

Highlights of the 1997 Institute on Psychiatric Services

Integrating Systems and Meeting Ethics Challenges in Response to Managed Care

The 1997 Institute on Psychiatric Services, held October 24–28 in Washington, D.C., drew more than 2,100 participants to a diversified program featuring symposia, lectures, workshops, debates, and poster sessions. The theme for the meeting, the American Psychiatric Association's 49th annual conference focusing on clinical care, was "New Challenges for Proven Values: Defending Access, Fairness, Ethics, Decency." Twenty-six professional and advocacy organizations met in conjunction with the institute.

At the opening session, Herbert S. Sacks, M.D., APA president, said that psychiatry has prevailed in its advocacy for patients' needs on multiple fronts, but "in the political realm, the reality is that you advance your cause incrementally." He cited as a setback the rules proposed by the Clinton Administration that could allow many employers to gain an exemption from the Mental Health Parity Act, signed in September 1996 and scheduled to go into effect in January 1998. The act, which requires insurance companies to set the same annual and lifetime coverage limits for mental illness and physical illness, allows the requirement to be waived if employers show that parity increases the cost of a group health plan by 1 percent or more.

Public opinion polls show that an increasing proportion of Americans believe that managed care is harmful to their health, Dr. Sacks said. He praised the work of the national advisory commission on consumer protection and quality in the health care industry that has sent recommendations to President Clinton for a patients' bill of rights. The recommendations include the right to an external review of managed care decisions that deny payment for services. Also recommended is disclosure to patients of important

new information, such as how often a doctor performed a procedure and how often treatment was successful, that would help them evaluate health care providers.

In another session, Steven M. Mirin, M.D., who became APA's medical director on October 1, discussed what might be expected over the next decade in the financing and delivery of clinical care. Advances in the treatment of mental illness and reduction in the stigma associated with it will increase the demand for mental health services, he said, but at the same time access to these services and the intensity and duration of care will be under increasingly tight control.

Employers and others who pay for health care will continue to put pressure on managed care companies and other intermediaries to reduce costs, Dr. Mirin said. Managed care will persist, but its form will change somewhat as managed care companies merge and are able to exert even more financial pressure on medical supply companies and hospitals, he said.

Currently, providers are also integrating vertically and horizontally to reduce fragmentation of care, control costs, and compete with other providers. Such integrated delivery systems are likely to become more common, Dr. Mirin said. An important principle in such systems is that mental health care is an integral part of general health care. In integrated systems, primary care physicians are responsible for referring patients in need of mental health care to psychiatrists or other mental health professionals, but true integration at the clinical level is yet to be achieved, and barriers to such referrals exist.

As reimbursement for all health care shrinks, Dr. Mirin said, the mental health professions will feel pressure to

demonstrate that integration of care saves money and that the costs of having mental health professionals treat mental health conditions are low compared with costs of letting mental illness and substance abuse go untreated. However, for psychiatrists and other mental health professionals to be players in integrated systems, they will need to strengthen their training and clinical relationships with primary care physicians, he said.

Creating networks and systems in response to managed care

Five years ago at the 1992 institute in Toronto, Paul J. Fink, M.D., concluded a well-attended session on managed care by exhorting the audience, "All the psychiatrists in this room today should go home and start their own network. Don't let the managed care firms do it" (1). The 1997 institute provided many indications that psychiatrists and other mental health professionals have taken his advice. Preventing managed care firms from dominating the scene and extracting a substantial percentage of a system's limited resources in the form of profits has become a unifying goal of care providers in the public sector and in academic medical centers. To achieve this goal, they have been forming partnerships, networks, and integrated systems that can operate by the rules of the for-profit marketplace while remaining largely not-for-profit entities and maintaining the values of the public sector and of traditional medicine.

In Pennsylvania, mandatory managed care for all public-sector mental health and substance abuse services is scheduled to be phased in by the year 2001. In a symposium entitled "County Governance in Managed Behavioral Health Care," Gordon R. Hodas, M.D., statewide child psychiatrist in

the Pennsylvania Office of Mental Health and Substance Abuse Services, and several of his colleagues described Pennsylvania's transition to public-sector managed care, which began in 1997 in a five-county area of the state's southeast region. The transition will continue over the next four years in four other regions.

In designing the managed care initiative in Pennsylvania, planners made two critical decisions: mental health and substance abuse services will be carved out from general health care, and counties will be the governance unit for delivering care. The planners felt that the carve-out design would ensure that the public sector's 30 years of experience in providing mental health and substance abuse care to vulnerable populations would not be lost. In addition, such carve-outs enable administrators to unify the many public funding streams for these services. Planners felt that in a carved-in system these funds would be swallowed up by the larger general health care system.

In deciding on county-based governance, the planners agreed that counties are uniquely positioned to coordinate the range of services needed by targeted populations. Because the county has authority over other public human service systems, it has no incentive to cost shift, which is a problem when private-sector companies manage care. Counties in each region are given the first opportunity to bid on Pennsylvania's request for proposals (RFP) for managed public behavioral health care services. Counties must organize networks of care to meet all the requirements and standards of the RFP and must be willing to assume full risk for their citizens in the managed care plan. If they cannot do so, the state will invite the bids of private-sector vendors for that region of the state.

Lenora Stern, R.N., M.Sc., chief of the division of research and program development, described the state's highly structured RFP (available online at www.state.pa.us/pa_exec/public_welfare/overview.html), which details the state's expectations of bidders in terms of policies and standards. So far, she noted, all counties and regions have decided to enter the bidding process, as none wants to let a private managed care firm control its funds.

Ms. Stern pointed out that counties are aware that they must be part of the managed care plan or else pick up the tab somewhere else in the system, such as in the jails. To ensure that counties bidding on state contracts can meet requirements in the RFP, the state uses teams to conduct extensive on-site readiness reviews.

All the Pennsylvania presenters emphasized the importance of entering public managed care initiatives with a well-articulated set of values and principles and a clear vision of the services to be provided. Just as important, consumers and their families should be involved in all stages of the process—from developing the RFP to conducting readiness reviews. In addition, Dr. Hodas strongly advised states to develop written protocols describing best practices and to disseminate them to personnel at every level of the system. Such protocols are not effective, he said, unless they are backed by systematic training of behavioral health care providers and cross-training with workers in other service agencies.

At another symposium, "The Psychiatrist in Integrated Delivery Systems," a panel of three psychiatrists from New England described their experiences playing key roles in the development of systems in which behavioral health care is integrated with general health care rather than carved out. Steven M. Mirin, M.D., the new medical director of the American Psychiatric Association and formerly psychiatrist-in-chief and president of McLean Hospital in Belmont, Massachusetts, laid the groundwork for their presentations by giving an overview of how managed care organizations have gradually gained a high level of control over where, how, and by whom care is delivered.

In a capitated environment or one in which care is heavily managed and reimbursement is discounted, integrated delivery systems are a way that hospitals and community-based providers can move beyond the role of vendor of services, Dr. Mirin said. "An integrated delivery system tries to capture a vital array of general health and mental health care services," he said. "It can then use its size, reputation, cash reserves, political influence—and anything else it can think of—as leverage

within the marketplace to drive better contracting with the people who pay for care, whether the payer is Blue Cross-Blue Shield, the commonwealth of Massachusetts, or any other payer entity." The "entry-level requirement" for such systems, he said, is the willingness to assume financial risk, usually in the form of capitated reimbursement.

Although many clinicians are not equipped to deal with the business aspects of organizing an integrated delivery system, Dr. Mirin said, "We must move beyond bemoaning our fate and focus on substantive fiscal issues, getting outside help if we need it." However, he cautioned, "Fundamentally, medicine is a calling, not a business. If we become solely business people, we will lose a tremendous amount of credibility—not only with the patients who depend on us for care, but also with the policy makers whom we are attempting to influence." Psychiatrists must ensure that fiscal incentives in the new care systems do not compromise clinical care, he said.

Dr. Mirin and the other presenters agreed that "currently there is no such thing as an integrated delivery system, only integrating systems," an observation made by panelist Andrew W. Brotman, M.D., chief of psychiatry at Beth Israel Deaconess Hospital and senior vice-president for network development at CareGroup, Inc., in Boston. In attempting to create a service continuum in which people are cared for from birth to death, system developers are at the stage of "amalgamating parts," Dr. Brotman noted. He said that within eight months in Massachusetts "there will be no more parts out there, and the real work of clinical integration will begin."

Dr. Brotman raised the question of how to achieve clinical integration within such large systems—how to avoid simply "handing off the patient from one piece of the system to another." Many system developers have placed their hopes for such integration in highly expensive management information systems, he said. However, he believes that "a shared vision is probably going to be much more important." The concept of a full continuum of care is deeply embedded in the

practice of community psychiatry, he reminded his listeners, and its roots go back to the Community Mental Health Centers Act and the 1960s. Many people whose training and background were in public psychiatry now occupy leadership positions in integrated delivery systems because of their expertise in continuums of care and their knowledge of case management and multidisciplinary team approaches.

All of the presenters affirmed that functional merger is a painful and difficult process, with winners and losers. Jobs, programs, and sometimes entire facilities are eliminated. They also acknowledged that the corporate side of the developing systems has had to work hard to convince physicians that such systems are truly physician driven. For example, the corporate arm of CareGroup, Inc., has delegated all its contracting authority—a total of \$300 million in current contracts—to its physician-operated provider services network, which is a separate CareGroup company with its own board, and which is not under the control of the corporate group.

A crucial role for psychiatrists in integrated delivery systems is to ensure that the importance of mental health and substance abuse services is recognized, said Richard J. Goldberg, M.D., psychiatrist-in-chief at Rhode Island Hospital and chief executive officer of the behavioral health division of LifeSpan, Inc., in Providence. Within these systems, behavioral health care typically receives about 3 percent of the overall premium. "You're a small piece of a big general medical system, and you're always trying to remind people that you're a bigger piece of it than they realize," he said.

As "product lines" are being developed, psychiatry must use its representation on the organization's committee structures to promote true integration of mental health care. For example, when a cardiovascular service line is being discussed at a meeting, Dr. Goldberg said, "I have to be at the committee table to convince people to routinely screen for post-MI [myocardial infarction] depression at month 3. Because at the end of that meeting, a vote is going to be taken. There are many places where mental health care can, and should, be integrated into ser-

vice lines, but it's tough to come in afterwards and have physicians change what they're doing."

Integrated delivery systems have done a very good job of stabilizing the market in Massachusetts and keeping out the major for-profit managed care companies, at least in general health care, said Paul Summergrad, M.D., chief of inpatient psychiatry at Massachusetts General Hospital and director of the psychiatry network at Partners HealthCare System, Inc., in Boston. Integrated delivery systems are something of a conceptual gamble—and a large financial gamble, he observed, noting that no one is certain how such systems will evolve over the next five years.

A critical assumption on which these systems are based is that the practice of capitation will increase, said Dr. Brotman, who pointed out that a "consumer backlash" bill is currently before the Massachusetts legislature that would in effect stop capitation in health care. However, he observed, other key assumptions, such as that reimbursement rates will fall and that indemnity insurance contracts will become scarcer—are in little doubt.

New challenges to confidentiality

In a special session sponsored by the Washington Psychiatric Society, Richard S. Epstein, M.D., of Bethesda, Maryland, chair of the APA ethics committee, discussed threats to confidentiality of patients' records posed by the administrative simplification portions of the Health Insurance Portability and Accountability Act of 1996, which encourage formation of a computer databank of personal medical information. The law charged the Secretary of Health and Human Services with developing recommendations for protecting the confidentiality of medical information in such a system.

The recommendations, now under consideration by the U.S. Senate Labor and Human Resources Committee, are supposed to strike a balance between the privacy needs of patients and the needs of the health care system and the nation. However, the proposals allow use of private medical data without patients' consent to achieve certain national priorities, in-

cluding law enforcement, administrative research, and public health reporting. (See the Law & Psychiatry column beginning on page 27 for a fuller description of the recommendations.) In addition, once entered into large centralized computer databases, medical information becomes relatively easy to trace to specific individuals and can be sold for profit, exploited, stolen by criminals, or misused by officials, Dr. Epstein said.

Dr. Epstein discussed the intense struggle of the medical professions in Maryland to reverse a 1993 state law requiring that personal data on every health care encounter be entered into a state database without notice to patients. The law was enacted to allow research on medical cost containment. In 1997 a coalition of medical societies, consumers, and civil liberties organizations were successful in getting the state not to use Social Security numbers as personal identifiers in the database, but even with this step, cross-linkages between databases can allow identification of individuals, Dr. Epstein said.

Carol C. Kleinman, M.D., of Washington, D.C., said that if patients cannot rely on confidentiality, they will not be motivated to seek treatment. Patients usually assume that what they say will be held confidential, but to get insurance, most patients have to sign a blanket waiver, meaning that any information in the record is disclosable to the insurance company, she said. She urged clinicians to be careful what they place in the record and suggested that clinicians may want to keep two sets of records—one that includes more personal process material and their own hypotheses about the patient's condition, and another, intended for the insurance company, that includes only basic information on the patient's mental status, diagnosis, treatment plan, and medications and some progress notes.

Brian Crowley, M.D., of Washington, D.C., said that society is moving in two directions in relation to privacy and confidentiality. In support of confidentiality, the 1995 Supreme Court decision in *Jaffee vs. Redmond* recognized the psychotherapist-patient privilege in the federal judicial system. In addition, when the federal government

does a background check on a potential employee for a sensitive job in diplomacy and defense, the investigator may ask mental health professionals who have treated the person only about the person's ability to handle the job. On the other hand, many state and federal government leaders view extensive databases of medical and psychiatric records as necessary for reducing health care costs.

Dr. Crowley said that the mental health professions need to establish standards for disclosure and to push aggressively to have them enacted. He suggested, for example, that insurance companies should get only as much information as needed to determine if they have a contractual duty to pay a claim—the patient's name, date of visits, diagnosis, and a little about treatment. If the need to disclose additional information arises, Dr. Crowley suggested that the patient should be involved in making the decision about what to disclose.

In a separate session, Denise M. Nagel, M.D., of Lexington, Massachusetts, executive director of the National Coalition for Patient Rights and chair of APA's committee on confidentiality, said most people still think that a visit to their doctor or mental health professional is an extremely private encounter and that any information released should be used only for purposes of paying an insurance claim. However, she said the definition of confidentiality circulating in government and industry is that a large circle of authorized users are entitled to access to medical records without the patient's specific consent and that a breach occurs only if someone outside that circle gains access to the information.

"While clinician-patient confidentiality is an issue about personal freedom and civil rights, it is first and foremost a therapeutic issue," she said. "If people see the health care system as too leaky, and if they see their friends and relatives harmed because of confidences betrayed, patients will withhold information and delay treatment until the last possible moment. They will approach mental health or medical appointments very much as they would a job interview, if they approach them at all." She advocated requiring informed consent from patients for any informa-

tion to be entered or accessed from a computer network and strictly limiting the amount of clinical information given to insurers for processing claims or determining need for services.

Speaking on confidentiality and computers, Harold Eist, M.D., of Bethesda, Maryland, immediate past-president of APA, said aggregating data in computer databases increases the likelihood of improper disclosure depending on the value of the data and the number of people with access to it. Dr. Eist cautioned practitioners never to send entire records to insurance companies. If an insurance company asks for a patient's symptoms, he recommended sending a copy of the relevant page from *DSM-IV* and checking off the patient's symptoms. If the third party continues to make intrusive demands, the clinician has an ethical responsibility to inform the patient.

Support for support groups

In 1986 mental health consumers and their families, professionals, and researchers established an organization to provide support to people affected by clinical depression and manic-depressive illness, to educate the public about the medical-biochemical nature of these illnesses, and to promote research into their causes and treatments. The activities of the organization—the Depression and Related Affective Disorders Association (DRA-DA)—were described by J. Raymond DePaulo, Jr., M.D., professor of psychiatry and director of the affective disorders clinic at Johns Hopkins University School of Medicine in Baltimore. Dr. DePaulo, who was instrumental in starting DRADA, is a leading researcher in the genetics of affective disorders.

A feature that distinguishes DRADA from other voluntary health organizations, Dr. DePaulo said, is its focus on leadership training and consultation for people with affective disorders who are interested in starting support groups. Many mutual-help groups founded by consumers are short lived, he observed, often due to consumers' lack of training and to the relapsing nature of their illness. When DRADA was founded in 1986 by several Baltimore-area families, they hired a social worker to provide training to interest-

ed consumers and families. The trainer has developed a manual that teaches people how to organize a group and how to understand group process and facilitate supportive interactions. Dr. DePaulo emphasized the importance of training two or three leaders for each group so that they can provide backup when one of them experiences a relapse and can support one another during difficult periods in the course of the group. The leaders themselves meet as a group with the DRADA trainer every few months to receive ongoing training and support.

Since DRADA was founded, 66 support groups for people with affective disorders have been started in the Baltimore area and 60 are still in operation. Comparably large metropolitan areas, such as Boston and Chicago, generally have only ten to 15 such groups, said Dr. DePaulo. DRADA does not start the groups, he was careful to note—"the groups belong to themselves"—and only about 15 percent of group attendees are DRADA members. DRADA's aim is to export well-trained leaders. An immediate future objective is to train leaders for groups throughout the Washington, D.C., area.

Dr. DePaulo stressed the importance of a person's having the correct diagnosis in order to find the right support group. The DRADA training program teaches leaders that a support group is not a substitute for diagnosis and treatment. Participants in groups led by DRADA-trained consumers must be either getting professional help or trying to find such help.

Only about 15 to 20 percent of patients with affective disorders are willing to attend a group, Dr. DePaulo has found. However, many are interested in some type of anonymous one-to-one support. About four years ago, DRADA established its peer-support network with more than 400 consumer-volunteers, most of them DRADA members. The organization maintains a large computerized database with a demographic and clinical profile of each volunteer. Each caller is matched with a peer-support volunteer. The volunteer contacts the caller and shares information about treatment and coping experiences.

For the past 11 years, DRADA has

sponsored an annual research and education symposium open to the general public. In 1997 the 720 seats sold out two months in advance. Dr. DePaulo is surprised by the enormous success of the symposium, which he attributes to families' desire for new knowledge about depression. During breaks at the day-long symposium, consumers, family members, mental health professionals, and researchers mingle and exchange information and support. Dr. DePaulo said that the symposium and other experiences in his work with DRADA have convinced him that patients, family members, and professionals can work together at all levels.

Physician-assisted suicide

The international controversy over physician-assisted suicide concerns proposals that would allow a physician to legally prescribe a lethal dose of medication for a mentally competent adult suffering from a terminal disease likely to result in death. Whether physician-assisted suicide should be legal in the U.S. was debated at the institute by Lawrence Hartmann, M.D., of Cambridge, Massachusetts, and Arthur T. Meyerson, M.D., of Newark, New Jersey. Alan A. Stone, M.D., of Cambridge, Massachusetts, was the moderator.

Taking the affirmative position that physician-assisted suicide should be legal, Dr. Hartmann said recent polls indicate that two-thirds to three-quarters of Americans approve of physician-assisted suicide in some circumstances. He questioned whether the wish to die is always a symptom of mental illness and whether a psychiatrist can always tell the difference between depression and a wish to die. He said that palliative care for terminally ill patients should be improved but that the constraints imposed on physicians by managed care will mean that palliative care will probably remain inadequate in the U.S.

Dr. Hartmann said that physician-assisted suicide does not involve imposing an ideology or philosophy on another individual. Rather, giving individuals some control over the time and way of death allows them to make serious personal decisions with as little interference as possible.

The American Medical Association,

which opposes physician-assisted suicide, allows for passive measures such as withdrawal of life support, Dr. Hartmann pointed out, adding that "it is a question of dying well, and modern medicine has made dying worse. I do not think more and more life is always better. I do not think pulling the plug versus prescribing a pill is a morally strong boundary."

Dr. Meyerson argued against physician-assisted suicide, saying that it is inconsistent with the life-giving and life-protecting values of medicine. The physician's duties are to prolong life and relieve suffering, he pointed out, but relief of suffering should not be achieved by actively intervening to end the sufferer's life. Palliative care and anesthetic coma can be used to manage pain until death, he said, adding that the end of life in an anesthetic coma is not appealing but that it does provide mercy without violating the ethical and moral boundaries of physicians.

Dr. Meyerson noted that proponents often contend that physician-assisted suicide increases the dignity of the dying person, but that dignity is a subjective and culture-driven notion. He questioned how society can delegate to physicians the right to decide which person in which situation in which culture should be helped to die. He added that the public image of physicians has deteriorated in recent years with the increasingly technical nature of medicine and predicted that public acceptance of physicians' role in assisted suicide would change the public perception of the profession forever. "We don't require doctors to kill—anyone can do it," he said, "We need to use the power of medicine to improve the care of the terminally ill."

While the institute was taking place, voters in Oregon were casting their ballots in a mail referendum that would decide the fate of a 1994 state law allowing physician-assisted suicide. The 1994 law had not taken effect, initially because of a federal judge's injunction barring its implementation and later as opponents of the law fought a reversal of that injunction. In the 1997 referendum, voters again supported physician-assisted suicide, but the federal government has questioned whether the state law

conflicts with federal laws governing the registration of doctors who prescribe drugs under the Controlled Substances Act. The federal Drug Enforcement Administration in November warned that Oregon physicians who prescribe lethal doses of medication risk losing their privilege to prescribe controlled substances.

Ethical issues in managed mental health care

In a session sponsored by the American Association of Psychiatric Administrators, Richard C. Christensen, M.D., of Gainesville, Florida, said that managed care is changing the way clinicians and administrators think about applied medical ethics. The ethical issues that have attracted the most attention over the past decade—confidentiality, informed consent, psychiatric paternalism, and conflicts of interest—can usually be adequately resolved by individual practitioners and their patients, he said. But the ethical principles that have been the basis for resolving such issues have limited relevance in the managed care environment, where individual practitioners are no longer in control.

Dr. Christensen suggested that ethical analyses in managed care settings must extend beyond cases and rules to the ethical values that underlie institutional policies and practices. In negotiating with other agencies, community mental health organizations need to keep in mind their traditional values of humaneness, fairness, social responsibility, and integrity and their longstanding commitment to care for the most vulnerable members of the community. Community mental health organizations need reflective mission statements and steering committees that identify the priorities that will not be abandoned in negotiating managed care contracts, he said.

Jeremy A. Lazarus, M.D., speaker of the APA Assembly and former chair of the APA ethics committee, said that under managed care, providers' incentives are often tied to providing less care, placing professionals in a conflict of interest between their traditional duty to advocate for individual patients and their new duty under managed care to advocate for a population of patients. He identified several fac-

tors that can help resolve such conflicts of interest, including clear guidelines for treatment, adequate utilization review, outside appeal mechanisms for denial of care, disclosure to patients of potential conflicts, and limits on the size of incentives.

Dr. Lazarus suggested that a potential solution to such conflicts is to use money to influence treaters and systems to provide better care by tying incentives to good outcomes, as measured by various indicators such as patient satisfaction, clinical outcomes, or hours worked. Some systems and health maintenance organizations are moving in that direction, he reported, but lack of good clinical outcome measures limits such arrangements.

Mark Russakoff, M.D., of Tarrytown, New York, said that market forces are diminishing the ability of small community hospitals to provide care based on ethical values. Managed care contracts that limit care to what is medically necessary push clinicians into practicing on the edge of malpractice, he said. "Failure to do what is medically necessary is malpractice, but what about care that is medically beneficial and appropriate but costly?" he asked, adding that there is a strong temptation to distort findings to suggest medical necessity so that treatment will be approved.

Dr. Russakoff noted that physicians feel they must accept the fee structure proposed by a managed care company, but then they resent the fee, and "it becomes hard to separate the fee from the patient, contaminating the relationship with the patient." Small community hospitals also face the need to add administrative staff to manage managed care contracts, with the result that hospital costs go up but managed care pays less, further degrading the care that can be provided.

Steven S. Sharfstein, M.D., president, medical director, and chief executive office of the Sheppard Pratt Health System, Inc., in Baltimore, said that the shift to the marketplace in managed mental health care provides an opportunity for clinical creativity and for using principles of public health and community mental health to get the best care to the most people. But a regrettable aspect of managed care is the substitute of marketplace

forces for professional power, he said. Costs are contained by imposing the wishes of the powerful customer—the payer or the employer—and taking medical decision making away from the professional. He added that recognition of the effectiveness of psychiatric diagnosis and treatment has lowered stigma and led to greater demand for treatment.

In a separate session, presenters discussed how managed care influences ethical dilemmas that arise in public psychiatry. Julia Eilenberg, M.D., medical director of a county mental health center in Kingston, New York, said that psychiatrists and other mental health professionals may be attracted to public psychiatry by the ethical ideal that impoverished people who are suffering from severe mental illness deserve access to the best the mental health field has to offer. But she asked whether the ethical implications of resource shortages—a long standing problem in public-sector settings that is now being complicated by managed care—lead to reluctance to enter public-sector work. Dr. Eilenberg suggested that clinicians may feel that their cherished values of what constitutes good patient care will be compromised in community settings and that they may be sued if treatment decisions influenced by resource shortages have bad outcomes.

Arthur T. Meyerson, M.D., said that public mental health systems have long operated in the face of political realities, including prejudice and limited fiscal resources. Providers have always had to strike a balance between serving many poorly versus some well. However, the intrusion of managed care into the public mental health care system has highlighted and intensified these conflicts.

Dr. Meyerson said that mental health professionals who act as administrators in public mental health systems may feel that they must agree with the push to managed care to keep their jobs, but at the same time they may be concerned that managed care will diminish the resources available for patients. He suggested that clinician-administrators and providers who negotiate contracts with managed care companies make sure their agency can do the work required for the money

that is agreed on. He noted that one of public psychiatry's most significant functions—advocacy—may offend managed care companies and prevent such companies from doing business with a public agency.

Ronald J. Diamond, M.D., of Madison, Wisconsin, discussed situational ethical conflicts faced by clinicians and case managers who work with public-sector clients in the community. He described situations in which clinicians may find it useful to breach confidentiality for the good of the client, for example, by communicating with a landlord about a client's clinical course to help the client keep his apartment.

Dr. Diamond emphasized that good ethics starts with a good understanding of the actual risks of various courses of action, which should include consideration of whether a proposed action will really help the client and its effects on others besides the client. He recommended that clinicians discuss ethical dilemmas with colleagues who are not directly involved to ensure that they are maintaining a balanced view of the situation.

Dr. Eilenberg concluded the symposium by discussing ethical issues in allocation of mental health care resources in the public sector. As resources for community treatment of seriously mentally ill patients have shrunk or stagnated and the technology of treatment has expanded, most front-line community mental health providers find they must engage in implicit rationing of scarce resources, she said. Such decisions are burdensome to front-line staff and are a source of discouragement and anxiety, she noted. She suggested that morale might be helped if some decisions were made at a higher administrative level, but she acknowledged that until society answers the question of whether health care should be a right, it may be difficult to resolve allocation problems even at the highest government levels. ♦

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Reference

1. Wagner J, Gartner C: Highlights of the 44th Institute on Hospital and Community Psychiatry. *Hospital and Community Psychiatry* 44:18-22, 1993