From the Archives

Confessions of an Ax-Wielding Gatekeeper or How I Learned that Death is the Ultimate Economy

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I am writing this because, like the homicidal law student in Dostoyevsky's *Crime and Punishment*, I can no longer live with my tormented conscience.

I became a physician with only idealistic goals. I wanted to help others, to heal, to save lives, to do no harm, to place the interest of the patient above my own. I wanted to and, at first, I really did. I was a good physician. I sacrificed my time, my youth, my personal interests, my family, my marriage, yes everything, to live up to these lofty ideals. Patients did well, and they and their families were grateful. I felt good about myself. And I made a decent living, not six figures mind you, but decent.

But then something changed. I don't know why and I don't know how (I was too busy caring for the sick to notice), but I became a "capitated provider," a "gatekeeper," in a managed-care health system.

It sounded all right at first. I was guaranteed a fixed amount per patient per month. Yeah, there was something called a withhold, but it seemed a minor point. After all, I should get most of it back. And there was utilization review to weed out the abusers of health care. That seemed fair enough. But the reality was quite different.

First of all, my good and grateful patients suddenly became more demanding when they perceived that their health care was practically free at the point of service. My number of office visits and volume of phone calls increased exponentially. I felt like telling these patients they could take care of their headaches, myalgias, and constipation at home. But they kept coming, and I couldn't keep up with the demand. What is worse, the worried well began crowding out the sick from my schedule, leaving little time for those who really needed me. I had to return the calls of ten healthy patients to reach the one who was really sick.

Finally I had to hire a physicians assistant to help me keep up. She was pretty good, but I felt I was no longer taking full responsibility myself. Once in a while it would backfire, and I'd have to perform an emergency admission for myocardial infarction on a patient who had been seen earlier that day by my PA for the diagnosis of "indigestion." I felt ashamed of the care my office was rendering now because I knew that such patients would never have slipped through before.

Evenings and weekends became busier than ever as patients now demanded to see me instead of going to the ER. In the old days I at least got paid something for seeing patients on evenings, weekends, and holidays. Now I got not one red cent more. My wife began to really resent the calls. Soon I did too. It seemed as though patients no longer respected my time at all.

My patients became demanding in another way that I came to realize was hurting me in the wallet. With every financial disincentive removed, they began expecting throat cultures for every sore throat, mammograms for every breast lump, CTs for every headache, and consults for every ailment. Though it cost them nothing, giving into their demands was depleting the withhold from my measly capitation rate. Suddenly it dawned on me–my patients and I had become adversaries! Whereas before I helped myself by first helping them, now I hurt myself by helping them! I knew this fact, but I refused to act on it at first. I continued doing what I thought was best and right for my patients.

But then it happened. That utilization review program for the abuser of health care singled me out! The review had found my practice pattern of labs, x-rays, consultations, and admissions outside the norm (meaning above the norm–no one cared if you did less than the norm!). I explained that I only did what I thought was necessary and in the best interest of my patients. They told me I needed to accept more risk–meaning that my patients needed to accept more risk when they were sick! I was told how I could remediate and threatened with expulsion from the managed-care contract and the loss of my patients and my livelihood if I didn't improve my practice pattern within one year.

After that ultimatum, I changed inside. Slowly, almost imperceptibly at first, I began to hate the sick. I now had to see a patient every five minutes to keep up and had to avoid labs, x-rays, consults, and admissions like the plague. The patient with the complex problem, the difficult management problem, or the diagnostic quandary became the enemy, the adversary, the drain on my wallet. Needless to say, I know more about medicine and disease than my patients do, so most of the time I could placate them with fancy words, low-cost tests, and drugs. What I never offered they could never accept, and so informed consent was turned on its head. You see, informed consent is based on physicians having the best interest of the patient as primary and having the financial incentive to do what is right to diagnose, cure, or at least help. The doctor offers a treatment course, and the patient can say yes or no after being informed of the pertinent risks, benefits, and complications. But when the patient is the enemy, the adversary, and his disease or problem are seen as a potential financial drain on the physician, what incentive is there to offer any more than will placate him? What becomes of informed consent when beneficial treatments are never offered"

Then the inevitable happened. In walked a patient with a complex debilitating disease, a high-cost diagnostic and treatment whirlpool that I feared would certainly take me down with her. I couldn't avoid her. I couldn't placate. I couldn't run. I had to do what was necessary. But every day as the patient got sicker and sicker despite my numerous interventions, consultations with specialists, hospital admissions, labs and x-rays, and even surgeries, I saw my own future as a physician dying too. I thought to myself, "There is no way you are going to fall within the norm this year, and then you'll be out on year ear, Buddy!"

When things are really bad they say you should wait awhile. I did. They got worse. It seems as though my patient was favorably impressed with my care and referred to me other patients with equally complex, debilitating problems, under the same managed-care contract. They were all costing me money and probably soon would cost me my future as a physician as well.

I became desperate. I realized that it was either them or me. The longer they lived and generated costs, the less chance I had of surviving financially or even as a medical practitioner in the managed-care environment at all. I knew that their deaths would be my temporal gain. I understood that death is the ultimate economy, the surest way to save money on health care.

The next logical step was to have these patients' lives terminated. I agonized. I was greatly tempted to violate my Hippocratic Oath to do no harm and my Christian Oath to do unto others as I would have them do unto me. These thoughts I confess to all. But finally the only thing that got my ax was my managed-care contract.

One day in front of an assembly of my sickest patients I confessed what I was going through and took an ax to my managed-care contract. Several of them joined in my tearing up their managed-care insurance contracts. Then together, in All-American fashion, we filed a class action suit against all managed-care insurers for offering bribes to physicians to deny or limit care to the sick, for blackmailing physicians into denying their Hippocratic Oath and ethical principles, and for creating an adversarial relationship between physicians and patients.

And so ends the confession of the ax-wielding gatekeeper who learned that death is the ultimate economy but preferred life instead.

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