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Setting Up Private Practice in Psychiatry*

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ABSTRACT

Setting up a private practice in Mumbai is an onerous task. The present paper looks at the difficulties face by young psychiatrists when starting a private practice in psychiatry. It suggests certain guidelines to be followed to ensure the development of a successful practice. It also suggests methods to gain popularity among patients and society along with the ethics to be followed, knowledge base to be garnered, and the role of using multiple therapies and versatility in private practice.

Key Words: India; Mumbai; Private practice; Psychiatry

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Introduction

“To be or not to be” will always be the question. But when it comes to setting up a psychiatric practice in Mumbai, this question takes on ominous proportions. For the psychiatrist in a teaching institution, protected as he is by the institution in whatever he does, or who feels comfortable and secure with the salary he receives, it is often a gamble, which he feels unsure about, and which causes much anxiety. For the psychiatrist who feels the pinch, especially when he confronts his affluent colleagues who have a lucrative private practice, it is often a source of restlessness, unhappiness, and discontent, which causes him to decide to take the plunge into private practice come what may. To the psychiatrist who has just graduated and must start private practice sooner or later, it can be the cause for insecurity, uncertainty and anxiety. To the psychiatrist who is working abroad and must return to India because of family ties, setting up practice can be a headache, a nuisance and a constant source of worry. This Address is dedicated to all such psychiatrists, and to all those who have known and suffered tension and disillusionment, since we have known and fought these circumstances ourselves.

Taking the Decision to Enter Private Practice

Toying and playing with a decision to set up private practice is indeed foolhardy. These decisions have to be taken, and lesser the delay, the better. He who hesitates is lost, and it is never truer than when you have to setup a psychiatric practice. The longer you delay, the more are the chances that you never will; and the longer you delay, the lesser will be the drive that you bring to your effort. Most of it will be lost in useless activity, which is considered under the category of planning and more planning, leaving very little for the real effort that is essential later on. Having taken your decision then, let it be a firm one. “Burn your boats behind you”, and do not look back. Summon your total strength and make a constant all-out effort while setting up practice. Be ready to take chances but give yourself the best chance. Remember, “Never Venture, Never Gain” and forge ahead. “Nothing Succeeds like Success”, but success only comes to those who want it and mount a true concentrated attack. Move like a bulldozer on your target, and do not let anything come in your way once your target is in sight. In all your efforts, learn to be an early bird. It is the early bird that catches the worm, and you will succeed if you are determined; so have no anxiety. A successful practice only needs an individual with drive, an individual who can deliver the goods, an individual who realises early what his patients want, and an individual who tailor-makes his therapy to suit the individual needs of the patient. It cannot be stressed enough that to set up a successful practice, you need to bring all you have in you in one solid effort. Once the decision is taken this effort has to come.
Where Should One Start Practice?

In large cities as well as in the smaller towns, it is common to decide to practice in the heart of a business area, especially where other medical practitioners are concentrated. It is also possible to join an established clinic, where contact with other practitioners of modern medicine may be easy, and the location known to the patient population. In deciding the area of practice, the following should be the prime considerations viz., the initial cost and recurring expenditure, the location of a proposed clinic from point of view of convenience both to the psychiatrist and the patients, the familiarity of the area, the patient drainage of the area, other conveniences like suitability of time schedules, assistants, transport and nursing home facilities close by.

It has always been a matter of discussion as to whether setting up practice separately is better than working in a polyclinic. Psychiatric patients, being what they are, may prefer the anonymity of a separate practice but having to enter a clinic of this type could identify them as well. On the other hand, in a polyclinic, they may be able to ‘mask’ their presence as visiting other medical consultants. Being familiar with an area helps the psychiatrist to know what to expect, and assures him of a certain amount of patient contact, but it may also prevent known patients from visiting him because of the stigma attached to psychiatry. All said and done, often the initial cost is generally the deciding factor with regard to the decision as to where to practice, and determines in some way the setup of the clinic and the type of practice expected and catered to. Here, again, too much of hesitation is bad and considerations that take plenty of time and are uselessly centred around calculations, only inhibit a decision and cause a final situation where no decision is taken; or, if a decision is indeed taken, causes a situation soaked with anxiety, worry and depression, which again prevents useful goal-directed activity.

Developing Contacts to Increase One’s Practice

Having decided the area in which to practice, it is befitting the psychiatrist to survey the “hinterland” and come to understand the drainage of practice to this particular area. His next job is establishing contacts and the following individuals and institutions must be kept in mind viz., relatives, friends and others known to the psychiatrist, hospitals in the area, especially those that do not have psychiatric facilities, polyclinics in the area and their medical consultants, general medical practitioners in the area, social workers and social welfare agencies in the area, schools/colleges in the area and their principals and teachers and any and every individual with whom there is even a fleeting contact. The psychiatrist should take every opportunity to disseminate the information that he is a psychiatrist and is practicing in the area. Most psychiatrists prefer to have an official opening of their clinics with much fanfare that often results in unnecessary expenses and fails to have the desired effect. It is much better to have in your service an ample supply of visiting
cards, which can be given freely to all demanding one, or even slightly interested in getting one. This minute reminder, in addition to providing reading material, serves as a good reference guide as most contacts prefer to preserve visiting cards.

The psychiatrist should take every opportunity to deliver lectures, to attend meetings and must make himself available in every manner possible whenever some opportunity is offered. The psychiatrist must make it his routine to write articles in journals as well as in the popular press, appear in the social media and television, as often and in whatever manner possible, whenever some opportunity is offered. It is foolhardy for psychiatrist to waste time waiting in the consulting-room of medical consultants with the hope that this contact may render an abundance of referral work. Most consultants and private practitioners, once they know the psychiatrist, refer the patient if they choose to do so; and if they don’t (with offence to none) it must be said that they should be forgotten.

The psychiatrist would do well to give lectures to parents of school-going children, who are not only prospective patients themselves, but could also serve the cause of preventive psychiatry in their children. The contacts must be built up from time to time, and the psychiatrist will do well to give the right image while establishing these contacts, with the aim of correcting misconceptions about psychiatry, and at the same time drawing patients by making them realise that they need to see the psychiatrist. If this process of building up contacts is undertaken on a war footing, the psychiatrist can firmly hope to have the waiting room of his consulting room filled to capacity in a short time. Remember patients are often waiting to leave one psychiatrist and move to the next. Only they must feel they are likely to get a better deal. The call from the psychiatrist must go out to them, and this call will be answered! Only ensure while doing so that you do not indulge in mudslinging of a psychiatric colleague, much as the patient, and your own flattered sense of importance, may tempt you to.

Attachment to Hospitals

Getting attachment to the local hospital has always been the first interest of any psychiatrist while setting up a practice. It is indeed true that getting attachments to good public hospitals assist the psychiatrist in getting known to prospective patients and getting an attachment to a teaching hospital helps him to keep abreast with advancements in the field, and prevents his knowledge from getting stale. While all these attachments are useful and assist the psychiatrist in setting up practice and giving the fillip he needs in the early days of his practice, getting ‘neurotic’ about getting an attachment should be condemned. In the present state of affairs, it is going to be more and more difficult for a psychiatrist to get attachments to a hospital, irrespective of his academic qualifications, teaching experience, specialty experience or for that matter social influence, especially in a large city like Mumbai. It is indeed possible to set up a lucrative practice.
without a hospital attachment if social contacts are established sufficiently, and the psychiatrist can bring about sufficient progress and social recovery in the illness of the patient. Remember, each individual patient treated well is your best advertisement, and work sufficiently with each patient to achieve this end. Building up a good reputation assures the psychiatrist of continuing practice, whether he has a hospital attachment or not. It is always possible for the psychiatrist to assist poor patients by making concessions in fees and at times treating some free, thus devoting some of the time for free work that in any case would have been done in the public hospital. Again these so-called poor patients do their best to bring in patients who can pay, in gratitude for favours received. The psychiatrist who does not have a hospital attachment, has that commodity that is impossible to buy, namely “time”; and he can devote this time for treating the patients with utmost consideration and care, and spending greater time with them for establishing a sufficient degree of rapport to bring about changes, which are possible in the patient’s personality and environment; and also giving the patient strength to accept whatever cannot be changed. Once again having sufficient time, the psychiatrist is free and available to his patients at different times. Thus, it could be possible for him to garner a lot more practice than his colleagues who devote hours to a hospital attachment.

Setting Up Practice

In the present state of practice in India, it is not possible for a psychiatrist to have a total team in the form of a clinical psychologist, social worker, occupational therapist etc., while setting up practice. Most patients in India cannot afford the luxury of attention from an expert team of this type, although it is desirable this happens as soon as possible. Accordingly, the psychiatrist will have to be all in one and do counselling on his own. Likewise he may have to give social advice, even occasionally visit the patient’s home and see for himself the situation that prevails. He will have to take various decisions on his own without the assistance of para-psychiatric professionals. This is especially applicable for a psychiatrist who sets up private practice after a stint either at an institution in India or abroad; he should be aware and prepared for practice along these lines.

Private practice is very different from institutional practice as not only the responsibility falls heavily on the shoulders of the psychiatrist but also it offers many new arenas and challenges that the psychiatrist has to be ready to accept. Even the question of what fee to charge can be not only a vexing point but also causes much uncertainty. The psychiatrist can do well to study the prevailing pattern of practice in his particular area, and it would be proper, at least in the initial stages, for him to rate his professional fees below those that are prevailing. This stand, in addition to showing conformity with whatever prevails, serves to get the psychiatrist the confidence of the new patients who are always looking for a cheaper deal; and if he takes care to deliver the goods just as well, he could
continue to have their confidence in the years to come. The psychiatrist who returns from abroad must be prepared to understand the pattern of practice in India. The authors have known many psychiatrists who had practiced abroad for sometime and came to India and become totally disillusioned in next to no time, causing them to pack their bags and go back.

With regard to therapies, each psychiatrist generally follows a particular regimen to which he is accustomed. Thus, it is common for a particular psychiatrist to rely heavily on drugs and psychotherapy while another relies on drugs and electroconvulsive therapy (ECT). To the psychiatrist returning from abroad it would be better to remember that ECT is well appreciated in India, and suits the needs of Indian patients who have to return to work without much delay, and accordingly cannot afford the loss of disability hours that often occurs with prolonged psychotherapy. It goes without saying that the treatment has to be tailor made to suit the patient, and it would be well to remember as to what exactly the patient wants. And thus at times, it is wise to withhold ECT on a patient who is reluctant, particularly if the relatives feel the same way; and at other times, it would be a good working plan to hasten the start of ECT without which the patient would be lost because of the feeling that the psychiatrist is ineffective. On deciding to give ECT, it is the best to be very firm in the decision because hesitancy puts doubts in the patients’ mind. Never tell a patient, ‘We will give you ECT, if you like’. It is always the psychiatrist’s decision and only consent is given by the patient and relatives. At times, the patients’ consent will have to be overlooked as he is not likely to give it, and in these situations, the psychiatrist will have to be content with the relatives’ consent.

With regard to medication, patients always ask how long they should continue the medication, and the reply is always difficult. Behind the patient’s mind, there is always a lingering doubt that psychiatrists are anxious that they should continue the medication indefinitely to keep their practice going, especially when follow-up consultation fees are charged. It is good to remind such patients that psychiatric illness is very different from physical illnesses like infectious diseases, wherein for example, if an organism is rooted out by an antibiotic, there is no need to continue medication any further. In psychiatric illness, medication needs to be continued because it takes a long time to change the psyche of the individual, if at all it does change. It is more like the long-term treatment of diabetes or hypertension. This would also explain why psychiatric illness seems to be so chronic to them, and also why some psychiatric patients do not get well. They should be made to realise that medication of any type helps to control the illness, changing moods, perception thinking and activity, but the real change in the individual will only come if this ‘status quo’ continues for an indefinitely long time.

It has always been said that there is a stigma attached to visiting the consulting rooms of a psychiatrist, and as a result patients tend to shy away.
Nothing is further from the truth that stigma is unwillingly created by the psychiatrist who gives in to the whims and fancies of the patients, encourages them to follow certain rituals and thus increases the tendency to be very secretive and exclusive about therapy. Every psychiatrist must endeavour to explain to the patients and relatives that there is no need for secrecy because this tendency increases the suspicions of those around. It is better to visit the consulting rooms of the psychiatrist like the visiting the rooms of other consultants. Often in the case of an unmarried girl or a person of high popularity and position, it may be necessary to maintain strict secrecy, but even here the relatives can often take the onus on themselves, saying that they are consulting the psychiatrist.

The psychiatrist would do well to spread education about the causation of illness not only at public meetings but also to the individual patients and their relatives. A successful psychiatrist, in addition to casting a proper image being a good clinician and maintaining a good rapport with the patient and relatives, should be a good liaison officer in keeping the contact going with referring sources, be it general medical practitioners, social workers, relatives of patients, or patients themselves. This manoeuvre does not entail discussing intimacies of the patients with these individuals but informing them that their patient is making good progress. This is particularly important when the improvement is hardly visible to the relatives and serves to make the referring authority feel reassured that he has done the right thing. Later on, when confidence is achieved, it may not be necessary.

The psychiatrist must not get hassled or disturbed by the attitudes of certain individuals either in his consulting room, at public meetings, or in society, who either tend to laugh at him or bring him down; and this attitude applies equally to the psychiatrist’s ability and his treatment programme. The psychiatrist who has faith and confidence in his own ability needs no compliments from his patients; and compliments should not affect him because they are likely to change and end just as quickly as they started. The same applies to insults and comments. It is a good working plan to let compliments, comments and insults from patients and relatives pass like water down the duck’s back, because these are everyday happenings in a psychiatrist’s life and should not affect the psychiatrist one bit, considering the population of disturbed individuals he deals with. The psychiatrist who knows he is doing his best has no need for any anxiety or alarm, should remain unscathed in all such situations, considering the fact that if he is doing his best, he cannot do better. The psychiatrist in his early practice may also face adverse criticism or remarks from senior colleagues who lack courtesy toward their fellow psychiatrists. This position sometimes arises out of seniors wanting to impress their patient, but a young budding psychiatrist should not let any of these affronts get him down. He should remember he will soon have his day; and he is inferior to none.
It is common for patients to move from one psychiatrist to another, and it is common for relatives to get disillusioned with therapy early due to lack of improvement, and thus terminate treatment and seek another psychiatrist. With this knowledge in mind, the psychiatrist should realise that this shifting tendency is rampant in a particular section of the patient population. Mental illness being what it is and results being a slow process, the tendency to get fed up easily should be accepted. The psychiatrist should take pains to establish rapport with his patient right at the beginning and make the patient as well as relative realise that they have come to the right person and that he is capable of efficiently treating the patient. If pains are taken to reach this state of affairs, the chances are that the patient is less likely to shift. Even then, should a patient choose to move away, the psychiatrist should not get affected by this drift but rather understand that it is at times bound to be so. After all, understanding the psychology of human beings is part of the psychiatrist’s training and considering the fact that all humans have a tendency to have multiple alliances and transferences, probably the transference in this case was not sufficient with this particular psychiatrist to keep the patient with him; and in such a situation there should be no regrets. If this is a recurring pattern, however, the psychiatrist would need to ask himself where he is failing. Could it be that he is lacking in knowledge or experience, or is his handling of the patient defective? In that case, it would be essential to undo and correct what is really going wrong. All said and done, the psychiatrist must be prepared to understand that this state of affairs is rampant in psychiatric practice and must be accepted.

The psychiatrist who returns from abroad and starts practice in India often finds that his working situation is very different from that which existed abroad. He further finds that the manner of conducting practice is different, and the requirement in his mode of handling the patient is totally different. The authors send out a word of caution to these psychiatrists to acquaint themselves sufficiently with the local conditions, the mode of practice, the requirements of Indian patients, and their expectations, before rushing into practice. It is good to remember also that there is a long waiting period during which frustrations may creep in, particularly if the psychiatrist has held a lucrative post abroad. It is also important to realise that India is India. The response is different and patient fail to keep appointments for the flimsiest of excuses. With the emphasis on ‘keeping the wolf from the door’, economic considerations are always foremost in the minds of Indian patients. Moreover, there are those who consider what return they can achieve, and these and other calculations determine in large measure their frequency in attending the psychiatrist’s clinic. By and large, the psychiatrist who decides to return from abroad and plunge into private psychiatric practice here must be ready to face the challenge that his colleagues in India face day after day before they can say they are well settled.
Ethics in Private Practice

It has often been said that everything is ethical in psychiatric practice till proved otherwise, and to an extent deciding on a particular treatment, how many treatments to give, how often to call a patient for psychotherapy, what to charge a patient, have so many aspects and is so individual, that it is difficult for anyone to decide what is ethical or otherwise. Fortunately, psychiatrists in India have not been often held up in the court of law with regard to this aspect, particularly with the abundance of stigma attached to psychiatry in India, which causes a tight secrecy to prevail which would become public if litigation was considered. Psychiatrists in India also have to be on their guard about professional secrecy. In some large joint families, this secrecy has to be maintained from certain members of the family who are only out to run down other members. By and large, in large cities where competition in psychiatric practice is high, as has already been mentioned, there is a tendency for senior psychiatrists to run down juniors for their inexperience. But this should not affect our budding psychiatrist who should remember that this state of affairs comes out of the insecurity of our senior colleagues. It is also possible for junior psychiatrists to run down their seniors in an immature attempt at establishing themselves. Such temptations should also be firmly resisted. It is the best for all psychiatrists to remember that in all psychiatric practice, there is a beginning, there is a rise, there is a dome-shaped peak, and a fall to perhaps termination, following the so-called ‘Gaussian curve’. Thus it is important to realise that the beginning may be slow, then we start skipping up the ladder, we have our heyday and then we start down the ladder to rest once again. Let us learn to bow in when the time is ripe and bow out when time is ripe, smiling all the way. Let us also learn to grow old and senior gracefully.

Alternative Psychiatry

Psychiatry has reached that stage where it has caused plenty of re-thinking and fresh thinking all over the world; and particularly in India, we have come to realise that our methods of therapy offer little to cure and that all they do is to arrest the illness for a while to set the ball rolling once again. In these circumstances, it is customary to ask the age-old question, ‘Quo Vadis’. The role of spiritual healing and religious forms of therapy has been well documented throughout the world from ages immemorial. Where better can we apply such forms of therapy than in psychiatry, particularly where a psychogenic cause has been postulated? In India, a land soaked with religiosity and superstitious beliefs, religion seems to be, and has been, the answer for many psychiatric illnesses, though it has failed in certain patients. The reason for such a predicament is that this form of treatment is not for everyone. It is indeed not possible for an individual who does not have sufficient faith in religion to benefit from religious therapy as such cures can only be achieved by a rather child-like faith. The
psychiatrists of tomorrow need to consider the utilisation of all forms of therapy in their practice. They have to arm themselves with a thorough knowledge of different religions and religious practices. They can then choose those patients who can benefit from religious therapy and start them on meditative processes that give such patients a liaison with a deity or a saint, wherein the psychiatrist acts as a guru or a minister. Having established a connection, the psychiatrist teaches his patients how to enrich their egos with this particular religious bonding, which they can invoke in all times of stress to feel refreshed and reassured. Even in patients with depression and neurosis, this form of treatment can be of immense help, provided the right patient is selected and the right mode of therapy offered by the psychiatrist. This could at times work much more than any form of psychotherapy, as it is a liaison with the Creator Himself and the ‘all powerful allay’. The psychiatrist of tomorrow needs to consider this paradigm of therapy.

The above modes of therapy could do well in specially selected group of patients who have a strong faith in religion, a faith backed by that of the relatives. On the other hand, in the disbelievers and atheists who choose to believe in natural causes and have a materialistic outlook of life, it would be necessary to use other modes of therapy. With this aim in view, yoga has been used successfully to treat minor psychiatric illnesses. Many explanations have been given to understand the theory behind these therapies, but the authors feel that it is a form of learning by which the person concentrates his energy in a particular organ, part of the body or bodily function, in addition to preventing this concentration from moving here and there. In short, yoga therapy serves as an ego-strengthening device as well as causes the ego to exercise certain controls, which stand the patient in good stead in times of stress. Psychiatrists of tomorrow will need to have a thorough knowledge of these forms of treatments and utilise them in their practice, if they want to offer cost effective forms of therapies that are better appreciated by their patients.

The psychiatrist who wishes to practice in India will have to be very versatile. He will have to thoroughly understand the ethnic, religious, cultural and social background of his patient and offer therapy that his patients appreciate. He will have to realise that following therapies based on western thinking may not be appreciated for long, and their results may not help his image an iota. On the other hand, offering cheaper modes of therapy that can be carried out by the patient and relatives will be more effective with patients. Also, the psychiatrist will have to understand the making of a delusion in his patient, especially when his background contributes to that delusion. The psychiatrist will need to comprehend the content of the delusions and lead the patient to a successful termination of his delusions; and the patient will automatically respond positively when the psychiatrist accepts the patient’s delusions and assists the
patient in getting rid of them without casting any aspersions on their stupidity and ridiculousness. Time and again the relatives are found to be happy when a psychiatrist follows this technique, as they know the psychiatrist respects their patient and will also respect their beliefs.

It must be realised that most mental illnesses are a result of the abnormal perception by the patient that is basic to the patient and relatives, and gets coloured by the background of the patient. Accordingly, it will not be good to shake this belief prematurely but rather to accept it as well as the traditional practices that are performed without a word of ridicule. After all, these practices only help strengthen the patient’s ego and are useful in no small measure. Mental illness being what it is, the successful psychiatrist will have to follow a different approach, especially when practicing in India where every demand comes heavily on him. Practicing here is a real challenge and the moment the challenge is taken, the challenge has to be met!

Conclusions [Figure 1: Flowchart of Paper]

- The present paper describes the strategies one needs to implement when starting a private practice in psychiatry.
- The points made in this paper are universal and applicable even today though written originally over three decades ago.
- The requirement for setting up private practice are discussed, where one must strike a fine balance between clinical and community work, along with the methods to spread one’s name so that a successful private practice may be built.
- The need for psychiatrists to reach out to the community and help in schools and colleges has been suggested along with not feeling bogged down by the challenges that private practice offers.

![Flowchart of the paper](Figure 1: Flowchart of the paper)
Take Home Message

Setting up private practice in psychiatry involves the psychiatrist doing an equal share of community and clinical work. Awareness programmes help build the psychiatrist’s name and reputation in society. There are bound to be challenges and hurdles while one sets up private practice, and such challenges have to be met.

Conflict of Interest

None declared

Declaration

We declare that this is our original unpublished work and has not been submitted for publication anywhere.

Questions that the Paper Raises

1. What are the factors to keep in mind when starting private practice in India?

2. What are the difficulties faced by young psychiatrists who start practice in India?

3. How does one overcome obstacles and become a successful psychiatrist in India?

4. What are methods one must use to develop a successful private psychiatric practice?

About the Author

Late Prof. Alan De Sousa MD (1932–2008) was Honorary Professor at Grant Medical College and Sir JJ Group of Hospitals between the years 1971 and 1992. He was head of the department of Psychiatry in the same institution from 1982 to 1992. He was an avid reader and writer and had over 150 publications in national and international journals. He was also the author of 6 books on the subject. He was popular with post-graduate students and well respected by his students and colleagues alike.
About the Author

Avinash De Sousa is a consultant psychiatrist and psychotherapist with a private practice in Mumbai. He has over 280 publications in national and international journals. His main areas of interest are alcohol dependence, child and adolescent psychiatry, mental retardation, autism and developmental disabilities and electroconvulsive therapy. He teaches psychiatry, child psychology and psychotherapy at over 18 institutions as a visiting faculty. He is one of the few psychiatrists who in addition to a psychiatry degree has an MBA in Human Resource Development, a Masters in Psychotherapy and Counselling, an MPhil in Psychology and a doctorate in Clinical Psychology.