Managed Mental Health Care: Attitudes and Ethical Beliefs of Child and Pediatric Psychologists

Lisa M. Buckloh, PhD, and Michael C. Roberts, PhD
University of Kansas

Objective: To examine child and pediatric psychologists’ ethical beliefs and attitudes toward managed mental health care.

Methods: In a survey mailed in spring 1997, 252 child and pediatric psychologists responded to three vignettes depicting ethical dilemmas related to working with managed mental health care (confidentiality, restriction of services, misdiagnosis). Data were collected about psychologists’ ethical choices and reasons given for choices, attitudes toward managed care, the extent to which managed care affected ethical decision making, and level of managed care involvement.

Results: Differences were found in choices made for the ethical dilemmas in regard to what participants thought they should do, would do, and actually did do. Overall, participants endorsed negative attitudes toward managed care. Participants reported that managed care somewhat affected their ethical decision making for the vignettes. Level of managed care involvement was not related to ethical decision making or attitudes toward managed care.

Conclusions: The findings suggest areas for examination as new ethical standards are created for work in managed care environments.

Key words: managed care; ethical decision making; professional issues; attitudes about managed care; children.

The health care system in the United States has witnessed rapid changes in structure and financing in attempts to control the dramatic rise in health care costs. “Managed care” has largely replaced the traditional fee-for-service model of reimbursement (Corcoran & Vandiver, 1996; Roberts & Hurley, 1997). Along with this change in the economic structure of health care comes a new set of ethical and legal issues for child and pediatric psychologists. Clinicians have been placed in conflicting dual roles, as both advocates for their clients and as employees with contractual obligations to managed care companies. It is unclear how managed care is affecting ethical decision making and how psychologists’ attitudes toward managed care may be related to their experiences and the types of ethical decisions they are making.

In addition to adhering to the principles embodied within the American Psychological Association’s Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992) when making ethical decisions, psychologists also must balance certain universal ethical principles, such as autonomy, nonmaleficence, beneficence, justice, and fidelity (Beauchamp & Childress, 1994; Kitche-
ner, 1984). Autonomy refers to the underlying principle that people can and should be able to make their own decisions without outside controlling influences. At the heart of this higher-order principle lie issues of informed consent and confidentiality and legal issues of privacy. Nonmaleficence means to “above all do no harm” and refers to the psychologist’s responsibility not to take or withhold any action that may harm the client. Beneficence refers to the concept of contributing to the welfare of others by being kind and merciful and doing good for clients. Justice refers to the treatment of people in a fair, equitable, and appropriate manner with regard to what is owed to them. Finally, fidelity refers to the obligation to keep promises, maintain contractual responsibilities, and act in a loyal, trustworthy manner.

Ethical dilemmas often result from a conflict between two or more of these principles, and decision making involves the balancing of two or more of these principles. Studies of ethical decision making have found that psychologists differ in their beliefs about what they should do in response to ethical dilemmas and what they really are willing to do (Bernard, Murphy, & Little, 1987). Managed care, with its emphasis on cost containment strategies, has produced many new ethical dilemmas and legal concerns for psychologists. In particular, psychologists confront ethical issues in managed care surrounding confidentiality, restriction of services/abandonment, and misdiagnosis.

With regard to confidentiality, psychologists routinely are asked to provide managed care companies with detailed information about client history, presenting symptoms, diagnosis, treatment plan, and prognosis. In surveys, 75% to 91% of psychologists reported beliefs that managed care practices compromise confidentiality (Murphy, DeBernardo, & Shoemaker, 1998; Sinnett & Holen, 1993). In these situations, psychologists are being asked to weigh issues of the client’s right of autonomy with fidelity toward the managed care company. On one hand, the clinician has a responsibility to protect the client’s right to decide what information is shared with other parties. On the other hand, the clinician has a contractual responsibility to the managed care company to provide services and to follow company rules and regulations.

Psychologists working within managed care settings face possible abandonment of their clients when they limit treatment to the allowable services authorized by the managed care company, even though their professional judgment indicates that treatment should continue. Again, this problem appears widespread, with 60% to 79% of psychologists surveyed reporting that managed care systems limit treatment length for clients or engender abandonment (Bowers & Knapp, 1993; BT Survey Results, 1987; Sinnett & Holen, 1993).

Finally, many psychologists have reported that managed care systems “foster an environment in which providers feel encouraged to choose the diagnosis [for their clients] most likely to assure insurance coverage” (Widmeyer Group, Inc., 1994, p. 2), regardless of the clinical appropriateness of the diagnosis. Although a misdiagnosis may be beneficial to the client in the short run because the client will be provided mental health services (beneficence), in the long run, the misdiagnosis could be harmful to the client (nonmaleficence). The client may receive inappropriate services for the problem if it is misdiagnosed, either in the present or the future. In addition to being an ethical concern, misdiagnosis is illegal, as it is insurance fraud.

**Study Questions**

Given the potential ethical conflicts posed for psychologists by managed care situations, it seems clear that professional attention should be directed to how affected psychologists perceive these dilemmas. By surveying a sample of child and pediatric psychologists, this study sought to provide answers to the following questions.

1. What are the ethical choices (and reasons for those choices) that child and pediatric psychologists think that they should, would, and did make in response to ethical dilemmas specific to managed care?

2. Are there differences between what psychologists report that they think they should, would, and did do to resolve ethical dilemmas resulting from managed care situations?

3. How are attitudes toward managed care related to ethical choices and reasons?

4. To what extent is managed care perceived by psychologists to affect decision making in the vignettes?

5. How does level of managed care involvement relate to ethical decision making and attitudes toward managed care?
Method

Procedures and Participants

Potential participants were identified from membership lists of organizations that were at the time of data collection (spring 1997) the American Psychological Association Division 12, Section 1 (Section on Clinical Child Psychology; 858 members) and APA Division 12, Section 5 (Society of Pediatric Psychology; 650 members). The sample included 800 randomly selected professionals who received mailed questionnaires. The proportion of Division 12, Sections 1 and 5 members in the sample reflected the proportion of total members in each organization. Two hundred and fifty-two completed questionnaires were returned, yielding a 31.5% return rate. Of the 252 participants, 131 were female (52.6%) and 118 were male (47.4%). Ages of the participants ranged between 28 and 84 years, with a mean of 44.66 years (SD = 9.96 years). The majority of participants held PhDs (94%), with the rest holding a PsyD (2.8%), EdD (0.4%), or master’s degree (2.4%). The median number of years that participants have been licensed was 11 to 15 years. The majority of participants work primarily in either a hospital setting (40.4%) or private practice (42%), with the remainder in a university clinic (8%), community health (4.8%), primary care (4.4%), specialty clinic (4%), psychiatric hospital (2.4%), or “other” (12.4%). All areas of the country were represented in the sample, including participants from 43 states and Washington, D.C. The sample is consistent with demographics of other surveys of these organizations.

Ninety-three percent of the participants reported treating clients under managed care insurance. Forty-nine percent of the participants reported belonging to one to five managed care provider panels. Seventeen percent of the sample indicated no involvement in managed care provider panels. Five percent of the sample (n = 11) indicated being employed by a managed care company.

Potential participants were sent a packet with the Ethical Dilemmas in Managed Mental Health Care questionnaire, a business reply mail envelope, and a postcard to request the results of the study. An introduction letter explained the purpose of the study, risks and potential benefits, the time involved completing the study, the voluntary nature of the study, and the anonymity of the responses. The research procedures were reviewed and approved by the institutional review board at the investigators’ university.

Measures

Ethical Vignettes. Section I of the questionnaire consisted of three vignettes we developed outlining realistic scenarios representing potential ethical dilemmas (confidentiality, restriction of services/abandonment, misdiagnosis) related to practice in a managed care setting. The confidentiality vignette described a managed care case manager requesting a detailed report of a client so she could decide how many treatment sessions to authorize. The psychologist did not have prior consent from the family to send this report. The restriction of services vignette described a situation in which a child with feeding and behavior problems needed additional services, but the managed care company would not authorize additional sessions. Finally, in the misdiagnosis vignette, a teenage girl met criteria for a diagnosis that was not covered by her managed care insurance and the family could not pay for services out of pocket. (Please see the Appendix for a complete description of these vignettes and the choices given to the participants to respond to the vignettes.)

The choices for each vignette were developed in a pilot study involving 21 (out of 100 members contacted) members of Division 12, Sections 1 and 5. The pilot questionnaire consisted of an introduction letter, three ethical vignettes (confidentiality, abandonment, and misdiagnosis), questions on attitudes toward managed care, and a demographics section. Participants provided responses to questions in an open-ended format about what they thought they should do as well as what they actually thought they would do to resolve each ethical dilemma. The participants gave a primary reason (open-ended format) for making each ethical choice and answered if they had experienced this dilemma in their own clinical practice. If so, they were asked to indicate how they did handle the situation, the primary reason for their choice, and how many occasions they had experienced this type of scenario. Questions were asked about the extent to which the participants perceived aspects of managed care to be responsible for their decisions for each of the should, would, and did conditions.

The study questionnaire followed the same format as the pilot study except that the choices for the vignettes were provided in a multiple-choice
format based on the data obtained in the open-ended format in the pilot study. The reliabilities for the ethical choices derived from the pilot were calculated for each condition by two independent raters. The interrater reliabilities were acceptable for vignette 1 (κ = .84), vignette 2 (κ = .89), and vignette 3 (κ = .94).

In contrast to the pilot, we developed the reasons for the ethical choices for the study questionnaire based on the pilot data and on the universal ethical principles of autonomy, nonmaleficence, beneficence, justice, and fidelity. In addition, “fear of professional/legal consequences or damage to reputation” was added based on previous research (Smith, McGuire, Abbott, & Blau, 1991). These reasons were provided to the participants in a multiple-choice format. The reasons offered to the participants for all three vignettes are as follows: (1) avoid harming the client; (2) consider financial/business obligations; (3) justly allocate limited resources; (4) maintain contractual obligations, act loyally toward the client; (5) maintain contractual obligations, act loyally toward the managed care company; (6) promote the well-being of the client; (7) protect the client’s right to make decisions and maintain privacy; (8) consider fear of professional/legal consequences or damage to reputation; (9) other.

The credibility of the three vignettes was assessed in this study to provide external validity of the project. Eighty-three percent of the study sample found vignette 1 (confidentiality) credible; 96.7% indicated that vignette 2 (restriction of services) was credible and 97.6% endorsed vignette 3 (misdiagnosis) as credible. Participants responded to the question, “Have you been in a similar situation as the above vignette in your clinical practice?” Forty-four percent of the sample had been in a similar situation as vignette 1, while 61% and 67% of the sample reported being in a similar situation for vignettes 2 and 3, respectively.

Attitudes Toward Managed Care. This section (II) of the questionnaire contained 24 items addressing attitudes and beliefs toward managed care adapted from a measure by Sazgar and Mitchell (1996). Participants were asked to rate their agreement to statements concerning managed care, using a scale of 1 to 7, with “1” indicating low agreement (strongly disagree), “4” indicating neutrality (neither agree nor disagree), and “7” indicating high agreement (strongly agree). There were six items in each category representing quality of treatment, ethical considerations, working conditions, and financial considerations. Example items included “Managed care peer review processes jeopardize confidentiality” and “Clinicians are allowed to make judgments about appropriate care.” A mean score was calculated for 24 questions. The reliability of the entire attitudes measure is considered good (α = .85).

Demographic Questionnaire. The final section (III) of the questionnaire requested demographic information and information about the respondents’ professional practice, including work setting, the amount of contact with managed care, type of managed care involvement, and position within the company if employed by a managed care company.

Results

Ethical Choices and Reasons (Study Question 1)

To answer study question 1 about the types of choices and reasons for choices the participants made, frequencies were calculated for ethical choices that the participants made in the should, would, and did conditions for each of the three vignettes. For vignette 1 (confidentiality), the majority of participants chose the option of allowing the client/family to decide the course of action for the should (67.2%), would (69.2%), and did (64.3%) conditions. Approximately 13% of the participants chose a combination of the choices in the three conditions (e.g., A and B). A small number of participants would discuss or complain only to the managed care company, and none chose writing a detailed report and sending it to the case manager.

On vignette 2 (restriction of services), there was more variability in the choices made. The majority endorsed either letting the client decide the course of action (should = 38.1%, would = 36.5%, did = 40.5%) or reducing the fee or providing a payment plan so the client can pay out of pocket (should = 21.1%, would = 25.8%, did = 27.0%). Approximately one-fifth of the sample endorsed a combination of choices or generated their own response. Low percentages chose options of telling the HMO it was liable, appealing the decision, or providing the family with a referral; none endorsed terminating services.

The majority also endorsed letting the client decide how to proceed for vignette 3 (misdiagnosis) (should = 37.3%, would = 32.1%, did = 27.8%). Twenty-six percent of the participants thought they
Attitudes Toward Managed Care (Study Questions 3)

To determine the participants’ attitudes toward managed care, we calculated a mean for the 24 attitude items. Out of a range of 1 to 7 (negative to positive), the mean for the total scale was 2.61 ($SD = .65$), indicating overall negative attitudes to-

should give a diagnosis of adjustment disorder although the diagnosis would not be reimbursed. Only 4% thought they should give a diagnosis of dysthymic disorder (incorrect diagnosis but would get paid), but 25.9% of those who actually have been in the situation (did condition) reported they have given an inaccurate diagnosis. Lower percentages of respondents endorsed appealing to the HMO, providing a referral, telling the HMO it is liable, or giving a reimbursable diagnosis and changing it later.

The participants gave a range of reasons for each vignette. For the confidentiality vignette, the majority of the respondents chose “protect the client’s right to make decisions and privacy” as their reason for making their ethical choice. On the restriction of services vignette, they primarily endorsed “promote well-being of client” and “protect client’s right to make decisions and privacy.” There was more variability with the misdiagnosis vignette, with participants choosing “promote the well-being of the client,” “protect the client’s right to make decisions,” and “act loyally toward the client.” Table I presents the data on the reasons given for the ethical decisions for the three vignettes and the three conditions (should, would, did).

**Differences in Choices and Reasons Across Conditions (Study Question 2)**

To determine if there were differences between what psychologists reported they should do, would do, and actually did do in response to each vignette, Cohen’s kappa reliability matrices were calculated for each pair of conditions (should vs. would, should vs. did, would vs. did). Nine Cohen’s kappas were calculated for the ethical choices and nine Cohen’s kappas were calculated for the reasons. A higher kappa reliability coefficient represents greater consistency of responses across the conditions (should vs. would, etc.). Table II presents the kappa coefficients for the ethical choices and reasons for the three conditions in the three vignettes. Overall, the ethical choices made for the should, would, and did conditions had lower agreement than for the reasons in the should, would, and did comparisons for all three vignettes. In addition, the agreement between should and did conditions (differences between ideal and actual behavior) was lower across all vignettes for both choices and reasons than in the other comparisons (should/would, would/did).

| Table I. Frequencies ($n$) and Percentages (%) for Reasons for Three Vignettes |
|-----------------|-----------------|-----------------|
| Reason                        | Should   | Would   | Did      |
| 1. Protect client’s right to make decisions and privacy | 166 (66.4) | 160 (65.3) | 62 (56.4) |
| Vignette 1                  | 66 (26.7) | 58 (24.0) | 30 (20.3) |
| Vignette 2                  | 52 (20.9) | 42 (16.9) | 25 (15.4) |
| 2. Act loyally toward client (maintain contract) | 32 (12.8) | 39 (15.9) | 20 (18.2) |
| Vignette 1                  | 35 (14.2) | 37 (15.3) | 25 (16.9) |
| Vignette 3                  | 44 (17.7) | 44 (17.7) | 26 (16.0) |
| 3. Avoid harming the client | 18 (7.2)  | 13 (5.3)  | 8 (7.3)   |
| Vignette 1                  | 21 (8.5)  | 28 (11.6) | 18 (12.2) |
| Vignette 3                  | 34 (13.7) | 31 (12.5) | 23 (14.2) |
| 4. Promote well-being of client | 14 (5.6)  | 11 (4.5)  | 3 (2.7)   |
| Vignette 1                  | 86 (34.8) | 77 (31.8) | 47 (31.8) |
| Vignette 3                  | 59 (23.7) | 68 (27.4) | 45 (27.8) |
| 5. Financial/business considerations | 0 (0)    | 1 (0.4)   | 0 (0)     |
| Vignette 1                  | 2 (0.8)   | 10 (4.1)  | 5 (3.4)   |
| Vignette 3                  | 4 (1.6)   | 17 (6.9)  | 13 (8.0)  |
| 6. Justly allocate limited resources | 1 (0.4)   | 0 (0)     | 0 (0)     |
| Vignette 1                  | 7 (2.8)   | 8 (3.3)   | 5 (3.4)   |
| Vignette 3                  | 3 (1.2)   | 2 (0.8)   | 3 (1.9)   |
| 7. Act loyally toward managed care co. (maintain contract) | 0 (0)    | 1 (0.4)   | 4 (3)     |
| Vignette 1                  | 1 (0.4)   | 1 (0.4)   | 1 (0.7)   |
| Vignette 3                  | 3 (1.2)   | 1 (0.4)   | 2 (1.2)   |
| 8. Fear of professional/legal consequences or damage to reputation | 0 (0)    | 1 (0.4)   | 0 (0)     |
| Vignette 1                  | 2 (0.8)   | 0 (0)     | 0 (0)     |
| Vignette 3                  | 15 (6.0)  | 10 (4.0)  | 6 (3.7)   |
| 9. Combination of reasons | 14 (5.6)  | 16 (6.4)  | 8 (7.2)   |
| Vignette 1                  | 23 (9.6)  | 19 (7.7)  | 13 (8.9)  |
| Vignette 3                  | 13 (5.2)  | 18 (7.2)  | 7 (4.2)   |
| 10. Other                   | 5 (2.0)   | 3 (1.2)   | 5 (4.5)   |
| Vignette 1                  | 6 (2.4)   | 4 (1.6)   | 4 (2.7)   |
| Vignette 3                  | 22 (8.8)  | 15 (6.0)  | 12 (7.4)  |

Vignette 1 = confidentiality; vignette 2 = restriction of services; vignette 3 = misdiagnosis.

**Attitudes Toward Managed Care (Study Questions 3)**

To determine the participants’ attitudes toward managed care, we calculated a mean for the 24 attitude items. Out of a range of 1 to 7 (negative to positive), the mean for the total scale was 2.61 ($SD = .65$), indicating overall negative attitudes to-
ward managed care. A series of 18 one-way analyses of variance (ANOVA) was performed to determine if attitudes toward managed care were related to ethical choices and reasons for ethical choices. Within these analyses, the dependent variable was the total attitudes toward managed care mean score, and the independent variable was either ethical choices or reasons. Those participants who endorsed more than one choice or reason were excluded from these analyses. After using a Bonferroni correction to take into account the number of analyses performed ($p = .0028$), we found that none of the ANOVAs was significant. These findings indicate that attitudes toward managed care did not seem to be related to ethical decision making (i.e., the types of ethical choices and reasons for choices given for each vignette). Within-sample contrasts were conducted for attitudes and demographic characteristics using one-way ANOVAs. Psychologists in private practice reported more negative attitudes toward managed care than those primarily working in a hospital setting, $F(1, 165) = 12.61, p < .01$. There were no other significant differences in attitudes toward managed care as a function of gender, ethnicity, years licensed, years of practice with children, or average length of treatment provided.

### Table II. Agreement of Ethical Choices Made and Reasons Given Across Conditions for Vignettes (Cohen’s Kappa)

<table>
<thead>
<tr>
<th>Vignettes</th>
<th>Should/Would</th>
<th>Should/Did</th>
<th>Would/Did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choices</td>
<td>.65</td>
<td>.44</td>
<td>.67</td>
</tr>
<tr>
<td>Reasons</td>
<td>.81</td>
<td>.73</td>
<td>.81</td>
</tr>
<tr>
<td>Restriction of Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choices</td>
<td>.61</td>
<td>.52</td>
<td>.68</td>
</tr>
<tr>
<td>Reasons</td>
<td>.73</td>
<td>.63</td>
<td>.79</td>
</tr>
<tr>
<td>Misdiagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choices</td>
<td>.51</td>
<td>.44</td>
<td>.77</td>
</tr>
<tr>
<td>Reasons</td>
<td>.59</td>
<td>.54</td>
<td>.80</td>
</tr>
</tbody>
</table>

For each vignette, the top entry is for the kappa for agreement of ethical choices across conditions; the bottom entry is the kappa for agreement of reasons across conditions. Generally, kappa values below .40 represent poor to fair agreement, those between .40 and .60 represent moderate agreement, those between .60 and .80 represent substantial agreement, and values above .80 indicate excellent agreement (Portney & Watkins, 1993).

### Effect of Managed Care on Ethical Decision Making (Study Question 4)

To determine the effect managed care had on ethical decision making, participants were asked to respond on a Likert-type scale (1 = not at all, 3 = some, 5 = completely) “to what extent are aspects of managed care responsible for your decision?” for each condition within the three vignettes. These data were compared across the conditions for each vignette using $t$ tests for paired samples. After using a Bonferroni correction to take into account the number of comparisons ($p = .006$), we found that only two comparisons were significant. For the restriction of services vignette, participants reported that managed care affected their actual behavior (did) ($M = 3.20, SD = 1.32$) significantly more than what they thought they would ($M = 3.02, SD = 1.30$) do in the situation ($t(1, 134) = 3.26$). On the misdiagnosis vignette, the participants endorsed that managed care affected what they would do ($M = 3.55, SD = 1.29$) more than what they thought they should do ($M = 3.31, SD = 1.33$; $t(1, 212) = −4.27$). These data suggest that psychologists perceive that managed care has some effect on their ethical behavior and that these effects are fairly stable for their ideal (should), hypothetical (would), and actual (did) behavior.

### Managed Care Involvement (Study Question 5)

To determine how level of managed care involvement relates to ethical decision making and attitudes toward managed care, participants were divided into three groups (low, moderate, and high) based on the percentage of time spent in clinical activities with clients with managed care insurance. The low involvement group ($n = 136$) consisted of participants reporting 0% to 33% of their time spent in clinical activities with clients with managed care insurance. The moderate involvement group ($n = 69$) reported spending 34% to 66% of their time involved with managed care insured clients, and the high involvement group ($n = 22$) reported spending 67% to 100% of their time with clients with managed care insurance. There was no difference in the amount of time spent in managed care among psychologists in private practice versus those working in a hospital setting. A series of 18 chi-square tests of the relationship between level of managed care involvement (low, moderate, high) and ethical choices and reasons for choices (ethical decision making) for the three vignettes in the three conditions (should, would, did) revealed no significant comparisons. Attitudes toward managed care and level of reported managed care involvement also were calculated using one-way ANOVAs. No differences were found in the attitudes toward man-
Discussion

This study was designed to give preliminary information about the ethical choices and underlying reasons for those choices that child and pediatric psychologists make when faced with ethical dilemmas related to managed care. Of the three ethical dilemmas presented (confidentiality, restriction of services, misdiagnosis), the participants responded most consistently to the confidentiality vignette across the three conditions (should, would, did), suggesting that they perceived few differences in what they think they should do and their willingness to engage in those behaviors when confidentiality was an issue. For the majority of the psychologists, the principle of autonomy appeared to outweigh the principle of fidelity in their decision making. They endorsed letting the client decide the course of action because they wanted to protect the client’s rights to make decisions and maintain privacy. It is encouraging that the participants were fairly consistent in their reports of their ideal and actual ethical behavior, because maintaining confidentiality is one of the most frequently encountered ethical issues in the profession.

Participants responded more variably to the restriction of services/abandonment vignette, suggesting that the choices in this situation may not be as clear for psychologists. The majority of the respondents chose either to let the client decide the course of action, to reduce their fee, or to provide a payment plan in response to the managed care company’s refusal to pay for additional needed services. The most common reasons given for their choices reflected the principles of beneficence and autonomy. In this study, the participants did not endorse abandoning their clients, even if this placed the psychologist at financial risk.

There also was considerable variability among the participants’ choices regarding how to handle pressure to misdiagnose. The reasons they cited for their ethical choices reflected the principles of beneficence, autonomy, fidelity, and nonmaleficence. Of note, approximately one quarter of the sample reported she or he had given an inaccurate diagnosis in a managed care situation, which, in addition to being an ethical concern, can be illegal. Another fifth of the sample chose to diagnose the correct disorder and risk not being paid or to reduce their fee in order and risk not being paid or to reduce their fee and allow the client to self-pay. Again, psychologists may be putting themselves at financial risk to maintain appropriate standards of care.

For all three vignettes, the participants reported some differences in their ideal (should) and actual (did) behavior. These findings are consistent with those of other studies that found psychologists and students report they would do less than they believed they should do in response to ethical dilemmas (e.g., Bernard et al., 1987). However, the differences found in this study are relatively small, suggesting that managed care ethical dilemmas do not elicit vastly different ethical decisions in ideal, hypothetical, and actual behavior.

In this sample, aspects of managed care reportedly influenced their ethical decision making, at least to some degree. Actual or hypothetical behavior (did or would) was perceived as more affected than ideal behavior (should) for the restriction of services and misdiagnosis vignettes. The actual aspects of managed care affecting decision making were not examined in this study but would be an area to investigate in future studies.

Overall, the participants in this study endorsed fairly negative attitudes toward managed care, indicating dissatisfaction with managed care in areas including ethical and financial considerations, quality of clinical treatment, and general work conditions. These negative attitudes toward managed care did not appear to affect ethical decision making in this sample. Similarly, there were no significant differences in attitudes toward managed care for any of the demographic or professional variables, such as gender, ethnicity, years licensed, years of practice with children, average length of treatment provided, or level of managed care involvement. Psychologists in private practice reported significantly more negative attitudes toward managed care than did those working in a hospital setting. Likely those in private practice are more affected financially by their involvement in managed care than those in the hospital setting. These results are similar to the findings of another study of general clinical psychologists working in independent or solo private practice (Sazgar, 1995). However, these findings should be interpreted with caution, as the parti-
pants' responses were negative enough that there likely was a floor effect, given the somewhat restricted variability in the sample.

Surprisingly, in this sample, amount of time involved with managed care was not directly related to ethical decision making. We expected that those with more managed care involvement would perceive managed care influencing their ethical decision making to a greater extent. In this sample, most did not have extensive managed care experience; a more diverse sample may show a different pattern.

As mental health care continues to change and managed care systems become even more prevalent, psychologists must be prepared to function competently and ethically in managed care environments. The results of this study indicate that managed care does affect ethical decision making in potentially negative ways. A majority of psychologists have encountered ethical dilemmas when providing services under managed care organizations that are not addressed by the Ethical Principles of Psychologists and Code of Conduct (Murphy et al., 1998). There appears to be a need for these types of dilemmas to be addressed more directly in the Ethical Principles of Psychologists and Code of Conduct, as well as in graduate training and continuing education for psychologists.

This study was the first step in identifying some of the underlying ethical principles that psychologists use while making ethical decisions in managed care situations. Other areas for future research could include investigating a sample with more diverse and heavier involvement with managed care insurance, including a bigger sample employed by managed care companies. Do psychologists with no or little managed care experience make ethical decisions differently from those employed by managed care companies? Does severity of client psychopathology affect psychologists' willingness to compromise their ethical beliefs? How do psychologists' ethical beliefs and attitudes toward managed care differ from their beliefs and attitudes about sharing information with other professionals, such as physicians or school personnel?

With the rapidly changing nature of the health care reimbursement system, ethical issues about managed care and professionals' responses to these concerns are also rapidly changing. By anticipating these changes, the profession will be better able to prepare psychologists to meet the ethical challenges of the next decade.

Appendix

Vignettes Used in Survey Questionnaire

Vignette 1: Confidentiality
You are part of the provider panel for the HealthSmart Managed Care Company. Forty percent of your business is with this company. A HealthSmart case manager informs you that you must send the company a detailed report containing client history, presenting symptoms, diagnosis, treatment plan, and prognosis for one of your clients who subscribes to their company. The case manager, who does not have any training in psychology, will then use the report to help her decide how many treatment sessions to authorize. The data also will be entered in the company's nationwide computerized database. You do not have prior consent from the family to send this report. The case manager tells you that if you do not send her the detailed report, your lack of cooperation could prompt the company to remove you from the provider panel.

Choices:  
A. Refuse to send a detailed report and possibly be dropped from the panel.
B. Write the detailed report and send it to the case manager.
C. Explain to the client/family that the managed care company wants the information. Ask the client to decide the course of action, such as to switch insurance providers or to give consent for the report to be sent.
D. Discuss with the case manager how the company uses the information and how confidentiality is protected. Make a decision about sending the report based on this information.
E. Complain to a managed care supervisor or executive about the situation and/or advocate for the family/client's rights to confidentiality.

Vignette 2: Restriction of Services
You belong to the MedPlan managed care provider panel. This HMO typically allows you three to five sessions for psychological services and then conducts a review of the case before authorizing payment for more sessions. You are seeing a family with MedPlan insurance for concerns about feeding problems exhibited by their 4-year-old daughter. Once you begin working with the family, you realize that the family has some additional needs, including help with behavior management of the daughter. You submit a progress report to MedPlan
with a request for additional sessions. MedPlan turns you down, stating that according to their guidelines, feeding and behavior problems should take five sessions to “fix.” You appeal, but the managed care company maintains the decision not to provide any more sessions. The family still needs services but cannot afford to pay your fees out of pocket.

Choices:

A. Provide the family with a referral to another agency that may be affordable so the family can pay out of pocket (e.g., Community Mental Health Center).
B. Continue to see the family but reduce your fee and/or set up a payment plan so the family can pay out of pocket.
C. Continue to appeal MedPlan’s decision.
D. Explain to the family that MedPlan will not pay for any more services and let them decide what to do (e.g., switch providers, pay out of pocket).
E. Tell the HMO that it will be held liable if help for this family is withheld and that you may inform the insurance commission, media, and/or legislative representative of this situation.
F. Terminate services with the family.

Vignette 3: Misdiagnosis

You are seeing a 17-year-old girl for some issues related to the divorce of her parents. She is covered by an HMO. You know that this particular HMO will not reimburse you for the diagnosis of adjustment disorder—unspecified, although this is the appropriate diagnosis for your client. You do know that the company will reimburse you for a diagnosis of dysthmic disorder, although the adolescent does not meet the criteria for this disorder. The family wants you to provide the services and have their insurance pay for the sessions. The family cannot afford to pay for services out of pocket.

Choices:

A. Give the girl a diagnosis of dysthmic disorder, so you can continue providing services and will get reimbursed for your services by the HMO.
B. Provide a referral for the client to a low-fee clinic.
C. Give the girl the diagnosis of adjustment disorder—unspecified and either provide services for a reduced fee or submit a claim to the managed care company knowing that you risk not being paid for services.
D. Tell the family about the situation and advise them of their options. Let the family decide how to proceed.
E. Terminate services with the adolescent.
F. Appeal to the HMO for coverage for the diagnosis of adjustment disorder.
G. Tell the HMO that it will be held liable if help for this family is withheld and that you may inform the insurance commission, media, and/or legislative representative of this situation.
H. Give a diagnosis of dysthmic disorder and get reimbursed. Then change the diagnosis to the more appropriate diagnosis at the end of treatment.

Acknowledgments

This article is based on the doctoral dissertation submitted by Lisa Buckloh under the direction of Michael Roberts at the University of Kansas, Clinical Child Psychology Program.

Received November 12, 1999; revisions received June 5, 2000, and November 8, 2000; accepted December 7, 2000

References

Kitchener, K. S. (1984). Intuition, critical evaluation and ethical principles: The foundation for ethical deci-


