Silent Grief

■ Diane H. Schetky, M.D.

As I speak with colleagues around the country, I realize that many of us, particularly those who have been around for a while, are experiencing silent grief. We are mourning the passing of the practice of psychiatry as we knew it. Managed care has taken away from us, not just income, but our sense of identity, purpose, and our autonomy. Initially, the medical profession reacted with denial to the prospect of managed care. In typical mourning, denial is usually supplanted with anger. We have been very vocal about our rage and some have channeled it into constructive ends such as managed care legislation and demanding better care for psychiatric patients under managed care. Our anger has brought us together and made political activists out of some of our members.

Our grief, on the other hand, tends to be more subtle and silent. It may manifest itself as irritability, outbursts with managed care reviewers, questioning our professional role, and fantasizing about early retirement or even change of career. We lament that it is no fun practicing psychiatry anymore. Reams of paper work and hours of being kept on hold while trying to get through to case reviewers are coming between us and our patients. We may experience waves of despair or sadness often associated with feelings of helplessness and frustration as we try to rectify this topsy-turvy system of medical care. Our traditional medical values have been shaken and torn asunder. How do we make sense out of being rewarded for not giving care, stockholders profiteering from restricting care to those in need, treatment decisions being made by persons with no psychiatric training, and being expected to divorce medication management from the rest of the patient's life and steer clear of psychotherapeutic interventions in order to squeeze more patients into each hour?

At every turn, we are being forced to re-examine our professional ethics and personal values. Child and adolescent psychiatrists must make their own compromises. Last year, I had one too many bad managed care days and made the decision to stop accepting patients for psychotherapy. I was tired of sharing highly confidential material with case reviewers in order to eke out four more visits, tired of my autonomy regarding treatment decisions being eroded, tired of endless hassles trying to get paid by managed care (I'm told they drag their heels with out-of-network providers in hopes we will go away), and fed up with the paper work. Green Spring's new six page computerized bed sheet, which needs to be filled out every four visits, was the clincher. I worried that if I didn't fill in enough circles they would not authorize further care, but could find few circles that seemed applicable to the reasons I was seeing my patients. The clinical questions were clearly geared to the extreme. I did not have any fire setting, homicidal, catatonic, or aphasic children in my practice, yet had to answer these questions repeatedly on each patient. I realized I was developing negative countertransference to my managed care patients. It was time to do something else and so I decided to restrict my practice to consultations and forensic psychiatry. I have kept a few chronic and mostly Medicaid and Medicare (thus far unmanaged in Maine) patients in therapy.

I feel a tremendous sense of loss — as if managed care, like Pac Man, is taking large bites out of my life. All of my years of training and experience in psychodynamic therapy are now devalued in favor of pushing medication in initial visits. While working in our local prison, I was running a bereavement/treatment group for inmates in protective custody. These men, who are at the bottom of the pecking order in prison, have experienced cumulative loss and rejection and have known little by way of caring in their lives. I was abruptly told by new management at the prison to cease doing the group, because the prison contract, which is managed, does not allow psychiatrists to do therapy, only evaluations and medication. Another loss. I dance daily with a prison drug formulary, vintage 1970s, which makes me feel like I am still in residency. I point out that many of the so called savings are illusory and bring in studies to document my point but nothing changes.

I grieve daily for our losses, but continue the fight for more equitable health care. At the same time, I feel myself letting go of some of my medical identity and turning my caring into unmanaged ventures such as Hospice volunteer work. I find I now have more time to invest in friends and in self care and realize the trade off is not all bad. I have down scaled my life and can live on less. I feel for younger physicians and those with college tuition to pay who do not have these options. I plead with AACAP members of all ages who brave the waters of managed care not to sacrifice their ethical integrity to the pressures put upon them. We can hope that our health care system, with our continued patient advocacy, may yet right itself and that we may look back on this period of time as a bad dream. ◆

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