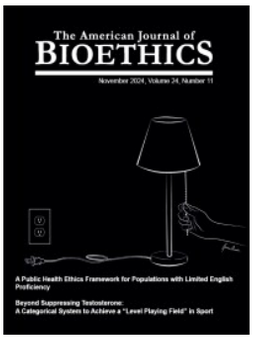

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Allocation of Treatment Slots in Elective Mental Health Care—Are Waiting Lists the Ethically Most Appropriate Option?

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ABSTRACT

Waiting lists are a standard approach to managing excess demand in elective health care. While waiting times are an important policy issue, the ethical validity of the first come, first served (FCFS) principle as such is rarely questioned. Presenting a psychiatric day hospital where all eligible patients have roughly equal claims as a case study, we criticize the reflex use of FCFS for allocation of elective psychiatric care, consider conditions under which this may not be the optimal strategy, and discuss alternatives. We conclude that in our example prioritizing more recent referrals (last come, first served [LCFS]) makes more sense, clinically and ethically. Where several referrals arrive (near-)simultaneously under LCFS, we propose that a higher level of scrutiny be applied to detect possible good reasons for prioritizing one of them. We believe that our observations can be applied to other health care settings that share relevant characteristics with our case.

KEYWORDS

Allocation; day hospital; first come, first served; last come, first served; psychiatry; waiting list

INTRODUCTION

In the context of non-urgent health-care interventions, including mental health services, waiting lists "arise" as a standard approach to managing excess demand (OECD 2020). Waiting time is a major cause of patient dissatisfaction and an important policy issue. Policies are usually focused on reducing waiting time (e.g., by increasing resources, improving efficiency, optimally targeting the treatment, finding alternatives etc.), as well as trying to account for differences in needs and expected benefit through prioritization (OECD 2020). The ethical appropriateness of using waiting lists as such, however, does not seem to be questioned in this context.

This paper has been motivated by our doubts about the ethical and clinical adequacy of the existing waiting list procedure in an adolescent psychiatric day hospital, and a lack of descriptions, to our knowledge, of valid alternative allocation procedures for this and similar settings in the scientific literature. After explaining the characteristics of the day hospital in our case study, we criticize the reflex use of waiting lists for allocation of elective mental health care, present some conditions under which a waiting list may not be the ethically most appropriate allocation strategy, and consider alternative procedures.

CHARACTERISTICS OF THE DAY HOSPITAL

The Therapeutic Day Center for Adolescents is part of the child and adolescent psychiatry services of our University Hospital, a tertiary referral center in Western Europe. It provides specialized psychiatric and psychotherapeutic care as well as individualized schooling for adolescents who fulfill the following basic criteria for admission: 1) age 13-17 years, 2) residing in the local administrative region, 3) presenting a severe mental health disorder of recent onset, 4) being, as a consequence, completely absent from school or education for an extended period of time, unable and/or refusing to return, 5) being capable of benefiting from a group setting. The program aims at treating the underlying psychiatric conditions, as well as enabling these young people to return to education, if possible. Referrals are accepted from psychiatrists or psychological psychotherapists, exceptionally from pediatricians or general practitioners. In other words, almost all referred patients already benefit from outpatient psychiatric and/or psychotherapeutic treatment, and day hospital treatment constitutes an additional and more intensive element of their care.

Treatment at the Center has characteristics of an indivisible good: even though the aim is to limit the

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duration of treatment as much as clinically possible for each patient, it cannot be shortened beyond a certain point without compromising its therapeutic value. It takes time to stabilize patients sufficiently for them to resume their development and minimize the risk of relapse.

Our day hospital is the only institution of its kind in its catchment area. There do exist other means to help its target population, including outpatient therapy, coaching, and interventions by educators or social services. While these measures may allow some youths to get better and return to education, they are not equivalent to day hospital treatment, but rather complementary. The only treatment option that bears considerable resemblance is a day hospital for *adults* in another institution that may accept selected referrals for older adolescents aged at least 16 years, on a limited basis as demand also exceeds capacity there.

New patients are admitted on an *ad hoc* basis throughout the year, whenever a slot becomes available. The admission procedure consists in meeting the patient and their family, in order to explain the nature of the program and perform a clinical evaluation. If the indication is confirmed and the patient consents to day hospital treatment, they are admitted, generally within several days. As the end of treatment is usually anticipated, the exact time when the next slot is freed can normally be predicted several weeks in advance. However, patients or families may themselves decide to stop treatment at any time and leave unexpectedly.

With a capacity of 18 places and an average length of stay of eight to nine months the day hospital is able to accommodate about 25 patients per year. While the total number of adolescents who fulfill the criteria for admission is not known, the annual number of referrals exceeds the Center's capacity by a factor of two to three. As we have been unable to rectify this imbalance, an allocation procedure has become necessary to decide which patients can be admitted.

THE WAITING LIST, a DEFAULT CHOICE

For some time, all referred patients were registered on a waiting list. Depending on the length of the list at the moment of referral, the referring professional was given a vague indication of whether a slot might be available rapidly (within a few weeks) or, more commonly, that waiting time would be indefinite. They were then contacted by order of entry whenever a slot became available to start the admission procedure. Patients who turned 18 years old while waiting dropped off the list and had to be referred to adult psychiatry services as required. These services also have shortages, but they have separate allocation procedures where the time spent on the adolescent waiting list is irrelevant. Patients admitted to our day hospital up until their 18th birthday can complete their treatment despite having come of age. As our Center is a public institution in a health care system with obligatory health insurance, any adolescent resident in the region may be referred and obtain a treatment slot.

This approach has many advantages. Although queueing is generally experienced as a nuisance by most of us, we do tend to consider it fair, given that (in a system with a single, simple queue) everyone appears to be treated equally. In an ideal queue, everyone has the same waiting time, on average, at a given moment, and everyone can eventually get the desired service.

More precisely, queueing systems are regarded as morally justifiable "to the extent that candidates have roughly equal claims to the good and are equally well positioned to compete for spots in the queue" (John and Millum 2020). This also applies to health care, where lay people, and to some extent health professionals, seem to think of waiting lists as fair (Krütli et al. 2016; Pinho and Araújo 2022). In our experience, referring health care professionals, including those who have no prior knowledge as to how treatment slots are allocated at our Center, seem to expect a waiting list, and that their patient will be put on it. They have never directly questioned the procedure as such.

Waiting queues are based on the principle "first come, first served" (FCFS). They are easy to implement and have low administrative costs. Additionally, introducing a delay may contribute to curbing inappropriate demand (potential overtreatment), as for some candidates the need or desire for the scarce good may diminish over time, without causing harm (Brown, Parker, and Godding 2002; Robin 1976). In situations which are not time-critical, patients seeking care may even be able to choose moments where waiting times are shorter ("off-peak"). Sometimes, being placed on a waiting list may represent a value in itself, as it may be perceived as a promise of a future good. It is important to note, however, that in situations where the good to be distributed is too rare to be attainable within a reasonable time interval, the waiting list may merely create an illusion and cause frustration because the "promise" has not been kept. Importantly, when the number of referrals added to the list persistently exceeds the number of patients who are allocated a treatment slot or who leave the queue for other reasons, the waiting times will become longer and longer.

The waiting list of the Center was exclusively based on egalitarian principles, i.e., the assumption that every referred patient should be treated fundamentally equally and be given an equal chance of access to the intervention (Arneson 2013). But is this really fair or can its fairness be improved?

IMPROVING THE FAIRNESS OF THE WAITING LIST, a COMPLEX MATTER

According to Broome (1991), fairness is about ensuring that claims are satisfied in proportion to their strength. In our example, claims can arise, e.g., on the basis of clinical need, understood as the degree of ill health and suffering (Cookson and Dolan 2000) or the likely capacity to benefit from treatment. Are we able to formally integrate prioritarian or utilitarian principles into the allocation procedure?

Prioritarianism holds that a benefit has greater value the worse off the beneficiary is. All else equal, then, those who are worse off should get higher priority for benefits than those who are better off (Holtug 2010). Utilitarianism generally posits that the morally right action is the one that maximizes the good, usually understood as the highest possible aggregate benefit for a given group of people (Driver 2022). This wouldn't necessarily prioritize the worst-off but rather those patients whose wellbeing is expected to improve the most, ideally with the shortest treatment (Persad, Wertheimer, and Emanuel 2009; Cookson and Dolan 2000; Hurst and Danis 2007).

As the Center is not an emergency service, there is, in principle, time to organize allocation procedures based on other criteria than (only) waiting time. Clinical information about the patient is routinely obtained at the moment of referral. On examining referral forms, our clinical intuitions do vary across presented cases. We may be more or less alarmed or touched by the description of the clinical picture or social context, or we may feel more or less optimistic about the patients' motivation or potential for recovery. We may be reminded of previous patients and how they fared with day hospital treatment. However, systematically and objectively prioritizing patients according to their needs and prognoses is a challenge in this context. There is a multitude of methods for grading severity of specific psychiatric disorders, with competing conceptualizations of severity, approaches to measurement, and outcomes (Zimmerman, Morgan, and Stanton 2018). Comparing and ranking patients across different diagnoses adds a layer of complexity, in particular if we wish to integrate prioritarian or utilitarian principles into our allocation decisions. For example, a young person suffering from schizophrenia may be severely impacted by their symptoms, but also slower to benefit from treatment and only partially recovering. Adolescents with an anxiety disorder, on the other hand, may suffer less acutely as long as they avoid phobic stimuli (such as school), but may be able to recover completely, with shorter treatment. In practice, these potential benefits are not quantifiable and difficult to weigh against each other.

Dedicated patient prioritization tools have been introduced in several non-urgent clinical settings (Déry et al. 2020). In child and adolescent mental health services, priority scores have been developed to rate the urgency of assessment or treatment among patients on waiting lists (Smith, Hadorn, and The Steering Committee of The Western Canada Waiting List Project 2002) or to help decide whether patients should be admitted to specialist level services (Kaltiala-Heino et al. 2007; Kaukonen et al. 2010). Priority scores correlate with clinical expert judgment (Kaltiala-Heino et al. 2007; Kaukonen et al. 2010; Cawthorpe et al. 2007) and are higher in those patients who receive more intensive and longer treatments (Isojoki et al. 2008), suggesting a positive correlation with the degree of ill health and suffering. Yet, it remains unclear to what extent they validly serve their purpose of quantifying actual need. Importantly, these tools are designed to prioritize patients among the *entire case mix* of patients presenting to mental health services, with a broad range of diagnoses and disease severities (Smith, Hadorn, and The Steering Committee of The Western Canada Waiting List Project 2002). In our case, a significant threshold is already set by the basic admission criteria. As the degree of ill mental health among our patients is thus by definition high, differences in need become smaller. What is more, our patients regularly surprise us once they are admitted—for better or for worse—regarding their capacity to engage in treatment and recover. To our knowledge, no valid prioritization tool exists for our kind of patient population.

Even if systematically ranking *many* patients seems highly problematic, it may be worth considering the particular case of a waiting list with only two or three patients. Our intuition and experience is that, in head-to-head comparison, we *sometimes* find arguments that may justify prioritizing one over the others; e.g. one of the patients might appear significantly more motivated to engage in day hospital treatment, at that point. This requires, however, having up-to-date clinical information for all of them, as well as additional scrutiny.

Yet, we consider that extending these head-to-head comparisons to a larger number of patients having arrived at different times on the waiting list is not reasonably feasible in our case. The clinical information transmitted via the referral form is not routinely updated. Patients' conditions, on the other hand, may change over time (weeks or months) and in different ways. One adolescent may recover from a depressive episode with outpatient treatment, while others may see their personality disorder deteriorate. Thus, defining patients' relative priority only at the moment of receiving the referral may not be sufficient. All patients on the waiting list would have to be reassessed at regular intervals. This would consume a lot of resources that may be more usefully dedicated directly to patient care.

These arguments raise fundamental concerns as to our ability and the merit of systematically and validly prioritizing patients on the Center's waiting list by need and likely benefit, once the basic admission criteria are fulfilled. The difficulty of ranking patients who clearly exceed a threshold for minimal benefit and need has also been noted elsewhere. For allocation of intensive care unit resources (outside of disaster triage situations), the American Thoracic Society has recommended that all patients fulfilling the threshold criteria for admission should be given equal chances of receiving treatment by applying FCFS (ATS Bioethics Task Force 1997).

In view of the above, we have come to consider, pragmatically, that all patients who fulfill our basic admission criteria have *roughly* equal claims, until proven otherwise. Our initial choice of a simple FCFS waiting list seems to be plausible and acceptable to referrers, while being logistically simple and convenient.

WAITING LIST AND THE BENEFIT FOR PATIENTS

Waiting time to admission has been highly variable and unpredictable in our case (from weeks to over one year, an eternity in the life of an adolescent). While some patients may recover spontaneously or by other therapeutic means during that time, others see their psychopathology become more severe and chronic. Some may even have to be hospitalized due to acute decompensation of their disorder. It has been noted that waiting lists may be associated with worse overall outcomes, psychological distress, and inappropriate use of scarce resources (Breslin et al. 2005; Brown, Parker, and Godding 2002; Tran 2024).

In addition, patients may become less motivated, less likely to start treatment and more likely to drop out as the waiting period increases (Tucker and Davidson 2000, as quoted in Brown, Parker, and Godding 2002; Westin, Barksdale, and Stephan 2014). Waiting lists for outpatient mental health services have been qualified as "barriers rather than gateways to access to care" (Tran 2024, 631). Some authors may argue that the long waiting time may be an incentive for patients to actively and creatively find alternative solutions (Schraeder and Reid 2015). Our own observations, in line with existing literature (Furukawa et al. 2014), suggest, however, that being on the waiting list tends to curb efforts of at least some patients (and of their care teams) to find and pursue alternative strategies, despite being informed that the chance of getting treated at the Center within a useful time frame is low. The longer someone is in a queue, the more they may feel entitled to treatment (Mann 1969). The closer the person seems to get to the front of the queue, the more difficult it becomes to leave the queue and forgo the good they set out to obtain—a bias known as the sunk cost fallacy (Arkes and Blumer 1985). Compared to physical queues, our patients would not need to leave the waiting list to seek a benefit elsewhere. However, relying on the entitlement that waiting lists promise may make patients, their families, and the referring professionals more passive and limit their search for alternatives. At least for some patients, being on the waiting list for more than a few weeks may thus have had a deleterious effect on them.

Importantly, clinical experience, as well as published data (Elliott and Place 2019) indicate that the longer a young person has been out of education, the more difficult they are to treat, and the longer it takes to help them to return to a "normal" social and professional life. Our use of a waiting list resulted in us admitting more patients who had been on stand-by for a long time, whose condition had become increasingly chronic and sometimes refractory to treatment. At the same time, the waiting list barred us from admitting patients early in the course of their disorder, where we may have had higher chances to benefit them.

Because of these factors, in our context, the use of the waiting list fails with respect to benefit-maximizing principles. It is also not fair for certain patients. On the face of it, it could be argued that patients who fulfill the basic admission criteria have equal chances of obtaining a treatment slot before being added to the waiting list. The place where one will be positioned on the list is epistemically random (John and Millum 2020), as long as the referring professional

has no prior knowledge of the current length of the queue. And as long as the length of the list is stable over time everyone on the list formally has an equal chance to access treatment. However, on a closer look, due to clinical or administrative factors, some patients' chances will diminish disproportionately compared to the strength of their claim, while they are on the waiting list. Under the FCFS rule, the longer a patient can afford to wait, the higher their probability of eventually being admitted, leading to inequality in assignment probabilities (Nikzad and Strack 2024). Most drastically, in our example, the chance of admission drops suddenly to zero when patients turn 18 years old. And those whose clinical condition continues to deteriorate while queueing may lose their capacity to successfully engage in day hospital treatment and may not be admitted in consequence of this.

Importantly, many patients wait in vain as they will never be admitted to the unit. Patients who are never admitted will, on average, have waited longer than those who obtain a treatment slot, unless they decide themselves to quit the queue early. The FCFS rule may end up doing more harm than good, as patients may be losing precious time to treat their disorder as early as possible, by the best means available, when there may be most to gain. Utilitarian principles would, however, require treating as many patients as possible early in their disease course to optimally promote their wellbeing. Additionally, anecdotic feedback from referring professionals suggests that patients who could have benefited from treatment at the Center were not even referred, as it was assumed that the waiting time would be prohibitively long. These pitfalls of the existing allocation procedure made us look for alternatives.

MOVING ON BEYOND THE WAITING LIST

Let us recapitulate the problem, as we understand it so far:

1. Not all patients who are referred and who fulfill the basic criteria for admission to the Center can obtain a treatment slot.
2. Among patients who fulfill the basic criteria for admission, we have not been able to reliably grade priority in terms of levels of need and potential benefit of treatment. We have thus come to consider, pragmatically, that they have roughly equal claims to being considered for treatment at the Center.
3. Referrals arrive at unpredictable times throughout the year and the number of referrals fluctuates.
4. Treatment slots are freed up, not entirely predictably, throughout the year.
5. It may be deleterious for patients to spend more than a few weeks on the waiting list.

The idea that waiting may be harmful conflicts with the common intuition that arriving early in a queue represents a merit and an entitlement to priority of service (Mann 1969). However, John and Millum (2020) assert that waiting time has no intrinsic moral significance. They consider that the obligation to respect the rules of this scheme derives solely from "the commitment […] made to candidates to the good" (John and Millum 2020, 187) and that "there is no moral reason to prefer the scheme that prioritizes candidates who have waited for more time over those who have waited for less time," as long as the alternative allocation scheme is equivalent (or better) "in every other morally relevant respect (such as efficiency, equality, and fairness)" (John and Millum 2020, 189). It is true that being placed on the waiting list of the day hospital does not directly impose any burden or hardship to patients, families, and therapists in question. On the contrary, they are given a chance (or, maybe more importantly, hope) of future admission. Yet, it is precisely this hope that may become counterproductive if the waiting time ends up being longer than a few weeks, or if a treatment slot never becomes available.

In order to minimize waiting times, the decision whether or not to admit a patient has to be made *at* (or *near*) the moment of referral. If, at the time of referral, there is no clear perspective for admission (i.e., a free slot within a few weeks), it is important that the referring therapist, the patient, and their family explore alternative solutions.

Some health care providers, in particular psychiatrists and psychotherapists in private practice in urban areas, may simply not accept new appointments when their practice is full (Chen et al. 2023), implicitly referring callers to other providers of the same type, who may or may not be available. This approach results in an immediate (negative) decision and avoids waiting times for a given practice. However, a specific procedure for *allocating* appointments is rarely, if ever, indicated.

Contrary to the psychiatrists' office that may be one of many equivalent private local providers, our Center is a singular public regional institution that offers a specialized level of care. We consider that such an institution should have a more formal allocation procedure.

If we abandon FCFS, what alternative procedure can we use that permit a more timely decision and

can be considered fair? Would a lottery be a better option?

LOTTERY

Broome (1991, 99), in his seminal paper "Fairness," suggests that, when "candidates' claims are equal or roughly equal," a lottery should be held. Lotteries respect the claimants' equal entitlements to the scarce good through a truly random process or, at the very least, "in a way that cannot reasonably be seen by the allocator or the claimants as favoring any claimant" (Wasserman 1996, 48).

In health care, lotteries have been advocated by some ethicists for the reason that chances should be distributed equally (Peterson 2008), that lotteries are hard to corrupt and that little information about recipients is needed (Persad, Wertheimer, and Emanuel 2009). A lottery system has been suggested for the allocation of scarce medication against Covid-19 (Jansen and Wall 2021; White and Angus 2020). Another example is the lottery procedure that the pharmaceutical company Novartis put in place to allocate a few free specimens of the costly drug Zolgensma to children with SMA-1. This policy has been heavily criticized, but rather for other reasons than the lottery itself (Dyer 2020).

In the context of routine health care, lotteries appear to be unpopular amongst lay people and health care professionals (Krütli et al. 2016) and are rarely practiced. One problem with this model is the connotation of the terminology, as people may associate it primarily with sports and gambling. In reality, lotteries have also been used in contexts where existential issues are at stake, such as draft for military service in wartime. In administrative contexts, lotteries seem to have been used more frequently to allocate burdens (e.g., selection of jurors) rather than scarce goods (Elster [1988] 2011).

A major problem to apply the lottery to our case study is a practical one. As candidates do not present simultaneously to the Center, to make this model applicable, one would have to combine waiting list and lottery. In other words, every time a treatment slot is freed up, one patient is drawn by chance among candidates on the list. While this would increase the chances of more recently referred patients to access the unit compared to the waiting list and has been considered more equitable than FCFS (Nikzad and Strack 2024), it would still favor those with a longer waiting time over those with a shorter waiting time. This is because chances increase if one participates in multiple lotteries over time. Our concerns regarding the drawbacks of waiting lists (cf. above) would only be mitigated but not sufficiently addressed by this option.

LAST-COME, FIRST-SERVED

If waiting time is not morally relevant *per se*, and may even be harmful for some patients, could we go all the way and *reverse* the waiting list, prioritizing those patients who have been referred *most recently* rather than earlier? The "last come first served" (LCFS) rule assigns every treatment slot that becomes available to the *latest* arriving referral. Under LCFS, the probability of being considered for admission is equal across all patients *at the moment of referral*, regardless of their ability to wait (which is contingent on, e.g., not reaching their 18th birthday as well as maintaining their capability of successfully engaging in day hospital treatment until a slot is available for them). LCFS is thus more equitable than FCFS in terms of allocation probabilities. (Nikzad and Strack 2024).

Importantly, by definition, the problem of long waiting times before an eventual allocation would be eliminated altogether. The LCFS rule would rapidly provide clarity to the referring professional as to whether their patient can be admitted: At the moment of referral, a slot is either available, or not. In the latter case, the allocation probability would rapidly tend toward zero as new referrals arrive, and referring professionals and families would be encouraged to explore alternative solutions without further delay.

The impact of LCFS on outcome inequality and total benefit is in part speculative: On average, those who will get admitted to the day hospital will receive speedier treatment than under the FCFS rule and may therefore recover faster and more completely. This will increase the accumulated net benefit for the population and may even, due to shorter treatment durations, increase the total number of patients treated at the Center. Those patients who will never be considered for admission will be no worse off under LCFS and might even have better outcomes compared to FCFS if the efforts to find alternative solutions for them are intensified, as we hypothesize.

In order for LCFS to be a fair process, it is essential that no one performs any action that increases the probability of a particular patient being admitted (in analogy to what Sher [1980] posits regarding lotteries), e.g., by reserving a slot in advance for a given patient, or by informing a referring colleague that a place is about to be vacant, thus allowing "just-in-time referral." This can be difficult at times, e.g., when a friendly colleague lobbies for one of their patients to be given priority, or when a referred patient is already

known by the team. A consistent and clearly formulated procedure may help maintain a high standard of fairness.

The moment where we know that a patient will leave varies. To facilitate rapid admission of candidates and standardize the procedure, the rule for allocation of a treatment slot at the day hospital might be the following:

> As soon as the date at which the next treatment slot will become vacant is known, but not earlier than four[1] weeks before that date, we will consider the most recently referred patient for admission.

If the patient given priority according to this rule ends up not being admitted for any reason (patient or family decline admission, clinical evaluation does not confirm indication, etc.), there are two possibilities: 1) If we have, in the meantime, received a new referral, then this patient will be prioritized; 2) otherwise, we will prioritize the penultimate referral. The more recent the referral, the higher its priority. Repeated referral of the same patient may be authorized for clinical reasons (e.g., disease relapse, increased motivation), but its frequency must, of course, be limited (e.g., minimum interval of six months).

LCFS seems counterintuitive to many. The idea that waiting strengthens the claim to a good and the view that everyone in need should be allowed to obtain a treatment slot at some time, are deeply enshrined in our intuitions. Notwithstanding, the theoretical advantages of the LCFS rule in terms of equality, maximizing total benefit, and elimination of morally irrelevant and potentially harmful waiting time cannot be ignored.

THE ELEPHANT IN THE ROOM

In our example, an important psychological and political factor in favor of maintaining FCFS is that it helps ignore the elephant in the room: rationing. When receiving a referral at a moment where there is already a significant number of patients on the list, one can simply say that there is no slot right away, nor in the foreseeable future, but will become available at some point in the future if only you wait long enough. This answer, although out of touch with clinical reality, does indeed avoid some conflicts and may protect professional conscience and reputation. In the worst case, the patient leaves the waiting list at some point, without having obtained the good. In a context where demand exceeds supply, waiting lists may instill false hope, whereas in reality they are a form of (covert) rationing.

Lotteries and, most drastically, LCFS, bring the frustrating notion of rationing to the foreground by explicitly refusing a good to some persons with a justified claim (rather than simply—or seemingly—postponing its settlement). This is probably another fundamental reason for the unpopularity of LCFS. Yet, confronting referring professionals and patients with this fact would not only be more honest but could also be beneficial by helping the patient, the family, and the professionals mobilize other potential care options.

ARE WE THROWING THE BABY OUT WITH THE BATHWATER?

The arguments brought forward so far converge on the surprising conclusion that we ought to base our admission procedure on LCFS. Is this the full answer? Let us once more return to square one: why are we looking for a procedure that would tell us which patients to prioritize for admission? This question shows our lack of confidence to reliably and efficiently rank numerous referrals who arrive in succession, on clinical grounds by need and potential benefit. At the same time, our intuition has been that, where we can compare a small number of concomitant referrals, we might sometimes be able to find good clinical arguments for prioritizing one of them in a head-to-head comparison. Under FCFS there is limited interest in changing the order of two individuals at the end of a long queue. Does this also apply if we use LCFS instead of FCFS? Let us assume that two or three referrals arrive roughly around the same time, say, within a couple of weeks before a new slot becomes available. According to the pure theory of LCFS, only time counts. However, in this particular kind of situation, the difference in arrival time is negligible in terms of potential harm due to waiting, and clinical head-to-head comparison is feasible as up-to-date information is available. It may thus not be the ethically best procedure to apply LCFS in a rigid way.

We can conceptualize this as a case of (apparent) indeterminacy where, according to Stone, we may ask two questions:

> First, could further scrutiny discriminate between these options on the basis of good reasons? Might good reasons still be found for selecting one option and rejecting others? Second, might further scrutiny

[1]Four weeks is a convenient interval from a practical point of view. At that moment, the departure date is known for most patients, and it leaves sufficient time to organize the admission procedure for the next patient.

> bring bad reasons[2] into play? Might bad reasons intrude so that one option gets selected over others in illegitimate ways? (Stone 2011, 39)

Good reasons would, essentially, be related to clinical characteristics of the patients, e.g., disease severity and process, degree of disability, capacity to benefit and motivation for treatment. Bad reasons could include appreciation or dislike of a referring colleague, pressure by a third party, considering a patient or their family as "difficult," etc.

Following Stone's (2011) reasoning, we ought to prioritize one of those patients in a head-to-head comparison where we find significant good reasons for it, without bad reasons influencing the decision. Where we have no good reasons and the possibility of bad reasons intruding, we should strictly apply LCFS.

CONCLUSION

Taking an adolescent psychiatric day hospital as a case study, we have argued that the allocation of treatment slots according to the classic FCFS waiting list is ethically inferior to a procedure that prioritizes more recent referrals (LCFS), even though there may be potential issues with social acceptability. Such an LCFS procedure would have to be carefully explained to the population, the patients, their families, and the health care professionals. Where a small number of new referrals arrives more or less simultaneously, we consider it appropriate and feasible to modify the LCFS rule and prioritize cases also based on ethically good reasons following clinical head-to-head comparison. Whatever allocation procedure is chosen, the appropriate and transparent communication toward patients, their families, professionals, and the populations is key. Patients that are not admitted should be informed about the reasons why they are not admitted to the care facility.

We are aware that our observations may not be applied to other health care settings that do not share all relevant characteristics with the case discussed. We argue that the appropriateness of a FCFS waiting list ought to be reassessed, and LCFS considered, wherever

1. Not all referred patients with a clear need for an intervention can receive this treatment from a given health care provider, and
2. It is not possible to correct the imbalance between demand and supply in an ethically acceptable manner, and
3. Patients' need for, as well as their capacity to benefit from the treatment cannot be reliably graded.

[2]According to Stone (2011, 36) "bad reasons" are "the kinds of reasons that people would (or at least should) be actively ashamed to allow into their decisions." The example he gives is racial bias. Stone states that "[l]otteries provide the *sanitizing effect* of a process independent of reasons" by screening out bad—but also good—reasons.

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