

APA Resource Document: I. The Professional Responsibilities of Psychiatrists in Evolving Health Care Systems

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I. Introduction

The practice of psychiatry—along with the rest of medicine—is undergoing a transformation driven primarily by efforts to control rising health care costs. It appears that we are in the midst of a revolution that is dramatically altering traditional patterns of practice and recasting professional institutions to face the new economic realities. These changes have created a crisis for psychiatry. Historically, the profession has been free to establish patterns of practice, institutions, and ethical traditions that have been in harmony, dedicated to the welfare of pa-

tients. Customs of practice have been crafted to encourage patients to seek health care and to trust their doctors; and psychiatrists have aspired to provide optimal health care and to promote their patients' best interests. In recent years, cost containment measures—including various forms of “managed care”—have threatened the independent moral values of the profession. Psychiatrists often feel that some techniques of managed care require them to discourage patients from obtaining needed services.¹ Moreover, some managed care practices have placed psychiatrists' financial interests at odds with patients' medical interests, thus jeopardizing the doctor-patient relationship.²⁻⁴

The methods of cost containment employed by insurers and managed care companies are rapidly evolving. The daunting pace of change has made it difficult for professional groups to formulate and articulate responses to the moving target of objectionable managed care practices. It is no surprise that many cli-

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nicians who are buffeted by these practices feel at sea and abandoned.

This document aims to develop a framework for ameliorating the problems raised by managed care and emerging health care systems. First, we list the core principles of psychiatric practice: those highly-valued principles that *must* be preserved under the new systems of health care organization and financing, whatever form they may ultimately take. These principles can be applied to specific contexts prevalent under managed care today and to new circumstances, contracts, and economic arrangements as they arise. Second, we consider the challenges to these principles raised by managed care and health care reform. We aim to encapsulate the problems, not to review exhaustively all cases. In the third section, we provide guidance to psychiatrists facing current dilemmas raised by managed care practices. In the fourth section, we discuss the ethics of allocating health care under conditions of constrained resources.

In a related document, we discuss managed care and cost containment at the level of systems of health care delivery. In order for psychiatrists to be able to practice in an ethical fashion, health care delivery systems must be structured to accommodate professional values. We suggest legislative aims and methods that may be considered as responses to existing problems and as efforts to improve the future functioning of the health care system.

Our hope is that these documents will serve two goals. First, our aim is to help orient practicing psychiatrists who are

facing the challenge of practicing sound medicine while contending with the economic and organizational whirlwind of change. Second, we seek to help set an agenda for policy makers at national, state, and local levels.

II. Principles of Psychiatric Practice

There are four crucial principles, related to the psychiatrist-patient relationship and patient care that must be preserved in evolving health care systems. These principles are founded on the ethical precepts of medicine.⁵

A. *Fiduciary Obligation to Patients*

The fiduciary relationship, under which psychiatrists are obligated to act in the best interests of their patients, is essential to good practice. Under the best of circumstances, lay persons do not have the specialized knowledge necessary to determine how the process of diagnosis and treatment should unfold; this is why they seek professional help. Moreover, patients are sick, in distress, and the sick role leads to feelings of dependency. And some patients have significant cognitive impairments that lead them to be poor decision makers, even when guided by a professional. Thus, for a variety of reasons, many patients are not able or disposed to act as though they are in arms-length, contractual relationships with their psychiatrists. Patients expect psychiatrists to act in their best interests without being explicitly directed to do so, and must be able to rely on this expectation in the future if the integrity of the health care system is to be maintained. A recent

AMA report described the importance of the fiduciary relationship well:

No other party in the health care system is charged with the responsibility of advocating for patients, and no other party can reasonably be expected to assume the responsibility conscientiously. Physicians care for patients directly, are in the best position to know patients' interests, and can advocate within the health care system for patients' needs. Without the commitment that physicians place patients' interests first and be agents for their patients alone, there is no assurance that the patient's health and well-being will be protected.⁶

The fiduciary relationship is the foundation of the doctor-patient relationship and must be preserved. Purely contractual arrangements among doctors, patients, and managed care entities cannot be allowed to supplant the fiduciary element of the doctor-patient relationship.

B. Patient Participation in Health Care Decisions

The autonomy of patients to determine the course and type of their health care is a fundamental tenet of contemporary medical ethics. In most instances, patients are the ultimate authority for health care decisions. Patient choice is especially important in two areas: the selection of psychiatrists and decisions about psychiatric services.

Patients should be able to select their psychiatrists freely, within the limits of availability. Patient choice of their psychiatrist is desirable because doctors vary widely in their interpersonal style, predisposition to particular methods of treatment, aversion to risk, and the discussion and advice they dispense. The selection of a psychiatrist may be particularly important to the success of psychotherapy. In order to achieve the best fit between

patient and psychiatrist and to maximize patients' trust of their psychiatrists, it is necessary to preserve patient choice.

Moreover, patients must have the freedom to choose psychiatrists as specialists to deliver their care when they believe this would be likely to maximize their health or to minimize their risks.

Individuals have differing treatment goals and bring highly personal values to decision making about psychiatric care. In order to exercise their autonomy in a meaningful way, patients must be able to rely on psychiatrists to provide relevant information about their care. Psychiatrists' duty to inform patients fosters the trust necessary to the doctor-patient relationship. The likelihood that treatment outcomes will fit patients' expectations is optimal when they are fully informed and involved in decision making.

Patient participation in making health care decisions is especially important when allocation decisions are being made. Whether health care is an entitlement established through the political process or a service purchased under insurance contracts, patients or citizens collectively have an interest in the just distribution of health care resources.

C. Access to Psychiatric Care

Patients should be secure in knowing that psychiatric care is available to them. The importance of access to psychiatric care is self-evident. All patients must have access to appropriate psychiatric services.⁷

In addition, patients must have reasonable assurances that their psychiatrists will continue to provide needed services. Continuity of care is necessary for the

treatment of many conditions. Moreover, for many psychiatric patients, the relationships they form with their treating psychiatrists are crucial to therapeutic efficacy. Unnecessary disruption of the therapeutic relationship must be avoided. Patients will be discouraged from seeking care if they are uncertain that the investments they make in treatment relationships will be respected.

D. Quality of Care

It is the responsibility of the psychiatric profession to ensure that practitioners are competent and to set the standards of care. The practice of psychiatry requires specialized knowledge and training outside the expertise of laypeople. Moreover, psychiatrists abide by moral and ethical principles that serve the therapeutic mission. Psychiatric practice is constantly changing, constantly improving. Judgments about the quality of care can only be made by psychiatrists, who are trained to evaluate research and to implement advanced treatments. Patients cannot be expected to have this expertise or to be able to bargain effectively with health care systems about appropriate care. Patients must rely on psychiatrists, ethically bound to act in their best interests, to establish standards and to provide competent care. Of course, there is a legitimate oversight role to be played by courts, consumer groups, and governmental agencies to ensure that professional norms are implemented. But psychiatrists must be the arbiters of professional competence and standards of care.

These principles have acted in concert to maintain the integrity of medical care. As the structure of health care delivery

continues to evolve, they must be preserved. In this document, the responsibilities of individual psychiatrists under managed care arrangements are discussed. A related document addresses the issue of structuring health care systems to allow these principles to be observed.

III. Problems Raised by Managed Care

In order to gain the necessary perspective on managed care, one must begin by considering the operation of the health care system prior to the introduction of aggressive cost containment measures.

Historically, the quality of care has been regulated by the medical profession. The competence of physicians has been regulated by professional groups, medical licensure boards, and, in hospitals, by medical staff judgments. As a backstop, the tort system—in the form of malpractice suits—has a regulatory effect on physician conduct. Even in the legal system, definition of professional standards has remained the province of physicians testifying as experts. Thus, determinations of standards of practice and competence have remained firmly in the hands of physicians.

Before medical insurance became widely available in the 1950s, patients made individualized decisions about the value of treatment. This meant that a given patient had to weigh factors such as the degree of distress suffered and the consequences of forgoing treatment against the costs of medical services. Concerns about costs or competing financial demands would lead patients to choose less expensive—and perhaps less

effective—options; for example, patients might choose to forego costly diagnostic evaluations or they might choose to make fewer visits to their doctor. In this era, costs were constrained by the resources of patients, including competing demands for these resources. The responsibility of the physician to advocate for the most effective course of treatment, while seeking to maximize the health of their patients, was not complicated by the involvement of third parties. Physicians and health care systems often provided services on a reduced or no payment basis. However, physicians accepted the fact that due to limited resources, it was not possible to provide every patient with optimal care. Thus, standards of care—which provide the referent for malpractice actions—were sensitive to resource considerations.³

Traditional indemnity insurance altered this arrangement by insulating patients from the costs of medical care. Insured patients, therefore, did not need to weigh the benefits of medical care against their need for other, non-health-related goods and services. Freed from feeling the economic consequences, patients were likely to choose the care most likely to optimize their health, regardless of cost. Under traditional insurance schemes, physicians' ethical responsibilities to advocate for the health of their patients were unchallenged. Moreover, patients were free to choose their doctors, including specialists. Patients received information and advice from their physicians and were free to determine the course of care. Ethical and legal sanctions protected patients from unreasonable termination of care.

During this period, physicians and the legal system recognized standards of care that were national in nature and, in hindsight it can be seen, insensitive to resource limitations.

The crucial flaw in traditional health care insurance schemes—the one that has contributed to escalating expenditures—is that neither patients nor physicians had any reason to consider costs. Because third-party payers were responsible for the bills, patients were free to choose the most costly care, to seek redundant diagnostic tests to achieve greater diagnostic certainty, and to pursue extraordinary treatments when routine ones had failed. Physicians, aiming to serve the best interests of their patients, also were motivated to achieve diagnostic certainty and to pursue any treatments that offered prospects for helping them, regardless of expense. While costly, the practices prevalent under traditional insurance schemes did not threaten the doctor-patient relationship.^{3, 8}

In recent years, the traditional insurance model is being replaced by various forms of "managed care." It should be acknowledged that this is an early period in the evolution of managed care structures. Therefore, it would be a mistake to believe that managed care represents a single approach to cost containment, or that the methods and structure of managed care will not change in the future. Indeed, corporate and government efforts to control health care costs are eclectic. To date, the cost containment measures that have emerged fall into two categories: (1) the regulation of physician judgment; (2) the injection of cost consider-

ations into clinical decision making. In addition, health care is undergoing a fundamental move toward corporate control. This latter development may ultimately affect medical practices in a more pervasive way than cost control efforts per se.

The regulation of physician judgment typically takes the form of utilization review (UR). Managed care companies employ a variety of methods to scrutinize physicians' decisions to treat and hospitalize. These reviews may take place prospectively, concurrently, or retrospectively. Initial levels of review are often performed by nonphysicians who have the authority to approve payment for treatment; denial of payment typically requires a physician's judgment that the treatment is not "medically necessary." The UR process may threaten the doctor-patient relationship in several ways. First, utilization reviewers are agents of managed care entities, not of patients. Therefore, the decisions they make may not be in the best interests of patients; decisions may be determined on fiscal rather than competent medical grounds. Second, treating physicians may regard UR determinations as final and they may not discuss denials of coverage with their patients. When this occurs, patients may not receive information about the basis of the decision from their trusted doctors, and they will be denied the opportunity to appeal. Third, as a result of denial of coverage, patients' access to care may be blocked.

Efforts to require physicians to consider costs while guiding health care decisions include Diagnosis Related Groups, HMOs, and capitation plans.

These schemes may place doctors in a conflict of interest. If, for example, a patient needs expensive care that will exceed the fixed-cost payment, doctors may be tempted to deny patients the best available care and not inform them of its availability. Contractual arrangements between managed care firms and physicians may increase this risk by providing incentives to deny care. These arrangements also threaten the four principles listed above. First, physicians may be tempted to make decisions based on their own financial interests rather than adhering to requirements of the fiduciary relationship; patients' interests may be relegated to secondary status. Second, patients may not be informed about the basis for decisions and will be deprived of the ability to choose medical care that is not offered. Third, access to needed treatment is denied, often outside patients' awareness. Fourth, medical decision making may be influenced by financial interests and, therefore, may not conform to the standard of care.

The corporatization of medical care also has implications for these principles. The doctor-patient relationship is placed at risk by increasingly important doctor-managed care and patient-managed care relationships. The arrangements among doctors, patients, and corporations take many forms and are rapidly evolving. In some manifestations of corporate medicine, corporate entities are taking increasing responsibility for decisions about the selection of physicians to participate in health care plans, the availability of various medical services, and the allocation of resources. In these corporate structures, the

ability of doctors to shape health care decision making is being eroded. Other corporate structures place substantial control of these decisions in the hands of physicians, within the boundaries of an overall expenditure cap. Physicians are, in effect, incorporating the function often associated with managed care: the allocation of medical resources within economic constraints. Physicians are called upon to determine what kinds of services are to be provided and which patients will receive—and which patients will be denied—health care.

The potential legal and ethical consequences of these developments have not fully emerged. How is the principle of fiduciary obligation to patients reconciled with the new roles that physicians are playing in the health care arena, specifically those that require physicians, in some circumstances, to deny health care to individuals based on economic grounds? Are physicians who act as utilization reviewers within managed care companies serving a role that is incompatible with the ethics of medicine? Are physicians who assume responsibility for allocation and rationing decisions acting contrary to ethical principles?

Physicians must also contend with the specter of legal liability. The movement to reduce medical expenditures has had an inevitable impact on standards of care. When costs are taken into consideration, diagnostic testing and treatment services are constrained. As a result, the margin of safety in clinical practice is narrowed, placing some patients at greater risk of harm. Many psychiatrists are concerned that courts that have grown insensitive to resource limitations will continue to ap-

ply the more expansive standards of care generated under the traditional insurance system. And, even though many decisions are actually made by managed care entities, it is feared that courts will find psychiatrists responsible when adverse consequences result. Indeed, it is now generally accepted that managed care companies' decisions about coverage do not preempt physicians' traditional responsibilities to their patients. Must physicians, once they assume responsibility for an individual, provide treatment and other services indefinitely, even after the insurance company has denied coverage? If, as some have suggested, there is a duty to appeal adverse managed care decisions, must physicians continue to provide all necessary care during the appeal? And how does the physician discharge the duty to appeal? Must every appeal be taken to the highest level in the insurance company? Must appeals be taken into the courts? Does the physician have the duty to appeal continuously?

In the remaining sections of this document, an attempt is made to reconcile ethical principles with the responsibilities of physicians in systems operating under cost constraints. In addition, the responsibilities of physicians under managed care are defined and reasonable limits to these responsibilities are offered.

IV. Responsibilities of Psychiatrists under Managed Care

In this section, we address the responsibilities of psychiatrists under current managed care practices and offer guid-

ance based on the principles previously identified. It is important to note that psychiatrists' responsibilities to their patients will need to evolve as managed care transforms psychiatric practice.

At this time, we can identify several new responsibilities that are derived from the principles of medical ethics and are related to the principles enumerated here.⁵ These responsibilities have been discussed in light of the few appellate court decisions in this area.^{2, 3, 9-11}

For the most part, the responsibilities proposed here are necessary because many patients are unaware of managed care practices—even though they may have voluntarily entered into contractual arrangements accepting them. Psychiatrists and their patients need to remain aware that managed care entities make determinations *about insurance coverage and payment*. Regardless of whether care is covered, patients make decisions *about their health care*. Many of the responsibilities discussed below are intended to facilitate patient participation in health care decisions in light of the new managed care realities.

A. Responsibility to Disclose

Because many patients are unaware of managed care practices, psychiatrists should discuss with their patients the features that are important and relevant to decision making or that may affect care. There are several common features of current managed care arrangements that should be discussed.

At the Time of Evaluation. In many cases, insurance policies cover only certain forms of psychiatric treatment. Psychiatrists should inform patients of all

treatment options, regardless of insurance coverage. Patients may prefer a treatment modality that is uncovered and choose to pay for it out-of-pocket. Psychiatrists must inform patients of all reasonable options, even if one or more options will not be covered by the insurer.

At the Outset of Treatment. Patients should be aware of the incentives to their physicians to limit care. As previously discussed, these arrangements are problematic because they create the possibility of a conflict between the treating psychiatrist's financial interests and the patient's interest in the best possible care. To date, there is no evidence that patients have been harmed by these incentives and the AMA has refrained from condemning the practice, opting instead to offer general guidelines.⁶ At this time, we recommend that any existing incentive arrangements be discussed openly with patients at the beginning of the treatment relationship. It is imperative that physicians maintain the trust of their patients. The future development of these arrangements should be closely monitored by the profession.

Psychiatrists should also discuss with patients managed care practices that may have an effect on the course of treatment. Unless informed, patients are likely to assume that their insurance will pay for treatment recommended by their psychiatrist, up to the policy limits. Patient should be informed in the following areas:

1. Patients should be aware of the review and monitoring required by the managed care entity. Patients should be aware that it will be necessary to disclose

information to the managed care entity for these purposes. Patients should be made aware of the access of reviewers and other insurance representatives to their medical records.

2. Patients should know that payment for treatment may be terminated under managed care arrangements. Patients should be informed of this possibility prior to entering into psychiatric treatments that may require a period of time before benefits are realized (psychotherapy, pharmacotherapy that may involve trials of medication). For patients with limited resources, this information may affect their decision to enter treatment.

B. Responsibility to Appeal

A psychiatrist whose patient has been denied payment for care has a responsibility to appeal the managed care entity's decision on the patient's behalf. This responsibility was first suggested in an early case on utilization review, *Wickline v. State* (1986). In deciding that case, the judge wrote, "the physician who complies without protest with the limitations imposed by a third party payor, when his medical judgment dictates otherwise, cannot avoid his ultimate responsibility for the patient's care."⁹ While the precedential value of that case is limited, the responsibility to make reasonable appeals when managed care entities deny coverage appears to be reasonable, as a component of psychiatrists' fiduciary obligations to their patients.

Managed care companies often have multiple levels of review and these procedures may require considerable investment of time and effort by the psychiatrist making the appeal. Some data suggest

that rates of successful appeal are low. Must psychiatrists appeal every adverse decision? When has the obligation to pursue "reasonable" appeals been discharged?

In our view, the responsibility to appeal arises when payment is denied for care that, in the judgment of the treating psychiatrist, is needed by the patient and should fall within the scope of coverage provided by the insurance company. The treating psychiatrist is satisfied when he or she has had the opportunity to discuss the appeal with a psychiatrist reviewer or has made a reasonable effort to do so. Lower levels of review, which generally do not involve psychiatrists as reviewers, do not give the treating clinician the opportunity to make the case for coverage to another medically trained professional who is in the position to make psychiatric judgments. Unfortunately, in most jurisdictions managed care entities are not regulated closely and psychiatrists may not be employed as reviewers or access to these reviewers may be made difficult. In these circumstances, treating psychiatrists must make reasonable efforts to convey their medical judgments to the available reviewers.

Treating psychiatrists have an obligation to discuss denials of coverage with their patients. Depending on the clinical circumstances, treating psychiatrists may choose to enlist patients' assistance early, prior to the initiation of the appeal process. Patients—and their families—may be able to bring additional pressures to bear on the reviewers. Alternatively, psychiatrists may appeal adverse coverage decisions and involve patients only after

appeals are denied. In all discussions about insurance denials, psychiatrists should make clear that while managed care entities make determinations regarding coverage and payment, patients make decisions about their health care. In the event of an adverse decision about coverage—including those cases which the treating psychiatrist does not believe must be appealed—patients should be made aware that their psychiatrist has recommended further care. In light of this knowledge, patients may choose to pay for services out-of-pocket or to pursue additional appeals with the managed care entity. Even when patients decide not to pursue either of these courses, knowing that their psychiatrist has recommended further care may lead them to monitor their condition more carefully and return to treatment more promptly.

In some cases, psychiatrists may have entered into contracts with managed care entities that preclude them from accepting out-of-pocket payment once coverage has been denied. Nonetheless, treating psychiatrists should make the appropriate recommendations to their patients, who may then choose to seek further care from another psychiatrist.

Psychiatrists have often felt that the burden of pursuing the appeal process without additional compensation is unfair. There is no ethical bar to prevent psychiatrists from seeking additional compensation from patients for time spent in pursuing appeals that are not required (i.e., beyond the level of the psychiatrist-reviewer, or in cases in which the psychiatrist does not feel treatment is needed or actually covered by the

insurance policy). Alternatively, psychiatrists may seek to be compensated by managed care companies. Of course, contractual agreements may limit psychiatrists from seeking compensation in these situations.

C. Responsibilities After the Denial of Coverage for Recommended Care

In the event that a managed care entity denies coverage for recommended care, psychiatrists continue to have obligations to their patients. In effect, the circumstances after denial of coverage are identical to those which prevailed prior to the widespread availability of insurance. Psychiatrists must negotiate with their patients about care and payment. In some cases, patients may be able to pay out-of-pocket for the recommended care. Alternatively, psychiatrists may be able to care for some patients for a reduced fee or for no payment.

What responsibilities do psychiatrists have if it is not possible to arrange recommended care? Managed care decisions and insurance limits may not allow optimal care to be provided, but often coverage is available for alternative care that falls within the standard of care. Treating psychiatrists have an obligation to formulate alternative care of this nature, or to refer their patients to psychiatrists who can perform this function. Within the limits of their expertise, psychiatrists have an obligation to provide the alternative treatment, or to arrange for another psychiatrist to do so.

What responsibilities do psychiatrists have if managed care entities deny coverage necessary to provide services within the standard of care and the patient

lacks resources to pay for treatment? In emergency circumstances, when psychiatrists have entered into a doctor-patient relationship with a patient, they have an obligation to provide necessary treatment. This duty is discharged when the psychiatric emergency is resolved or the care of the patient is assumed by another psychiatrist. In non-emergency situations, psychiatrists should attempt to arrange for care, if that is possible (i.e., free or low-cost services); if this is not possible, appropriate termination of treatment is permissible.

The most troubling cases arise when managed care reviewers deny payment for services that are not emergency measures, but treating psychiatrists judge that services are necessary to substantially reduce risks of harm to their patients or others. In these cases, termination is likely to be untenable to the treating psychiatrist. When this occurs, psychiatrists should follow their judgments and assure that services are provided when failure to do so would fall below the standard of care. In some cases, psychiatrists may be obligated to provide free care if they are unable to arrange the necessary care through public sector services.

V. The Allocation of Psychiatric Services

We are moving toward health care systems modeled on capitation plans and HMOs, in which groups of physicians will be responsible for making allocation decisions. Under these systems physicians internalize the allocation function. As psychiatrists, we will be called upon

to determine what kinds of services are to be provided and which patients will receive—and which patients will be denied—health care. It is becoming increasingly important that medicine develop ethics and principles related to the allocation of health care.

Although it has rarely been made explicit, the tension between our fiduciary obligations to patients and the need to make allocation decisions that deny health care has always existed. Doctors have always had to make decisions about the allocation of health care. The country physician, alone in an isolated community, has had to choose which patient to attend to first. In common practice, physicians have had to decide who gets the remaining ICU bed and who must leave the ICU to make room for the more severely ill patient. Psychiatrists have had to decide who gets admitted and who must be discharged to make way for more acutely ill patients. The decisions physicians must make range from life and death triage decisions made in emergencies to decisions about whose phone call to answer first. Every time a physician makes a decision that assigns a higher priority to one patient over others, an allocation decision is made.

Allocation decisions made under traditional models of health care delivery have been accepted as within the code of medical ethics. This professional discretion model of decision making has relied on the judgments of physicians to distribute resources to best meet the needs of all patients. The acceptance of professional authority has been based—implicitly, if

not explicitly—on the fact that physicians are in the best position to understand the impact and consequences of illness and trauma, and can best determine how to deploy available resources to maximize patients' welfare. Moreover, decisions often have to be made quickly, leaving physicians no alternative to assuming the burden of making decisions.

Evolving forms of health care delivery exceed the traditional boundaries of the professional model of allocation. Under the prevailing conditions of constraint, important allocation decisions are no longer restricted to emergency situations. And access is no longer restricted on the basis of absolute necessity. Increasingly, even where services could be delivered, access to routine diagnostic tests and treatments are denied on the basis of economically based, centralized criteria.

The Principles of Medical Ethics offers some general guidance to physicians that can be applied to allocational decisions: physicians are required to provide competent medical service with compassion and respect for human dignity.⁵ Moreover, physicians must deal honestly with patients and colleagues.⁵ However, it is not clear how these ethical principles should be applied. In these circumstances, a new model of professional involvement in the allocation of medical resources must be developed. Because the new allocation decisions arise in routine health care delivery, it is not necessary for physicians to bear the responsibility for allocation decisions alone. The principle of patient participation in health care decisions requires professionals to share this responsibility.

The outlines of a model for making allocation decisions can be sketched. Evolving health care systems typically arise from contractual agreements between groups of patients and groups of physicians; patients contract for a bundle of medical services (and limits). It is at this group level that patients must participate in the formulation of the centralized criteria governing the provision of services. To the greatest extent possible, allocation decisions should be made in advance by patients collectively. In a related document, we discuss the structural changes that need to be made to permit patients to participate in making these allocation decisions. Psychiatrists would then follow these criteria, which reflect the judgments of patients regarding the appropriate trade-offs between costs and access to services. Thus, in routine cases, psychiatrists would not be required to make allocation determinations in individual cases.

Of course, even in an ideal system that maximizes patients' participation in collective decision making, there will still be a need for psychiatrists to concern themselves with allocation decisions. Not all allocation decisions can be made in advance, by establishing criteria. There may be disagreement about interpretation of general criteria in applying them to a specific patient's case. Nor is it reasonable to expect that all clinical circumstances can be anticipated and guidelines established in advance. Inevitably, cases will arise that have not been foreseen or that have special circumstances worthy of consideration. In these circumstances, a group of psychiatrists could constitute an "allo-

cation board" representing the group of responsible clinicians. The board would assume responsibility for making the difficult allocation decisions. When constituted as a board, the psychiatrists' primary responsibility would be to interpret and to implement the established criteria as intended by patients collectively. In the absence of explicit patient-determined guidelines, the decision-making body would be required to make allocation decisions to maximize the welfare of patients collectively with the available resources.

Under this model of making allocation decisions, it is important to preserve treating psychiatrists' role as the guardian of the best interests of patients. Patients should be able to rely on their psychiatrists to represent their interests before the allocation board: to advocate for access to services in unclear situations. Therefore, with the exception of emergencies as under traditional health care systems, in evolving systems of health care, psychiatrists cannot assume a treatment role and make important allocation decisions for the same patient. *It is necessary to separate the allocation function from the treatment role.*

The allocation board model can be structured to ensure that allocation decisions are made in a way that respects the needs of all patients. Ideally, membership on boards would rotate, giving all clinicians the experience of making allocation decisions. Broad participation on the board would ensure that a range of clinical experience is brought to bear on these decisions. Thus, the members of the allocation board would retain their primary

identity as care givers. Moreover, as members of the board, these psychiatrists would bring to the process their experiences, as treating psychiatrists, of the impact of board decisions on patients.

A centralized allocation board can facilitate the just distribution of health care resources. The board will be able to consider individual claims in light of the competing demands of other patients to available resources. In addition, by documenting their decisions, the board can create an institutional memory for future reference. Thus, the likelihood of inconsistent, unreliable—and unfair—decision making can be minimized.

References

1. Council on Ethical and Judicial Affairs: Financial incentives to limit care: financial implications of HMOs and IPAs, in Reports of the Council on Ethical and Judicial Affairs of the AMA (vol I). Chicago: American Medical Association, 1990
2. Appelbaum PS: Legal liability and managed care. *Am Psychol* 48:251-7, 1993
3. Hoge SK: The regulation of psychiatry, in *Psychiatry* (vol 3, ch 34). Edited by Michels R. Philadelphia: Lippincott, 1992, pp 1-16
4. Stone AA: Law's influence on medicine and medical ethics. *New Engl J Med* 212:309, 1985
5. American Psychiatric Association: The Principle of Medical Ethics, with Annotations Especially Applicable to Psychiatry. Washington, DC: APA, 1993
6. Council on Ethical and Judicial Affairs: Ethical issues in managed care, in Reports of the Council on Ethical and Judicial Affairs of the AMA. Chicago: American Medical Association, 1994
7. Council on Ethical and Judicial Affairs: Ethical issues in health system reform: the provision of adequate health care, in Reports of the Council on Ethical and Judicial Affairs of the AMA. Chicago: American Medical Association, 1994
8. Kassirer JP: Our stubborn quest for diagnostic

- certainty: a cause of excessive testing. *New Engl J Med* 320:1489-91, 1989
9. *Wickline v. State*, 192 Cal App 3d 1630, 1645; 239 Cal Rptr 810, 819 (1986)
 10. *Wilson v. Blue Cross of Southern California*, 222 Cal App 3d 660, 271 Cal Rptr 876 (1990)
 11. *Hughes v. Blue Cross of Northern California*, 215 Cal App 3d 832, 263 Cal Rptr 850 (1989)