

To: Altha Stewart, MD
Chair, Joint Reference Committee
From: Ezra H. Griffith, MD
Chair, APA Ethics Committee
Date: March 29, 2018
Re: Assembly Action Paper Assignment to Ethics Committee (2017A2 12.K)

The Assembly voted to approve action paper 2017A2 12.K, which asks that the APA will direct the authors of the *APA Commentary on Ethics in Practice* to bring its language into congruence with that of the *AMA Principles of Medical Ethics 10.1.1*, including a thoughtful exploration of the complexities involved. This would apply to any psychiatrist making any benefit and/or policy determinations.

BACKGROUND

The action paper sees a conflict between APA's *Commentary on Ethics in Practice (Commentary)* and the AMA's Ethics Opinion 10.1.1 (AMA Opinion) and asks that the *Commentary* be modified to reflect the AMA Opinion. The Ethics Committee does not agree there is a conflict because the two address different issues. The Ethics Committee does not see any need to change the *Commentary*.

For your reference, at issue here is whether, in the case of conflict, the patient's interest should always come first regardless of the role the psychiatrist is in, and regardless of whom or what the conflict is about. The *Commentary* and the Ethics Committee opinions on this issue illustrate the preferred approach to resolving conflicting ethics principles. It is in practice not helpful to see ethics rules in black or white and to apply them rigidly. Context matters. The *Commentary* does not set out hard and fast rules, but provides a framework for evaluating ethics dilemmas and seeking their resolution.

The Ethics Committee recommends two resources to help members resolve potential conflicts:

1. McCarthy J. Principlism or narrative ethics: must we choose between them? *Medical Humanities* 2003; 29:65-71.
2. Mol A. *The logic of care: health and the problem of patient choice*. New York, NY: Routledge, 2008.

McCarthy reminds us that in morally difficult situations, no principle is a priori privileged. And any principle, while obligatory on first impression, may be overridden in certain situations. Thus, it is important to seek "reflective equilibrium," evaluating strengths and weaknesses of competing principles before we decide on a prescriptive action.

Mol uses a simple example to make us reflect on the basic principle of autonomy. She makes clinical rounds on Monday morning and finds a patient asserting his claim of preference. He wishes to stay in bed. Mol honors the patient's choice. At rounds the following week, the patient is claiming choice

again. Now Mol raises questions about clinical sequelae. She asks staff to consider the possibility of maleficent outcomes that attend staying in bed. Suddenly, autonomy, one of the major guiding principles of care, is seen in a new light. The outcome may well be patient neglect and poor care. So even the primary commitment to autonomy is now no longer absolute, assuming the overall care of the patient is your goal. But Mol is not being prescriptive. She wants you to reflect before you decide, weighing the pros and cons, and the possible impact on the patient.

Whether working as a medical director, in a system of care, or in private practice, relying on absolute values without reflective equilibrium is potentially problematic. Yes, it is true that we should be serious about committing to caring for the patient. The patient's welfare should be uppermost in our minds. But no one physician is always in control of all the forces at play in the marketplace. Thus, there may come the occasion when other interests preoccupy us. Reflective equilibrium demands thoughtful assessment of the competing forces, their advantages and disadvantages. Then we make a decision, with the patient's interests always in mind. But we know that there are times when our hands are tied, and the reality of the situation forces a reordering of the usual primary commitment to the patient.

DISCUSSION

The *Commentary* emphasizes the need for such reflective equilibrium.

By virtue of their activities and roles, psychiatrists may have competing obligations that affect their interactions with patients. The terms "dual agency," "dual roles," "overlapping roles," and "double agency" refer to these competing obligations. Psychiatrists may have competing duties to an institution (e.g., employers, the judicial system, or the military) and to an individual patient, or to two patients or two institutions.

The treating psychiatrist has a primary, but not absolute, obligation to the patient. Wherever possible, the treating psychiatrist should strive to eliminate potentially compromising dual roles by attending to the separation of their work as clinicians from their role as institutional or administrative representatives. However, as the medical system becomes increasingly complex, it is critical for psychiatrists to recognize that not all competing obligations may be resolved.

Psychiatrists should remain committed to prioritizing patient interests as treating physicians, expecting that they will find themselves in the position of having to reconcile these interests against other competing commitments and obligations. Psychiatrists should inform patients about the potential for competing obligations within the treatment or other non-clinical evaluation, such as a forensic evaluation. At a minimum, the psychiatrist should inform the person being treated as a patient or or evaluated for another purpose of the purpose of the clinical encounter or evaluation, the limits on confidentiality of the treatment/examination, and the parameters of the relationship between the physician and the patient or evaluatee, (e.g., who requested the examination/evaluation, whether an ongoing relationship will occur, and, if so, the parameters/expectations of that relationship).

Commentary Topic 3.1.3 Dual agency and overlapping roles

While psychiatrists enjoy professional autonomy in their practice, an increasing number of psychiatrists nonetheless work within at least one system of care, such as a hospital, group practice, multispecialty group practice, accountable care organization, government system, military system, or work for third-party payors. These systems have increased in complexity but can create opportunities for improved patient care through innovation, clinical research, integration of health care, collegiality, and peer relationships. *However, they also create potential for conflict between the primacy of the individual patient and the legal, business, and political interests of the care system about which the psychiatrist should be aware and monitor.*

In increasingly complex systems of care, treating psychiatrists will encounter situations in which the primacy of individual patient care competes with other compelling interests and obligations. *Psychiatrists in any system of care, whether or not they are providing clinical care to individual patients, maintain responsibility to patient interests and commitment to promoting organizational ethics supportive of individual patient care and care of patients more generally.* Care systems may employ a variety of cost-containing measures, including prospectively, concurrently, or retrospectively reviewing treatment, emphasizing preventive or primary care services, requiring specific approvals for specialty procedures or referral, promoting the use of treatment guidelines, or creating economies of scale to streamline care within large systems. In these systems, other values often compete with the interests of the individual patient. *The fundamental tension of psychiatrists working in organized settings, then, is that the terms of employment relate to the needs of the venture, but as physicians, psychiatrists working in organized systems of care cannot wholly ignore the needs of patients. Psychiatrists practicing within such systems must be honest about treatment restrictions, maintain the confidentiality of patient information, ensure reasonable access to care within the system, and help identify alternatives available outside of the system when the patient's psychiatric or medical well-being requires it.*

Commentary Topic 3.4.1 Working within organized systems of care

The Ethics Committee, in addressing questions about the role of a managed care or utilization reviewer, has noted that the reviewing psychiatrist is not a treating physician in this circumstance. The interests of the managed care plan or system of care are not the same as interests of the patient, although they overlap to some degree.

The patient's treating physician has a duty to advocate for the best interests of the patient, while the reviewing physician has a duty to assess whether the care meets the criteria the plan has established. In fulfilling his/her duty to the managed care employer, the reviewing physician continues to have a responsibility to keep in mind the health interests of the patient. This responsibility is grounded in respect for persons and in the physician's commitment to the health of individuals and of society.¹

¹ E.g. *Ethics Opinion on Dual Agency Issues When Working Within Organized Systems Of Care*, at <https://www.psychiatry.org/psychiatrists/practice/ethics>.

All of these comments and opinions deal with a conflict between the interests of a patient and the interests of an organization. The Ethics Committee continues to believe they address the issue thoroughly and provide the tools necessary for members to evaluate ethical dilemmas in this context.

The AMA Opinion at issue states:

10.1.1 Ethical Obligations of Medical Directors

Physicians' core professional obligations include acting in and advocating for patients' best interests. When they take on roles that require them to use their medical knowledge on behalf of third parties, physicians must uphold these core obligations.

When physicians accept the role of medical director and must make benefit coverage determinations on behalf of health plans or other third parties or determinations about individuals' fitness to engage in an activity or need for medical care, they should:

- a) Use their professional expertise to help craft plan guidelines to ensure that all enrollees receive fair, equal consideration.
- b) Review plan policies and guidelines to ensure that decision-making mechanisms:
 - i. are objective, flexible, and consistent;
 - ii. rest on appropriate criteria for allocating medical resources in accordance with ethics guidance.
- c) Apply plan policies and guidelines evenhandedly to all patients.
- d) Encourage third-party payers to provide needed medical services to all plan enrollees and to promote access to services by the community at large.
- e) **Put patient interests over personal interests (financial or other) created by the nonclinical role.**

The Action Paper suggests that there is incongruity between the *Commentary* sections noted above and the highlighted sentence above. The Ethics Committee does not read section (e) to mean that patients always receive the treatment they need from their insurance plan regardless of plan coverage. Rather, it means that the physicians reviewing and making the coverage determination must not put **their individual personal interests** (i.e., bonuses for saving money, good personal evaluations for keeping to budget, etc.) over the interest of the patient. In other words, they need to review and evaluate the case honestly, using their medical knowledge, without letting their *personal interests* and *personal benefits* dictate the patient's care plan.

There is of course no doubt, that a physician should not effectively be bribed into denying care to a patient when that care is medically necessary and covered by the plan. The concept of honesty in dealings with patients and not exploiting patients financially or otherwise permeates the *Commentary* and is consistent with section (e) of the AMA Opinion, e.g., *Commentary* Topics 3.1.1 The Physician Patient Relationship; 3.2.2 Honest and Integrity; 3.2.3 Non-participation in Fraud. However, that does not mean that the patient's interest always trumps the personal interest of the physician. In response to a different action paper last year, the Ethics Committee opined:

The ethical issue of conflict between limited resources or allocation of resources in systems of care are similar for psychiatrists in private practice. Psychiatrists in these settings often find their own financial interest at odds with the interest of the patient. For example, psychiatrists who do not participate in insurance limit the ability of certain patients to receive care. Likewise, psychiatrists who elect to do only medication management when both medication management and psychotherapy are the standard of care put their own financial interest before the patient's care. In these situations, both of which are ethical, psychiatrists meet their ethical obligations if they explain to patients why they do not accept insurance in the first instance. In the second, psychiatrists must provide a complete evaluation of the patient, share their conclusions as to the best course of treatment, explain why they will only provide partial treatment and aid the patient in finding another person who can provide the necessary psychotherapy. While this inconvenience for the patient is financially motivated by the psychiatrist, it is nonetheless permissible as long as the limitations are made known. The same holds true in managed care settings. Allocation of limited resources is ethical where the patient is given honest feedback about what is and is not available and what is and is not necessary treatment.

Response to Action Paper 2016A1 12.Y, May 2016 Assembly.