# Guest Editorial

# Are Family Physicians Ready to Be Gatekeepers?

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Innovations intended to control health care costs have come and gone rapidly in recent years. Community-based health facilities planning has had its day. Utilization review and medical care audits have taken a variety of forms in response to pressure from insurers and government agencies. Numerous new financing systems, primarily variants of prepaid health care, are being tried. Recently the term *gatekeeper* has been introduced to describe persons, usually primary physicians, who control access to laboratory, hospital, and consultant services for patients in various types of health maintenance organizations and preferred provider organizations. The primary intent is to prevent costly overutilization of medical care. One may further hope that gatekeepers will help make such services promptly and easily accessible when they are indicated. The concept is still evolving, but in a real sense it represents refinement and institutionalization of a basic family medicine tenet: Family physicians should determine when their patients need subspecialist services and should make referrals based on their consultants' clinical abilities and willingness to provide cost-effective care. Since this view fits so comfortably with the way family physicians have practiced for years, it should come as no surprise that planners are turning to family physicians to act as clinical gatekeepers in new delivery systems.

Some published reports have indicated that the use of gatekeepers has not saved money.[1,2] A review of these papers suggests that many variables are involved and that the concept itself has not been discredited. Other organizations are known to be using the idea successfully, and there has recently been a surge of interest in using physician gatekeepers to control overutilization of services by a minority of Medicaid recipients.[3,4] The concept is attractive, and we may be entering a time of unprecedented opportunity for family medicine to assume a position of leadership.

Are family physicians ready in adequate numbers to do the job effectively? No one can say for sure at this time, at least in part because we can only speculate about the volume of future demand

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for the service. There are, however, reasons for concern. First, many decisions for or against consultation are made on subjective grounds. The physician's view of the medical universe is based on a conglomeration of objective data, the opinions of mentors, and impressions derived from personal encounters with patients and many other categories of people. There is relatively little solid information that can be used to determine whether a given patient of specific age and sex with certain signs and symptoms of specified duration will benefit from a particular consultation or diagnostic procedure.

Second, we do not know as much as we should about the processes by which clinical decisions are made. Anecdotal evidence suggests that personality and past interpersonal experiences are important variables in this process and that there is a wide variation in evaluative and planning skills among physicians. We need to know more about this process and then use that information to teach the next generation of physicians to be better problem solvers and decision makers.

Third, most family physicians know less than they should about the nature of institutions and how to function effectively within them. They therefore are ill equipped to deal with the political realities they will face as gatekeepers. Medical students and residents work in large organizations during their years of training but receive little formal instruction in how institutions function and how best to cope with them. It has been said that generals tend to teach soldiers how to fight the previous war. It may be equally true that today's young physicians are being trained to practice in the 1970s, when most ambulatory care took place in private fee-for-service settings rather than the health maintenance organizations, corporations, and other large organizations currently developing.

Gatekeepers may encounter major political obstacles as they try to do their assigned jobs. One would hardly expect procedure-oriented subspecialists to take kindly to the idea of family physicians telling them to do fewer of the sophisticated tests that constitute a major part of their clinical activities. This possible problem may be of little concern in communities where family physicians now enjoy a major role but could be a problem where subspecialists have held a position of dominance. Perhaps even more disturbing is the fact that in many settings control is exerted by administrators who come from a tradition quite different from that of the physician. Gatekeepers will need to understand these issues and find ways to cope with them.

Finally, a consensus must be developed among physicians, legislators, ethicists, the courts, and others that resources available for health care are finite, that the ability to raise medical care standards has surpassed society's ability to pay for every possible service, and that fulfilling the gatekeeper role is rational, ethical, and in the best interest of the patients physicians serve. It is too early to predict just how great the medicolegal risks of serving as a gatekeeper will become, but it would be foolhardy to dismiss them as trivial.

Ambulatory health care supervised by family physicians is being recognized as rational, cost effective, and preferable to subspecialist-oriented, hospital-based treatment for the health problems most people have most of the time. This recognition offers a great opportunity for family medicine to assume a position of leadership, whether in the form of gatekeepers as envisioned at present or in some modification yet to be developed. However, as Geyman[5] has noted, there is a need for demonstration projects, research, and specific educational programs to define the function and to help family physicians, both those in training and those in practice, to acquire the knowledge and skills needed to do the job.

**References**

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