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ORIGINAL PAPER

Ethical Challenges in Psychiatric Administration and Leadership

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Abstract As with all professional ethical principles, those in psychiatry have to evolve over time and societal changes. The current ethical challenges for psychiatric administration and leadership, especially regarding for-profit managed care, need updated solutions. One solution resides in the development by the American Association of Psychiatric Administrators (AAPA) of the first set of ethical principles designed specifically for psychiatric administrators. These principles build on prior Psychological Theories of leadership, such as those of Freud, Kernberg, and Kohut. Supplementing these theories are the actual real life models of psychiatrist leadership as depicted in the memoirs of various psychiatrists. Appreciating these principles, theories, and models may help emerging leaders to better recognize the importance of ethical challenges. A conclusion is that psychiatrists should have the potential to assume more successful leadership positions once again. In such positions, making the skills and well-being of all in the organization seems now to be the foremost ethical priority.

Keywords Ethical principles · Leadership · Administration · Organizational ethics · Psychological theories of leadership

Introduction

Ethical challenges for psychiatrist administrators and leaders in the USA continue to proliferate [1], adding to those that have bedeviled psychiatry since its beginning. Indeed, one of the implicit goals of the American Psychiatric Association (APA), an entity initially created by superintendents of American mental hospitals in 1844, was to reduce the use of

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patient restraint in the pursuit of a more humane and ethically acceptable environment. To this day, restraint remains a challenge under constant reassessment, let alone the ethical question of whether and when hospitalization is medically advisable or necessary. Related issues such as involuntary inpatient or outpatient commitment continue to be controversial. Over the subsequent decades, the list of ethical challenges grew in concert with the complexity of the field. The focus of the profession also has expanded from hospitals to community based settings, with concern for extending competent care to underserved or poorly served groups such as the poor and minorities. This paper describes some of the ethical challenges facing the field of mental health service today. It also provides an overview of what the authors believe ethical psychiatric leadership requires.

To review ethical challenges in psychiatric administration and leadership, definition of "ethics" must be established. Indeed, there are many definitions of "ethics." Depending on how it is being applied to medical care, one can see the potential complications that arise in modern psychiatric practice. According to an American Language source, the adjective ethical means "1. pertaining to or dealing with morals or the principles of morality; pertaining to right and wrong in conduct;" or "2. being in accordance with the rules or standards for right conduct or practice, especially the standards of a profession: *it was not considered ethical for physicians to advertise*; …" [2]. Also, the first meaning given has to do with right and wrong in general conduct. These standards change over time. For example physician advertising has moved from telephone book limitations to a broader permissiveness. Conversely, the rules against pharmaceutical businesses advertising prescription drugs to the public have loosened in recent years to the point where direct marketing to consumers leads patients to demand certain products from their physicians. Thus there are no absolute ethical rules for many of the challenges facing psychiatrist administrators.

The British Dictionary definitions for ethic: "Noun: a moral principle or set of moral values held by an individual or group: *the Puritan ethic;* Adjective: another word for ethical; Word Origin: C15: from Latin ēthicus, from Greek éthikos, from ēthos custom; see ethos;" "ethics; noun; 1.(functioning as singular) the philosophical study of the moral value of human conduct and of the rules and principles that ought to govern it; moral philosophy See also meta-ethics; 2. (functioning as plural) a social, religious, or civil code of behaviour considered correct, esp. that of a particular group, profession, or individual; 3. (functioning as plural) the moral fitness of a decision, course of action, etc.: he doubted the ethics of their verdict [3]. This definition introduces the concept of *justice* to that of *custom*, *virtue*, and *acceptable practice within an affinity group*. Those in administrative roles often struggle with this when dealing with medical colleagues and trying to achieve cost-effective patient care. Of course, even a clinician must interpret ethical guidance according to internal stances nurtured through upbringing, experience, and peer influences.

The overarching ethic for physicians, *primum non nocere*, provides another example. Meaning, "most importantly, cause no harm" the phrase literally would prevent most medical treatment. In psychiatry, many of our medications can cause concerning side effects and the benefit/risk assessment must often be done. Thus, the ethical imperative is often interpreted "don't make matters worse." Even this guidance is insufficient, as it doesn't specify who makes the value judgment of "worse." How often, do the patient and physician share the same perspective? How accurate are our forecasts of success, particularly in uncommon or emergency procedures? How often are we as clinicians provided biased information about available treatments through industry detailing, or even improper presentation of research findings? What is the administrator's role in balancing clinical and organizational needs?

Although since 1973 there have been explicit ethical principles that apply to the psychiatrist clinician, which are the APA's adaptation and annotations of the American

Medical Association's Principles of Medical Ethics [4], there were not any corresponding principles for psychiatrist administrators. In the past, psychiatric administrators tried to follow these clinical principles where the patient holds the centrality. However, the increasing infringements of business, political, and legal ethics often associated with larger organizations of care rendered that approach no longer adequate. Administrators encounter problems in the ethical arena in a significantly different way than those encountered by clinical psychiatrists [5].

For the clinician, that of the APA's [4] states: *As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self.* Here, the patient comes first. The principles go on to state that the ethical expectation is for "competent" care. For psychiatrist administrators, these principles are less distinct in the AAPA principles [6], per Annotation #1 to the Preamble: *A psychiatric administrator will have a greater or lesser degree of responsibility for the well-being of the work setting and for the lives of those employed in the setting. Thus, the psychiatric administrator will need to pay more attention to the needs of society and other health professionals than would the typical psychiatric clinician. When conflict exists between the needs of the organization or society and the needs of patients, the psychiatric administrator must be guided by an ongoing commitment to the needs of patients.* Here, the administrator has more of a balancing act among the needs of society, of the organization, of the staff, and of the patients.

There has not been an established, standard of guidance for ethical psychiatrists in administrative or leadership roles. As a response to this omission, for the new millennium, the American Association of Psychiatric Administrators (AAPA) developed ethical principles for psychiatric administrators in the year 2000 [6], presented in Appendix. As the preamble states, it distinguishes ethical standards for psychiatric administrator: "A psychiatric administrator will have a greater or lesser degree of responsibility for the well being of the work setting and for the lives of those employed in that setting. Thus, the psychiatric administrator will need to pay more attention to the needs of society and other health professionals than would the typical psychiatric clinician. When conflict exists between the needs of the organization or society and the needs of patients, the psychiatric administrator must be guided by an ongoing commitment to the needs of patients. If and when the psychiatric administrator can no longer follow these principles, resignation would be an ethical option." This clear delineation between the psychiatrist the clinician and the psychiatrist as the administrator and leader is one that can be difficult to navigate.

Ethical Principles

More well known are the ethical challenges associated with the rapid rise of for-profit managed care in the 1980's, which introduced new and more complex challenges [7], including new kinds of organizations such as mental health carve-outs, utilization review systems determining medical necessity, and many opportunities for increasing revenue. Dramatically reduced inpatient stays, less intensive psychotherapy, over-reliance on pharmacotherapy, and brief visits for medication management without formal psychotherapy have resulted. While these changes in the treatment management environment emphasized increased efficacy and efficiency, the apparent goal of these developments was to achieve cost savings. Staff members were expected to do more with fewer resources. Psychiatrists who then had administrative and/or leadership positions were faced with

determining the appropriate ethical solutions. Currently, these challenges of managed care organizations are evolving into those of the Accountable Care Organizations (ACOs) of healthcare reform, which some informally describe as "managed care on steroids" [8].

On a macro ethical level, managed care pitted *business* ethics against the ethics of *healthcare* professionals. Such potential macro ethical conflicts occur in other settings too. In community psychiatry, the choice between rationing resources for an entire population versus attempting to meet the more extensive needs of certain individual patients [9] presents a different ethical dilemma. Nonetheless, a recent survey by the Group for the Advancement of Psychiatry (GAP) of psychiatrists in key administrative positions found that ethics was not viewed as a major challenge to the respondents [10]. It fell to ninth place out of ten possible administrative challenges, with fiscal resources being first. Experienced administrators, however, provided an exception to this ranking seeming to give more weight to ethical issues than did more junior colleagues.

By virtue of psychiatric training and experience, psychiatrist administrators bring unique tools to the task of finding ethical and acceptable strategies as well as heightened conflict related to training as a clinician. While we, as psychiatrists, may often have a limited background in many areas of program administration, we bring many compensating skills that are relevant. Among these clinical skills are therapeutic neutrality; careful listening; the ability to ask well-timed questions and to permit the patient to figure out answers; setting clear boundaries; drawing on the literature and acquired knowledge in our work; being conscious of our responsibilities as agents of change; seeking consultation when appropriate; and believing in what we do. These qualities, when added to the administrative skills set, clearly differentiate a psychiatrist leader from a non-psychiatrist leading a mental health care delivery system. However, we must also be careful that our perch does not distort our vision. For example, a superintendent at a forensic hospital may think forensics is at the center of the public mental health system, whereas forensics may be at the periphery for the state mental health commissioner. For a psychiatrist Director, the mental health system may be at the center, but it cannot be the center for the Governor, given that public mental health services are a small part of the State's obligations to its citizens. Ultimately, it's about balancing clinical needs against finite resources, balancing individual needs in the context of distributive justice, being attentive to the broader context of issues facing us, and most importantly being attentive to the ethical dimensions of all these issues that we face at the intersection of the administrative and clinical worlds.

Ethical Leadership

Leadership provides the overarching vision for what are the right and ethical things for the organization, aside from lots of other things. Often the terms administration and leadership are used either in concert or interchangeably. Leadership expects the psychiatric administrator to "do the right thing" as well as motivating the organization in that direction versus the administrative task of getting it done "right." For example, the passage of the Affordable Care Act (Obamacare) reflected many aspects of presidential leadership; the rollout of internet and computer based enrollment was evidence of terrible executive administration. For this reason, both words tend to be used in book titles and the naming of committees. One really can't be a successful leader without attending to getting the job done, but the terms reflect different skills. This paper focuses primarily on leadership issues.

The psychiatric administrator in a leadership role is responsible for motivating others, when it is necessary, to fulfill the vision. Though leaders are usually thought to be at the top of any organization, leadership can exist at any level. In its broadest, and potentially best sense, leadership is ubiquitous, ranging from parents to patients, or from role models to role mentors. Leaders can lead from behind as well as ahead. Leadership can occur in a formal role or informally. Theories of what goes into leadership abound [11]. For psychiatrists, the Psychological Theories may be particularly attractive, for they are the most familiar and easily adapted. Freud's psychoanalytic theory posited the leader as the psychological father of the clan, a parallel to the psychoanalyst-analysand relationship. As such, it is particularly important for the leader to watch for, not take personally, and address transference reactions, that is, the unconscious transfer of childhood feelings of followers onto leaders. Corresponding counter-transference feelings do need to be taken into account and analyzed personally for the leader to lead more objectively. A more modern development of Freud's theories is that of Kernberg [12]. He concludes that it is normal and healthy for a leader to have a "slight" degree of paranoia, given the likely envy by both foes and friends. Kernberg also warns the leader about how groups can readily regress under perceived threats such as rumored change, too many new projects, and financial stress.

Another later spin-off from Freud is Kohut's understanding of the self-psychology of narcissism [13]. Narcissism is both the fuel and fire of leadership. It is flamed by the idealization and/or mirroring responses of the followers. A healthy dose of narcissism is necessary to lead, and relates to the traits of ambition and courage. However, this same narcissism, coupled with the temptations of power, can often lead to the abuse of that power. At its best, it is difficult to maintain the same enthusiastic lock and key of a leader and an organization over long periods of time. That is, there are inevitable failures and disappointments in promised accomplishments and fantasies that have not been met, which will then lead followers to less idealize the leader and not provide as much mirroring praise. One ethical solution to this challenge is to realize that the goals and visions of the organization may change over time, and the leaders need to reestablish the excitement of these new challenges, and change what they do and say accordingly.

Sometimes, there may be conflict between these professional ethics and one's personal moral values and/or the law. The potential conflict between ethical principles and the law, which codifies some of these ethical principles, is fraught with potential problems and risk. If a situation is professionally untenable, what are the obligations of the psychiatrist administrator to report the issues to governing bodies, licensure and/or accreditation agencies, the media, or professional societies? Inequitable access to health care, the favoring of clients with good insurance coverage, discriminations in direct service due to crowded facilities, undue physical and mental risks borne by service staff, unavoidable flouting of legal or regulatory standards, the compromising of professional integrity and ideals—all burden the ethical and judicial consciousness of the administrator [5].

In a personal moral sense, psychiatrist administrators also have had to pay attention to their own well-being. Otherwise, their effectiveness is likely to decline and they may also be at a high risk for burn out. At an extreme, the leaders may have to consider quitting or allowing himself or herself to risk dismissal from their positions. One reason for that expectation is stated in Annotation 1 of the AAPA ethical principles: *If and when the psychiatric administrator can no longer follow these principles, resignation would be an ethical option*. However, that should only be done after asking for consultation, help, and exploring various options. If the administrator is concerned that the systemic problems and demands are too dangerous for patients, whistle-blowing becomes an ethical option, thought that usually imposes further personal stress on that person.

As the AAPA principles indicate, the leader may have to choose between ethical goods. Most obviously, that includes the well-being of the organization as a whole, the well-being of the staff, the well-being of patients, and the well-being of administrators themselves. How to choose, then? Patients can't be served without the viability of the organization, large or small. However, fortunately, at times, there will be alternative organizations for patient care, if needs be. More difficult may be finding and keeping skilled clinicians, so much so that an ethical argument could be made that the needs of staff, at least insofar as their skills an abilities go, should be the highest ethical priority of all. The problem for psychiatric leadership is that ethical arguments can be made for a variety of choices. No set of guidelines can provide formulaic responses to complex moral, ethical, and professionally competent judgments incumbent upon psychiatrist leaders.

Models of Ethical Psychiatrist Leaders

If fortunate, the would-be psychiatrist administrator will receive good preparatory education for that career, as well as helpful mentors along the way. If not, or in addition, another way to learn how to be ethical psychiatrist leaders and administrators is to read about how other psychiatrists did it. Though not voluminous, possibly due to the confidentiality pervading the field, there are enough memoirs and autobiographies that depict real life ethical journeys, including Drs. Blackwell [14], Brazelton [15]. Dumont [16], Laing [17], Lifton [18], Montross [19], Parker [20], Rickels [21], Rosenthal [22], Sabshin [23], and Taney [24], amongst others. Respectively, they portray psychiatric journeys, often heroic at times, in discovering unexpected medication "side effects"; how to educate the public about raising psychologically healthy children; the resignation of leadership; admission of mistakes; addressing counter-transference; day to day ethical challenges; being a pioneer woman leader; going from a German POW to a pioneer in USA psychopharmacology; from apartheid in South Africa to Seasonal Affective Disorder in the USA; the transformation of the American Psychiatric Association; and from the Holocaust to understanding murderers.

One of those others is the unique example of Lindner [25], who combines the qualities of a psychiatrist in her training as a physician and a psychologist, growth from early personal trauma, and an early career in cross-cultural and multi-country practice, to successfully develop a global organization devoted to increasing dignity and decreasing humiliation in individuals and groups, small or large. Lindner's is one model of how psychiatric leaders can go beyond the field of psychiatry per se to ethically address societal problems, which might also include gun violence in the USA and climate change globally.

Measuring Leadership Success

Of course, the ultimate ethical goal of leadership is how well it is done. Leaders, including psychiatric leaders, can keep their position due more to power and connections than outcomes. Moreover, it is hard enough to measure the patient outcomes of solo practitioners without also adding the complexities and multiple needs of systems. Nevertheless, there are at least ten areas to focus on that can provide some useful information, such as [26]:

1. Extent of adherence to the Ethical Principles for Psychiatric Administrators, with adequate explanations for deviations;
2. Outcome studies and consumer satisfaction of patient care;

3. Success in providing care at the institutional level (population-based) that is effective, efficient, and evidence-based;
4. Employee well-being and turnover;
5. Leadership well-being and turnover;
6. Organizational development;
7. Relationships to other leaders and organizations;
8. Resolving conflicts of the areas above;
9. Influencing or advancing the field of psychiatry; and
10. Contributing to the solution of societal problems.

Conclusions

Leadership and administration in psychiatry is ubiquitous, ranging from solo practice to leading large organizations. Many of the psychiatric administrator's problems in the area of ethics revolve around the lack of resources needed for providing quality care, retaining a skilled and competent workforce, and upholding the ethical and moral obligations related to numerous constituencies. Other problems involve when and whether the administrator should take social and/or political action after other measures have failed and the situation has deteriorated to unacceptable levels.

Ethical leadership and administration requires paying attention to both clinical ethics and organizational ethics. To do so requires knowing how to best translate research studies to providing practice, including what best practices to use.

Although the complexity of ethical leadership by psychiatrists almost defies scientific study, we do know a lot about the variables that are most likely to produce such leadership. We do have ethical principles for psychiatric administration, which all leaders should know, review periodically, and help revise as needed. Nevertheless, the organizations and their leaders that sponsor these ethical principles, the AMA, the APA, and the AAPA, should also not be immune from criticism when they fail to live up their ethical potential.

Decision making in ethical leadership is rarely a clear-cut black or white, or right or wrong. Rather, it takes place in the ambiguity between ethical ideals (often competing ones) and social practicalities.

Of course, psychiatrists aren't the only discipline that has leadership and administrative positions in mental healthcare. Psychiatrists often have broadest and longest educational experience as well as the experience of ultimate clinical responsibility for very ill and dying patients. These experiences potentially should lead to high quality leadership, all other things being equal, but all other things are rarely equal. If psychiatrists don't recognize the importance of ethical challenges, as the recent survey suggests, it is doubtful that they will address them competently.

Although typically patients and organizations are put as ethical priorities, they can't be served well without the well-being and skills of staff and of the leader. Therefore, realistic expectations, compassionate concern, and professional development can be argued to be the utmost ethical priorities of all.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

Appendix: Ethical Principles for Psychiatric Administrators: The AMA Principles of Medical Ethics, with Annotations Especially Applicable to Psychiatric Administrators

Approved by the American Association of Psychiatric Administrators October 28, 2000.

Preamble

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.

Annotation (1) for Psychiatric Administrators A psychiatric administrator will have a greater or lesser degree of responsibility for the well being of the work setting and for the lives of those employed in that setting. Thus, the psychiatric administrator will need to pay more attention to the needs of society and other health professionals than would the typical psychiatric clinician. When conflict exists between the needs of the organization or society and the needs of patients, the psychiatric administrator must be guided by an ongoing commitment to the needs of patients. If and when the psychiatric administrator can no longer follow these principles, resignation would be an ethical option.

Section 1

A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

Annotation (1) for Psychiatric Administrators Knowing that the quality of medical services can be affected by a wide variety of variables, including the skills of clinicians, the organization of the delivery system, and the adequacy of funding, the psychiatric administrator will strive, though may not always succeed, to do what is possible to have competent mental health services in the organization. "Competent" does not mean ideal services, but rather refers to the average expectable outcomes given the current state of psychiatric knowledge and available delivery systems.

Annotation (2) Whenever competing ethical needs, such as under-funding or the survival of the organization, jeopardize the provision of competent medical services, the psychiatric administrator will strive to have the organization still provide the best possible services with compassion and respect for patients.

Annotation (3) Given the targeted patient population of the organization, the psychiatric administrator should not allow discrimination of patients based on race, religion, or other sociocultural characteristics. Likewise, staff discrimination should not be tolerated.

Annotation (4) To substantiate that competent psychiatric services are being provided, the psychiatric administrator should support and/or foster the development of relevant outcome studies and strive for continuous quality improvement.

Section 2

A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

Annotation (1) for Psychiatric Administrators To deal honestly with patients and colleagues, the administrator needs to try to be aware of the psychological factors that may prevent that. Such factors may include dependency, narcissism, and guilt. To monitor and help maintain such honesty, advisory committees and consultation with more senior administrators in other settings is advisable.

Annotation (2) The role of the psychiatric administrator in a system of care should be explicit to the public, patients, and clinicians. Effort should be made, via newsletters, meetings, or other mechanisms, to make the administrator known and visible.

Annotation (3) When an administrator who is a psychiatrist decides or chooses not to follow these ethical principles, an ethical course would be to try to make that publicly obvious in one way or another, such as not using "Doctor" or "M.D." as part of their administrative title.

Annotation (4) Whenever incompetent or inappropriate behavior on the part of the clinicians or other administrators comes to the attention of administrators, the administrator must intervene.

Section 3

A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.

Annotation (1) for Psychiatric Administrators A psychiatric administrator should know and follow the laws relevant to the healthcare system, and strive to advocate for new laws that may improve or develop healthcare systems that can provide costeffective, quality care.

Annotation (2) The psychiatric administrator should not support policies, nor receive financial benefits based on such policies, that compromise quality of care.

Section 4

A physician shall respect the rights of patients, of colleagues, and shall safeguard patient confidences within the constraints of the law.

Annotation (1) for Psychiatric Administrators While psychiatric administrators may have an ethical right to obtain patient information that, in its aggregate, will help to monitor and improve outcomes, every effort should be made to inform patients and clinicians as to why and how such clinical information will be used. It must be clear that appropriate safeguards for the confidentiality of the information are in place, including the use of coding whenever possible. Especially given the importance of confidentiality for psychiatric patients, the potential benefits must outweigh the risks of less confidentiality.

Annotation (2) Aggregate patient data may be shared within the healthcare institution and publicly, but any presentation of a specific patient must protect confidentiality unless the patient willingly provides informed consent in writing.

Annotation (3) The psychiatric administrator must be cautious in the use of power, so as not to take financial, social, or sexual advantage of clinicians or patients.

Section 5

A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

Annotation (1) for Psychiatric Administrators A Psychiatric administrator should have appropriate training and evaluations relevant to the position.

Annotation (2) The psychiatric administrator should stay abreast not only of general psychiatric advances in knowledge, but also relevant administrative, political, and business knowledge that may influence the functioning of healthcare systems. Information relevant to others in the organization and to the public should be shared with them.

Annotation (3) In order to avoid conflicts of interest, which may compromise patient care, the psychiatric administrator should make available consultants, clinicians, or reviewers outside of the system to provide objective opinions, care, appeal, or review.

Annotation (4) Given both the unique as well as occasional overlap of skills and training of the different mental health disciplines, the psychiatric administrator should strive to make the most cost effective use of the apparent strengths of each mental health discipline.

Section 6

A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

Annotation (1) for Psychiatric Administrators When psychiatric administrators are responsible for a third party influence on the doctor-patient relationship, such as in a community mental health center, state psychiatric hospital, or managed care system, the administrator should strive to select the best clinicians possible for the staff or network.

Annotation (2) Although a psychiatric administrator need not continue to provide direct patient care, if one does not do so, some mechanism should be found to help maintain empathy for the perspectives of clinicians and patients.

Annotation (3) When new environments, such as telemedicine or e-mail, are used to provide treatment, the psychiatric administrator should assess whether they are at least equivalent or better, with respect to benefits and risks, to traditional environments.

Section 7

A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Annotation (1) for Psychiatric Administrators Whenever and wherever possible, the psychiatric administrator should try to address and reduce the stigma associated with psychiatric patients and disorders.

Annotation (2) Psychiatric administrators should use their knowledge and management of healthcare systems to improve the well being of our communities, but when communicating on societal issues, should be careful to clarify whether he/she speaks as an individual citizen, individual physician, or as a representative of an organization.

References

1. Moffic HS, Sabin J: Ethical Leadership in Psychiatry. In: Sadler JA, Fulford B, van Staden CW (Eds) The Oxford Handbook of Psychiatric Ethics, Vol. 1, Oxford, Oxford University Press, 2014
2. Dictionary.com Unabridged. Retrieved November 20, 2014, from Dictionary.com website: http://dictionary.reference.com/browse/ethical

3. Collins English Dictionary—Complete & Unabridged 10th Edition. Retrieved November 20, 2014, from Dictionary.com website: http://dictionary.reference.com/browse/ethic
4. American Psychiatric Association: The Principles of Medical Ethics: With Annotations Especially Applicable to Psychiatry. Washington, DC, American Psychiatric Publishing, 2001
5. Greenblatt M: Ethics of administration: The California crisis. Administration and Policy in Mental Health and Mental Health Services Research. 17:177–183, 1990
6. Moffic HS: Ethical principles for psychiatric administrators: The AMA Principles of Medical Ethics, with annotations especially applicable to psychiatric administrators. Psychiatric Administrator 4:447–451, 2004
7. Moffic HS: The Ethical Way: Challenges and Solutions for Managed Behavioral Healthcare. San Francisco, Jossey-Bass, 1997
8. Moffic HS: Behavioral healthcare à la Toyota. In Behavioral Healthcare, March 2, 2012. http://www.behavioral.net/blogs/h-steven-moffic/behavioral-healthcare-la-toyota. Accessed February 24, 2015
9. Moffic HS, Bateman H: Ethics for Community Psychiatry: Evidence-Based Policies and Procedures. In: McQuistion HL, Sowers WE, Ranz JM, Feldman JM (Eds) Handbook of Community Psychiatry, New York, Springer, 2012
10. Merlino JP, Saeed SA, Silver S, Petit JR, Moffic S, Lucey J, Moyhuddin F: Current perspectives on psychiatric administration and leadership. Journal of Psychiatric Administration and Leadership (JPAM) 3(1):1–19, 2015
11. Van Vugt M, Ahuha A: Naturally Selected: The Evolutionary Science of Leadership. Toronto, HarperCollins, 2011
12. Kernberg O: Ideology, Conflict, and Leadership in Groups and Organizations. New Haven, Yale University Press, 1998
13. Kohut H: The Restoration of the Self. New York, International University Press, 1977
14. Blackwell B: Bits and Pieces of a Psychiatrist's Life. Bloomington, Xlibrus Corporation, 2012
15. Brazelton TT: Learning to Listen: A Life Caring for Children. Boston, De Capo, 2013
16. Dumont M: Treating the Poor: A Personal Sojourn Through the Rise and Fall of Community Mental Health. Belmont, Dymphna Press, 1994
17. Laing RD: The Making of a Psychiatrist. Edinburgh, Canongale Classics, 2001
18. Lifton RJ: Witness to an Extreme Century: A Memoir. New York, The Free Press, 2011
19. Montross C: Falling into the Fire: A Psychiatric Encounter with the Mind in Crisis. New York, Penguin Press HC, 2013
20. Parker B: The Evolution of a Psychiatrist: Memoirs of a Woman Doctor. New Haven, Yale University Press, 1987
21. Rickels K: A Serendipitous Life: From German POW to American Psychiatrist. Evergreen, Notting Hill Press, 2011
22. Rosenthal N: The Gift of Adversity: The Unexpected Benefits of Life's Difficulties, Setbacks, and Imperfections. New York, Tarcher, 2013
23. Sabshin M: Changing American Psychiatry: A Personal Perspective. Arlington, American Psychiatric Press Inc., 2008
24. Taney E: Passport to Life: Autobiographical Reflections on the Holocaust. Ann Arbor, Forensic Press, 2004
25. Lindner E: Making Enemies: Humiliation and International Conflict. Westport, Praeger, 2006
26. Moffic HS: Ethics column: How do you know a good psychiatrist administrator when you see one? An ethical analysis. Journal of Psychiatric Administration 1:49–53, 2012

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