The Business of Psychiatry:
Marketing Your Practice

by Gerald P. Perman, M.D.

This article is addressed to those of you who are in, or are considering entering, a full- or part-time private psychotherapy practice. However, even if you think of your psychotherapy practice, it is a small business owned and run by yourself. If you are entirely content with how your business is going—your income and the number of patients you see per week—read no further. Otherwise, read on.

Although things may have changed in psychiatric residency programs since I was in training, I do not remember having been taught in how to manage the business aspects of my practice. I am sure I must have asked some questions of supervisors or young colleagues. I must have started their own practices. The biggest influence on me in this regard was probably my analyst and how he seemed to run his practice. Aside from the way and where he set up his office, he mailed me a handwritten bill at the end of each month for which payment was due by the 15th of the following month. He probably told me that he charged for all scheduled appointments; I don’t remember, but after a few years I just assumed that he did. I’m sure when I told him that I did not plan to attend an analytic hour because it was going to be on Yom Kippur and I was going to shul with my family, he let me know that according to the Hebrew Bible God allowed Jews not to go to synagogue if they were ill (i.e., had a neuronosis). I came to the session. He was not Jewish. Was his intervention considered an interpretation or a clarification?

In my first year out of psychiatric residency 24 years ago, I contracted to work with a psychiatrist who ran a day and evening outpatient partial psychiatric treatment center and alcohol and drug treatment program. This psychiatrist had me become incorporated so that my corporation entered into an employment agreement with his corporation to manage the business aspects of his practice. I became a “participating physician” with a number of other corporation. This was obviously his way to not have to pay for my health insurance and other benefits. I retained this corporate status over the years and believe it has been a good thing from a business and tax perspective. My accountant tells me so. I left after a year to open my half-time private practice and to work half-time at a community mental health center. After two years, I went into the full-time private practice of adult general psychiatry, which I have maintained ever since.

Over the years, the robustness of my private practice had fluctuated. An important influence in this regard is that which has affected us all—changes in the insurance industry and perhaps the economy. For the first ten or fifteen years of practice, I had privileges at several local hospitals in Washington, D.C., and I was a “participating physician” with a number of health insurance companies. When managed-care came on the scene, I became frightened and quickly joined a number of panels. After a short time I had the same feelings of rage, disgust, demoralization, and depression (Adjustment Disorder with Depressed Mood, DSM 309.0), with which I am sure many of you are all too familiar. In an effort to regain a modicum of control over my feelings, my practice, and my integrity as a psychotherapist, I discontinued my participation with all managed-care panels, and after a while, I stopped the hospital work as well. In order to receive hospital referrals one needs to be on the managed care insurance panels to which patients who are being admitted to the hospital belong.

I had enjoyed treating sicker patients in the hospital as well as the camaraderie of the staff and fellow hospital psychiatrists, but after getting “siphoned” by a few patients, I did not pay me and kept the insurance checks for themselves, I threw in the towel. I remember one patient in particular, a poor alcoholic woman who was admitted to the psychiatric ward with florid delirium tremors. Over a difficult two-week hospitalization, her hallucinations, tremors, and metabolic disturbances gradually resolved. She and her husband were very appreciative for my help. Although I do not remember the follow-up plans, she returned home and promised to pay me when she received her insurance checks. She never did pay me, and the insurance company told me the checks had been made payable to her. I was not a “participating” physician, and there was nothing that they could do to get me paid. This caused some of the icing on the cake that ended my hospital work. In spite of my anger I remember also having felt pleased for her that she got this money, which might have slightly and temporarily ameliorated her difficult financial situation. Reaction formation, I’m sure.

Several times when my patient hours were low, I had the anxious fantasy that they would never rise again, and I would make inquiries into other psychiatric employment opportunities. By the time this process had gotten underway, my practice was always rebounded, and I returned to the idea of full-time practice. This roller-coaster was always disconcerting, and I felt I had little control over the flow of referrals and no idea what I could do about it.

“Marketing” then consisted of my attendance at weekly psychiatric Grand Rounds at a local teaching hospital, supervising psychiatric residents, and teaching medical students in a variety of capacities, hoping that my visibility would generate referrals from this professional community. It did from time to time. I also wrote letters to non-psychiatric physicians about my practice, and I told anybody who might refer me patients that I had open hours. I cannot complain too much about my practice over the years; I own a home, have been able to support my family (with the help of my wife and her part-time biobehavioral and family therapy practices), took vacations, and paid my analysts on time when I was still in analysis. Nevertheless, I rarely was seeing the forty to forty-five hours of patients per week in psychodynamic psychotherapy that I desired.

Then, two years ago, while my practice was again only three-quarters full, I had an idea, maybe even a revelation. I decided that maybe I did not know all there was to know about how to market a psychiatric practice. I thought that perhaps I needed the help of a professional with a particular expertise in the area of marketing. As I frequently tell others, being able to say “I don’t know” is a developmental step that usually occurs when we are about forty years old, although I was then slightly older than that. So I went through the yellow pages and called six or eight marketing and public relations firms. I left a number of phone messages, spoke to a few individuals with whom it did not seem there would be a “match,” and then I found one
person with whom I felt I might be able to work.

While I have told a number of my psychiatrist and other physician friends and colleagues about the success that I have had as a result of my marketing efforts, and I am enjoying writing this article for my fellow AAPD members, I do not provide "competitors" with the name of the company that helped me nor with the specific details of where I have sought to market my practice. However, I welcome the opportunity to provide you with some generalities from my experience and which may be beneficial to you. The best advice I can give you is to find a marketer for your own psychiatric practice with whom you can work.

Here we go. I met with this person, liked him, and after an initial introductory interview agreed to pay him a retainer for ten hours of his time (about $2,000.00). He and I met another couple of times, and then we spent the rest of the allotted time in e-mail correspondence, implementing the ideas that we came up with along the way.

What did he do for me? He helped me greatly improve the referral letter I had been mailing from time to time to non-psychiatric physicians. My previous letters had a stiff, overly formal tone to them. The new letter started with "Permission to introduce myself!" (perhaps taken from the Rolling Stones song "Sympathy for the Devil"). I continued, "My name is Gerald P. Perman, M.D., but my friends call me Jerry." Horrors! I would never have allowed myself to let my hair down in such a letter to doctors I didn't know in the past. The rest of the letter then had a certain je ne sais quoi tone that combined the informal with the appropriately formal and businesslike. He had me list in "bullet" fashion the kinds of problems I treated, using my computer, I made a database of names and addresses of local physicians from a physician directory and mailed letters to a third of that list. I still have the other two thirds of the list in reserve for the future should I need it. From this letter several of these physicians have since become regular and trusted referral sources.

The marketer had me contact a number of agencies and businesses that have also become regular and frequent referral sources. He had me use a professional photographer to have "executive photographs" made which I then used in display advertisements (prepared by a graphic artist with whom I subcontracted) and which I ran in a number of local newspapers. These ads added to my referral stream. I also had my teen-age son create an informational website for me to which I refer in my ads.

The marketer also suggested I try my hand at writing some psychiatric articles for the local popular press to solicit reader referrals. After a couple of such articles were rejected (writing for the general public has never been my strong suit), I came up with another idea. Most of us receive the usual free psychiatric newspapers - APA News, Clinical Psychiatry News, Psychiatric Times, etc. I decided to summarize articles from these newspapers on one page - one article per page - and then fax these summaries which I call "Psychiatric News Summaries" - to the same list of physicians to whom I had previously written letters of introduction. I now fax these summaries twice a month and have done so for the past two years. I have set up a fax list on my computer and do the faxing automatically overnight while I am sleeping. It takes a few hours to send a cover page with a brief note and the summary to all of the physicians on my fax list. I let them know they can be taken off the list by e-mailing or calling my office. Three or four physicians have asked to be taken off the list; three or four have told me how much they like my summaries; and the vast majority just keep receiving it without contacting me, but some of whom have become new referral sources.

Since I hired the marketer two years ago, my practice has been virtually full - 40 to 45 hours of patients a week - with a consequent increase in my income. My wife chides me that it took me nineteen years (actually a little longer) to generate this success. Virtually all of my patients are full-pay. I opted out of Medicare at the beginning of the year and see one former Medicare patient once a month at a slightly reduced fee, and I participate on no insurance or managed care panels. I also have one patient whom I see at a slightly reduced fee paid for by her managed-care company. I have an "out-of-network" contract with this company and have seen her at a frequency that has ranged from four times a week to her current twice a week treatment for the past ten years. I reported on this treatment at an Academy meeting three years ago in a paper titled "Intensive Psychotherapy in an Era of Managed Care."

There is of course no guarantee that my current practice will remain as full as it has been. At the same time, as we all know, the past is the best predictor of the future. I feel that I have a spigot that I can open up more fully should the need arrive. This gives me a sense of greater control over the flow of patients to my psychoanalytic psychotherapy practice.

One downside to all of this is that I am sometimes tired, distracted, and irritable after seeing as many as eleven patients a day, although on some days I see as few as seven. I pay particular attention to my sleep. I am in bed by 10:30 P.M. each night and at 6:20 A.M.; my family ribs me about my obsession about getting to bed on time. I see patients for 45-minute sessions usually followed by a 15-minute break. I work out at a gym twice a week and teach and attend psychiatric conferences a few hours each week.

Psychoanalytic psychiatry is not a profession in which one is destined to get rich. Certainly not for those of us who like me do things "the old fashioned way," one patient at a time. We, those of us who do this challenging, amazing, and often grueling work, are often stuck in the past in more ways than one. We have been (and will continue to be) criticized that our "science" is behind the times, and we are working furiously to combat that criticism. But the same could be said of how we run our "business" of psychoanalytic psychiatry.

In the "old days" both in psychiatry and in medicine, advertising, not to mention marketing, was seen as unkosher and verboten. Referrals were to be had by dint of the analyst's word-of-mouth reputation. Times have changed. Currently most referrals in medicine, perhaps as many as 75% (the percent of the population that I have heard is enrolled in HMOs) and under managed care), are made based on this insurance network. Therefore, if we are to maintain healthy psychotherapy practices and at the same time offer treatment to the greatest numbers of patients who can benefit from our help, we must let them know that we are here, I hope that I have been helpful to some of you towards these ends.

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