Ethical Gatekeeping: The Ongoing Debate

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The word *gatekeeper,* virtually unheard in discussions of medicine and health policy a mere five years ago, now labels a debate that many view as the most important emerging ethical issue in primary care. To begin the inquiry, the Society of Teachers of Family Medicine and the Society for Health and Human Values jointly sponsored a panel discussion in Washington, DC, in October 1985. The distinguished speakers—Edmund D. Pellegrino, Kennedy Institute of Ethics; G. Gayle Stephens, University of Alabama; Melvin Museles, Whittaker Health Services, Arlington, Virginia; and Frank H. March, University of Colorado—laid an excellent foundation for evaluating the ethical implications of the financial gatekeeper role for the family physician. This editorial briefly summarizes some of their conclusions, and also draws upon more recent literature to update the status of this debate.

Unavoidability of Gatekeeping. The panel rejected the rear-guard assertion that financial gatekeeping is never ethical because the physician must exclusively serve as patient advocate, never as manager of society's scarce resources.[1] Financial concerns, whether social and institutional interests or self-interest, have never been absent from the physician's decision making.[2] To say that the physician should do everything possible to benefit the patient regardless of cost is to suggest that the physician should function, not in the real world, but in a fantasyland where resources are unlimited. The true question is not whether, but under what circumstances and with what safeguards the family physician should explicitly function as gatekeeper.

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Types of Gatekeeping. Dr. Pellegrino distinguished several possible gatekeeper roles with very different moral implications.[3] Family physicians have always functioned as gatekeepers in the sense that not all patients received all requested services—unnecessary surgery might not have been performed; a work excuse may not have been signed. What is novel in the physician working in a prepaid setting is the explicitly financial rationale for denial of services. The old role may have pitted the physician against the patient's free choice; the new role, as Prof. Marsh notes, also involves a potential conflict with the physician's moral duty of fidelity or trustworthiness. Most problematic to Dr. Pellegrino is the "positive gatekeeper," who in the employ of a for-profit health system opens the gate as wide as possible in the name of maximizing profits among patients able to pay.

While the role of closing the gate for financial reasons is new, potential conflicts of interest in family medicine are not. Caring for multiple family members, or working in the employ of an athletic team, a factory, or a prison are only some examples. Skills used in mitigating the possible negative consequences of these other potential-conflict situations may be usefully applied to the gatekeeper function.

Disclosure Requirements. Addressing legal implications, Prof. Marsh suggested that violation of the fidelity duty can be avoided by frank disclosure to patients when financial considerations affect the physician's recommended care.[4] This requires a reeducation of physicians, as most of us have traditionally been embarrassed to raise fiscal issues openly in discussion with patients. Cassel,[2] in an excellent paper, suggests that one of the conditions for ethical gatekeeping within an institution such as a health maintenance organization (HMO) is a clear, ethically sound method for deciding who gets what treatment that is open to public review and discussion. Dr. Museles suggested that a functioning ethics committee is mandatory in any prepaid health plan.

Physicians and Corporate Management. Increasingly, physicians are urged to adapt to the world of cost con-

tainment by acquiring business management skills.[5] Dr. Stephens warned that we will be ill-served if we use a morally bankrupt corporate model as our rudder in these strange waters; we do not need medical counterparts of the recent cases of E. F. Hutton or General Dynamics.[6]

Research and Quality of Care. To say that cost containment must never be allowed to compromise quality of care is a comforting formula. It fails to take into account that our current standards of quality evolved over several decades during which it was never asked, as a component of medical research, whether the resources existed to provide these new advances equitably to all patients in need. In effect, unfairness was a hidden, built-in feature of current concepts of quality. A recent American Medical Association report acknowledges that efficiency and cost factors must henceforth be part of the definition of "quality."[7] Ethical gatekeeping ultimately requires new research to identify technologies whose marginal benefits for selected groups of patients do not justify their high cost.[8] Family physicians should play an active role in such research.

Protecting the Vulnerable. The working of politics and the marketplace in the United States make it inevitable that the first burdens of cost containment will be felt by the politically and economically powerless—the poor and the elderly, among others. Ethical gatekeeping requires attention to protecting these vulnerable groups. Cassel[2] therefore urges that financial gatekeeping is inappropriate in the absence of some means of assuring a decent minimum of care to all citizens.

Rhetoric vs Performance. Cost containment is a challenge to the core professional values of physicians.[9] Real performance in protecting vulnerable patients and defining quality of care through new research will help meet this challenge, but the standard rhetoric of organized medicine will not. Dr. Museles pointed out one reason why the physician's traditional rhetorical posture of defender of the public's interest in health matters no longer holds water:

> [The striking increase in physicians' income since Medicare and Medicaid] has cost us. Right or wrong, the public thought there was something obscene about a group of professionals becoming wealthy from the illness of others. When you go to the community hospital and see BMWs and Mercedes . . ., people become uneasy and angry.

The study of medical ethics in the past two decades has largely excluded consideration of physicians' income as an ethical issue. This taboo must soon be eliminated if the ethics and politics of gatekeeping is to be addressed squarely. Primary care physicians, for the most part, are not part of the "fat cat problem"—our incomes since the mid-1970s have not been keeping up with the consumer price index, while incomes of subspecialists have been running far ahead of consumer prices (Hudson JW, May 24, 1986, personal communication). Nevertheless, all physicians are lumped together when public perception labels physicians as a group as rich, greedy, and uncaring. Recapturing the moral high ground in the political arena may mean addressing income issues publicly and taking action on our own to limit excesses.

Educating Tomorrow's Gatekeepers. As family physicians, we are struggling to adapt to all of the factors listed above; as educators, we cannot afford to produce new family physicians who lack a thorough understanding of these issues and their ethical implications. Dr. Gail Povar of George Washington University noted during the audience reaction to the STFM-SHHV panel that residents who gain experience serving on a quality-assurance committee within a prepaid setting as part of their training will be better able later to judge issues of quality and efficiency of care within institutional constraints. As the gatekeeper debate continues, we must be willing to update our teaching to prepare future family physicians adequately.[10]

References

1. Levinsky NG: The doctor's master. N Engl J Med 1984; 311:1573-1575
2. Cassel CK: Doctors and allocation decisions: A new role in the new Medicare. J Health Polit Policy Law 1985; 10:549-564
3. Pellegrino ED: Rationing health care: The ethics of medical gatekeeping. J Contemp Health Law Policy 1986; 2:23-45
4. Marsh FH: Health care cost containment and the duty to treat. J Legal Med 1985; 6:157-190
5. Hillman AL, Nash DB, Kissick WL, Martin SP: Managing the medical-industrial complex. N Engl J Med 1986; 315:511-513
6. Shore MF, Levinson H: On business and medicine. N Engl J Med 1985; 313:319-321
7. Council on Medical Service, American Medical Association: Quality of care. JAMA 1986; 256:1032-1034
8. Thurow LC: Learning to say no. N Engl J Med 1984; 311:1569-1572
9. Brody H: Cost containment as professional challenge. Theor Med 1987, in press
10. Merenstein JH, Berg AO, Eidus R, et al: Training residents for the future: Final draft report. Family Med 1986; 18:29-37