

Interviewee: Bailey, Rahn

Interview: December 3, 2006

UNIVERSITY OF HOUSTON ORAL HISTORY OF HOUSTON PROJECT  
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Interview with: Dr. Rahn Bailey

Interviewed by: Tim O'Brien

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Transcribed by: Suzanne Mascola

TO: Dr. Bailey. December 3, 2006. So, let's talk about your educational background first.

RB: Yes. I am from Beaumont, Texas. I finished high school there, in public school in 1982. I went to college at Morehouse College in Atlanta, Georgia. I finished there in 86. I went to Texas for medical school here in Galveston, Texas, UTMB. I finished there in 1990. I completed 5 years of post medical school training: the first, an internship in Houston at UT; the next three in general psychiatry at the affiliated hospitals of the University of Texas system, also in Houston, and then a fifth year at Yale University in forensic medicine. So, I finished all education in 1995.

TO: O.K., and in college, you majored in what?

RB: I had a bachelor's in science and biology, a minor in chemistry. And I also had met the credentials, criteria for pre-medicine, like 5 courses of pre-medicine requirements.

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TO: O.K., so Morehouse is a historic black college. How did you get to choose . . .

RB: Yes, it is a historical black college – I think one of only four all-male colleges in the country and the only all African-American all-male college. Actually, my venue there was interesting. I actually played basketball growing up. My father was a coach. And I went to Morehouse on a basketball scholarship. So, I had a chance to continue basketball but also I picked it because it was like a little premed factory, well-known for its ability to get African-American males into medical school. That was my interest.

TO: O.K., so was there something in the University courses as an undergrad that led you to decide medicine was definitely the field for you?

RB: Yes, I grew up really always wanting to be a doctor. My parents were school teachers. I think that they encouraged science and math early on in my years there. I had a 10th grade teacher, Esther Bailey, who was a biology teacher and was very interested in getting as many of us as possible interested in medicine as a career. That worked real well for me. And then, I attended some summer programs - one at Texas A&M in 1981 particularly that really interested me more so in science. I thought about going into either engineering or biology pre-medicine, because I chose to go to Morehouse in part because of the basketball scholarship, they are really more known for biology premed. Had I gone to UT or Texas A&M, my other interests, I probably would have majored in engineering. But in either case, I really wanted to get a bachelors degree in a science field and then go on to medical school.

TO: O.K., then, talk about your experience at medical school at University of Texas in Galveston.

RB: I had a very good experience. I loved Galveston. It was the oldest medical school west of the Mississippi River, as I understand. Certainly the oldest one in Texas, well known for its clinical approach than certainly some medical schools that may have more of a research interest or more of an economic interest perhaps for those, but Galveston was really known for producing very good clinical physicians - docs who would go back to their hometown, go back into their community and work in private practice taking care of people. And that was certainly my interest. When I went there in 1986, I was there from 1986 to 1990, I fully thought that I was going into primary care, go back to Beaumont, Texas which was always my goal and practice there for 40 years in general medicine. My career has taken some interesting turns since then. I still enjoy what I do. I am not practicing in Beaumont, unfortunately, the 15 years I have been out, but I certainly think Galveston well prepared me to be a great clinical doctor.

TO: So then, your internships - how did you narrow the focus to select your specialty?

RB: It was difficult. I didn't really go to medical school with a prior interest, that I was singly interested in surgery or medicine or psychiatry or radiology or pediatrics. That happened to me some extent. I also didn't really have any relative or friend or neighbor who was a blank, you know, an ophthalmologist or anesthesiologist that I

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wanted to follow after them. And I also wasn't the guy that married somebody whose father was a doctor in an area. All of those are some of the options that you tended to see young docs like myself pursue. I think really I enjoyed a little bit of everything and my last rotation was psychiatry. I enjoyed that. I decided doing a rotation to stay on for an extra rotation or externship they called it, early in my last year doing electives. I really enjoyed that even more. I do think that I was always interested in law and medicine, including the area of medicine that is most tied to the law, is psychiatry, particularly forensic medicine. So, it is not surprising I went into psychiatry since I didn't really have another area that I really was gung-ho about and that eventually once in psychiatry, I'd pursue a fellowship in forensic medicine.

TO: Then you said you completed all your medical training in 1990?

RB: I completed college in 86, medical school in 1990, and all 5 years of post medical school training in 1995.

TO: O.K., so then while you were in your post medical training, besides, you know, the desegregation experience at that time, the Rodney King thing was going on . . .

RB: That is correct.

TO: One of the more well-known racial case in the United States. Can you relate any experiences you have had at this time? Obviously, America has race relations problems

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today so at that time when you were either in medical school or doing rotations, did you have any experiences related to America's deep seated racial problems?

RB: I would say yes. I would say in general, I did not have a lot of very negative experiences. I think as I understand racial issues in this country and I agree with you that America continues to have very deep seated racial concerns that existed when I was in medical school and Galveston a decade ago and exist now, but I certainly had a few. It may be part of the nature of life to go through bad experiences. I have always tried to be very cautious to not be over-reaching in my approach and not over-read race or racial concern or racism in just bad behavior . . . you know, people who are bad to other persons in general. But there have been a few.

I can certainly remember when I was a third year medical student, a few experiences - one of which was . . . well, I should have said three years into medical school because in Galveston, the first two years, you are spending all of your time in the classroom, in the library studying, taking pen and paper exams pretty much just like undergrad college. Maybe it is more difficult then to be overtly negative towards someone. The third year is a very subjective year. You walk around in a white coat. You ask questions just kind of arbitrarily. Someone may read or read positively or negatively into what you do. So, there is a lot more opportunity because of the subjective nature of it for mistreating like if someone dislikes you, for any reason, racism, sexism, gender, what have you.

I had one experience when I was a third year medical student when I thought I was being singled out, mistreated inappropriately. It is a hierarchical system so you are a

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JMS or a junior medical school – you are at the bottom of the totem pole. And above you is an intern. Above them is a resident. Above them is a fellow and it keeps going up the ladder - chief fellow, chief resident. Well, my resident intern during my medical school term on this one particular rotation told me at the very beginning of the rotation that she was going to judge me as if I was a senior level student or a higher level student when I was clearly a third year level student. And I just happened to be . . . it was kind of an individual meeting. And I just happened to be pretty good friends, because we lived pretty close to each other, with another guy who was Caucasian who was a medical student and was my classmate. I had known the guy 2 or 3 years. We had lived in Port Holiday, the same area together. And I guess during his one-on-one meetings before it all happened, before the rotation took place, he met with her as well and she hadn't told him the exact same thing. Now, some might argue, well, it was really an irrelevant point and we both went through the month or three months, whatever it was and obviously, we both passed and we became doctors and we moved on, but it certainly led to a lot of stress for me throughout that year. My wife . . . I was married at the time, comments about how, during the years she has known me, I have never had as much stress that exuded outwardly as I exhibited during that time in that time period because, of course, I was thinking, man, she is judging me harder or at a higher level. I mean, I performed well, and if you perform well, you may fail and I never failed at anything in my life. And all my relatives and friends in Beaumont, Texas, I think to some extent, maybe thought good things about me, maybe looked up to me, maybe thought, man, maybe Rahn Bailey can do this. It would have been a nightmare for me to fail and go back to Beaumont, Texas, and say, well, I wasn't able to cut it, you know, I failed out. I am not sure why she

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did that. There was really no signal. I didn't know her. There was no reason to believe she would be upset with me or against me. There was no rationale behind it. But I can remember feeling the anxiety throughout the rotation, what we called a pyeloerection or the hairs standing up on your skin. I would be at home trying to study at night because I wanted to know everything. Of course, in that business, if I should say it, when you are 30, you are brand new, you are starting, so they ask you a lot of questions and they don't generally expect for you to know everything. They expect you to not know it primarily because you are just getting into the clinics, they call it, more in clinical medicine, so they ask you questions during the day on what they call rounds. If you don't know things, you know, you have to go out later and read your little book and figure it out. But once you are at a higher level, once you are a fourth year, for example, or what they call an active intern, an AI, you are expected to know a lot of that stuff. Then, they ask you more questions in a way that is more humiliate or embarrass you if you don't know what you should have learned during your JMS year. So, clearly, she put me in an odd way and I have always thought that that was unfortunate. Again, maybe she did that because she was having a bad day or bad month or she just didn't like me because I was tall or for whatever reason. But the additional comments by my colleague - I won't mention his name - it certainly seemed to me that it was done on purpose. It wasn't an accidental conversation and I couldn't figure out why because I was too afraid to try to ask her about it throughout the rotation. I had to just work hard and survive and fortunately, I passed. But that may be one experience that I thought was somewhat negative.

Probably a more negative one that did not happen to me but to a colleague was during the aspect of asking these questions, some people called it . . . they had all kind of

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terms for it – this intense questioning that happens when you are in this third year on rotations. I had a friend who was African-American, who told the story regularly about how a particular attending, when he would ask him questions, would stand on his toes. Just imagine somebody asking you questions and they are standing so close to you that they are almost nose to nose with you and they are facing you and their toes are on top of your toes, there was saliva probably coming out of their mouth hitting you in the face. I mean, obviously, this is unnecessary and does not enhance the quality of the educational experience. You know, you are paying to go through this which is what is so bad about it. That is probably a more direct version of what did happen because I would hear these types of stories and I would always ask, "Does that happen everywhere or is this something that only happens to males versus females, or African-Americans?" It is hard to say. But there certainly were some experiences that I was aware of and some that happened to me that I thought could have been based on bias and discrimination.

TO: O.K., does the advent of managed care . . . you went to become a solo practitioner after you finished your residency?

RB: I have done a little bit of everything, I have been in full-time university, I have done private practice. I am in private practice now. I have worked in inpatient settings and outpatient. I have been an administrator over a big, 400 bed hospital in Alabama, briefly early in my career. So, I have touched every . . . in my 15 or 16 years, really every aspect of financing of health care including but not exclusive to managed care.

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TO: O.K., so then when this came about, where were you? What were you doing?

RB: Well, the stories that managed care has its roots in the so-called DRGs or diagnostic-related groups that some expert or group of experts from the northeast, maybe Harvard University came up with in the late 1970s, as I understand, theoretically saying that persons are treated for a certain type problem, whether you are in New York or Boston or Kansas, there is usually some reasonableness, comparativity of what you charged and how much time it takes to be treated, how many days in the hospital - some commonalities. Now, doctors have historically been against that because there is such tremendous variability in medicine. Some patients are sicker than others. Some are more compliant than others - all kinds of differences. But managed care, some might argue has kind of been shoved down our throats, and it is what it is. Clearly for me, when I finished medical school in 1990 and I went in internship, managed care was an active and fundamental component of my day-to-day work. I often tell the story that I remember getting a phone call once from one of my higher ups during my training between 1990 and 1995 and, to make a long story short, they were suggesting or recommending or telling me I needed to document differently what I would write about the patient. Now, of course, you are expecting, if you hear a story like that, that I was in training - I didn't really know what I was doing perfect . . . that is what you are in training - to get better at it but, you know, telling you how to write it in such a way that it helped the clinical perspective for the patient - helped the doctor communicate with another patient or help the doctor make their point in such a way that, you know, they can remember it better, or what have you. Really nothing could be further from the truth. This entire conversation

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was solely around helping the hospital bill the insurance company for more money which was just striking to me but trust me, that was everywhere in every specialty, everywhere I've worked. Then, the story was to bill, and I may get some of these wrong so I don't want to be quoted . . . there was something called bullets, and bullet points were particular items, bits of clinical information that theoretically were directly tied to a certain diagnostic category. So, let's say a certain third party payer Medicare, Medicaid, Aetna, NYLCare, whomever, might say, we are going to pay you for treating asthma, as an example, or depression – I am a psychiatrist - you have to show that they had these certain number of points. And, of course, if you show so many points, maybe it meets what is called a level 1 code. Fewer points but some points, maybe some level 2 code. Maybe no points is a level 3 code. And the amount of reimbursement or money the hospital or clinic will receive is more for level 1 versus level 2 or level 3. So, there certainly was some interest or push or encouragement, in other words, you may choose to use to ensure that the proper code was met because a certain number of bullets were adequately addressed. Just that entire construct did not sit very well with me then. I had to learn to deal with it because it is the reality of medicine now that, you know, the big boys kind of run the show, be they the insurance or whomever, and that is kind of how they want it done. The unfortunate reality is though that sometimes the patient sitting in front of you doesn't fit nice and neat into that little box. And they may still be sick and have a problem and need your professional interest and care and decision making and clinical judgment, but they may not have the exact symptoms or number of bullet points if you will to meet that certain criteria that is artificially established in advance. That is where difficulties come in and some might argue that ethically, it really challenges some

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doctors . . . you know, do you do what is in the patient's best interest of saying what needs to be said to get the care they need or do you do what is exactly right by the letter of the law although it may limit some of the response, the reimbursement, whether you get into the hospital or not, whether you qualify to get the surgery or not - all of these issues very often, at some level, are judged based on how many bullets you can meet. People should know that.

TO: O.K., so then, that's an aspect when you are in your residency, then as a hospital administrator, do you have a different angle on that same issue?

RB: Well, I have been an administrator twice in my career. It is a small example but two substantial times. For two years, 98 or so to 2000, close to 2001, I was the medical director of an outpatient series of clinics here in Houston called Continuum Health Care and all of their billing was to the federal government, Medicare, third party payers, etc. Very little, if any, was private pay. Very sick patients, you know, those with chronic persistent mental illness so they didn't have jobs, didn't have money, didn't have insurance. They are dependent on the third party, the government generally, to reimburse us for what we did for them. So, we had to document it correctly, etc. I lived in Alabama for a year, I got a job as the medical director of a large 400 bed inpatient state hospital, at Bryce State Hospital in Tuscaloosa, Alabama. The experiences there were very disparaging. In Houston, it was very clear that in its private entity, we had sick people to take care of and we had to find out what the government would support us on taking care of them for them. And if the government wouldn't pay for it, we couldn't treat them. It

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was as simple as that. And many don't like to hear that but it was really true. If you didn't meet the criteria, we couldn't take care of you. It is like if you were in a private world and you didn't have any money, we couldn't take care of you. There just was no extra there. It was a private business that billed the government secondarily for the work that we actually did. I was medical director. We were large. At times, we had 250, 300 patients and almost half that many employees, and maybe 5 or 6 psychiatrists all working for me at any given time, all for the state of Texas. In Alabama, it was very different. It was an inpatient state hospital, you know. It was a physical facility with brick and mortar. And in those days, very often the state said just take care of them and we will send you the money later. So, we didn't turn anybody away. If you showed up and you were sick and you were psychotic and you were violent, dangerous, aggressive, and paranoid, delusional and all those kinds of things, we put you in the hospital and then later, somebody had to try to bill the state for it and kind of fight to actually get the money. So, two very different paradigms or models in providing indigent care. Those have been my two primary experiences as a psychiatric facility administrator.

TO: And the one in Alabama, is that federal funds or state sponsored?

RB: It was all state. The public mental health system, all states in the country have a DMH or a Department of Mental Health and they are funded out of the state budget just like education and roads and Medicaid. We always argue in psychiatry . . . we probably don't receive our fair share that we are a parody, if you will, and I agree with all of that but generally as a stop gap, a last place for you to go. If you are psychotic and impaired,

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psychiatrically as is possible, and if someone needs to go there to provide a baseline level of care. They often call these places safety nets. So, there should be some place for you to go rather than just have you be homeless or in prison or on the streets.

TO: So that place would be comparable to Texas State Hospital in Austin?

RB: That place is exactly the same as . . . every state has, you know, 5 or 6 big state hospitals. We have Austin State Hospital, we have San Antonio State Hospital, we have Terrell State Hospital outside of Dallas, Rusk State Hospital is near Houston. There is a Big Sandy or Big Springs. I think there is one called Kerrville near San Antonio. Texas is a big state so we may have 10 or 11 of them. But every state has these long-term inpatient indigent facilities for the chronically mental ill.

TO: So then, now, you are in private practice?

RB: Yes, I am in private practice in the Clearlake area outside of Houston. One week of the month, I actually staff the psychiatric services for a private suburban hospital, Clearlake Regional Hospital. I also remain . . . I have an appointment at UT Medical School, so I do some teaching there. I gave a lecture about one month or so ago to the child residents on general psychiatry. I do a lot of lecturing on risk management. I am a forensic trained guy. I am involved with administrative work now with organizations. So, my two big ones now are I am the Secretary of the House of Delegates for the

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National Medical Association and I am also on the Committee of Law and Psychiatry for the American Psychiatric Association.

TO: And that is another national body?

RB: Yes, the APA works directly with all 35,000 psychiatrists in the country and the NMA theoretically represents the 21,000 black physicians in the country.

TO: Then if the learning aspect of this project is focused on middle school and high school kids, trying to get them interested in getting in the medical field, what is some advice you can give them, maybe you have a canned reply or something, to encourage kids to go to medical school and become successful physicians like you?

RB: I am not sure I have a canned response but I certainly have a few things that I always say since I go to schools and do career day all the time. I think medicine is a wonderful profession. I love what I do. I am very happy about that. It is always disheartening when I see other physicians who have lost interest in medicine or are quitting or changing specialties or retiring early, or patients who dislike whatever profession they are in, spend so much time doing this, it would be horrendous to not enjoy doing it. So, the technical nuts and bolts of what I do and I enjoy thoroughly . . . I am fortunate in that I have chosen the right specialty. I am a pretty verbal kind of guy and psychiatry allows some exchange, I think, with people. You certainly have some specialties where the guy is asleep so you can't talk to him, or radiology, in a dark room.

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I really thoroughly enjoy the human exchange. I probably wouldn't enjoy those type things. I really thoroughly enjoy the human exchange. I think that medicine is academically challenging and that is just thrilling to me. I think the reality is that you have to pick a specialty or a profession that gives us some reason to grow and to reach and to kind of push ourselves. Many people laugh and criticize being in medical school, staying up all night, drinking coffee and all that but many would argue, those are some of the best times of your life. Like being a football player. It is when you learn to do something that you can feel good about yourself and who you are. And medicine, I think, gives us a lot of opportunities for that. I think medicine is also a specialty by definition that it has both depth but it also has breadth. I love the fact that what I do in psychiatry, there is 100 things that I need to know tomorrow that I didn't know last week but there is also the breadth of what I do - I need to know psychiatry and I also need to know some good general medicine, some endocrinology because I have patients with diabetes; some rheumatology - I have patients with lupus, etc., some arthritis or what have you, so that I can know how the medicines work in a fashion that is good for patients and not adverse to them. I think all those issues are relevant for me. I also think though, that you know, from a perspective of just good quality, honest work, you know, medicine requires discipline and I am strong believer that discipline is good for the soul inside and out. All too often, I think our young people hope that they can kind of hit it real fast. I can sing a song and I'll get one million dollars. I am not against singers. Or I can win the lottery and I'll get \$10 million. I'll just play the lottery. But there is something different about the joy and the self aggrandizement, I think, that comes from the discipline of putting in a tremendous workload, developing a core foundation of who you are, kind of watering

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your plants, so to speak, and then watching it, I think, develop into something where you can help others later in life. Many would argue that that is the most enjoyable thing that we do. When you go to a meeting of physicians and they are retiring or ending type thing – I often comment about this - you never hear a guy or woman retiring or leaving or whatever, speaking anything about how big your house is or what car they drive or how much money they make. It is always about that patient that you helped, that one where you figured something out where that person got back on their feet or got back to work, or you got off disability, who you did something for that many people could not have done, and that even you could not have done had you not put so much effort into developing yourself in a way that you had something to offer. To me, that's gold.

TO: So, the fulfillment for you is more how you helped a human being have a healthy life, rather than any financial or monetary concerns?

RB: Absolutely. I think that the reality is I am very fortunate because in psychiatry, so much of what we do is functionality it is what I use every day in my practice. I get people who come to me who have a problem . . . at one level or other, they wouldn't come to me if all was good. So, we are already friends early on cause we know why I am there and why they are there. And their problem may be relationship - you know, they got a divorce or maybe are getting one or changing a spouse or don't like the one they have. It could be vocation, you know, they can't get a or they don't like the job they have or need a better one or what have you. A lot of stress on the job. It could be housing. It could be finance. It could be education - either go to school or go back to school. There

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is always a problem that needs to be addressed. It could be legal, like the forensic work. Been in jail or going to jail or whatever - write me a letter, you know get me off. It could be vocation, work. So clearly, I think that when people walk out of my office, I am hoping that I have done something that, at least in part, that will move them one step closer to solving whatever the problem or series of problems are that they actually came in with. I don't mean to be adverse to the other side. The reality is I've got 3 kids so you got to work to make a living. They have got to eat, too. But I don't think, especially in the day and age now where money is going down for physicians, stress is going up . . . you know, we are talking \_\_\_\_\_ sued a lot more, there is a lot of difficulty, this probably wouldn't be the area to go into. If you are strictly money-based, go in investment banking or some area where you could make a lot more return, yield, on your time investment. Doctors spend a tremendous amount of time trying to get to where we can help individuals. You can make a lot more money in a different area without a lot of time investment. But I think it is difficult, not impossible but difficult, to get as much self-reward in another area as compared to practicing medicine.

TO: O.K., great.