An Open Letter to Early-Career Psychiatrists

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The author addresses early-career psychiatrists (ECPs) and graduating trainees about the challenges they will face in preserving the psychotherapeutic aspect of their professional identity during the coming years. Rapidly changing health care systems, high demand for services, conflicting paradigms for treatment, inadequate compensation for psychotherapy, disruptive third-party payers, bureaucratic demands, ECPs' own educational debts, and personal and family needs—all present the potential for stressful internal conflicts and difficult choices. However, ECPs are a scarce commodity. They hold the power of decision about what they will and will not do, and they can be guided by the satisfaction of living out a truly integrated biopsychosocial identity.

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Dear early career psychiatrist, or advanced trainee about to become one:

"*Illegitimi non carborundum*" (mock Latin for "don't let the bastards grind you down") was a phrase I first heard from the Dean of Harvard Medical School in his welcoming address to my freshman class 60 years ago. Wikipedia tells me that it originated among the British troops of World War II, became the motto of American General "Vinegar" Joe Stillwell, and was popularized by Barry Goldwater. I quote it despite the reported information that John Boehner displays it on his desk. Checkered history aside, it is a worthy attitude for you to adopt as you embark on your career as a psychiatrist.

Do I sound paranoid? Perhaps, a little. You face a world full of big changes (with uncertain outcomes) dominated by mammoth health care systems to which individual humans are widgets. They will want you to do things their way and not necessarily the way you were trained. You will have to decide where you draw the line.

Why continue developing psychotherapy skills?

You were trained in psychotherapy—supportive, psychodynamic, and cognitive-behavioral—to a level of "competence" as required by the Accreditation Council for Graduate Medical Education. Unless you were in an extraordinary program, you know that competence at the PGY-4 level is not equivalent to proficiency. There is a lot of variability in programs, and few can provide the extent of patient experience that is required to be proficient in even 1 systematic treatment, such as cognitive behavioral therapy (CBT) or psychodynamic psychotherapy, as applied to a wide variety of patients.[1,2] By "systematic," I mean applying the full technique of a specific therapy tailored to a specific condition for the extent of time and duration that is needed to achieve results. Usually, those techniques are supported by a consensus in the field and/or by evidence-based research. Although you have probably used basic supportive psychotherapy with all kinds of patients in a wide range of psychiatric situations, you still have things to learn even about supportive psychotherapy, which is part of the generic trunk of the psychotherapy tree from which CBT and psychodynamic therapy branch upwards in a metaphoric Y-model of psychotherapy as defined by Plakun et al.[3] There is no reason to be daunted by your inexperience and level of proficiency. There is much to learn in many fields to become a psychiatrist, which constricts the time available in residency for learning psychotherapy. It takes years to become a highly skilled and versatile psychotherapist, just as it takes years to become a mature surgeon. In fact, one goes on

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developing the skills of psychotherapy for the rest of one's career.

Why do it? Each one of us has to discover that for himself or herself. I say that because the reasons lie within us. They lie within our life experiences, our emotions of love and fear and anger, our intellectual curiosity, even our motivations for becoming a physician and then a psychiatrist. Something drew us to wanting to work with people in this way and to help them change or be more the masters of their lives. But we are also driven by the gestalt of what it is to be a psychiatrist—a vision that integrates all that we know of the physical body, the vast subjective world of the mind and imagination, the culture in which we live, the whole mysterious and amazing idea of what it is to be human. All of that is wrapped up in the concept of "biopsychosocial" that so easily becomes a buzzword but is actually so profound.

Unfortunately, that vision is getting lost in today's world of psychiatry. Recent surveys show a marked decline in the percentage of psychiatric office visits involving psychotherapy. Those providing psychotherapy in 1 study were more likely to be white, over the age of 65, and graduates of US medical schools.[4,5] I know some of those psychiatrists who do not provide psychotherapy; they admit it with regret and even shame, and they usually ascribe this lack to forces they cannot control, such as poor third-party payment for psychotherapy or the demands of the health care organizations for which they work. But, as psychotherapists, we know that complex inner forces are also involved in our decisions.

There are more pragmatic reasons to keep developing your psychotherapy skills. The evidence base is now much stronger for the effectiveness of psychotherapy in treating depressive disorders, a variety of anxiety disorders, personality disorders, and chronic, severe mixed disorders.[6–9] Even with patients for whom medications are the primary mode of treatment, supportive psychotherapy enhances adherence. Another way to put it is that a therapeutic relationship is a powerful foundation for any kind of treatment. True, in many present day practice settings, the psychiatrist can refer the patient to a nonmedical therapist for effective psychotherapy, but would you really want to see *all* of your patients with one hand tied behind your back (ie, without using the power of your psychotherapy skills)? And the twists and turns of life may place you in a situation in which you are the only available professional who can deliver comprehensive psychiatric care that includes skillful talking with patients.

Sooner or later you will probably find yourself serving as a teacher and a leader. You will be supervising others and, as an administrator, you may have to run a service. You need to know what it takes for your staff to deliver effective psychotherapy services, from the booking and scheduling to the soundproofing and procedures for preserving privacy and confidentiality. You will be showing your staff how to listen and how to talk and how to manage time. You will be helping them to understand what they hear and observe, what to say, and when not to speak. You will need a diverse and in-depth psychotherapy experience base of your own to get it right. You must have learned the hard way what works and what does not. Clumsy and inept mistakes by a team leader can have serious consequences.

Role of psychotherapy in the future of psychiatry.

The Group for the Advancement of Psychiatry (GAP) has a Psychotherapy Committee made up of leaders in the field of psychotherapy by psychiatrists. The GAP committee recently wrote a collection of papers on the state of psychotherapy by psychiatrists. Published last fall in the journal, *Psychodynamic Psychotherapy*, it focused particularly on the effects of (1) mandated parity for the treatment of mental illness; and (2) the *Affordable Care Act* (ACA). A paper that I cowrote in this collection was "Obstacles to practicing psychotherapy by early career psychiatrists."[10] It goes into much greater depth and detailed documentation of what I am saying in this column, as do several other articles in that collection that I reference here.

How can the power of the biopsychosocial model enable the psychiatrist to shape his or her role in the health care delivery systems of the future? Fundamentally, the outcome will depend on the willingness of psychiatrists at all levels to insist on the conditions required to assess patients properly, to establish good therapeutic alliances, to manage medications correctly, and to conduct individualized psychotherapy under the right conditions. You will

have to be assertive. Psychiatrists are desperately in demand. You have choices, and that empowers you to speak up.

The practice settings of the future will be different and we need to try to shape them. Whether in today's community mental health clinics, in the managed care environment, or in the ACA's accountable care organizations that are struggling to emerge, employed psychiatrists must insist on having flexibility to spend sufficient time with patients. Ten or 15 minutes to write prescriptions every 3 months are simply not enough. Before I retired a few years ago, I always saw my patients who were primarily on medication at least 25 to 30 minutes to talk about their condition and their lives, and to do a little supportive therapy if needed —and sometimes a piece of insight work. In crisis, I saw them more often or for longer sessions. For patients who need full-bore CBT or psychodynamic psychotherapy, fully protected hours on a regular basis once or twice a week for a sufficient duration of weeks or months or even years are essential. By fully protected, I mean a private, confidential, quiet setting with no interruptions and no telephone calls.

Patients need access to good psychotherapy—and you need to be doing it. You will be using your basic psychotherapy skills no matter what kind of patients and treatment situations you will be working with. But to continue your development as a psychotherapist, you will have to carve out ongoing time to fully implement the methodology of CBT, interpersonal therapy, or psychodynamic psychotherapy with patients for whom it offers the best chance of recovery or change. Some early-career psychiatrist (ECPs) arrange to do this within an organized setting, but others divide their time between a mental health facility and a private office or group practice where they have more control over their time and working conditions.

The ACA encourages development of medical homes capable of providing the full range of health care services. The full-service ambulatory medical center where I practiced has served well for decades as a de facto medical home to many thousands, although medical records were not integrated while I was there. Perhaps stimulated by the ACA, organized psychiatry is going full throttle into promoting integrated medical and behavioral care, with mental health professionals working side by side with primary medical providers. Much of the rationale for this development comes from evidence that those who suffer from severe mental disorders are likely to die much earlier from common medical illnesses for which they failed to obtain proper medical care. Having routine primary and preventive care in the same facility as mental health care also makes sense for commonplace disorders such as anxiety, depression, and psychophysiological conditions. In such integrative care models, the psychiatrist is in an overseeing and consultative role, and almost all of the direct mental health care is administered to patients by nonmedical mental health providers. In my view, the model is promising, but there is a risk of blurring the psychiatric and medical aspects of care if the differences in expertise are not respected.[11] The challenge is to avoid providing second-class care in both specialties. Many psychiatrists would also find it very unsatisfactory not to be seeing patients directly.

Psychotherapy notes and the electronic health record.

Still another challenge from the new world of health care comes from the all-out drive to get all medical records into electronic health record systems. Every organized system demands it. Even in private practice you are financially penalized by Medicare if you do not use electronic health records. The risks to privacy and confidentiality are massive.[12] So are the costs. Compounding that are the new CPT codes for psychotherapy with medical evaluation and management (E&M). To justify the E&M code you have to document that you did something medical. I got out just in time by retiring, so I cannot write from personal experience, but I do have 2 pieces of advice.

One is to scrupulously maintain a descriptive clinical record on each visit with the information needed to document the fact of the visit and the diagnosis, relevant changes in the patient's mental or physical status or external circumstances, and so on, and a few generic words to epitomize the psychotherapy session (eg, "psychodynamic psychotherapy," "discussed family relationships," "practiced behavioral management of anxiety"). These should not reveal intimate, subjective, personal details. Maintain a system of psychotherapy notes that meets the Health Insurance Portability and

Accountability Act definition of being "part of the medical record maintained separately" and is *completely outside of electronic records.* Here can go sensitive personal information or detailed accounts of psychotherapeutic process that you want to record for your use as a therapist, as well as for defense in the rare situations of being sued for malpractice or having to take emergency action to avoid imminent harm. These should be kept as permanently as the basic clinical record. They are regarded as privileged psychotherapy notes as defined by the Health Insurance Portability and Accountability Act and based on the 1996 Supreme Court decision in *Jaffe v. Redmond.* The content of psychotherapy notes cannot be disclosed without the express authorization of the patient, which cannot be required as a condition of being insured. The patient does not have the right to see them unless the therapist so chooses. I would not work in any facility that did not respect the complete privacy of psychotherapy notes.

The other suggestion originates from hearing distressed concerns from colleagues who are struggling with massive overkill on the part of their systems' approach to documentation of psychiatric services, specifically psychotherapy with medical E&M. The time for psychotherapy is eaten up by taking unnecessary vital signs at each visit, completing detailed check-off systems for every element of the mental status examination, filling in redundant data fields for every visit that would suffice for a whole initial work-up—rigid lockstep sequences through irrelevant categories of information. This is a world-class example of the tail wagging the dog. Avoid it, find ways to change it, routinize it with templates, settle for a lesser E&M intensity code—but connive to preserve the time and equanimity for the process of psychotherapy. Obviously, this would be easier to deal with in a private practice. If you work in a facility or system, I hope you can find channels for effecting sensible changes.

Choosing a practice setting.

Now, to the matter of how you earn your living. Working in an agency or a health care system gives you a salary with benefits, which is very appealing if you have big educational debts and small children. That comes with the price (and the satisfactions) of being a team player. You can choose where you work, so you may be able to negotiate for the conditions needed for quality care and your professional development.

In my view, private practice is not only a viable option in today's world, but an appealing one. You have much better control over your patient load and balance, as well as their privacy and your working conditions. You will be in demand. Many patients came to me after seeing several other psychiatrists. In their first contact, they frequently said they were "looking for a psychiatrist who talks with patients." The internists in the medical building where I worked for 32 years before retiring have asked me to come back and reopen my office for the same reasons. Like-minded psychiatric colleagues who stay in touch with primary medicine physicians also find their practices filled.

For ECPs coming out of training with big educational debts and young families, the costs of setting up an office and paying for rent, insurance, health care, and retirement funds may seem daunting, but it works out well in time. It is not that hard. The freedom to practice as you think best is worth it. Solo practice requires discipline to manage the business side of having an office, getting insurance, handling taxes, billing, and electronic records; some of this can be shared by partnering with a group. I never had an employee, because I have the computer skills to handle scheduling and billing with a good practice management program for a small psychiatric or psychotherapy practice. Such programs are now available with facilities for electronic records and prescription transmission. I always enjoyed the autonomy. Many of my younger colleagues start off with a mix of part-time hospital or clinic work with private practice, and gradually shift the balance as their practice grows.

Parity and reimbursement.

The world of reimbursement is a jungle now. The parity law and the revised CPT codes for psychotherapy have resulted in some increase in reimbursement for psychotherapy, but Medicaid, managed care, and now the new plans structured for the ACA have a miserable record of low compensation. Aggressive, intrusive utilization reviews and artfully contrived visit limits are designed to pay as

little as possible. The GAP Psychotherapy Committee is studying violations of parity and effects of the ACA in some common disorders for which psychotherapy is a primary, evidence-based modality. The committee has an attorney consultant who has initiated large class action suits against large insurance companies that commit such violations.[13] Psychotherapists should aggressively oppose excessive and illegal constrictions of therapy and reimbursement through supporting their professional associations' efforts to influence the system. Therapists may have to deal with assertive utilization review procedures on behalf of their patients, but maintaining patient privacy and the process of therapy has to be the first priority. Further problems arise because of insurance company manipulations of provider networks, which cause frequent disruptions of continuity of medical care.[14]

In a recent survey, only 55% of psychiatrists in office-based practice, compared with 88% in other specialties, were accepting insurance.[15] Self-paid therapy and therapy that is partially reimbursed through out-of-network benefits are insulated from intrusions and third-party manipulations, and this was the way I practiced. I accepted traditional Medicare patients as a matter of principle because it is universal health insurance, and claims were never reviewed, even for psychoanalysis. But—with the exception of Medicare—such access is limited to people with better resources. Solo therapists often do some low-fee or pro bono work out of a sense of responsibility to society and because such cases can be very professionally satisfying.

Peer support and consultation.

Psychoanalysts and other psychotherapists often work alone and are constrained from talking about patients except in the confidential ambience of consultation or supervision. Even very experienced analysts form small, long-term "study groups" to discuss their work in a kind of peer supervision. For people starting off as therapists, such study groups can provide invaluable support and learning. Psychoanalytic, CBT, and Gestalt institutes often have formal continuing education programs in psychotherapy that meet for several hours weekly with a curriculum and case studies; the best of them include individual supervision and encourage participants to have concurrent individual therapy. (These are apart from full-scale training to become a psychoanalyst.) They are personally and professionally enriching. Some offer distance learning. ECPs who live farther from the big cities that offer such opportunities may at least consult with nearby colleagues. The American Psychoanalytic Association has a Fellowship program in which all applicants, even those not selected to be Fellows, are offered a mentor—an analyst who meets with them monthly or more often for a year to discuss psychoanalytic aspects of their work. I do this in person or by telephone or videoconferencing. The American College of Psychoanalysts is now developing a pilot program of analysts conducting biweekly small consultation groups of ECPs by conference call or videoconferencing; the hope is to make these available for ECPs in more remote places. I can provide more information about this at naclemens@cs.com.

Final thoughts.

I have great respect and admiration for ECPs: your knowledge of psychiatry today is far broader and more current than mine could possibly be. I write this in the hope that you have caught the spirit of skillful talking with patients wherever you work in the wild world of health care. Then, as a practitioner, an educator, a team leader, or an administrator, your skills will give patients the benefit of full-service psychiatry. I have written this and many other columns in this journal over the years because engaging in psychoanalysis and psychodynamic psychotherapy was the greatest source of challenge and professional satisfaction in my career as a psychiatrist.

Sincerely yours,
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