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PSYCHIATRIST ADMINISTRATOR

NewsJournal of the
American Association of Psychiatric Administrators

Volume 2, Issue 2 Spring 2002

NEWSJOURNAL OF THE AMERICAN ASSOCIATION OF PSYCHIATRIC ADMINISTRATORS

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Published 4 times a year
Winter • Spring • Summer • Fall

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Reducing and Eliminating Racial and Ethnic Disparities in Health Care:
Are We Ready to Face the Challenge?

Sy Atezaz Saeed, M.D.

A recently released, congressionally mandated, report from the National Academies' Institute of Medicine (IOM) states that racial and ethnic minorities tend to receive lower-quality health care than whites do, even when income, insurance status, age, and severity of conditions are comparable[1]. According to the report, these differences in treating cancer, heart disease, and HIV infection partly contribute to higher death rates for minorities.

The report points to a large body of research that underscores the existence of disparities. For example, minorities are less likely to be offered appropriate cardiac medications or to undergo bypass surgery, and are less likely to receive kidney dialysis or transplants. Studies also show significant racial differences in who receives appropriate cancer diagnostic tests and treatments. Minorities are also less likely to be given the most sophisticated treatments for HIV infection, which could prevent the onset of AIDS. By contrast, minorities are more likely to receive certain less-desirable procedures, such as lower limb amputations for diabetes and other conditions.

Today we live in an era marked by remarkable advances in our understanding of health and illness. Do ethnic and racial minorities completely share in the hope afforded by these remarkable scientific advances? Is the promise, and the hope that accompanies it, the same for ethnic and racial minorities who have mental disorders? Last year, the US Surgeon General released a supplement to its landmark report on mental health[2], reporting striking disparities in mental health care for racial and ethnic minorities[3]. This Supplement documented the existence of several disparities affecting mental health care of racial and ethnic minorities compared with whites:

- Minorities have less access to, and availability of, mental health services.
- Minorities are less likely to receive needed mental health services.
- Minorities in treatment often receive a poorer quality of mental health care.
- Minorities are underrepresented in mental health research.

There are many possible reasons for racial and ethnic disparities. Unequal treatment occurs in the context of persistent discrimination in many segments of American life. Some evidence suggests that prejudice, bias, and stereotyping on the part of health care providers may contribute to differences in care. Although it is reasonable to assume that the vast majority of health care providers find prejudice morally repugnant, several studies show that even well-meaning people who are not overtly biased or prejudiced typically demonstrate unconscious negative racial attitudes and stereotypes[1]. In addition, the time pressures that characterize many clinical encounters, as well as the complex thinking and decision-making they require, may increase the likelihood of stereotyping.

The IOM report points out that although studies of racial and ethnic disparities have been controlled for insurance status, they have not fully accounted for variations among health plans. Minorities are more likely to be enrolled in more inexpensive and "lower-end" health plans, characterized by fewer resources per patient and stricter limits on covered services. The disproportionate number of minorities in these plans is a potential source of disparities in treatment. Insurance companies' caps on the coverage of treatment costs can also pose greater barriers to minority patients since they are less likely to be able to afford high co-payments or deductibles. Even when insured at the same level as whites, minorities are less likely to enjoy a consistent relationship with a primary care provider, in part because of the lack of doctors in minority communities, the report adds.

Although there are studies that have found that minority patients refuse recommended treatments more often than whites, the IOM report points out that the differences in refusal rates are small and do not fully account for racial and ethnic disparities. Likewise, overuse by white patients of some services does not explain the disparities either.

A variety of barriers exist that deter minorities from seeking mental health treatment. Many of these barriers operate for all Americans: cost, fragmentation of services, lack of availability of services, difficulty to access services, and societal stigma toward mental

illness. But, as the Surgeon General's supplement report points out[3], additional barriers exist for racial and ethnic minorities: mistrust and fear of treatment, racism and discrimination, and differences in language and communication. This supplement further points out that although the ability for consumers and providers to communicate with one another is essential for all aspects of health care, it carries special significance in the area of mental health because mental disorders affect thoughts, moods, and the highest integrative aspects of behavior. The diagnosis and treatment of mental disorders greatly depend on verbal communication and trust between patient and clinician. On a larger level, mental health care disparities may also stem from minorities' historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status. The collective weight and interplay of all barriers to care, not any single one alone, is likely responsible for mental health disparities.

The Surgeon General's supplement report also found that racial and ethnic minorities collectively experienced a greater disability burden from mental illness than did whites. This higher level of burden stems from minorities receiving less care and poorer quality of care, rather than from their illnesses being inherently more severe or prevalent in the community. By not receiving effective treatment, they have greater levels of disability in terms of lost workdays and limitations in daily activities. Further, minorities are over-represented among the Nation's most vulnerable populations, which have higher rates of mental disorders and more barriers to care. This preventable disability from mental illness comes with a very high cost to our society and affects all Americans.

Reducing Disparities

The evidence for the existence of disparities is compelling. The real challenge lies not in debating whether they exist but in developing and implementing strategies to reduce and eliminate them.

Specific steps to reduce and eliminate disparities are presented in the Institute of Medicine's report. Amongst their recommendations are the following:

- Increase awareness about the disparities among the general public, health care providers, insurance companies, and policy-makers.
- Consistency and equity of care should be promoted through the use of "evidence-based" guidelines to help providers and health plans make decisions about which procedures to order or pay for based on the best available science.
- Health care plans should not be fragmented along socioeconomic lines. Public programs such as Medicaid should strive to help beneficiaries access the same level of care as privately insured patients.
- If congress passes a "Patients' Bill of Rights" to protect enrollees in private HMO plans, it should accord the same protections to people in publicly funded HMO plans.
- More minority health care providers are needed, especially since they are more likely to serve in minority and medically underserved communities.
- To overcome language barriers that may affect the quality of care, more interpreters should be available in clinics and hospitals located in neighborhoods with many foreign-language-speaking residents.
- Community-based health workers, such as nonmedical personnel who help patients navigate the health care system, are an important tool to reach some minority neighborhoods, and the health care system as a whole should encourage their use.
- Training for current and future health care professionals should help them understand different cultures.
- Patient education programs should be expanded to increase patients' knowledge of how to best access care, ask the right questions during clinical encounters, and participate in treatment decisions.
- More research to identify sources of racial and ethnic disparities as well as promising intervention strategies. Future research should include a strong effort to better understand the prevalence and influence of bias, prejudice, stereotyping, and clinical uncertainty on the part of health care providers.
- To ensure that the nation can track its progress in reducing disparities, hospitals should, without violating patients' privacy, collect and report data on health care access and utilization by patients' race, ethnicity, socioeconomic status, and primary language.

The recognition of these disparities brings hope that they can be seriously addressed and resolved. The Supplement to the Surgeon General's Report offers guidance on future courses of action to eliminate these disparities and to ensure equality in access, utilization, and outcomes of mental health care.

As recommended by the Surgeon General, "a public health approach to reducing mental health disparities will require a national commitment, bringing together the best of the public and private sectors, individuals and communities, Federal, State, and local governments, universities, foundations, mental health researchers, advocates, health service providers, consumers, and their families. Through active partnership, these stakeholders can generate the knowledge and resources necessary to improve mental health services for racial and ethnic minorities in this country."

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"The Future of Administrative Psychiatry: Is There One?"

Tuesday, May 21
12:00 noon - 2:00 p.m.
Courtyard by Marriott
Meeting Room 102 - First Floor

John Talbott, M.D., Professor of Psychiatry,
University of Maryland
School of Medicine and Senior Editor, APPI
Textbook of Administrative Psychiatry,
2nd Edition 2001

Jack W. Bonner, III, M.D., Medical Director, Behavioral Health Services of the Greenville Hospital System and Marshall I. Pickens Hospital, Greenville, South Carolina was elected President of The American College of Psychiatrists (ACP) at the Annual Meeting held in Kohala Coast, Hawaii, February 27-March 3, 2002. Dr. Bonner will serve as president through the 2003 meeting to be held in Vancouver, British Columbia. The ACP is a national professional association which is dedicated to the pursuit of continuing education for all aspects of psychiatric theory and practice. Election to membership confers honor and privilege on those selected.

Welcome! New Member

February 2002

Andrew J. Kolody, M.D.

CALL FOR PAPERS

The ***Psychiatrist Administrator*** invites articles on all areas of psychiatric administration and management with a focus on the roles and perspectives of psychiatrists in leadership and management roles. Please make submissions and inquires to:

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A Primer on Leadership

William H. Reid, M.D., M.P.H.
Daniel J. Reid, D.P.P., M.B.A.

EDITOR'S NOTE: *This is the second of two articles designed for clinicians who are new to health care administration, or merely confused by it. Some may be enthusiastic about moving from a primarily clinical base to a management career. Some may be stuck in a frustrating environment and want to do something about it. The article is purposely informal and practical, even simplistic, compared to most books and papers on the topic. It is a guide, not a scholarly reference. This article is taken from a similar chapter by the authors in the forthcoming Handbook of Mental Health Administration and Management, edited by William H. Reid and Stuart B. Silver (New York: Brunner-Routledge, 2002).*

People are hired for their technical competence, fired for their technical incompetence, and promoted for their leadership skills.
— Jack Zenger

Leadership is the art of getting someone else to do something you want done because he wants to do it.
— Dwight D. Eisenhower

Let's go back to the carriage manufacturer in the article in the last issue (Reid WH; Reid DJ. A primer on management and the management environment. *Psychiatrist Administrator*, Vol 2; No.1: 14-19, 2002). Henry Ford has just developed a practical automobile (and production lines) and the horse-and-carriage business is in deep *kimchee.* The company CEO is nearing retirement and wants to choose a successor who will get the company through these trying, changing times. He calls Ted and Bob[1] his two top vice presidents:

"I know you two don't see eye to eye," he says, "but one of you has got to carry on after I'm gone."

((insert sad violins here))

He continues: "The violins are nice, but what I really care about is this company's survival. You've each got 30 days to come up with a plan. The winner becomes the new CEO."

((Close-up of calendar pages flying away; a month passes.))

The CEO opens the discussion. "Today's the day. You first, Ted."

"Well, Dad ... er, Chief, the automobile's here to stay. That's bad news; but there is some good news. First, it's 1908 and cars aren't very sturdy. Sales are confined mainly to cities, where roads are pretty good. The rural areas will remain a market for our carriages for years. Second, Ford is looking for manufacturing space and warehouses to hold his inventory. We have lots of both in the cities.

"I say we close down most of our manufacturing plants in the cities and sell our plants and warehouse space to Henry for top dollar. Then we concentrate our sales in the rural areas to fill continuing rural customer need. We'll lower our overhead and operating expense and reduce our debt. The balance sheet will look good and our stockholders will continue to receive dividends for the foreseeable future."

The CEO grunted, and seemed to be thinking of Tahiti. "Your turn, Bob."

"Chief, I agree with Ted that the automobile is here to stay. I also agree that the automobile is currently sold and used in cities. My plan, however, is different.

"I'd retain most of our existing plants and personnel and concentrate on retooling and retraining to take advantage of this new automotive industry. Henry Ford knows engines, but we make great coaches and we know how to create a smooth ride on bumpy roads. I think Henry would be interested in a joint

[1]We wanted to make one of the vice presidents a woman, but this is 1908.

venture to furnish leather seats, good wheels, and maybe even frames for "horseless" carriages. At the same time, I'd like to take some of our more entrenched personnel, non-convertible equipment, and sizeable inventory, and do exactly what Ted wants to do: Go to the rural population, although for the short term.

"I know we'll have to raise lots of capital, and there will be some risk. Our debt and overhead will increase in the short term, and we'll have to stop paying dividends for a couple of years to plow profits back into the company."

Pop quiz. Both plans were worthwhile, but who is the better leader and who is more a manager?

Who ended up heading the rural division (not a bad job either)?

All levels of successful management require leadership. Unfortunately, not all managers are good leaders. In a lot of ways, management is not even the same as leadership, and may sometimes conflict with it. That's why we tend to separate the two concepts. Peter Drucker has said that the requirements for leadership are identical to those for being an effective manager.[2] We're in awe of the man, but we live far enough from him to come right out and disagree. Warren Bennis's concept, that managers and leaders are different in both thinking and temperament, seems closer to the truth.
The fact remains, however, that if you can't lead the people who are important to your organization — who may or may not report to you — you will have trouble getting where you want to be.

As much as we'd like for you to believe that this article can teach you everything you need to know about leadership, we must, in all conscience, tell you that book-learning can take you only part of the way. We do *not* believe that good leaders are "born that way," nor do we feel that natural charisma is always helpful; much of what is important can be taught, and can be learned. You'll have to work at it, though, and practice whenever you can.

[2]*The Wall Street Joumal*, January 6, 1988

We recommend that you carefully observe some real-life models of leadership (better yet, try to secure a *mentor).* Age, sex, situation, and century are unimportant (remember Napoleon). You may not even like the person, since the qualities you are learning about aren't all part of your daily life yet. But be certain (1) that he or she has a track record of successful leadership and (2) that his or her characteristics can reasonably be translated to your own situation.

Power

Some authors say leadership depends on power or authority for its effectiveness. If you are new to management, however, it is important that you not focus your leadership style on power and authority right now, for several reasons.

First, it is unlikely that you have direct authority over very many people at the moment. Your ability to reward others, or coerce them, is probably limited; most of your power is "inferred" (i.e., related to attributes such as being well-liked, having useful knowledge, or possessing special training or experience, rather than to direct authority). Second, and more important, many of the people you will want to lead at various times don't report directly to you (e.g., members of a committee or task force, or people outside the organization). Finally, reliance on power is simply not the most effective way to lead.

Power is not the most important part of leadership.

Here's why. Of all the quotations about leadership that we have seen, these two come closest to summarizing what you have to know:

The best leadership situation is one in which the led want the same thing as the leader.
—Russell Fershleiser

Find a great parade and get in front of it.
—Somebody we wish we could remember

Most leading is really the artful taking advantage of an *opportunity* to lead, not dragging other people kicking and screaming toward what you want them

to do. Those being led sometimes complain, to be sure. But if you are successful, the complaints will be about the conditions of the journey, not about the destination.

> During the Battle of the Bulge in World War II, the 101st Airborne Division was surrounded by enemy troops at the town of Bastogne, and faced with near-certain defeat. In one of the most incredible feats of the war, General George Patton marched his exhausted Third Army over 100 miles to the rescue, in the dead of winter, in less than three days.[3]

Cold, hunger, and exhaustion are not the best motivators for any group. What got them there? Patton knew how to make *his* vision into his *troops'* vision. They responded as much to the goal as to the leader. Patton had power; but the rescue would almost surely have failed if the troops had not responded willingly.

Soldiers sometimes seem to hate good leaders, but they'll follow them anywhere.

Martin Luther King, Jr.[4] in his "I Have a Dream" speech, summarized four things one has to do to "move people."

1. Move them toward a vision they feel is positive.
2. Draw upon values they feel are important.
3. Give them something they want.
4. Present it in a compelling, inspiring way.

Note that three of the four are related to the desires of the follower.

Leadership Requirements

Ask yourself, "Why should people want to follow me?" "How will they *benefit from* following me?" If people feel you are doing something that has value to them, they will pay attention. If the value you tap is an important one, their attentiveness increases.

All leadership experts are required to outline the things leaders have to do. Here's our list, with some critical items highlighted:

- **Have a clear vision of what you want others to achieve.**
- **Make your vision their vision** (better still, make their vision yours).
- Realize that others usually want to act on their/ your vision.
- Convert the vision into attainable goals.
- **Motivate others to move toward the goals.**
- Bring people together to work toward the goals.
- **Engender their trust.**
- Guide their actions.
- **Empower them to act without you.**
- Oversee progress toward the goals.
- Realize that change is likely, and invite it to occur.
- Be (or be closely associated with) a symbol for your vision.
- **Give visible credit for success.**
- **Take visible responsibility for failure.**
- **Be absolutely credible to your followers.**

Sounds like a lot of work, doesn't it? Let's take a look at the most critical **(boldface)** items.

Clarity of vision is critical both to the mission and to the follower's view of the leader. The vision should be realistic, not pollyanna-like or overly grandiose. Manageable goals and priorities can be successfully developed only if the vision is clear.

Melding the visions of leader and followers provides the initial energy for group action. If the leader's view remains separate from that of the followers, there can be no coordination of expectation or purpose.

Continuously motivating others to pursue the vision is the leader's way of replenishing the energy just mentioned. Sometimes the common vision is enough. Often, though, you'll have to figure out what else the follower wants. Money drives some people, but in the long run most clinical employees have other, stronger values. The need to produce something worthwhile is an important one. Others include helping

[3]To this day, the 101st Airborne maintains they didn't really need rescuing.

[4]We can't recall a more effective leader, and none of his followers *had* to do anything he asked.

the organization (provided one feels positively about it), helping other people, feeling good about oneself, being associated with a successful project, and securing a favorable position with the leader or the organization. Look for values you can tap in those you want to lead or influence. Become aware of values that may be related to, for example, a person's age, social situation, background, culture, or position in the organization. Stereotyping is not the answer, but different things motivate different people.

Trust is a big part of loyalty and commitment. Trust has little to do with being liked, but everything to do with being reliable. It has little to do with the mission at hand, but everything to do with the leader's consistent belief in that mission.

Empowering followers to act without you is one of the hardest things for some people to do, but it is critical to long-range success. Stop thinking that unless *you* do something, you won't get credit for it. We know you're ambitious, and that's good, but we want you to realize that your followers can multiply your effectiveness many-fold. Stop being afraid that others' strengths and successes imply that you are a failure. Your followers' successes are truly yours as well. In fact, your superiors are more likely to judge you by your followers' accomplishments than by the things you do alone. Ask any executive who has been promoted — or fired — for the actions of his subordinates. Upper management is less upset by bad performance than by bad leadership.

You will be judged by your followers' accomplishments.

"Empowerment" is the placing of control over a situation into the hands of the people who are affected by it. It is the opposite of paternalism and autocracy. Empowerment shows faith in subordinates' ideas and talents.

Empowerment shows your faith in subordinates' talents.

In an organization, empowerment implies an opportunity for individuals or groups to do things their own way. It allows employees and groups to make decisions on their own, and to focus their strengths and experience on goals without undue restraint or fear of reprisal from the boss. It means they may try new things and if they fail, they will be recognized — perhaps even celebrated — for trying.

To take advantage of empowerment, the manager or leader must give up some "ownership" of the group or project. (Readers who are into control will have to work on this.) By empowering employees or followers, you almost always increase your chances for success and create very loyal workers.

Good leaders take responsibility seriously. They know they will be given credit for success, and they take responsibility for failure. Their followers trust that the leader won't let them down, and won't steal the spotlight when the job is over. Followers don't become deeply dedicated to leaders who are primarily in the game for their own profit.

Followers can smell lack of credibility a mile away. Enough said.

You may have noticed that "charisma" isn't on our Mandatory List of leaders' qualities. It's fun to think about dashing exploits and fodder for legends and movies, but a lot of very effective leaders seem to have been fairly boring folks. Drucker cites a couple of presidents (no, not Gerald Ford) in this regard. He also notes that charisma can disguise inflexibility, or even incompetence.

It is good to enumerate the tasks of leadership, but what we really want you to understand is that *you usually have to do all of the above to be an effective leader*. Fortunately, your followers will help if you let them.

Leadership Behavior and Style

Leadership Behavior. Leadership behavior is basically related to two things: The job to be done and the people who are to do it. You must consider both, and balance them, to most effectively accomplish any goal.

Your view of those you would lead is crucial to your success. Douglas McGregor's "Theory Y"[5] says

[5]The opposite of McGregor's Theory "X." Really.

people want to do a good job. They also want to be led by good leaders.

People want to do a good job.

Some situations require great emphasis on treating people with extra care and respect, in an effort to let their talent, human nature and cooperativeness produce the necessary results. Others demand that you be much more directive. Learn to vary your attention to the group's needs to fit the situation at hand. Your followers are your most important resource.

Workers may be motivated by money or security, or by accomplishment, recognition, or self-actualization. Giving the people (workers) what they want is a very good way to motivate them to do what *you* want (there are exceptions). In short, satisfying the follower is an important part of leadership. This takes time and energy from the immediate task, but it is often worthwhile. It may even make it possible to achieve goals that are otherwise not attainable. Dissatisfied followers, even those over whom you have direct authority, make life tough for everyone.[6]

Satisfy the follower

Let people have some influence over what you want them to do. When people are empowered and *participate* in the conception, planning, implementation, and evaluation of their work, they become *invested*. In modern factories, for example, productivity increases when line employees are allowed to organize their own tasks, measure their own quality, and arrange their own work schedules. Participation and investment are especially important when the project at hand is unpleasant, or when it involves any kind of organizational change.

Sometimes, however, time is short. You are handed a job that simply has to be done by next week; no arguments; no flexibility. Or maybe the job is so stressful that your followers really need to be told what to do. When one of these happens, those you lead must follow your autocratic demands without question or input. Unless you already have lots of power, the best way to ensure this is to have built a prior foundation of trust and respect for your leadership. What kind of person were you before the new project was assigned? Can you run on your reputation for a few weeks? Will your followers go out of their way to help *you*, or will you have to rely on their wish to help the organization?

Leadership Style. If you've been listening, you have already learned a lot about leadership style. You may also have thought about how you lead. The real **autocrat** is concerned only with production. He (most seem to be "he") is also pretty *passé*. We suppose Attila was one, but his followers probably had few alternatives. One still finds the autocrat in small organizations, but they don't get very far in modern ones. Their superiors recognize their shortcomings and stifle their progress. If they happen to own the company, the company is headed for a fall. We did *not* say that firm leadership is a thing of the past. It is alive and well, has a place in most organizations, and attracts employees and managers who work well in such a system. It suffers from an intolerance of new ideas from the ranks, however, which can be a problem.

The **benevolent dictator** recalls everyone's fantasy that "if I had the power, I could really set things right." Organizations led by benevolent dictators tend to stagnate since, as with the autocrat, there is limited opportunity for change from below.[7] If market competition is a factor, they eventually lose.

What we are saying about an organization's fate may be generalized to your own fate. If your style is primarily autocratic or dictatorial, it may work for a leadership project once or twice, especially if you get the job done. But if you insist on doing everything your way, people (including your bosses) will see that you are ignoring opportunities for valuable follower participation and not planting the seeds of follower investment in your work.

At the other end of the spectrum,[8] one finds leaders and managers who are so concerned with people that

[6]Look in the dictionary under "sabotage."

[7]"Below" is a great source of positive organizational change.

[8]There really is a spectrum that summarizes much of this, called the Blake-Mouton Grid.

all they want to do, in one consultant's words, is "grow humans." They have trouble focusing leadership on the present task, and rely almost completely on the goodness of the follower to get the job done. As one can imagine, projects that rely on this "country-club" management style often take a long time. Success is a hit-or-miss proposition unless one's followers are extremely committed to their work (as is the case in some medical settings).

One can develop the people in an organization without entirely abandoning productivity. People are the key to most worthwhile organization endeavors. Leaders willing to allow some followers, or even a project, to fail while pursuing lofty goals are often rewarded with extraordinary loyalty and commitment from all employees. The more skillful, experienced, and ready for responsibility the followers are, the better this leadership style will work. It may also be the style to use when employees and followers *expect* to be allowed meaningful participation (e.g., when it is an important part of the organization's culture).

Although one may try for *both* the highest possible "relationship quotient" and the highest possible level of production, opportunities for such an ideal match of people and production are few. Delaying action while waiting for the perfect balance can be a waste of everyone's time. A good leader is adept at analyzing the needs of the situation and the organization, then choosing the leadership style that will produce the best overall result.[9]

Mandatory (Abbreviated) Chart of Leadership Styles

Authoritative (autocratic, dictatorial)
Values production over people.
Advantages. Gets things done fast. Decisive. Can overcome follower anxiety in stressful situations.
Disadvantages. Quashes follower talent & initiative. Quickly uses up leader charisma.

"Country-club," super-democratic
Values people & consensus over production.
Advantages. — (We can't think of any, unless all the followers are expert and committed, as in some medical settings.)
Disadvantages. Inefficient. Time-consuming. Leader looks weak.

Participative
Allows input but leader retains veto power. Participation of followers may range from simple input to delegated authority for major parts of the task.
Advantages. Taps the potential of followers. Empowers them. Builds commitment & teams.
Disadvantages. Slows decision making. May make leader appear a little indecisive or weak.

The late, great Gene Roddenberry gave us some fine illustrations of leadership style. *Enterprise* Captains Kirk and Piccard, and their officers, seem to do it all. The crew knows the mission and is empowered to act. The Captain listens to his people and takes decisive action. When they win, they all win. The Captain takes full responsibility for failures. There are times when the Captain is authoritative and times when he is super democratic. Kirk and Piccard "walk the talk" (see below), although the Captain and First Officer shouldn't be on so many dangerous "away teams."[10]

Take a look at some of the subordinate officers:

Spock and "Data." Brilliant. They lack people skills, but each is aware of that deficit and compensates for it. Spock is not ready to be a starship captain; Data will never be.

Scotty and Warf. Totally linear thinkers (see below). Very competent, but they'll never make Starship Captain.

Geordy. Seems smarter than Scotty, not so linear a thinker, and probably has a healthier liver. Good bet for advancement if he wants to expand

[9]Pay attention to your CEO's style. It is likely to be both successful and consistent with the prevailing organizational culture.

[10]Homework assignment: Watch a lot of *Star Trek* reruns and identify different leadership styles. Pay no attention to others' ridicule. Tell them you're on a mission.

his horizons.[11]

Bones, Dr. Crusher, Counselor Troi. Very democratic; not fully organization oriented. They'll never lead the ship, but they're indispensable to the team.

Piccard's #1. Getting there. Piccard allows him to make mistakes. Sometimes BIG mistakes.

If your leadership style limits your options for either people or tasks, we encourage you to broaden it. If you believe you will always be able to choose people and projects to fit your favorite style, you are either very powerful or you're watching too much television.

Your leadership style should be flexible enough to fit different situations.

Linear Thinking

Your ability to focus on a task and think it through to the end has helped you make a good living for years. You developed that talent early, and it served you well in clinical training. Too bad it may be keeping you from being the leader you could be.

The ability to focus, consolidate, and follow a train of thought is good, but it's not enough to lead a group or organization through a complex world. The best minds in management are "geometric," not "linear." They can focus when necessary, but unlike the average manager, they know when to relax their mental constrictions and invite innovation. In the carriage factory example at the beginning of this article, the executives agreed on their research results, but only one saw ways to enter a new arena, and to use new technology to service an existing market.

You don't need Eastern mysticism to learn to open yourself to new ways of seeing problems. Don't try too hard; most solutions involve simplifying the issues, not complicating them.

[11]A model for technically-oriented readers.

Leading Your Professional Peers

Try not to treat followers who share your professional background differently from those who do not. If you are a former outpatient psychiatrist or psychologist recently promoted to facility clinical director, you will be tempted to spend lots of time with the outpatient clinicians, and with the Outpatient Department in general. On the other hand, you may consciously or unconsciously slight your former peers.[12] The same principle applies to people like academic chairpersons and hospital nursing directors.

Remember, your role in the organization has become much less clinical (with less or no direct care). You now have a responsibility to focus on *organizational* issues and goals. Your friends in the Outpatient Department may not like this, but they should be able to understand it.

You may not always like it either, but it's part of the reason the organization gave you a shot at management. Some professionals in management positions continue to see patients or keep a little laboratory space. It works for some, but for others it confuses the management role and limits the way one is viewed by superiors and subordinates alike. Leadership is a little like parenting in that respect: When the chips are down, both kids and coworkers need leaders, not peers.

Leadership in Bureaucracies and the Public Sector

This deserves some special mention. We have been speaking of leadership as if it had only to do with the leader, the followers, and the goal. In almost every organization, however, a project of any size involves the interests of many departments, and often those of people outside the organization. If you are asked to expand a partial hospitalization program, for example, space and staffing resources aren't the only things you have to worry about. Clinicians and staff in other areas, such as inpatient and outpatient units, advocacy

[12]We don't mean to imply that you are no longer any kind of peer to your professional colleagues. They are, however, no longer your organizational peers. Remember, "Identify with that which you want to become."

groups, and local practitioners are likely to speak up (and if not, you should query them). Budget people may complain about how you're spending their money.

The complaints may not come directly to you, but to your boss, to a powerful person in another part of your organization, or to an influential outsider (such as a legislator). You will be expected to respond to them, and to deal with both the people and the management issues necessary to get the job done.

As in many touchy management situations, broadening the base of input and participation usually helps. Inter-departmental meetings and public hearings can be used to your advantage, but the real answer is participation from the very beginning. Appoint both outsiders and section employees to a planning team. Better yet, let organized groups (such as other departments and outside groups) send their own appointees. *Give those with a stake in the outcome a chance to be heard*.

Listen hard. You will have to live with them during the entire project. They may even have some great ideas. And if you aren't honest in your attention to them, they will know it very soon.

Consider the broadest effects of your project, then listen to those who will be affected.

Dr. Rodney M. was head of a large hospital psychiatry department, part of a major medical complex. He was well known for quality care, up-to-date medical knowledge, and getting along with his clinical peers. The physicians in his department looked to him for leadership and representation to the hospital director. They did not depend on him for income, since each was a partner in the hospital's group practice plan. Rodney became aware of changes in the mental health practice environment, with lowered reimbursement and increasing constraints on clinical work. He knew evolution is inevitable, and he was looking for ways to expand his career horizons.

The hospital felt the pinch of changing health care reimbursement patterns, too. The Hospital Director asked Rodney to chair a committee to recommend changes in the hospital's clinical focus, payer mix, and marketing. She appointed four additional committee members — the marketing director, a staff physician with a large surgical practice, the assistant administrator for planning and strategy, and an outside business consultant. Rodney was to select three or four others.

This was Rodney's chance to help lead the hospital into a new era, to show his value to the larger organization, and to multiply his career options. All he had to do was make sure his team provided the results the hospital needed.

Picking the Team. Rodney decided to appoint four more people to his committee: The medical director of a successful health maintenance organization (HMO) that contracted with the hospital, an entrepreneurial physical therapist who represented several non-M.D. clinicians who used the hospital, a regional telephone company benefits manager, and a local banker whose husband had recently endured a lengthy hospital stay.

Criticism from peers. Several clinical colleagues, mostly fellow psychiatrists, wanted to be on the committee. They were miffed at not being appointed, but most figured Rodney would represent their interests. Some were also irritated that some of the committee members came from backgrounds they felt were "anti-medicine" (in this case, the physical therapist and the HMO director) or insensitive to mental health (the surgeon).

Using the Team Members. As the committee began its work, Rodney listened to the other team members. He wasn't quite sure why the marketing director wanted to ask local employers what they wanted in a hospital, but he went along with it. He had always thought HMOs practice poor care, but when the assistant administrator told him that HMO contributions to hospital revenues had increased fivefold during the past decade, he listened. In spite of "turf" battles between physicians and non-M.D. professionals, he realized that the latter refer patients to doctors

and to the hospital, that employers and payers see them as cost-effective caregivers, and that they represent "value added" to the hospital's traditional clinical "products."

Rodney was tempted to steer the committee toward the kinds of issues that affect physicians' practices. Instead, however, he decided to let the other doctors on the committee present most of the physician-related points. Sometimes he was surprised to find that the non-physicians could hold their own in the deliberations, and had some pretty good ideas.

Input From Internal and External Customers. The committee surveyed a number of professional staff members, employees, community physicians and health care professionals, local employers, and even local citizens and families. They invited several groups, including physicians in various hospital departments, to speak to the committee in person.

Today, both Rodney and the hospital are thriving in the modern health care environment.

Leadership Tidbits — Some Things to Keep in Mind

"Walk the Talk." People pay a lot more attention to what you do than to what you say. You must set the example for those whom you would lead. If you want your subordinates or project participants to come to work early, then be the first one there. If you want them to participate in some kind of training, go through it yourself. If you promise something, keep your promise. Your behavior must embody what you say, including your vision, your advice, and your ethics.

Robert L. Dilenschneider, CEO of the giant public relations firm of Hill & Knowlton, once had to choose between two lucrative projects, one of which seemed to contradict his personal standards. He chose the other, and wrote to company employees.

"The only conduct we can control is our own, and it is imperative that it be — and be seen to be — always in the high end of the ethical scale. And it is our responsibility to urge the same conduct of our clients."

Meetings. Sometimes it is good to exert your power or leadership in meetings. At other times, you will want to draw others out and see what they have to say. The quickest way to establish a leadership position in a meeting is to ask the opening question. The person who asks the first good question — and gets someone to answer it — is immediately seen as a leader.

If you want to play down your role, to keep other people thinking and contributing, keep your mouth shut. Don't sit at the head of the table. Don't even open the meeting.

Close That Open Door. Every management applicant we interview says the same thing: "I'll have an open-door policy. I want to be available when my people need me."

Peachy keen, but not very realistic. An open door is not the moral equivalent of accessibility and fair play. The farther you move up the managerial ladder, the more you are paid to think, not merely to be available to other people. Of course you should be approachable and supportive, even available at times. But you also need privacy and a chance to work uninterrupted when you want to. If others see your closed door as unusual or ominous (like "I'll bet she's chewing somebody out" or "he's probably talking to his girlfriend"), try opening and closing it randomly for awhile.

Delegation. Delegation is one of the most important skills of management, and is very often a part of leadership. You can't do everything. If you try, you may drop all the balls you've been juggling. If a follower or subordinate can do something, it is often poor use of your (and organization) time to do it yourself.[13] This way of looking at delegation is associated with several other concepts we discuss in this article, such as empowerment and expectations.

[13]One of Dan's mottos is "Do everything you have to do and nothing you don't." Bill has always been aware of Dan's innate laziness, but acknowledges that it has contributed greatly to his success.

Expectations. What you *expect* is almost as important as what you do. When you are a legitimately-appointed leader, you should act and feel the part. You have a right, even an obligation, to expect respect for your position and for the goals of the group and the organization. You also have a right, and an obligation, to expect *performance* from the group and its members. Those expectations can lead to a self-fulfilling prophecy for success. If you stop expecting either performance or respect, both will abandon you.

Expect performance and respect from your followers.

This is confusing for many first-time leaders and managers. Picture the classic movie stereotype of the new lieutenant, fresh from officer training and trying to establish himself. He tries an authoritarian approach and fails. Then he learns, usually from that old sergeant played by what's-his-name, that he doesn't have to be so nervous; his subordinates expect to be led; he can rely on them more than he thought; rank really does command respect; and it's O.K. to listen to subordinates' ideas. Try it.

Stewardship. Camille Barnett, an experienced city manager, speaks of organization leadership as "stewardship." The leader doesn't merely succeed; he or she takes custody of the organization, does work of significance, and brings the organization (or part of it) to the next phase of its existence. This concept is especially applicable to leadership in the public sector. Take your position seriously.

Followers

Robert Kelley wrote a nice *paean* to followers in the *Harvard Business Review*[14]. They are important, and they deserve to be treated well. Good ones take care of their own job needs, are committed to the organization and to important things beyond themselves, try to do a good job, build their competence as they go along, and are pretty honest and forthright folks. A good leader, by the way, turns "subordinates" into "followers."[15]

In spite of that advice, we'd better talk about some problems one can encounter, and what to do about them.

Problem Followers. People who like to work are easy to manage and lead. People who don't are a real pain. *The simplest solution is to avoid putting them on your team.* Give them an opportunity for input, but don't give them a chance to slow things down or sabotage them. These are often the same people who passively obstruct projects and progress, and they strongly resist being told that they're doing it. The old "80:20 Rule" suggests that 80% of the problems will be caused by 20% of your followers.

Judith Bardwick is an expert on employees like that, who feel "entitled" to their jobs but don't do very much to deserve them. She says entitlement behavior has little to do with intelligence or experience, and everything to do with motivation and fear. Leadership should not be delegated to "entitled" people. They don't make very good team members, either, although they may work acceptably in groups. And there is a difference between teams and groups.

Deep down, many people who feel entitled are very concerned about security and anxious about change.[16] Being overly firm with them probably won't help. The best approach is simply to require performance. Focus on getting the job done, and on their peers' expectation that the job will get done. It's harder for them to hide from peers than from the boss.

When you can, use different rewards for problem employees than for other workers. In some organizations, it is almost impossible to treat some people differently from others, but do your best. Consider rewarding problem workers or followers as individuals rather than as part of a group (but reward teamwork). Don't be afraid to let your pressure create losers as well as winners. Increasing morale, with incentives for example, doesn't work with these folks. In Bardwick's words, "The best morale enhancer is increased productivity."

[14]November/December, 1988

[15]Russell Fershleiser again.

[16]Bill said that. He's a psychiatrist; he has to talk that way. —Dan

Conclusions

Managers do things right.
Leaders do the right thing.

This clever *bon mot* was coined by Warren Bennis, a man who is concerned about the stifling of crucial leadership roles by a national culture in which many people are fearful of others' accomplishments and bent on protecting their own mediocre positions.

We're not so sure this is really the end of American leadership. We think there are lots of people like you ready to take the reins, and — just as important — lots of health care executives and senior managers who see your value to their organizations. We *don't* think you are doomed to suppression if you show leadership skills. Those skills and the good things they bring are simply too important for the facility, company, or agency to ignore. We admit that some clinicians can't exercise much leadership in their current roles. You may have to consider a "lateral" move to start your climb out of the clinician bailiwick. We told you earlier that such a change is scary, and we never said it would be easy.

APA/AAPA Administrative Psychiatry Award Lecture
Does the Psychiatric Hospital Have a Future?
Steven S. Sharfstein, M.D.

May 23, 2002
9:00AM • 10:30AM
Convention Center, Street Level, Rooms 109 A/B

Chairperson
William H.Reid, M.D.

Co-Chairperson
Sy Atezaz Saeed, M.D.

ADMINISTRATIVE PSYCHIATRY AWARD

The American Psychiatric Association (APA) and the American Association of Psychiatric Administrators (AAPA) jointly sponsor the Administrative Psychiatry Award. The recipient is someone who has demonstrated extraordinary competence in psychiatric administration over a substantial period and has achieved a national reputation for the foregoing. In addition, he or she must have directed a comprehensive program for the care of patients with mental illness and have contributed significantly to the field of psychiatric administration through activities such as teaching and research. Membership in APA and board certification are additional requirements.

Nominations for the 2003 award may be made by any interested individual, who should write a letter indicating why the candidate should be given consideration.

A copy of the nominee's curriculum vitae must be enclosed; the recipient will present a special lecture at the next APA annual meeting.

The deadline for nominations is August 1, 2002. Material should be sent to the Chairperson, Committee on Psychiatric Administration and Management, APA, Office of Education, 1400 K Street, NW, Washington, D.C. 20005.

The Meaning of Life

Reflections of a Retiring Psychiatric Administrator

Ugo Formigoni, M.D.

Editor's note: After serving the Illinois Office of Mental Health (formerly Department of Mental Health and Developmental Disabilities) for over three decades, Dr. Formigoni retired recently. He started as a Research Associate of Bruno Bettelheim in 1960. During his distinguished career he served in various roles of leadership, most recently as the Manager of Metro West Network in Hines Illinois. He was recently invited to speak to a group representing the leadership in the Illinois Office of Mental Health. The following article is based on his reflections as he addressed the group.

Just the title makes me feel humble and old — a depressive condition, one of six variables reflecting uncontrollable factors in successful aging. In case you are interested, the other five are: parental social class, family cohesion, ancestral longevity, childhood temperament, and physical health at 50. According to Valliant (1), who studied successful aging, the concept of aging must be viewed from three dimensions: decline, change, and development. Decline is not successful, but that starts at 20 and only gets worse thereafter. Change has a relatively neutral meaning and might provoke some anxiety, but we are used to it. Development and maturation sound more positive. At my age, most people are often more patient, more tolerant, and more accepting. Well good for them! With increasing age, spirituality and serenity increase, by that we mean faith, acceptance, and allowing someone else to take over. Finally, like age itself, experience can only increase with time and that, I guess, is the reason I was asked to write. I would like to share some thoughts about why we do what we do, what keeps us going and remind you that the future has a past.

Paraphrasing Nancy Andreasen, (2), I think most of us are in mental health because we are interested in what makes human beings tick. We chose this field because we are interested in people and we want to help them. We care for people with mental illness because we believe in the importance and dignity of the individual human beings. We have confidence in resiliency and trust in recovery. We want to understand the human mind, spirit, and behavior as well as the human brain. We like to think about people in the context of the social matrix in which they live, their past and current experiences, in order to understand how their symptoms arose and can be treated. We believe in rehabilitation and in Bill Anthony's equation: "skills + support = success and satisfaction" (3).

Many of us, at times, feel overwhelmed by the speed of neuroscientific growth and are threatened that we cannot keep pace with the knowledge and resources needed. Of course, it helps when as a system today we are embracing evidence-based practices. We are emphasizing the distinctions between monitoring, evaluating and offering technical assistance to mental health providers, in order to constantly improve the health of the community. Can we keep our optimism, vision and ability to see the forest and the trees?

Factors like age, race, poverty, unemployment, suicide rates, and money spent for services are easier to measure, but the confluence of multiple and simultaneous bureaucratic expectations is taxing and not always inspiring. Our Quality Managers would like us to struggle with the elusive abstraction and subjective concept of quality: how to define, assess and improve it. Our research and measurement experts at the same time, expect us to baseline, profile, monitor and report functional states and outcomes. We need to pay attention to the proper implementation and compliance with crisp definitions of services with particular attention given to Children and Adolescents populations. Then there are areas like mentally ill in jail, boards of health, standardization of practices, etc. To manage all that we may need to hone particular skills and, perhaps learn some new.

Public service has never been more challenging, onerous and taxing. We need "survival strategies for the new world." (4) There is a sense of urgency, keeping in mind what is at stake, who will be affected and the changing environment in which we are operating. It is important to recruit and retain staff who have leadership capacity, management skills, a broad range of experience, diverse backgrounds and points of view and work with the heart, even if we have a freeze on hiring or spending. We have made strides in cultural awareness, involvement of consumers, empowerment and recovery, but there is a long way to go. Effective community interventions, such as Assertive Community Treatment, have been

established, but are not uniformly available and are targeted to frequent State Hospital users. The Network staff and their Advisory Council have focused their efforts on the gaps between facility inpatient units and community services with improved Continuity of Care, but the amount of cross traffic exceeds the pre-screening and linkage resources of the Connect Initiative and the capacity of the integrated system. The funding disallowance for Alcohol and Substance Abuse treatment, the Welfare Reform and the public housing demolition impact the safety net functions of the remaining scarce state institutions. The volume of admissions increases, especially for first timers seeking refuge from overwhelming crisis. The well-intended, less funded and lower esteemed direct care staff cope with conflicting expectations of no refusal and clinically sound treatment. Gaining access to complementary, necessary alcohol and substance abuse and rehabilitation services is arduous.

It is difficult to do the right thing and never more so than when you are on the front line. Properly channeled and supported tension can be a creative force. Unbound and unchecked, it is stressful and demoralizing. Leadership is more than management. At a time of national crisis, safety and security take precedence, but care and compassion remain essential. We need to ask ourselves: "What do I stand for? What makes me proud to work here? Do I still belong here? Am I willing to take risks?" and then act on the answers to those questions. Authority and responsibility are a privilege and a burden. The rewards are in the relationships with people. We have to look for ways to create momentum. We have to keep reminding ourselves that the goal is to preserve the mission. Rewards come when you help people. It makes you feel good, proud and alive!

We are here again at our retreat. We came to a far away, safe, and known place where we can regroup, do an inventory of our losses and our gains, re-evaluate the situations and the direction, recharge our enthusiasm and go on. VIPASSANA is a Buddhist term for a remarkable clarity of vision. Did we achieve it?

"Real effectiveness hinges on knowing what is most important to you" said Peter Senge. (5) The subconscious seems especially receptive to goals in line with our deeper aspirations and values. Mastery is integrating reason and intuition. Picasso once said: "It would be very interesting to record photographically, not the stages of a painting, but its metamorphoses. One would see perhaps by what course a mind finds its way toward the crystallization of a dream. But what is really very serious is to see that the picture does not change basically, that the initial vision remains almost intact in spite of appearance." (6).

In my child psychiatry training, Dr. Bettelheim taught "that the end is always in the beginning" (7). Earlier in my life my grandfather used to ask me "What do you want to become?" Now our Quality Manager reminds me "there is no growth without struggle." I have experience with that. Inclusiveness leads to facing differences, which is not always a harmonious process; like contemporary music it is often dissonant, but it is enriching, intense and real.

We are here to share our thoughts, get inspired, and feel the emotional support. We follow the principles of interpersonal group psychodynamics:

- The group cohesiveness;
- The group providing a corrective emotional experience;
- The group operating as a social microcosm;
- The essential role of feedback in interpersonal learning; and
- The overarching principle of working in the here and now.

We have engaged in cognitive re-framing, in a context of general supportive measures and accommodations, using humor, transparency, and forging work groups; but for me this is the time for disengagement, giving up one's investments, feeling the pending object loss, fearing the separation and isolation. I hope to transcend the exciting rock and roll, and invest in more spiritually age-appropriate concerns, balancing the group's wish to experience itself as uniquely special, with a less solipsistic view. Is it safe to share? Self-exposure is reciprocal. We know it and see it. In this brief time we cannot explore in depth, all the systems that infringe upon us, the tensions between us, and the way we reinforce each other, but we can feel them. Healthy elders are less prone to many of the anxieties of earlier life, to power struggles or to narcissistic injuries and maybe more interested in matters of meaning, and creating new options for connectedness. My life goes on, establishing alternative residence, finding new partners, realigning the pattern of retirement in creative ways, finding tools for improved functioning. At the same time, I have to deal with the fear of losing what I was; the self, a combination of social role and internal feeling state by which one defines oneself. This process of separation from the past and present, still emotionally charged and meaningful, heightens my entrenched

ambivalence as I reflect over our openness and transparence. We know about participative openness, the freedom to speak one's mind. People feel free, sharing their views to different degrees; and we know about reflective openness, which leads people to look inwardly, based on skill and effort, not just good intentions.

Reflections and inquiry require time and persistence to:

- Know what is really important to you;
- Make a commitment; and
- Be truthful with those around you.

Learning builds on past knowledge and experience. Openness is a characteristic of relationships when people become willing to share their thinking and susceptible to have their thinking influenced by one another. Goethe wrote: "A man who would do the best work must make sure his tools are good." What are our tools? We talked about strength of character, personal integrity, introspection, caring and openness, meaning and spirituality. Are they enough?

During the bleakest days of the Great Depression, another remarkable Mayor of New York Fiorello LaGuardia closed his Sunday radio addresses with a stirring phrase meant to sustain his listeners through the gloomy ordeal that still lay ahead. The uplifting words "patience and fortitude" (8) struck a hopeful chord among his constituents, so that they became the unofficial names of the two lions that have stood outside the New York Library since 1911. Maybe we should practice patience and fortitude.

Functionality and beauty are the very essence of Italian civilization, as freedom and democracy are the hallmarks of the American civilization, as hope and respect are for Mental Health. From the beginning, Italian genius has tended to be practical, down to earth and concerned with getting things done, but it has also emphasized form, harmony and radiance. The greatest achievements are in the pursuits of life, and in addressing a large urban centers' complexity, I add another tool, Sprezzatura, (9) the art of effortless mastery giving the impression of doing difficult things well, making them look easy. Art produces the illusion of spontaneity, style, and substance. Fare una bella figura, to make a good impression gracefully and thoughtfully, is the Italian characteristic.

In conclusion, I believe what gives meaning to our life is having something important to do, sharing a common purpose and holding a consistent direction. It is a long journey, bumpy at times, but always stimulating. We have learned and grown together, ready to face new challenges.

I want to end with two English quotes for my co-workers:

I am certain of nothing but the holiness of the heart's affections and the truth of imagination.

John Keats

And almost everyone when age, disease and sorrow strikes him, inclines to think there is a God or something very much like him.

Arthur Hugh Clough

And for myself, I remember Kazou Ishiguro, a Japanese native who grew up in London, and wrote in The Remains of the Day (10)

The evening is the best part of the day.
You have done your day's work, now you can put your feet up and enjoy.

Age as youth has its rewards. I hope to get them, but sometimes I will miss my working life and friends.

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Computerized Performance Monitoring Systems:

Learning and Living with Their Limitations

Daniel J. Luchins, M.D.

Six years ago, when I took the position of Clinical Director at the Illinois Office of Mental Health, after twenty years as a researcher, I felt like the fox in the chicken house. Instead of having to spend years struggling to collect data, I had access to unbelievable amounts. There were computerized records, which in any year provided diagnostic and demographic information on all 10,000 patients admitted annually to our ten state hospitals, as well as the 1.2 million prescriptions written and the one million laboratory studies ordered on these patients by over 200 staff physicians. As a researcher this seemed like a goldmine. All this data to analyze, all these articles to write.

But my new job required that I do something more with this data, not simply advance my career, the field, or the truth, but use it to make decisions which would improve clinical care. Developing a computerized performance monitoring system seemed a reasonable compromise that would allow me to improve care while pursuing a research agenda. So working with a computer savvy psychiatrist, Dr. David Klass, we integrated what were actually several administrative data bases into a unified system that allowed us to examine laboratory monitoring of medications by our physicians. In 1997 we began to send out to each facility's medical director monthly reports that tracked about 30 indicators related to laboratory monitoring of medication by their physicians. Unlike the NRI ORYX system, our system is unique to Illinois. I will not go into great detail about the technical aspects of this system. Rather on the basis of our experience with this system and its evolution, I would like to share some thoughts about the uses and limitations of a computerized monitoring system and indirectly the uses and limitations of data in administration as opposed to research.

Let me begin by admitting the obvious. I find computerized performance monitoring systems seductive. The near instantaneous ability to analyze huge amounts of data, define norms and identify outliers, graph and portray it on screens; make it seems so real. Even the words we use like "indicator" or "instrument panel" to describe this output, heighten the sense that this data is not only providing us with an accurate picture of reality, but will help us steer the mental health system in the right direction. As a researcher, playing with this system is like playing with a flight simulator. However, as an administrator, I am using these computerized systems to make decisions in a real, not ideal world. This is a world of bureaucracy, in which decisions are made not only on the basis of controlled studies but by the exigencies of the most recent crisis and where reality has more to do with the current politics than the current literature. And therefore as an administrator I need to be concerned not only about the decisions I make with these systems but maybe more importantly, the decisions others will make because of their belief in these systems.

In making decisions using any of these "indicators," or even the totality of them "an instrument panel" it is essential to remember that they don't actually measure good or bad performance, at best they are proxy measures, which under certain limited circumstances, may be related to the underlying value towards which we strive, such as better or more humane care.

There are at least four ways that these indicators can become disengaged or disassociated from the underlying value. First, there may not be a relationship throughout the entire continuum between the indicator and what we really value. Second, change in an indicator may not be associated with comparable change in the underlying value. Thirdly, the valence of an indicator can change depending on the context. Fourth, the very act of measuring an indicator can change its valence. If this were simply a research exercise, there are obvious technical solutions to these problems, and I will suggest one. But computerized performance monitoring occurs in a real world, bureaucratic/political realm in which it may be impossible to deal with these problems in a technical fashion. Therefore, as clinical administrators we must deal with this political dimension and discuss how we must be not only cognizant of its existence but be willing to engage it for our purposes.

Let me now focus on the technical problems that grow out of this possible disassociation of an indicator and the underlying value. First, there is not necessarily a relationship throughout the entire continuum between

the indicator and what we value. To refer back to ORYX measures, at some point, pursuit of decreased use of restraints or increased use of new generation antipsychotic medications may be counter to better or more humane care. I will illustrate with this an example from our computerized pharmacy monitoring system. As mentioned above, we developed monthly reports that we sent to our medical directors. These reports covered a series of about 30 indicators relating to laboratory monitoring of medication prescribing by their physicians. An example of such an indicator would be a thyroid screen within 6 months prior to starting lithium, or a serum lithium level 5 to 10 days after initiating or increasing lithium dosage. The reports gave the statewide average for each indicator, the facility average, each physician's average, and listed each instance when a particular physician failed to order a particular laboratory test on a specific patient. Overall, averages for these indicators were in the 80% range. As might be expected, the overall average for any given physician also tended to be in the 80% range. However, there were outlier physicians with 40%, 50%, or 60% correct monitoring, as well as those with 90% to even 100%. Not surprisingly, many of the physicians in the 40% to 60% range tended to be those who in my opinion were our weakest, but in keeping with the point I am trying to make, so were many of the physicians in the 90% to 100% range. At some point along the continuum, beyond 90% this indicator is no longer related to what we value. Because at least 5%, or l0% of the time, good clinical judgment would argue against ordering laboratory tests in such a routinized fashion. Therefore, at 90% or above it stops being an indicator of a physician's skill or good clinical practice.

The second technical problem is that change in an indicator may not be related to comparable change in the underlying value. Again let me turn to our own experience. We recognized that simply ordering the right test in a routinized fashion is not the most robust measure of a physician's ability. Dr. Klass and I developed a second module, which examined whether physicians responded correctly to the actual laboratory result that they had previously ordered. For example, if a lithium level was low, did the physician increase the lithium dose in a timely fashion?

Before sending out these reports, we wanted to validate our system. We, therefore, had the chief resident at The University of Chicago, at that time Dr. Moshin Qayyam, do a research elective, in which he reviewed, at one facility the clinical records of all cases in which our computerized system identified a physician as responding in an inappropriate fashion to an abnormal laboratory test. In his clinical analysis, the great majority of the clinically relevant cases involved failure to raise Depakote dosages in response to low valproic acid levels. When we compared the 249 cases in which such a failure occurred, to the 226 in which the dose was increased in a timely fashion, the former group of patients, on the average, stayed almost twice as long (96 vs. 57 days). On the basis of this finding, we undertook a lecture program on Depakote titration at our facilities, after which there was a decline in inappropriate physician responses to low valproic acid level (Luchins et al. 2000).

We had a new indicator, percent incorrect responses to abnormal laboratory tests, which we hoped if it could be improved, would dramatically reduce length of stay in our facility. This view was strengthened when we noted that for all indicators, not just low valproic acid levels, incorrect responses were associated with a longer length of stay. In a system wide study comparing all patients during a 17 month period with at least one such abnormal laboratory test, if the physician responded incorrectly, patients on the average stayed 55 days from the time of the abnormal test, which was more than twice as long as the 25 day average length of stay for patients in which an abnormal laboratory test was responded to correctly. When we rank ordered physicians by the percentage of times they made the correct response to an abnormal laboratory test, there was a negative .45 correlations between this ranking and their patients' average length of stay. But our hopes that length of stay could be dramatically reduced by preventing such inappropriate responses was dampened by the discovery that this same ranking was correlated negatively (-.27) with how long these physicians' patients stayed even when restricting our focus only to patients who didn't have any abnormal laboratory test (Luchins et al 2001). Thus, about half of the relationship between incorrect response to abnormal laboratory test and increased length of stay was explained, not by any specific failure to respond to the laboratory test, but rather by a more general measure of a physician's pattern of practice. Percent incorrect response, aside

from being a measure of a specific type of failure, was a more general indicator of slowness, or sloppiness. Even if we could dramatically reduce the number of such incorrect responses (for example by implementing real time computerized feedback) it might have less effect on length of stay (or other measures of good care) than expected, because of broader, suboptimal practice patterns. The point I am trying to make is that dramatic changes in an indicator may have only modest effects on the underlying value.

A third technical problem is that the meaning or valence of an indicator may change depending on the context. For example, I have been relating a physician's incorrect response to laboratory findings, and by implication poor physician practice, to increased length of stay. Within our system, with a mean length of stay of two to three months, this is probably a valid assumption. However, in a setting in which patients stayed only three to five days and especially if there were strong financial incentives for rapid discharge, the physicians with the most incorrect responses might hospitalize their patients for a shorter, not a longer period of time.

Fourth, and finally, the valence of an indicator can be changed by the very fact that it is monitored and this information feedback. Let me make reference to our earlier work on whether physicians were correctly ordering laboratory tests. Initially, when some physicians scored in the 40% to 60% ranges, I found this consistent with my own estimation of their poor clinical skills. But after 6 months of feedback these same physicians had raised their scores. Since no physicians remained in a 40 to 60% range there was now a reversal of the previous relationship between percent performance on this indicator and my own estimation of physician skill.

So far, the problems I have been describing are technical and there are potential technical solutions. Let me suggest one such solution in which we yoke together two related indicators. One indicator is directly under the clinician's control; on it we give frequent feedback and anticipate significant change. But, this change should be still seen as a "process measure". The real outcome measure, the true measure of success, should be some indicator less directly manipulable by the clinician but related to the underlying value. Feedback on it would not, and maybe should not, be provided in such a frequent fashion. To some extent in our pharmacy laboratory system we used length of stay as a less easily manipulated indicator. Another example might be the number of injuries (either staff or patient) as a validating indicator for measure of changes in restraints and seclusion.

Now, what I had said so far, deals primarily with the technical; but computerized performance monitoring is imbedded in a political process. The actual choice of indicators and the valence put on the direction they "should" move, is determined by political forces. It is not simply a technical question, of what our indicators should be. It is not by chance that seclusion and restraint are popular ORYX indicators and the directions in which these measures "should" move does not require a two tailed test of significance. We all know the direction in which this indicator is supposed to move. As an administrator, I need to be sensitive to this political dimension. Although it will overstate the contrast between the technical and the political, let us imagine, that we were in a pro- life, or an anti- capital punishment conference and the indicator we were discussing was the national abortion rate or the number of death sentences in the United States. In this context, if greater than zero, that indicator would be seen throughout its continuum, and regardless of circumstances, as an index of evil. All the technical issues that I have previously raised that dissociate an indicator and the underlying value, would have no meaning at such a convention. Now, to some extent, our quality performance indicators can take on this significance. Measures become benchmarks and benchmarks quotas. Average is not a statistical phrase but a judgement and below average a term of approbation. It is for this reason that the technical solution I had offered may not be viable. I had suggested using staff or patient injuries as a validating indicator to assess the impact of changes in rates of restraints and seclusion. But even if, at a specific rate of restraints and seclusion, injuries began to go up; because of this political dimension, administrators may not be able to reset the dial and return to the previously higher rate.

We felt this political dimension with our own computerized measurement system. After we began sending out reports to the medical directors on whether their physicians were correctly ordering laboratory tests, we did not anticipate that the hospital administrators at several facilities would begin to put pressure on the

medical staff to achieve 100% performance, even though we had been saying that 100% is probably not a measure of clinical skill but clinical insensitivity.

One could go on in detail about how in the political environment each one of the technical problems that I've outlined, can become an additional complication that might undermine the value of computerized performance monitoring. However, the political dimension is an essential ingredient in the ability of computerized performance monitoring to produce change for the better. To continue the metaphor, just as any of the indicators that we have been discussing are proxies for something that we value, in our technological society, the very act of developing indicators and measuring them is a proxy for something else; for caring. We care enough to measure and we measure enough to show that we care. If we try to dissociate the technical act of collecting, analyzing, and feeding back data from this political dimension, computerized quality management would lose its impact.

Again, let me turn to our own system for an example. I mentioned that after the first 6 months of instituting feedback to the physicians regarding their ordering of laboratory tests, the low outlier physicians had significantly improved their performance. However, one year later, when we followed up the performance of these physicians, they had begun to slip back to their previous low levels. Now, you can argue that feedback needs to have consequences, and that we had simply demonstrated the failure to build consequences into our system. But this was not the case. In the first 6 months that we had carried out the monitoring there were no official consequences, it was only later that we began to integrate these indicators as part of the credentialing, privileging and job evaluation process. However, these formalized methods, I would suggest, had less effect then the vague sense amongst our physicians that the central office was watching and cared. Once we had moved on to develop our second module, once we had formalized feedback from the first module, central office's attention, that of the medical directors and consequently that of our physicians had moved on.

It is difficult to separate the specific effect of computerized quality monitoring from the non-specific effect of this impression that the administration cares. No doubt, the resources allocated to computerized quality monitoring: including equipment, personnel and administrative effort, send a message about what we as an organization consider important. As a skeptical researcher, I remain unconvinced, that the resources allocated to computerized performance monitoring have a greater impact on improving care than other equally costly interventions that show that we care; for example, spending the same resource and energy on staff appreciation dinners.

No, I am not actually recommending such dinners. I think it's easier to get money from the legislature for computers than for champagne. Nor am I trying to say that the impact of computerized quality monitoring is simply a Hawthorne effect; the tendency of workers to increase productivity in response to nonspecific intervention by management. But some of the effect surely is. Therefore, to paraphrase Patrick Henry, I would have to say if this is a Hawthorne effect let us make the most of it. As a researcher I need to control for the placebo effect, but as a physician I use the placebo effect to help my patients improve, so then as a clinical administrator, I will use the Hawthorne effect to improve the mental health system.

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Is There An Ethical Way?

Column Editor: H. Steven Moffic, M.D., Chair, Ethics Committee

COLUMN INTRODUCTION:

In our prior column, the last response we received on the ethical appropriateness of a differential pay to locus tenens ended with the following, which becomes this issue's topic.

ETHICAL QUESTION:

"(A famous comedian) said that if you are going to tell people the truth you better make them laugh or they will kill you. Now I am medical director of and chief clinical officer of . . . If I don't tell lies, how can I last?"

RESPONSE 1:

Dear Steve:

In response to the latest "Ethics Column, " here is my answer:

Most all of my administrative experience has been in the private sector. Honesty was a part of the good communication that was necessary to the multi-disciplinary staff that ran the facilities where I was medical director, psychiatric director or service director. I found dishonesty to be intolerable, and this inclination of some people to tell lies led to their downfall, even more quickly than those of us who told the truth.

In addition to lying, I was particularly put off by accommodating amnesia, hairsplitting evasions, misrepresentations by omission or by silence, negotiations with the truth, mythomaniacs, unethical manipulations and athletes of the alibi.

Dave M. Davis, M.D., F.A.P.A., F.A.B.F.P.

RESPONSE 2:

I have served continuously as some type of psychiatrist administrator, often with concurrent clinical duties, for at least 32 years. This tenure has involved both public and private sector, including 16 years in academic settings. While I doubt that it is possible for anyone to get through life without telling a few "white lies" in various situations, both professional and personal, I have consciously avoided the kind of lying that I believe the question implies. While there have been times, usually in private sector situations, that I felt a covert pressure not to always tell the whole truth, I was able to resist. Management would frequently feel rebuffed and might have had to shift plans or strategies as a result. I could be snubbed for a while. But I never came close to being dismissed or forced out in some indirect way. We must never lie, but rather set, at the top, the moral/ethical tone for all organizations in which we play an administrative leadership role. How long can I last?: At least 32 years and, I believe, indefinitely, as we all will when we persevere on the side of integrity, regardless of occasional pain.

Roy Varner, M.D.

RESPONSE 3:

Dear Steven:

Your question, "if I don't tell lies, how long can I last?" is an unnecessary concept. The alternative to not telling lies is to say nothing. There are some things that we, as administrators, have to sleep with and about which we may have to hedge or be obscure, but telling a lie runs the risk of jeopardizing credibility and without credibility you cannot be effective as an administrator.

Cordially,

Gerald H. Flamm, M.D.

RESPONSE 4:

At last year's Psychiatric Services Institute (Orlando, October 2001), the question of lying came up at a workshop led by Steven Moffic, M.D. and Sy Saeed, M.D. on ethical principles for psychiatrist administrators. One response, from a prominent APA officer, stated simply that administrators should be honest. A response to that added that even if an administrator is honest, one can still manipulate what is honestly said, i.e. what is left in or taken out. For instance, in the anthrax crisis in the United States, how much should public health administrators reveal in order to avoid the possibility of public hysteria?

RESPONSE OF EDITOR:

There seems to be some consensus for psychiatrist administrators not to tell lies. There is less consensus about telling the whole truth.

From our own "Ethical Principles for Psychiatric Administrators", Section 2 presents a clear statement on the issue of honesty: "A physician shall deal honestly with patients and colleagues…." The following annotations #1-3 discuss some of the implications. Annotation #1 discusses the psychological factors that may inhibit honesty and presents external feedback as a way to monitor and maintain honesty. Annotation #2 maintains that the role of the administrator should be open and explicit. Following upon that, if a psychiatrist administrator decides to solely act as a business administrator, then "Doctor" or "M.D." should not be used to identify them.

However, the challenge to not tell lies becomes more complicated when we review all the ethical principles, since at times these principles may come into conflict. For instance, should honesty be considered a less important ethical principle than safeguarding patient confidences (Section 4)? When such ethical conflicts or dilemmas arise, returning to our central ethical principle usually will provide the answer. The preamble states: "The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self." Therefore, when ethical principles come into conflict, it would seem that the benefit of the patient would be the deciding factor.

Then, again, perhaps the fortune I read in a fortune cookie as I was finishing this column should be the last words: "A liar is not believed even though he tell the truth."

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The choice of "Psychiatrist Administrator" is intended to distinguish the NewsJournal from other publications in mental and behavioral health administration in terms of its focus on the roles and perspectives of psychiatrists in leadership and management within evolving systems of care.

The purpose of the NewsJournal is to provide up-to-date, accurate, and easily understandable information to our readership and to contribute to the body of scholarly work in the area of psychiatric administration and management. Your article should be written in a clear, straightforward style that is pleasant to read.

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Manuscripts should be typewritten on standard (8 1/2" x 11") white paper with 1" margins on all sides. The entire manuscript, including references and figure legends, should be double-spaced. Each element of the manuscript should begin on a new page: title page, abstract, text, references, tables (typed 1 per page), figure legends. Number pages consecutively through the manuscript. Manuscripts should be no more than 3000 words of text (not including references or tables).

A separate page should be included giving the title of the paper, the names, titles, and affiliations of each author, and the mailing address, email address, and phone and fax numbers of the corresponding author. Any grant support requiring acknowledgment should be mentioned on this page. Acknowledgments other than those of grant support should be put at the end of the text.

An abstract should be provided, preferably no longer than 200 words.

Tables should be typed double-spaced one per page. Provide a clear, descriptive title for each table. Tables should be numbered consecutively as they appear in the text.

Figures should be numbered consecutively as they appear in the text. Illustrations - line drawings, graphs, or charts - should be of camera-ready quality.

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Authors will receive page proofs before publication. The author should return corrected proofs to Frances Roton, Executive Director AAPA, within three days of receipt; delays in returning proofs may result in postponement of publication.

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Manuscript submission is a representation that the manuscript has not been published previously and is not currently under consideration for publication elsewhere.

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Co-Directors: Christopher G. Fichtner, M.D. and Thomas A. Simpatico, M.D.

Faculty: **L. Mark Russakoff, M.D., Stuart B. Silver, M.D., Sy Atezaz Saeed, M.D., Shivkumar Hatti, M.D., M.B.A.**

Course #23: Basic Concepts in Administrative Psychiatry: Care Management, Law, and Ethics. Sunday, May 19, 2002, 9 am - 4 pm

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Faculty: **Stephen H. Dinwiddie, M.D., William G. Wood, M.D., Ph.D., Steven Moffic, M.D., John A. Talbott, M.D.**

These courses are intended to complement one another, and may be helpful for psychiatrists contemplating certification in administrative psychiatry. For more information on these courses, please consult the APA 2002 Annual Meeting CME Course Brochure.

NewsJournal is supported by a grant from Wyeth-Ayerst

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