

**Dealing with  
managed care organizations:  
A second opinion**

by  
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**T**he question from the young surgeon was this: “I am new to practice and need some guidance on how to deal with managed care. What do you suggest?” (*Bulletin*, November 2000, p. 37). The well-intended and thoroughly constructed answer from the College broke the process down into 10 steps:

1. Perform background research on the managed care organization (MCOs).
2. Perform internal practice reviews of the MCOs.
3. Develop an MCO questionnaire.
4. Meet with MCO provider representatives.
5. Analyze the MCO’s practice data.
6. Present to physicians for decision.
7. Negotiate the contract.
8. Renew or terminate contracts.
9. Educate the office staff.
10. Continue the process; repeat at least yearly.

These steps all seem worthwhile. However, upon reading them, even as an experienced surgeon, I was left with a strong feeling of frustration and hopelessness. Then it dawned on me; despite the fact that I have a fine surgical career in what I refer to as “the Garden of Eden of managed care” (the Sacramento and San Joaquin Valley), I have needed little of what the article recommended. So, why this disagreement?

### ***Managed care’s promise***

I went to medical school and trained as a general surgeon at the University of Michigan and St. Joseph’s in Ann Arbor, MI, during the 1960s. Even then, medical education, research, and practice were really about managed care—managing the care of a patient using protocols developed from studies showing which treatments provided the best outcomes. Medical education will always be about how to properly manage health care delivery—whether we call it “managed care” or not.

Clinical protocols were designed to provide an adjustable basic framework to support appropriate health care for a population of patients. If carried out too rigidly, patient care could no longer be adjusted according to an individual patient’s needs. Such clinical rigidity was euphemistically referred to as “cookbook medicine.” This kind of non-thinking practice has always been considered the dark side of managed care.

We were also taught to be our patients’ advo-

cates and that if we concerned ourselves with what was in the best interests of our patients—even if it meant withholding unnecessary care and not receiving payment—in the end, they would do well and we would prosper. It has always been true that the most sophisticated and difficult health care decisions involve defining and withholding unnecessary care. Critical thinking of this nature is the essence of medical professionalism.

After a tour as a fleet surgeon in the Tonkin Gulf during the Vietnam War and two years on the full-time medical school faculty at the University of California-Davis, I went into the private practice of general surgery in Davis and Sacramento, CA, while maintaining my faculty appointment. In Sacramento, during the 1970s, the first non-Kaiser health maintenance organization (HMO) in the country was formed—Foundation Health Plan (FHP). I was in the inaugural group to participate in FHP. Other HMOs soon followed.

In the early 1980s, it became apparent that health care spending was still running away from the intended budget. The feeling was that physicians had failed, for various reasons, to control spending. Much of this was because the patient population was continually expanding and becoming more treatable because of advances in knowledge and technology. However, some of this inflation was also due to professional greed, often disguised in a self-righteous cloak of refusing to practice cookbook medicine.

We were the most highly trained professionals in history and not about to turn the practice of medicine into a non-thinking art. We also weren’t about to give up the autonomy of fee-for-service billing. In the end, our good intentions were doomed because we failed to adhere to our mission of patient advocacy and to recognize the need for maintaining traditional professionalism.

### ***Enter the gatekeepers***

As a result of the medical profession’s administrative disinterest and failure to reduce health care spending, nonphysician administrators took command of the MCOs. Health care spending, it was thought, must be brought under control through any measure. Because these new corporate heads and administrators were not physicians, it became easier to sacrifice medical professionalism and patient advocacy to the relative mindlessness of cook-

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book health care. This, then, became the new standard of practice for marketplace MCOs—a cookbook.

The stage was set to try to control the health care budget by simply withholding or denying care. What had traditionally been the most critical decision in health care delivery now became easy, as the difference between necessary and unnecessary care no longer mattered to those granting access; they weren't health care professionals.

The economic device used by MCOs to control spending was called "capitation," and the crucial decision-making process used to control access was called "gatekeeping." Using capitation, MCOs pay contracting groups of physicians and hospitals a set amount over a given period of time to care for an individual, irrespective of how healthy (or unhealthy) that person may be, as if we were all the same. As long as health care needs fall within this cap, there is money to provide care. However, if a patient becomes too ill, the cost of care could exceed the cap and payment for care could end. The emphasis is on protecting financial reserves through the rigidly programmed authorization and denial of care. The obvious incentive for the capitated caregiver is to provide less care.

Gatekeeping is the decision-making process by which a capitated patient is authorized or denied health care. Gatekeepers are typically chosen for their inexperience with special health care decision making. Using out-of-specialty gatekeepers makes them easier to control by MCOs because they are unable to think critically about their decision-making process. Also, they are usually lower-income health care providers rewarded for their aggressiveness in denying care—the infamous "gatekeeping bonus" or "physician incentive."

Unfortunately, it is relatively easy for gatekeepers to deny care they don't understand, for patients they don't know, in a system that is already understaffed and overworked. Further, the appeals processes are usually too burdensome to be clinically meaningful. Further yet, even though the MCOs prebudget for certain legal losses, the Employee Retirement Income Security Act (ERISA) protects HMOs from most liability for their health care decisions.

From a business standpoint, the concept of capitated health care is brilliant. Corporate profit and administrative salaries are ensured because

they can be taken off the top of the health care dollar. In effect, the MCO is able to fund administrative salaries and stock dividends before any care is authorized. Overnight, the viability of a health insurance business became virtually a no-risk proposition. Health care spending quickly came under control because, when health care dollars ran out, spending stopped. When spending stopped, inflation stopped. Unfortunately, the number of patients without health care access continued to increase, as did the cost of care.

### ***Medicine depersonalized***

Another interesting change took place. We stopped hearing about patients and patient advocacy. These two important concepts were replaced with common industry terms, such as clients, customers, consumers, lives, and, the ultimate depersonalization, units. Instead of patient advocacy, we began hearing about consumer advocacy.

A consumer is a person who chooses to use common goods or services to maintain a desirable lifestyle. A patient is someone who must use special goods or services to maintain acceptable health—to maintain life. There is a big difference between the two, not just with respect to economics and market forces, but also with respect to issues of human rights and freedom of choice. A consumer may easily be regarded as a statistic, but a patient is always a person.

The results included the depersonalization of the most personal of human services, the crippling of a most honored vocation, and the destruction of our fundamental freedom of choice. Individuality was wiped away by a rigid economic protocol, by a cookbook. It all worked beautifully—for a while.

If disease, health, and life could be quantified, a cap could rightfully be placed on health care delivery, but such is not the case. Capitation is incapable of distinguishing patients from consumers. Capitation does not entitle patients to health care services; it entitles corporations to remain solvent. Using capitation, the managed care industry sacrifices access to health care for the sake of a balanced budget, and managed care has become nothing more than managed cost. The reality is that capitation is void of social purpose, and the only aspect of health care delivery that should be capitated is the cost of administration.

The HMOs, for obvious reasons, fear the loss of

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capitation and gatekeeping, as well as the threats of re-personalization and the return of independence and choice to health care delivery. They continually link independent practice and fee-for-service with the runaway costs of health care delivery in the 1960s, '70s, and '80s. They use these fears (plus a fortune in lobbying funds) to control legislation. Worse, government lacks the will to stand against the health insurance industry and assume responsibility for assuring better access to care. It's all a thinly veiled form of insurance industry tyranny.

### ***Managed cost replaces managed care***

It is human nature to leave well enough alone. "Well enough" consists of a workforce that is largely healthy, needs little care, and (despite the recent economic slowdown) is living through one of our greatest periods of prosperity. The MCO industry tells us that the control of health care spending is "central" to this prosperity, and this may, in part, be true. Even so, we are sacrificing the health of a sizable segment of our population for the health of our economy by allowing the MCOs to capitate health care spending. We will be forced to deal with this reality by providing more expensive treatment in years to come for our patients who are denied care today.

MCO gurus counter by pointing to the emphasis they place on prevention. However, they are only concerned with preventive medicine for their own "clients," and then only if it doesn't cost too much, if it doesn't threaten their solvency. A booklet educating a patient on a low-salt or low-fat diet is one thing, but providing timely coronary bypass or hip replacement surgery is quite another. Further, the managed care industry completely ignores the historic commitment of the medical profession and the government to providing significant care, preventive or otherwise, for the underfunded populations. The MCOs are, in effect, cost-shifting their expenses into our children's economic future.

HMOs ignore that our standards of quality were established by physicians unconfined by capitation and gatekeeping and are maintained by specialists whose residual professionalism drives them to do their utmost for patients regardless of how the MCOs cut payments. Physician professionalism, like a fatal flaw, helps keep the MCOs solvent. Even so, last year saw the return of double-digit infla-

tion in health care costs.

While they are eager to use the research, clinical protocols, and health care providers that come out of our universities and government institutions, the MCOs spend little of their resources funding the process. The MCOs pay only a small fraction of the billions of dollars spent on medical education, research, and development. Most health care "R&D" money comes from tax dollars and the manufacturing industry that will profit from the sale of its products to the MCOs.

Here is the strange scenario: The MCO patients work, earn livings, and pay taxes. Billions of dollars of this tax money goes toward government-sponsored medical education and research. The MCOs base their operations on the knowledge acquired, basically free of charge, from this process and then profit from the denial of health care to the very patients who paid the taxes to begin with. This bizarre relationship is a vital part of the parasitic MCO life cycle.

### ***The remnants of managed care***

The reality of health care delivery in a humane industrialized society is that the patient population continually gets larger, older, and more treatable. Therefore, the cost of health care delivery must increase as time passes. The only way to live with this situation is to define the basics of health care in a responsible fashion, minimize inflation, and commit to a solvent delivery system that is financially able to sustain the provision of basic care.

To this end, quality health care, universal access, patient individuality, independent practice, professionalism, and even fee-for-service in health care delivery are completely compatible with managed care and MCOs. However, the health care delivery system should not be employer- or employee-based because such a system eliminates the hope for universal access by barring access to the unemployed. It cannot be capitated because the MCOs have shown us that capitation just guarantees corporate solvency while destroying the individuality, choice, and professionalism inherent in proper health care delivery. Finally, gatekeeping should be kept within specialties; to do otherwise is morally and intellectually dishonest. Gatekeeping out of specialty devalues patient advocacy, medical professionalism, and patients' rights.

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The cost of health care continues to climb and insurance premiums continue to increase. Large commercial independent practice associations are going bankrupt. Other MCOs—after a series of mergers, realignments, and lawsuits—are failing. This includes a large number of badly needed metropolitan and rural hospitals. Some MCOs are beginning to reject capitated contracts in an attempt to return to the open market. Our health care safety net has been left threadbare.

The number of uninsured Americans under age 65 who are without financial access to regular medical care continues to climb. There is a surging feeling that if MCOs don't reinvent themselves they will soon perish, and it is highly unlikely they will reinvent themselves because there's no longer enough money in it. The result of all this is that the U.S. is experiencing one of the greatest socio-economic transformations in its history—possibly the greatest since the abolition of slavery and the industrial revolution. How can any young surgeon go through an intelligent, cost-effective process of negotiation, even on a small scale, with a system that is failing this way?

The legendary English physician and teacher, Sir William Osler, wrote that there were three "A's" to successful medical practice, and he listed them in decreasing order of importance: availability, affordability, and ability. However, industrialized managed care is purposefully designed and administered to systematically restrict availability. Recent history tells us there is certainly little affordability left in the MCO system. Sadly, in the end, all the ability in the world is useless to a patient who can't struggle through the gates. As stated earlier, the reality is that marketized health care delivery has no social purpose and provides Americans with much less care than is theirs by right. How can any of us seriously negotiate with such a system?

Having said all this, I love the original promise of managed care—that it would be the door to the future of quality health care delivery. However, I have grown to hate the MCOs.

### ***The second opinion***

Finally, let's get back to the original question: "I am new to practice and need some guidance on how to deal with managed care. What do you suggest?" After reviewing all the contradictions and fallacies associated with MCOs, my best advice is to worry

less about negotiating with the corporations and focus more on truly managing care. Hence, here is my simple, effective plan for dealing with MCOs:

1. Get the best training available.
2. Stay well educated.
3. Become a strong advocate for your patients.
4. Put yourself in a position to care for the largest patient population it interests you to serve, but care only for those you can help and help triage the rest.
5. Don't worry about dealing with the MCOs; let them worry about dealing with you.
6. "This above all, to thine own self be true:  
And it must follow as the night does the day,  
Thou canst not then be false to any man."

(William Shakespeare—*Hamlet*)

As physicians and surgeons we must stay true to ourselves as well as to our profession. No one else can provide the care we provide—and the MCOs are worried. □

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