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Shooting For What I Want

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I'm starting out. For 3 years in my Resident's Column, I've shared the excitement, frustration, and even outright anger that I experienced as a second-career psychiatry resident. Because I had completed a different residency years earlier, I was in the position to step back a bit and observe my experiences in a way that would have been impossible the first time around.

But now I am in a different position. Now you, the readers of this column, are the ones with experience. For the first time, I will bear the weight of the true responsibility of psychiatric care. While I intend to network and seek professional supervision, I will no longer have the luxury of consulting an attending psychiatrist for assistance with difficult situations. This is a situation that most readers of this column have faced already, perhaps years ago. And so I ask myself, what do I have to offer?

I think of my friends who are still in residency. Some are in fellowships and others have a year or two remaining in the general program. And I remember my thoughts 15 years ago, as I finished my residency in anesthesiology. As I think of that time of my life, my memories are merged with disjointed images. I picture baby robins nudged from their nest, not quite ready to fly on their own. The proverbial young actress from Omaha steps lightly from a bus in Times Square and meets an exciting character who claims to have her best interests at heart. A college football player swaggers into the draft with untested bravado, sure that he will become the next Jim Thorpe. All of these scenes contain hope for a great future, fear of the unknown, confidence in one's abilities, and the genuine risk of independence.

I imagine that people of different personality structures will have varied affinity for the different scenarios presented here and that each person may vacillate between scenarios depending on his or her day-to-day experiences, the seasons, and even weather forecasts. Rather than test my own bravado before experienced psychiatrists, I will try to share my successes and failures as the first robin, the naive actress, or the star athlete . . . my perspective changing, I would expect, with my own day-to-day experiences.

For introduction, I am a Midwesterner who has lived "out East." I have worked for health systems, for the federal government, and as a member of a single-specialty group. I am old enough to remember what those my age call the "golden years" of medicine. And I now share the train ride, with all other physicians, toward the great wall that we all know is ahead—the change in health care that will come sooner or later that will include restructured reimbursements, cloaked rationing, a single-payer system, more uninsured patients, or a combination of all of these. As health care costs increase and baby boomers grow into an already-stressed Medicare system, the only thing certain is that things will change.

I have already witnessed changes in health care that would have alarmed my early instructors. Individual physicians are now interchangeable employees. Treatment plans are influenced by payers and administrators. And the once-respected concept of the art of medicine is almost seen as obsolete in a world of scanners and treatment protocols. These changes have come in subtle fashion. We were the frogs

that were placed in the tepid water, and we didn't notice the rising temperature.

When I worked as an anesthesiologist, I remember the first time that I received a quality assurance memo asking why the medication that I administered during a code did not strictly follow Advanced Cardiac Life Support (ACLS) guidelines. I attempted to ex plain to the quality assurance nurse the value of thinking physiologically—that when the reason for the cardiac arrest is considered, the choice of catecholamine may vary from protocol. I tried to point out that a milligram of epinephrine in a 90-year-old woman is a different drug from the same dose in a 20-year-old man. Weeks later, I was dismayed when the hospital required physicians to join the emergency medical technicians and nurses in rote memorization in ACLS certification classes, as if it were a given that we could not be trusted to have adequate knowledge of physiology. But back then I had cases to do, people to treat . . . and the administrators had nurses who did nothing but create more protocols and who had the time to write more letters. Not worth the trouble, I decided. Where is that protocol sheet?

I watched as senior physician partners of multispecialty clinics took the money and ran, selling the futures of their younger partners and new hires to ever-growing systems. I watched as more and more physicians signed contracts with no-compete clauses without realizing or caring that they were giving away control of their destiny. I watched as these no-compete clauses eliminated . . . competition, leaving the owners of the contracts a clear path to design health care according to their own interests. And I now watch as new graduates step lightly off the bus into the only city they will ever know, lacking the frame of reference that is necessary to long for the past.

Psychiatry may be the last bastion of anything that resembles the traditional physician-patient relationship. Perhaps as evidence of what patients truly want, cinematic portrayals of psychiatrists rarely show busy waiting rooms or even office staff. We may be the only specialty that does not assign patients to individual rooms with fluorescent lighting, only to disrobe, wait, and hope that the footsteps in the hall are finally headed their way. Any cursory consideration of the psychiatrist-patient relationship reveals the problems with such an approach. But I doubt that clinic administrators will necessarily see the point, and I will not be completely surprised to one day see psychiatric patients lined up in such a way for the sake of efficiency.

All of these thoughts are assembled in an attempt to explain my intentions— course that will appear quixotic to many. But after all, I do have a frame of reference. And I am old enough to consider it more palatable to take risks to create something special than to work in frustrated security.

It is not difficult to imagine my ideal practice. I want to know the details of my patients' lives, and I want to have the time to sit quietly with them long enough for doorway revelations to arise. I want the time to explain all of the treatment options and to come to a collaborative treatment plan tailored to their individual circumstances.

I want to set my own schedule and my own workload, so that I have the time and energy to offer my full at tention to each patient. I want to make my own determination of appropriate "usual and customary" fees, rather than accept arbitrary payments from businessmen. I don't want to work "on volume."

I want to pick my furniture. I want to implement only the paperwork that makes sense. And I want to make clinical decisions based only on the welfare of my patients, with no help from utilization review nurses. I would rather advocate from the outside than apologize from the inside.

On this note, I start out. I hope that readers enjoy the journey. Perhaps my experiences will encourage those with similar desires to follow their interests. Or perhaps my experiences will provide validation for those who find comfort in their roles as employees/psychiatrists.

A local network psychiatrist assured me that my destiny was not pretty. "You'll never make it—that just doesn't work anymore. Everybody comes to us."

I guess we'll see.

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