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ORIGINAL PAPER

Career Paths and Trends: How Does One Become a Leader in Psychiatric Administration? Implications for Residency Training

Farooq Mohyuddin[1] · Ashwin Jacob Mathai[2] · Pamela Weinberg[3] · Sy Atezaz Saeed[4]

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Abstract In the changing landscape of healthcare the number of psychiatrists entering leadership positions has declined steadily over the years. One factor contributing to this appears to be lack of leadership training during residency training. International competency frameworks have addressed this and some programs, both national and international, have designed innovative curricula to provide didactic and experiential learning in administration during and after residency. Despite guidelines by the Accreditation Council for Graduate Medical Education regarding competency in administrative aspects of health care delivery, most psychiatrists feel ill-equipped to assume a leadership position after residency training. Inculcating comprehensive administrative training into residency faces many challenges related to funding and saturation of existing curricula. Administrative training should be a mandatory element in the training of all residents irrespective of the setting in which they intend to practice. Accreditation Council for Graduate Medical Education should consider taking a prescriptive approach in shaping competency frameworks to address the need for residents to be fluent in administrative aspects of practice. Training psychiatrist-administrators will be crucial in the future of mental health-care, both from the perspective of consumers as well as psychiatry as a specialty.

Keywords Psychiatric leadership · Leadership training in psychiatry residency · Training psychiatric administrators

✉ Farooq Mohyuddin
farooq.mohyuddin@dc.gov

[1] Saint Elizabeths Hospital/DBH, 1100 Alabama Ave., SE, 238.02, Washington DC 20032, USA

[2] Psychiatry Residency Training Program, Saint Elizabeths Hospital/DBH, 1100 Alabama Ave., SE, 238.00, Washington DC 20032, USA

[3] Promoting Specialized Care and Health, Inc., 142-02 20th Ave., 3rd Floor, Flushing, NY 11351, USA

[4] Department of Psychiatry and Behavioral Medicine, Brody School of Medicine, East Carolina University, Greenville, NC 27834, USA

Introduction

Psychiatry has seen immense advances in the last century which have transformed the field completely. Majority of the changes have been extremely beneficial for patients and for implementation of better treatment practices. However, somewhere in the transition from institutionalized care to community mental health, psychiatrists were separated from leadership roles [1–3] Currently, leadership in Psychiatry is often limited to the ability to work in multidisciplinary clinical teams or head a team of clinicians involved in the care of the patient. Curricula in many psychiatry residency programs include administrative aspects of psychiatric practice and directing psychiatric services under the purview of leadership training [4]. Seldom are policy change, allocation of resources, quality control and administration-in-general mentioned in the same breath [5]. The lack of consensus in defining leadership can lead to challenges in training physicians for leadership roles.

An important discussion in literature is whether there is a difference between administrators/managers versus leaders. These roles have differentiated conceptually as the administrator/manager working in existing systems to meet targets versus leaders' role to use innovative approaches, shake up the system, motivate and inspire others. In our opinion, there is a risk in separating these roles. Successful managers/administrators need leadership skills and good leaders need to incorporate managerial tasks. Both need to have a broad overview of systems and be able to motivate others. We recommend defining leadership broadly incorporating elements from clinical, administrative, system/resource based decision making processes as well as providing inspiration to the organization. This will allow us to train future psychiatric leaders suited for a variety of roles in many organizations. A potential benefit of this broader definition could be higher recruitment to leadership roles.

Current emphasis of residency training programs on clinical excellence and reduced focus on leadership training makes it hard to recruit for administrative positions. One approach to fill the leadership gap is to recruit for leaders rather than just administrators. This leadership model also moves psychiatrists from the current roles as Medical Directors with limited system wide authority to leadership roles where they can have a significant impact on systems of health care delivery.

Physicians, especially psychiatrists, are in a position to offer a unique perspective and impact health care delivery. In the larger systems of health care delivery such perspectives are necessary to ensure a broader understanding and comprehensive assessment of the multitude of issues facing health care delivery today. Recent health care changes call for increased focus on integrated care of patients with severe mental illness in order to reduce expenditure and increase quality of care [6]. This will require psychiatrists of the future to work in models which integrate other specialties to improve outcomes. A comprehensive understanding of system structure is likely to enable them to optimize care in these models of the future [7]. Psychiatrists trained in the tradition of the biopsychosocial approach understand the impact of health care delivery systems and mental health policy on the lives of their patients and their families. They have a unique understanding of resource allocation, advocacy and policy reform; a perspective which is aligned with the needs of their patients, including, the use of surrogate courts, capacity issues involving the right to treatment, and guardianship issues. After all, "management decisions are clinical decisions, in the end" [8].

It is often stated that the number of psychiatrists in administrative positions has declined over the last half century. This is evidenced by the fact that majority of the positions of

state or territorial mental health commissioner or director of mental health are occupied by non-psychiatrists. CEOs of State mental health facilities are increasingly non-psychiatrists. The administrative role of Psychiatrists has diminished often with the relegation to medical director positions with little line authority [9]. The American Association of Community Psychiatrists was formed in part due to psychiatrists struggling to find a role for themselves, beyond medication management, in the community mental health movement [10].

A survey of job descriptions of Community Mental Health Clinic Directors listed supervisory responsibility over medical services and staff but few job descriptions noted supervision of non-medical staff or administrative responsibilities such as policy development and quality assurance [11]. Despite this trend, the medical director retains significant authority for clinical administration. Ranz et al. surveyed members of the American Association of Psychiatric Administrators and American Association of Community Psychiatrists. The results suggested that medical directors perform a wider variety of tasks and experience increased job satisfaction compared with staff psychiatrists. The performance of administrative tasks most highly correlated with overall job satisfaction, although respondents believed that clinical collaboration was the factor contributing most to job satisfaction [12].

Physicians and Psychiatrists in Leadership Roles

Despite most hospitals in the U.S being led by non-physicians [13, 14], there has been a discussion about better hospital performance and patient care when physicians are in leadership roles [13–16]. An interesting report, though not a scientific study, raised the possibility that hospitals that ranked higher, as identified by a widely-used media-generated ranking of quality, were disproportionately led by physicians [17].

Physicians are often promoted to leadership positions based on their career achievements with less emphasis on management skill and experience. Physician-leaders are in large part "accidental administrators" who "learn on the job" the skills to be effective managers and executives [18]. This can result in a loss in confidence in physician-managers, limited career development of those unsuccessful in their positions, and the mismanagement of systems. This problem can be addressed by incorporating leadership training in residency training. Graduate medical training is a transitional period when most residents decide the direction of their future career. In the changing landscape of healthcare, leadership training during graduate medical education may be a worthwhile intervention.

A study of fellows at the Royal Australian and New Zealand College of Psychiatrists conducted by Tobin et al. identified that most respondents felt ill-equipped to take on a managerial role and felt they lacked decision-making skills, financial, human resource and industrial relations management expertise; and a greater knowledge of how health systems and bureaucracies work [19]. The authors proposed that the impediments to psychiatrists being effective managers are many, including using their clinical skills in management settings, citing examples like "interpreting executive group behavior in group dynamics terms, reflecting senior managers' comments back to them, and adopting a patronizing tone with administrators who are enforcing rules and regulations". Psychiatrists also tend to emphasize interpersonal approaches to management while undermining the role of authority. Interpretation of perceived lack of support to one assuming a managerial role from colleagues, as transference/countertransference or developmental dynamics appears

to be detrimental as well. On the other hand, Somers et al., in their position paper on administrative training in psychiatry residency in Canada, argue that psychiatric skills like conflict resolution, interpersonal communication, understanding of group dynamics and behavioral principles enhance the ability of psychiatrists to function as able administrators and leaders [20]. Psychiatrists are also able to design practices which make significant contributions to the society at large with the knowledge about population needs and configuration of mental health services. Assistance with advocacy efforts and policy change are bolstered when psychiatrists emerge with a fuller knowledge of mental health systems. But lack of administrative training leads to unsatisfactory first experiences with system-related issues like resource allocation, which sets the tone for long-standing difficulties with other members of the mental health system. This contributes to psychiatrists staying away from administrative aspects of mental health delivery systems [20]. Psychiatrists are also facing increasing competition from a large group of professional and semi-professional groups who claim the ability to provide better services at a lower cost and seek to replace psychiatrists in various roles through reallocation of public health care funds. In psychiatry, the use of more non-clinicians in general (case managers, peers, etc.) has been gaining ground, as though the training involved in becoming a psychiatrist has only to do with general medical issues, not understanding the psyches of the patients, and understanding how to better engage them in their treatment. Unlike other specialties, for example Surgery or Radiology, where an MD cannot be replaced with non-MD, psychiatric privileges are being challenged more by other disciplines. Psychiatrists will need skillful representatives participating in the planning processes at various levels (organizational, regional, state, and national) that will shape the future of mental health care, including psychiatric practice [20]. These representatives will also ensure that the policy makers receive evidence demonstrating the value of psychiatric care.

In psychiatry, the concept of "physician-manager" has emerged in the light of an increasingly complex mental health care environment [21]. Health care organizations are considered to be professional bureaucracies rather than machine bureaucracies [22]. Professional bureaucracies assume an inverted power structure where staff at the bottom of the organization is in a position to impact decision-making on a day-to-day basis [22]. Staff members are highly trained individuals who demand control over their own work and decision making is decentralized. Front-line staff, like physicians, have a large degree of control and implementing new policies can only take place through negotiation and being sensitive to the culture of the organization. Control of professional bureaucracies is exerted via horizontal processes rather than hierarchical processes evident in machine bureaucracies. Professionals like physicians play key leadership roles. Leadership is dispersed and distributed in microsystems and collective leadership is important. Physicians play leadership roles in professional bureaucracies by virtue of their training and credentials. Their standing among colleagues has a major bearing on their effectiveness to fulfill the role of agents of change [23].

An additional challenge in recruiting psychiatrists to leadership positions include the physician mindset where the focus is on the individual rather than the Leader/Manager role where the system/population is the primary focus. Of course, the challenge for physicians in leadership roles is to transition their mindset from an individual-focused to a system-focused role. The need to broaden the emphasis of serving a larger population sometimes at the cost of individual benefit as leader can be ethically and personally challenging without a grounding in the decision making process during training. A prime example of this is the leadership of insurance companies which are businesses and the primary role of leadership there is to maximize profits. This probably plays a role in leadership of insurance

companies not being a usual career goal for most graduates of residency training. However, not participating in one of the most influential sectors of healthcare leaves psychiatrists out of an area where they can influence and inform the delivery of healthcare to millions of patients. In parallel, if we study the leadership challenges of nonprofit systems, majority of them funded by Government, there are different priorities which can be in conflict with physicians' primary training. Leaders in government funded systems have to balance competing priorities and political realities with limited resources. Most physicians' goal is to help the patient get well and how to make a state well is not a priority which will hinder successful leadership and drive people away.

Review of Current State of Training in Psychiatric Administration and Leadership

Despite broad guidelines regarding competency in executing the Physician-Manager role, training in psychiatric administration has lagged behind, especially when compared to nursing and social work graduate training programs [24]. A 1989 survey of the American Association of Directors of Psychiatry Residency Training revealed that 56 % of the responding programs offered didactic sessions about administration to their residents and 58 % offered an experiential module in administration [1]. Gaps in residency training in the areas of administration, leadership and a general lack of competency in fulfilling the managerial role have been identified in various reports[25–32]. These range from lack of knowledge of funding sources and regulations, to lack of administrative mentorship [33]. Formal curricula have been developed by very few programs in the training of physician-managers.

In the review by Ham et al. [23], it is noted that there is a general lack of leadership training at the undergraduate level (medical school) in the countries reviewed. At the post-graduate level (residency), most countries did not assess competence as leaders while some countries had mandatory leadership training modules which were primarily didactic. While Denmark stood out in terms of efforts to engage doctors in leadership training, mandatory leadership courses did not appear to improve leadership skills of consultants responsible for education [34].

Graduate and post-graduate medical accreditation councils around the world have recognized this need and framed broad guidelines to integrate leadership training into residency education. A position paper by Canadian Psychiatric Association emphasized training in the following areas of administration: organizational structures and change in mental health; models of mental health delivery; quality assurance; program development; conflict management and skills for team-building; leadership and lifestyle management [20]. The CanMEDS framework adopted by the Royal College of Physicians and Surgeons of Canada includes the role of the Manager as one of the seven core domains of competence for all specialists. The CanMEDS guidelines state that "as managers, physicians function as integral parts of healthcare organizations, organize sustainable practices, allocate resources and contribute to the overall effectiveness of the healthcare system" [35]. In United Kingdom, the Academy of Medical Royal Colleges and the National Health Services Institute for Innovation and Improvement jointly developed the Medical Leadership Competency Framework [36]. As per the framework, in order for effective delivery of services, doctors have to demonstrate competencies in five domains which include demonstrating personal qualities, improving services, working with others, setting

direction and managing services. Within each domain, there are four elements. The domain of managing services encompasses four key elements which include managing performance, people, resources, and planning. The domain of improving services addresses quality control and improvement. Setting direction touches upon awareness of social, political and legislative environments and interpretation of accountability frameworks. Organizational decision-making process is included in this domain. The 10 day mandatory leadership course for postgraduate trainees in Denmark further highlight the global importance of physicians' being better managers [23].

The Accreditation Council for Graduate Medical Education (ACGME) introduced the System-based Practice competency to address the need for administrative skills training in residency. The Psychiatry Milestones Project developed collaboratively by American Board of Psychiatry and Neurology and ACGME, lists some physician-manager skills in the 22 sub-competencies for semi-annual review and assessment of psychiatry residents; communication skills, conflict management and team-based care, quality improvement, providing care as a consultant and collaborator and community-based program administration to name a few [37]. The ACGME sub-competencies are graded from beginner to role model on a five point scale. Although achieving Level 4 in all competencies is a graduation goal, it is not a requirement.

There have been attempts by psychiatry residency training programs to incorporate leadership training in the curriculum. The major innovations in the last few years are summarized below.

A core curriculum which covered four topics with four clinical case presentations, at the now defunct Cabrini Medical Center targeting psychiatry residents, has been described [38]. The eight session course was designed to emphasize the practical use of the course by pairing a didactic session with case vignettes. The topics were organizational theories in Mental Health, leadership in the administration of psychiatric systems, strategies for Organizational Change, and the market for mental health change. The course used Textbook of Administrative Psychiatry, edited by Talbot et al. as the core text [39].

Another advance in training was the physician-manager curriculum used at the University of Toronto. Sockalingam et al. assessed the perceived deficiencies and gaps in knowledge and skill in physician-manager competencies of psychiatry residents in Canada. The results suggested that residents recognized the areas of Program Planning and Professional Self-Care as the most glaring deficits in their training within the physician-manager competencies. These results of the authors' pilot study were used to form the physician-manager curriculum for psychiatry residents at University of Toronto [27]. Four junior workshops were offered to PGY-2 and four senior workshops for PGY-4 residents as a mandatory part of training. Each workshop used didactic training, small group discussions and interactive techniques like case studies, think-pair-share and buzz groups. Reference materials and handouts were given to residents to supplement the sessions. The junior workshops covered Teamwork, Conflict Resolution and Negotiation, Measurement-Based QI, and Program Evaluation. The four senior workshops dealt with Leadership Skills in Managing Change, Mental Health and Addictions Reform, Organizations Structure in Mental Health and Self and Career Development. Anonymous post-session feedback determined that residents found interactive teaching methods, clinical illustrations and case studies drawing from resident experience and clinical rotations most useful, as they made learning contextual. Residents also suggested mentorship opportunities [33], quality improvement projects, elective opportunities and participation in administrative committees as effective ways to reinforce learning.

Another innovation for the beginning trainees is a course offered at the University of British Columbia Department of Psychiatry which is designed to provide a comprehensive orientation to mental health system with the rationale of introducing residents to these concepts early in training being that they are free to give thoughtful consideration to issue and questions raised and are open-minded before they are immersed in traditional practice settings and influenced by practice patterns of their supervisors [20].

Although the focus of this is article is training during residency there is much to learn from the Columbia Public Psychiatry Fellowship that has been in existence since 1981 and is the oldest program of its kind [40]. Alumni frequently fulfill roles of agency medical directors. Many fellowship programs have been created around the country, modeled on the Columbia PPF. In addition to a comprehensive academic curriculum, the program emphasizes the congruence model. Fellows present their field placements, residency training program, advocacy, fiscal and system-oriented clinical presentations. The congruence model focuses on the congruence between the goals, staff, organizational structure and culture to enhance performance. The effectiveness of training goes beyond field experiences, with individual preceptors during the fellowship and mentors beyond the fellowship year [41].This is of paramount significance as experiential learning, including mentoring, coaching, and role modeling, has been identified as the most effective method for teaching and learning leadership [42, 43].

Some programs offer administrative electives which vary from well-structured to unstructured. These electives are an opportunity for trainees interested in administrative psychiatry to be trained in Administrative Psychiatry. For example Saint Elizabeths Hospital/DC-Department of Behavioral Health psychiatry residency training program (Authors FM and AM associated with the program) offers a supervised elective with the CEO of the hospital and the Director of Department of Behavioral Health. This 6 month part-time elective allows the trainees to become part of leadership team and decision making process at the highest level in a state equivalent mental health system. Other training programs use supervised administrative electives to foster resident's interest.

The yearly chief residents conference organized by Albert Einstein College of Medicine for the last several decades is another avenue for training the chief residents who are involved in many programs in administrative capacities.

The Management and Leadership Pathway for Residents in some programs have been developed for residents with both a medical degree and management training, targeting residents from many different clinical residency programs. These can be designed for MD-MBA graduates who are contemplating traditional MBA career choices with an alternative opportunity to remain active in clinical medicine while pursuing management experiences. The programs incorporate focused didactic curriculum, practical management rotations, a longitudinal project, and committed mentorship.

Discussion

Although some programs have been successful in training psychiatry residents in administration, graduates frequently hold the role of medical director with minimal impact on resource allocation, policy change and setting direction. Their roles tend to be limited to the supervision of clinical staff. The need for leadership training during residency is very important. In our opinion, this should be required training not only for residents with a documented interest in fulfilling administrative roles, but all residents since all residents

are impacted by real-world encounters with organizational structures, policy reform, quality improvement and resource allocation. There is also increasing recognition that psychiatrists will be expected to fulfill roles and demonstrate competence in areas that impact health-care at large, not only for their patients but also for improving wellness of communities and for advancing the field of psychiatry and to preserve its relevance. Guidelines have been prescribed by graduate accreditation councils around the world but not much has been done in the way of implementation of curricula or arranging for experiential learning opportunities. Most programs that have attempted translating these guidelines have used didactic education to fill the gaps. While residents by-and-large embraced these new training modules, suggestions for improvement focus on administrative mentorship and rotational experiences in management settings are still needed.

Challenges to Administrative Training

The challenges to curricular change are not limited to funding, lack of administrative mentorship and faculty members qualified to deliver didactics and practicums are important impediments [5, 20]. The existing curricula are already saturated. The burden placed on residents by additional training needs to be taken into consideration. A realignment of financial incentives is fundamental as compensation for policy-input is limited [20]. Experience from across the Atlantic teaches us that clinicians need to be involved in both informing and leading change for health care reform [15]. The greatest difficulty for providing access is for patients at greatest risk and this include patients with chronic mental illness. Psychiatry needs advocates for funding to be reviewed in a way that puts quality of care before financial gain. Henry's editorial in JAMA 20 years ago asserted that "physician-executives may be the only ones capable of coping with the rapid and profound changes as well as the medical, financial, and ethical complexity that now beset the practice of medicine" [44].

Reccomendations for the Future

- Administrative training and teaching the physician-manager role should not be limited to residents in dedicated tracks. It should include all residents as a prerequisite for graduation.
- ACGME should consider explicit guidelines regarding demonstration of competencies that are central to fulfilling the role of the physician-manager along the lines of other graduate medical education councils around the world. The competencies should include resource management, management of fiscal and staff challenges as well as demonstrating an understanding of broader policy changes impacting healthcare.
- Didactic teaching on mental health policy and reform, organizational structure and funding, quality improvement and program assessment, should be required training during residency training.
- Administrative training should not be restricted to mandatory didactic teaching, but should include dedicated time for elective experiences and rotations in the management setting.

- Managerial mentorship should be established early in residency training, with sights set on continuing that relationship post-residency to provide guidance and streamline efforts to a managerial career.
- Residency programs and academic centers should work with public sector mental health services and provide opportunities for hands-on experience with players outside the physician network.
- Clinical practice should be balanced with early and continuous experience as a leader and manager for physician-executive development [45]. This training should start early to target physicians early in undergraduate medical schools.
- Training in finance of running programs is essential to help the physician acquire skill set in this area.

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Farooq Mohyuddin, MD is the Chair of Psychiatry Training and Director of Residency Training for Saint Elizabeths Hospital/DC Department of Behavioral Health. He is an experienced educator and leader in the field. His faculty appointments include George Washington University, School of Medicine, Washington School of Psychiatry and Howard University, School of Medicine. He has been appointed to the Group for Advancement of Psychiatry Administration and Leadership Committee. He has been in leadership positions in various organizations including General Secretary Washington Psychiatric Society, Past President Mid-Atlantic Group Psychotherapy Society, and Member Board of Directors American Group Psychotherapy Association.

Ashwin Jacob Mathai, MD is a PGY-III Psychiatry Resident at Saint Elizabeths Hospital, Department of Behavioral Health. He has been particularly interested in research and psychiatric administration. He has been chosen as the chief resident for Psychiatry Residency Training as an acknowledgement of his leadership potential. He graduated from Kasturba Medical College Mangalore in 2009. Originally born in Thrissur, India, Dr. Mathai chose to return there to complete his Compulsory Rotatory Residential Internship.

Pamela Weinberg, MD is currently the Senior VP for Medical and Quality Affairs at PSCH, Inc., a not-for-profit in NYC, working with the mentally and developmentally disabled populations. Prior to that, Dr. Weinberg was the Clinical Director of Pilgrim Psychiatric Center. She attended the University Of Cincinnati College of Medicine, trained at the Mt Sinai Hospital in NYC, and completed her Fellowship in Public Psychiatry at Columbia University.

Sy Atezaz Saeed, MD is Professor and Chairman in the Department of Psychiatry and Behavioral Medicine at the Brody School of Medicine, East Carolina University. He is the current Chair of GAP Committee on Psychiatric Administration and Leadership. He is the Director of the North Carolina Statewide Telepsychiatry Program (NC-STeP). He was Chairman of the APA's Committee on Psychiatric Administration and Management.