ETHICS

Leaving Medicine

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Several years ago I attended a weekend course on Cape Cod on "Medical Fiction Writing for Physicians." I went because I wanted to hone my writing skills and, like many physicians, fantasized about turning some of my professional experiences into fiction.

I was amazed to find over 200 physicians in attendance, many of whom were wannabe writers ready to risk leaving their unsatisfying medical practices for fledgling careers as writers of medical thrillers. Our teachers, both well known physician authors of bestsellers, kept us in the palms of their hands for two days, much the way they keep their readers turning pages. The organization sponsoring the course soon capitalized on the palpable discontent among the attending physicians as was apparent in their recent flier for a new course entitled "Non-Clinical Careers for Physicians."

I received the flier in the same mailing with a *U.S. News and World Report* special issue entitled "Who Needs Doctors?" which led me to wonder if we are becoming an endangered species. The magazine's articles commented on what most of us know, namely, that physicians harried by bureaucracy, paperwork and lack of autonomy are pulling back from patient care and that those who hang in have trouble making enough to cover their costs and little time for listening to and getting to know their patients. A nationwide survey reported that 60% of doctors said their morale had declined in the past few years (Hobson). Applications for medical school are down, more physicians now opt for early retirement or disability than in the past, and many drop their primary care practices for more rewarding subspecialties with less demanding schedules. Boutique practices have evolved that permit physicians to see fewer patients, most of whom are wealthy, spend more time with them, and regain control over their practices. Much of the country is now experiencing a shortage of primary care doctors and nurse practitioners and physician assistants are increasingly filling the void, with many patients actually preferring to see them.

Nationwide, alternative care is thriving and, in some states, psychologists now have limited prescription privileges and pharmacists dispense education and advice to patients. Of interest, the average time a physician spends with a patient (16–22 minutes) has not changed that much in the past decade. What has changed, however, is that physicians must ask more questions due to oversight by insurance companies and out of fear of malpractice suits. In addition, well-informed patients now ask more questions and all of this transpires in the same allotted time (Fischman).

I confess that four years ago I dropped my therapy practice because I was tired of going home still raging over managed care battles and was weary of being on call, which I had done almost continuously for 28 years. In addition, I was becoming increasingly anxious over liability issues when non-clinicians in managed care were dictating medication decisions and the number of visits I could have with a patient. The final straw was being told that I could only get one hour approved for doing a complete diagnostic assessment on a child and her family. I was fortunate in that I was able to make a lateral move to forensic psychiatry, which I have always found to be challenging and intellectually stimulating. It is particularly gratifying because it draws upon all of my training in medicine, pediatrics, and adult and child psychiatry, as well as forensic psychiatry. Fortunately, I am able to spend as much time with them as I deem necessary and also have time in which to review their relevant prior psychiatric, medical, educational and police records.

We are fortunate in that in child and adolescent psychiatry, in contrast to other medical specialties, we are more likely to have the luxury of time in which to listen to children and their parents and develop ongoing relationships with them. However, I worry that we are perilously close to giving away the entire field of psychotherapy to non-medical therapists. All too often, insurance companies and treatment programs attempt to restrict our role to being mere diagnosticians or writing prescriptions. We need to keep current with the broadening range of cognitive behavioral therapies and remain in the driver's seat while not abandoning psychodynamic theory. I worry that as a result of the practice of using psychi-

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atrists just for medication management, which is unfortunately more lucrative than therapy, there will be no psychiatrists skilled in psychotherapy left to teach the next generation of trainees.

If we are to continue doing what we do well and enjoy doing, we need to continually advocate and lobby lest the potential scope of practice slip away from us. For instance, there is evidence that split therapy is not more cost effective than having a psychiatrist do both medication and therapy. In addition, a recent study found that only about two-thirds of physicians engaged in split treatment were in compliance with the American Psychiatric Association standards of practice regarding coordinating care (Lopiccolo et al). We need to educate managed care companies and the public about our special training and what goes into a psychiatric evaluation of a child. I would often ask managed care reviewers and supervisors, "Would you want your child assessed in one hour?" The answer was inevitably "No, but you are the only psychiatrist who has ever complained to us about this." I continued to complain and eventually the one-hour restriction was changed.

The State of Vermont is a model of effective lobbying and advocacy by child and adolescent psychiatrists who were able to exempt child and adolescent psychiatrists from drug formularies, get them reimbursed for phone consultation with primary care physicians, and get higher reimbursement rates than adult psychiatrists. In a talk delivered to the Maine Council of Child and Adolescent Psychiatry last September, **David Fassler, M.D.**, an AACAP member in Vermont who is also AACAP Assembly Vice Chair, explained that this was because there are not many child and adolescent psychiatrists in Vermont and the money insurance companies pay them pales when compared with other specialty groups. Hence, it has not cost the state that much to increase the reimbursement fees of child and adolescent psychiatrists. This is an advocacy success story and shows what can happen when child and adolescent psychiatrists rally and take hold of the reins. ■

Dr. Schetky practices child and adult forensic psychiatry in Rockport, ME.

References

Fischman, J. Who Will Take Care of You? A growing gap separates doctors and patients. The new healers are now stepping in to fill the void. U.S. News and World Report. January 31-February 7, 2005: 44-46

Hobson, K. Doctors Vanish from View. U.S. News and World Report. January 31- February 7, 2005: 48-53

Lopiccolo, C, Taylor, E, Clemence, C and Eisdorfer, C. Split Treatment. Psychiatry. 2005: 2(1): 43-46

Assembly Membership Drive Gains Speed– Now Has Five Winners!

Congratulations to the regional councils of **Arkansas**, **Central Pennsylvania**, **Montana**, **Nebraska**, and **Puerto Rico**, which have already qualified for a free ticket to the Assembly meeting during the 2005 AACAP Annual Meeting in Toronto, Canada! As was announced during the 2004 Assembly meeting in Washington, D.C., any council that increases its membership by 10% will win a free ticket. *Four councils–Alaska, Delaware, Northwest Ohio, and South Dakota—only need one new member to qualify!*

The rules of the recruitment drive are:

Beginning totals for councils are based on the number of General and Fellow members in a council October 1, 2004. To find out how many your council needs, please contact Sherri Willis, AACAP Membership Coordinator, at 800.333.7636, ext. 134.

All new General and Affiliate members recruited between October 1, 2004 and October 1, 2005, will be counted towards the 10% total. Residents are not counted.

By necessity, numbers will be rounded either up or down to get to a total. Example: a council with a total count of 39 General and Fellow members would have to increase its membership by 4 to qualify for a complimentary ticket. (38 x 10% = 3.80, rounds to 4).

For more information on the Assembly membership drive, please contact:

Guy K. Palmes, M.D., Chair: gpalmes@wfubmc.edu
Sherri Willis, AACAP Membership Coordinator: swillis@aacap.org