if they accept money for trying. Moreover, it is not at all clear that patients want the family physician to supervise all their medical care.

Saying no to a patient about a referral or a procedure, and having the power to make it stick, is a level of responsibility entirely different from simply trying to be persuasive but leaving the decision, finally, in the patient's hands. In the same way, it is one thing to tell a patient what you think the trouble is, but quite another to imply that you know there is nothing else wrong. The presence of occult or coincidental diseases in a patient who has innocent complaints or functional complaints is a nightmare of liability in a system of gatekeeping by contract. One may be correct in diagnosing muscle contraction headaches in a patient, but that knowledge does not mean one also *knows* that the patient does not have a hemispheric cyst or an arteriovenous malformation that is asymptomatic. To have refused a referral under such circumstances on the grounds of lack of medical necessity might be correct, but it would be very hard to explain convincingly if, later, the cyst or the malformation ruptured. The financial contract puts diagnostic certainty in an entirely new light.

Along the same lines, one of my HMOs has a paragraph on the refusal to accept treatment. If a patient refuses recommended treatment, the HMO denies, on its own and my behalf, any further responsibility to the patient for that condition. This policy seems very shaky, and I would not like to be the first to test it.

The late Ron Christie[4] co-authored a book in which he demonstrated, to my satisfaction, that a specialty is defined by its ethical limits, not by what it claims about itself. Using his reasoning, I believe that the gatekeeping role has been expanded, for fiscal and administrative reasons, beyond what can be carried out ethically. The chronic awareness that one is overcommitted clinically and ethically is a constant source of uneasiness and worry.

CONCLUSIONS

My experience with contracted gatekeeping is that it is an untenable and hopelessly conflicted role that undermines the voluntarism and earned trust which lie at the heart of the family physician's effectiveness. By introducing elements of compulsion and control into the physician-patient relationship, gatekeeping transforms an intimate, covenantal relationship into a hard-edged contract between strangers—a bad exchange under any circumstances. Gatekeeping involves family physicians in structures of power, secrecy, and risk that are foreign to their traditions and ideals, and reduces their role to that of a corporate watchdog. This role is so untenable that I predict it will be eliminated in future versions of managed care. If watchdogging is a necessary job in current and future systems of medical care, let it be done by technocrats who have no stake in intimacy.

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