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Shooting for What I Want, Part 2

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How time flies! It has been more than a year since my last column, when I staked my claim in psychiatry. I planned to eschew the medical rat race and find my own little piece of medicine as it used to be, when doctors were doctors, nurses were nurses, and insurance salespeople were . . . salespeople. Should one read anything into the long delay between that column and this one? Absolutely! But I'll get to that.

Before I start I would like to thank the people that called, e-mailed, or wrote to express their support after reading about my plans. That column, which, among other things, expressed my frustration with the current structure of medical economics and the effect of this structure on health care delivery, caused the greatest response of any of my columns by far—apparently touching a nerve in many physicians. The support, which came mostly from senior physicians who remember how things used to be, was very helpful during the times when fear threatened the confidence of my convictions. The letters helped me realize that I am not doing anything that has not been done before; in fact, quite the opposite—I am doing what always was done before.

And so, more than a year ago I began. I found an empty shell of a space overlooking a wooded lot, signed a 5-year lease, and sketched plans for the layout of my new office. My residency rotations and personal experiences with psychiatrists gave me some idea of what I wanted, including a nice view, enough room for a couch and chairs, and an exit hallway that bypassed the waiting area to provide a greater degree of confidentiality. I bought a few Web domains and learned to make a Web site, eventually choosing fdlpsychiatry.com over dsmv.com for my main Web presence. My wife (now my business partner) applied her skills in business, decorating, and marketing, just as we had proposed more than 20 years ago during one of those "what if" discussions when stressed but excited couples try to look beyond medical school. Before too long, I was sitting at my new desk, excited that it was mine, and worried that nobody would make an appointment and help me pay for it.

A variety of work

I planned to find a regular source of income that would pay the bills while I waited for the practice to build to a sustainable level. Conveniently, I live a few miles up the street from the Taycheedah Correctional Institution, Wisconsin's only maximum security women's prison. Many states, including Wisconsin, are at a crossroads for providing mental health services for prison inmates. An aggressive effort is under way to improve the quality of mental health care in the prison system, and one outcome of these efforts is the need for more prison psychiatrists.

I had mixed feelings about taking such a position; my perception of prison medicine was not entirely complimentary, admittedly a perception that was not based on anything that I could specifically identify. Perhaps the negative perception was a natural reaction to considering a mysterious and closed place that contained the

people that society chose to avoid. At any rate, the prison position turned out to be a godsend, because it allowed me to set my own schedule and to work whatever number of hours I wanted to work. These are 2 wonderful elements in any job, but particularly helpful when setting up a solo practice. For my purposes, the prison work fills Monday and Friday.

I would like to write about my prison experiences at some point, but to do so will likely require permission from multiple levels of bureaucracy. For now, suffice it to say that the work is incredibly challenging. Picture your most frustrating patients with Cluster B features, multiply by 400, and then divide by 3 part-time psychiatrists. There will be more psychiatrists coming, but I expect that the demands of the patients will grow to fill the number of appointments available, given the abundance and nature of Axis II diagnoses.

Wednesday has become my favorite day—the day each week when I leave town for Milwaukee to lead a group of first-year medical students, and to sometimes visit with former colleagues still in residency. I also teamed up with a psychologist who has a significant solo practice in the area and whose philosophy about third-party payers matches my own. His patients are a different population from those of my solo practice; they are spending time and money for weekly psychotherapy, and so I think it is a fair observation that they tend to have a higher commitment to getting help and a greater desire for insight into their conditions.

Tuesday, Thursday, and Saturday mornings are reserved for my private practice, and I initially planned to drop one of the other positions when my practice demanded more time, but I enjoy different aspects of each area and I am reluctant to give anything up. I also need to set myself apart from the competition, a group of 5 psychiatrists in the local health network, and so I offer appointments on evenings and weekends. I consider such a schedule to be one of the features necessary to get patients to try someone new, especially when potential patients are so familiar with the competition: there are only 3 other independent physicians in town, and so the county's entire population walks through the doors of the local hospital/clinic megaplex for essentially all of their health needs. I realized at the start that the playing field was not level and that I had to provide something better and emphasize the differences.

A growing practice

Apparently deciding that my solo practice had legs, my wife left her university administrator job to run the business side of the practice. As the practice grows, she presses me for more time slots, and I try to hold onto my precious time on Wednesday in Milwaukee. Other opportunities come my way from time to time: I became the medical director of a residential Alcohol and Other Drug Abuse treatment center; I developed an informal relationship with the counseling staff of a local college; and I will be on the radio this Monday for 16 minutes, talking about Mental Health Awareness Month. (Since I wrote this article, the radio thing went so well that I now have a 30-minute show every other week.)

The practice is working mostly as I had planned. I set my fees, and discount as I see fair and appropriate. I check insurance benefits and submit claims, but the ultimate responsibility for payment lies with the patients.

I initially planned to send invoices to patients after appointments, but I learned (with some disappointment) that a significant number of people do not consider a bill something that requires action. I even had patients who regularly showed up, and when finally confronted with the bill told me that they didn't have that kind of money—as if it was unreasonable for me to ask such a question. After several months of trying to "let go of anger," I changed to a policy of payment required at time of service, by cash, credit card, or check. I likely lose a few potential patients with this policy, but I am much happier with the patients who decide to see me, who currently number more than 200.

A busy schedule

At the beginning of this column, I alluded to the delay in writing. The reason for my tardiness is simply a lack of time. My practice has developed as I had hoped—I truly feel a sense of involvement in the lives of each of my patients. When they are

struggling, they call, and I am the person they talk to—rather than some unknown person covering the phone. I believe that for many patients, just knowing that I am readily available reduces the number of times they actually need to call. This is evidenced by my observation that patients will call frequently early in treatment, as if testing my availability, and then stop calling for the most part.

The sense of always being on call has taken some getting used to, and there are obvious pluses and minuses to taking one's own calls that are easy to predict. But the experience has made me appreciate other aspects of independent psychiatry that I did not anticipate. For example, calls from patients are rife with transference (and countertransference) issues. Patterns of telephone interactions also provide one more way to learn about how a patient experiences the world—for example, a dependent patient will deal with a call situation much differently from a person who is narcissistic.

But the time spent taking and returning calls does not deserve all of the blame for my loss of free time. For the first time in my life, I am in a situation in which the workload is determined by nobody but me. And so, for the first time, I am faced with the balancing act of working for additional income versus spending free time at home with my family. I certainly worked hard as an anesthesiologist, but at the end of the day I had to stop working because the work was done—or at least it was someone else's time to take over. Now, instead, there is always more that can be done. I could increase referrals by speaking here or there, or by setting up meetings with local counseling centers. I could schedule one more person on a Thursday night, leaving a spot for the caller who needs to be seen "as soon as possible." There are always more hours available at the prison, and headhunters call frequently, looking for a psychiatrist to provide short-term coverage here or there. After 3 years of residency (and after an interrupted career as an anesthesiologist), I tend to lean on the side of more work for more income. But there are some weeks when I clearly work too much, and everybody suffers—at work and at home. I anticipate slowing down as time goes on, as I lose that occasional fear that some day, for some reason, I'll run out of patients.

Liking where I am

Overall, I like where I am. I like the fact that I have some control over what I do, where I go, and whom I see. I like it that patients pay me for my time and expertise and choose to see me for the care that I provide, rather than because my name is in their insurance book. I like it that when I am invited to speak to a group of people or a college class, the decision whether to go rests entirely with me. I like it that psychiatry is at least as lucrative as any other medical specialty, provided one expects and demands payment for what one is worth. How lucrative? Without being too specific and at the risk of being provocative, I believe a full evaluation by a psychiatrist is never worth less than $250, and a follow-up is never worth less than $100. Looking around at other professionals, my expertise is worth significantly more than these amounts. And given the amount of time, education, and money required to learn medicine and psychiatry, anyone accepting less than these amounts is doing himself or herself, and the field of psychiatry, a big disservice.

I imagine I will do this for awhile yet. Maybe in 10 years I will cut back and work 2 days per week. Maybe some day I will stop taking new patients and enjoy a lifetime of work with the patients that I have. Maybe the inevitable changes in the economics of health care will push me, reluctantly, in directions I do not want to go—or perhaps more and more, psychiatrists will choose to control their own destiny, and our numbers will carry the clout to save the medical profession from itself and from those nonphysicians who hope to make physicians nothing but powerless employees. Until then, I have optimistically purchased the domains www.independent-shrink.com, www.autonomouspsychiatrist.com, and www.theindependentpsychiatrist.com. If you share my vision and have a knack with Web sites, maybe we can talk sometime.