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### Ethical Leadership for Psychiatry

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### **[–] Abstract and Keywords**

Solutions for the current challenges in mental health care worldwide require improved ethical leadership and administration. Though psychiatrists have the broadest training for stewardship, other disciplines and patient consumers provide their own potential. Business leadership and ethics also need consideration. How to meld the strengths and ethical principles of the various mental health care constituencies is a major global task, but one that can be met. Possible ethical ways to do so are to use emotional intelligence and a culture of compassionate love to prioritize the professional and personal needs of the staff, and to have more leadership provided by formerly disenfranchised prosumers and/or leaders from marginalized cultures. Those responsible for mental health care systems must include the representative viewpoints of all stakeholders. One country, the USA, is highlighted for what can be generalized to other countries, supplemented by some important differences found in other societies.

Keywords: administration, business, consumer, cultures, emotional intelligence, ethics, leadership, love, prosumers, stewardship

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Defining good leadership is the million dollar question.

(Shine 2013, p. 39)

The ethical dilemmas confronting mental health system leaders are challenges involving profound consequences.

(Baggett 2003, p. 272)

Any time would be an important time for ethical leadership in psychiatry. At stake to some extent is the mental well-being of patients and the public. However, now is a most crucial time. Despite advances in understanding the brain, mental health care is awash with ethical conflicts, concerns, and controversies.

Since the diversity of psychiatry and societies is so extensive, there could be two major ways to review these most relevant issues. One would be to review the different official ethical principles for psychiatry in as many countries as possible, and then look at how psychiatric leadership—of any relevant discipline—has wrestled with the practical applications of these principles. As valuable as this approach could be, such a project might require a separate book due to its scope and necessary numbers of global authors.

Another method would be to focus on one country, but supplement that with examples of important differences in psychiatry elsewhere, as well as highlighting wherever there is worldwide consensus. The USA is in some ways a macrocosm of the microcosms of psychiatry around the world. Perhaps this is why the annual meeting of the American Psychiatric Association (APA) is the largest gathering of psychiatrists around the world, with large numbers of overseas psychiatrists attending, as is the APAs annual Psychiatric Services meeting, which attracts the largest number of multidisciplinary mental health care professionals.

In an unexpected way, perhaps, the USA is a laboratory of sorts for the problems of psychiatry around the world. For example, the USA has representations of many systems found in other countries, from the Canadian-style single-payer system reflected in US Medicare for those over 65, to the private practice seen in both Germany and the USA. The USA has inner-city poverty and rural outposts that can remind one of New Delhi and rural China. Given its multiculturalism and reception of periodic waves of refugees, the USA has experience with trying to achieve cultural competent care, surely a challenge in other countries such as South Africa. While the USA lacks the politically motivated hospitalizations seen in some communist countries, it grapples with how and when forced hospitalization should apply.

The psychiatrist and anthropologist, Arthur Kleinman (2012a), who has been a prominent participant-observer of psychiatry for many years, and the psychiatrist and philosopher, David Brendel (2006), both recently plead for a shift to a more humanistic biopsychosocial model in the USA. By no means are they alone. H. Steven Moffic (1997), who had led most of the mental health care systems in the USA and chaired many professional ethics committees, used the conceit of a fictional managed care company to present the new ethical challenges of managed care, where business ethics have changed and limited the provision of services. Allen Francis (2013), the former chair of the prior *Diagnostic and Statistical Manual (DSM)*, questions many of the changes in the new DSM-5, blaming much on a lack of transparency and the ethical conflict-of-interest ties to pharmaceutical companies of its main contributors.

Although the USA is the focus of these concerns, the challenges are global. Patel and Saxena (2014) argue that human rights abuse of the mentally ill is a global emergency. Richards (2013) poses five major global areas that need attention: global integration of mental health into general medical services; improving the supply of cheap and effective medications; establishing community-based care; improving access for children in particular; and improving the mental health component in the training of all health care personnel.

Given the impact of leadership in any field, the inevitable conclusion is that some of these problems stem from leadership in different parts of the system(s). The classic investigation of Stanton and Schwartz (2000) into mental hospitals made it clear that ineffective leadership causes harm to patients. As Becker and Kleinman (2013) point out, the extensive worldwide disability and suffering as a result of mental illness suggest the need for increased ethical leadership globally.

Unfortunately, as Johnson and Stern 2013 conclude, research and surveys on ethical leadership in psychiatry are virtually non-existent. Some cynics have informally wondered if ethical leadership might be an oxymoron. Given that leadership is not a required psychiatric professional educational requirement, either in basic or continuing education, it is necessary to extrapolate from what is known about leadership in general, what ethical leadership additionally means, the unique characteristics of the psychiatric field, the most accepted principles of ethical leadership for psychiatry, and models of leadership in both society and psychiatry, in order to understand what ethical leadership for psychiatry has been, can be, and should be.

### Leadership Models

The complexity, controversy, and diversity of leadership in general are well illustrated in the annual *Time* magazine Person of the Year selections. As Gibbs (2013a, p. 8), the managing editor, defines it, the Person of the Year is "the individual who, for better or worse, had the greatest impact on the news and our lives this year." Such a definition makes these people *de facto* leaders in one way or another.

Examining the ramifications of the top choices for 2013 may also resonate with leadership in psychiatry, as it likely would in any year, given that psychiatry always relates in some way to the greater society in which it is licensed. For example, the top choice for Person of the Year was Pope Francis. As Gibbs (2013b) portrays him, Pope Francis exhibits great empathy coupled with the ability to engage people, qualities not unlike those one would hope for in psychiatric caregivers. As the leader of the huge Catholic Church, he has the potential to become a transformational leader for a system that has experienced some stagnation and increasing criticism, especially in the case of a problem of great concern for psychiatry, the sexual abuse of children, in this instance by priests. One of his prominent moral concerns seems to be the status of the poor. In 2013, 50 years after President Kennedy's establishment of the Community Mental Health Act, designed to better serve the poor, his nephew and mental health care consumer, Patrick Kennedy (Kennedy, Greden, and Riba 2013), called for a revitalization of his

uncle's vision.

Conversely, as Scherer (2013) discusses, the runner-up, Edward Snowden, did not lead any formal organization, but following his release of confidential US governmental information, was the subject of international focus and following on the matter of whether he was a traitor or whistleblower. He was an employee who was suddenly thrust into informal leadership. Similarly, his decision and the responses to it, including the issue of the compromised privacy of all citizens, strike at the essence of psychiatric ethical concern for the confidentiality of patients, which is supposed only to be compromised when the clinician perceives danger to the patient or others.

As for third place, Gray (2013) discusses the less well-known leader of the gay rights movement. Edith Windsor has a history of being a leader at different times in her life, characterized by a combination of pugnacity, humor, tenacity, and extroversion. Certainly, as Drescher (Drescher and Merlino 2007) has discussed, the gay rights movement has struggled with the leadership of organized psychiatry. From the first DSM of 1952 up to the third edition of 1980, homosexuality was listed as a psychiatric disorder. As a compromise of sorts, the DSM retained the diagnostic category of Ego-Dystonic Homosexuality until it too was removed in 1987 in DSM-III-R. From the publication of DSM-5 in 2013, this APA leadership seems to be following a similarly controversial path regarding gender identity variations.

In Bashar Assad, ruler of Syria, Klein (2013) identifies a different kind of leader in a contrasting culture. Of note is that Assad was not thought by his family and others to have any kind of leadership potential, but was thrust into his position due to family deaths and illnesses. In fact, he may first have embraced medical ethics when he was a budding ophthalmologist, only to prefer the apparent Machiavellian political ethics of his family when he took power. In psychiatry, the turn of some psychiatric leaders to for-profit managed care that put business ethics first, as Moffic (1997) describes, was a shift that one APA president called "evil."

In fifth place was US Senator Ted Cruz. As Von Drehle (2013) indicates, he became a successful leader of the more conservative Republicans by dramatically challenging so-called ObamaCare in a prolonged and passionate speech. There seems little question that psychiatric leaders would hope that he would fail, given the inadequate insurance coverage of so many with mental disorders.

Following these extensive portraits were several briefer ones on the South African leader Nelson Mandela, who died just before the announcement of the award. All depicted a real-life leader in relation to the mythical heroic journeys described by Joseph Campbell (1949), depicting great redemption at the end of difficult trials and suffering. Despite what he had experienced, like the Old Testament Joseph, Mandela was able to forgive and achieve reconciliation, though not necessarily to forget or ignore justice. Fehr (Fehr and Gelfand 2012) has shown how a leader, modeling forgiveness rather than retribution or holding grudges, can help systems move on positively. In organizations with a culture of forgiveness, people are more likely to give extra effort, take risks, and have the capacity to admit and learn from inevitable mistakes. The potential therapeutic benefit of forgiveness is embedded in many aspects of psychiatry. The last step in recovery from posttraumatic stress disorders can be the forgiveness of who was responsible for the trauma.

### **The Characteristics of Leadership**

Despite the variety of the *Time* magazine selections, leadership can be simply defined as the functions of leaders. One of these functions is administration. Administration essentially consists of the establishment of the rules and structures of the organization. The goal is to do things right by providing direction and guidance. Leadership adds something more—an overarching vision of what it is right to do for the organization. Once that is clear, the leader tries to motivate others, when necessary, to fulfill that vision.

Though usually thought of as related to the highest organizational levels, leadership can exist at any level. In its broadest sense, leadership in society is ubiquitous, ranging from parents to patients, from role models to role mentors. One can be a leader in one sphere of one's life and not in another. Despite the implication of the term, leaders can sometimes lead from behind. Leadership can occur via a formal role or through informal influence.

The literature on leadership is ubiquitous. There are countless studies, books, and papers on the nature of leadership, especially in the larger and more long-lasting fields of politics, the military, and business. Most of the

more formal studies on leaders and teamwork appear in business publications. Exemplified by Shakespeare, literary fiction often explores the moral challenges and dilemmas of leadership in another way.

Although there may be other references or ideas, a relatively recent publication by van Vugt and Ahuja (2011) reviews many different explanatory theories of leadership in one source. Van Vugt conveniently identifies and discusses several major theories of leadership: the Great Man, trait theory, and psychological theories, as well as behavioral, charismatic, distributed, servant, transformational, and situational leadership. At different times, different theories have achieved prominence.

Going back in history, the Great Man theory was established by the philosopher Aristotle and others. From the historical evolutionary point of view, he was called the Great "Man" because of the early historical patriarchal dominance of men. Over the last century, in different times with different needs, leadership has increasingly expanded to include women. Newer brain research, such as that of the neuropsychiatrist Brizendine (2006), is helping to indicate the differences that could contribute to some women becoming different kinds of leaders. Though the brains of men and women are much more similar than different, the hormonal differences on the female brain may more likely lead to verbal agility and the establishment of deeper, less conflicted, relationships. Dovetailing this biology with a cultural analysis, Gilligan (1982) suggested that women tend to resolve ethical dilemmas based on an ethics of care in relationships, whereas men tend to do so more on principles of justice. Caring relationships, of course, are at the essence of health care. Focusing on the group teams under leaders, Woolley and Malone's (2011) study found that if a group includes more women, its collective intelligence rises.

The later trait theory was about having the "right stuff." Such leadership traits are now generally thought to be in part biologically based, but also molded by learned behavior. Long ago, Plato argued for philosopher kings to be leaders because of their wisdom. Later, common leadership traits were thought to include cognitive intelligence, ambition, authenticity, courage, flexibility, and usually some outgoingness. As Goleman (Goleman, Botyatzis, and McKee 2002) has researched and analyzed, the one trait that seems to rise above the others to predict not only who is to become a leader, but a great leader, is emotional intelligence (EI). It is characterized best by self-awareness, self-regulation, motivation, empathy, and social skills. Stoller (2013) posits that several components of EI seem to be especially important to health care: a service orientation, being collaborative and adaptable, being a change agent, having vision and initiative, and developing the potential, including EI, of others.

In the last century, with the emergence of the fields of psychiatry and psychology, other theories emerged, which can perhaps be called psychological theories of leadership. Freud's psychoanalytic theory posited the leader as the psychological father of the clan, something reflected in the people of South Africa calling Mandela the father of their country. This theory is an expansion of the psychoanalyst-analysand relationship. As such, followers unconsciously transfer childhood feelings related to their father to their leader. The leader should be aware not to take these transference displacements personally, as many of the best do naturally. However, countertransference should be considered personally, and is more difficult to recognize, as that relates to the leader's own childhood feelings being displaced onto followers.

A more modern extension of Freud's theories is by Kernberg (1998). He concludes that a "slight" degree of paranoia is healthy for a leader, especially to ward off attacks of envy by foes and friends alike. Kernberg also warns the leader how easy it is for groups and populations to regress under destabilizing conditions such as rumored change, too many new projects, and financial stress.

Another relevant later theory is Kohut's (1977) understanding of the self-psychology of narcissism. 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, as Ludwig and Longennecker (1993) describe in King David's pursuit of Bathsheba. 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 idealize the leader less and not provide as much mirroring praise.

Too much narcissism can lead to other leadership problems. For example, a mild degree of excessive narcissism is likely to cause a leader to have difficulties cooperating with other leaders, as well as contributing to difficulties in the transfer of power to a successor. More malignant narcissism, either as a situational trait or more chronic

personality characteristic, leaves the leader more susceptible to self-esteem injuries and/or narcissistic rage when the need to be idolized or mirrored is not being met adequately. At its worst, the malignant narcissism of a beloved leader, if coupled with the regressive tendencies of an unstable organization or country, leads to the scapegoating of outsiders. Thankfully fairly rare, this combination is ultimately likely to cause the leader and the organization to fail, but in the wake of much destruction. One would think that by dint of their knowledge of narcissism, psychiatric leaders would be less susceptible to its potential harm, but there is no evidence of that.

Besides narcissistic pathology, can mental illness help or hinder leadership? Ghaemi (2011) makes the case that some mild degree of bipolar disorder, especially in times of crisis, can be helpful for leadership.

Behavioral leadership theory reflects another psychiatric perspective. It posits that leadership could be taught to some extent, as a series of skills subject to positive and negative reinforcement.

Charismatic leadership theory is based mainly on inspirational oratorical skills. This can be used to influence populations with vastly different value systems, from the World War II Germany of Hitler to the Great Britain of Churchill. Charisma, at times, can also be conveyed in writing—"the pen is mightier than the sword"—and occasionally through the nonverbal media of music and art. Certainly, the great historical religious tomes have had a lasting inspirational impact. Some aspects of charisma can be taught behaviorally, such as improving oratorical and media skills.

A more modern leadership theory is that of distributed leadership, where leadership is more spread around. Taking that further is servant leadership theory, where the leader puts stewardship of their human resources first, and leaders take their role with acknowledgement and acceptance of the potential risks to themselves in serving the group. Martin Luther King, Jr. might be a prime example of that, predicting, as he did, that he was likely to die as a consequence of leading the civil rights movement. Robert Jay Lifton (2011), who, among other research projects on humanity's potential for destruction through the psychological mechanism of "doubling," knowingly confronted the horror of being a Jewish psychiatrist trying to interview objectively the Nazi doctors who killed so many of his people, then was later willingly jailed for protesting the Vietnam war. Indeed, clergy and psychiatrists are commonly expected to put service to their congregants first.

On occasion, there seems to be a visionary leader who inspires and elevates their followers for the better. Called transformational leadership, it is usually practiced by the kind of leader most people imagine to be ideal, such as Gandhi.

Certainly, leaders in psychiatry will reflect the characteristics, opportunities and, of course, the ethical values of their field. Situational leadership theory is a socially based one. It concludes that the type of leadership varies according to situational demands. The stern and structured military leader differs from the consensus-building diplomat. Individuals in the group led will also vary in competence and commitment. Different leadership may be required in the calmness of everyday life versus the crisis of a disaster.

However, in any given situation, the particular individual who will successfully lead can vary enormously and is to some extent unpredictable. The common key seems to be to be true to yourself. This is most readily seen in sports, with its many spectators and extensive journalistic coverage. We will take American basketball coaches as an example, though similar contrasts are also likely to be found in soccer coaches around the world. At least as far as winning goes, there are such very different successful basketball coaches, ranging from the volatile, aggressive Indiana University coach Bobby Knight to the Chicago Bulls "Zen master" Phil Jackson on the other. Jackson (2013) has written extensively on his methods, including giving different books to different players, players who were mainly action-oriented. Jackson hoped to improve teamwork, and did. For example, he gave Michael Jordan *Song of Solomon*, Toni Morrison's novel about the coming-of-age of a Black American male grappling with how to integrate his uniqueness with those around him.

Perhaps the final leadership theory worth mentioning beyond those covered by van Vugt and Ahuja's book is change theory: the theory that leaders in many fields, including health care, need to be able to adapt to a more quickly changing world. As Bryant (2014) points out, leaders and administrators need to be nimble: establishing simple plans that can be changed quickly, making rules that fit the plan, demonstrating respect for all in the organization, and giving priority to teamwork and more face-to-face communication.



## Ethical Leadership

Just as theories of leadership change over time, so does ethical thought. The moral philosopher Slote (2009) recommends the integration of a philosophical and a psychological understanding of morality. Instead of distinct principles such as the Golden Rule, the greatest good, or virtue ethics, he posits a psychological spectrum for moral theory, which he sees as consisting of a continuum from separateness to connectedness, a kind of Gilligan's care ethics.

There are distinctions, however, that are useful in distinguishing between morality, ethics, and the law. Whereas morality usually refers to an individual's personal values, ethics refer to that of a profession. Kleinman (2012b) suggests an especially close connection between morality and ethics in medicine, with caregiving for patients as a moral experience being the essence of medicine. For leaders especially, this ethic of caregiving and stewardship can extend to the environment, taking into consideration climate instability for example, and other social areas relevant to human health.

When more than one value system is crucial to a leader's tasks, prioritization can be difficult. A leader may at times have to struggle with the conflict between personal morality and professional ethics. If your personal morality is that people are more important than rules, then you might distribute free samples of medication to needy patients outside the clinic that obtained them and is legally bound to use them. At the other end of the ethical spectrum there may be a choice between following the law, which to some extent is codified ethics, and our broader professional ethics. At the very least, when the law inhibits clinical care, resulting, for example, in having only one day to evaluate risk in an acutely dangerous patient, the system leader should advocate for a change in the law.

Given the potentially agonizing ethical choices facing leaders, it is crucial for leaders to be able to manage themselves, especially in the clarification of values, as the business guru Drucker (1999) discusses in his classic book on leadership. To complement that, it often helps to have trusted and trustworthy advisers. Whether that is mentors, spouses, friends, or colleagues outside the organization, such people can not only provide useful information, but also tell the leader when they may be doing something wrong or dangerous, or will be perceived to be doing so. Perception may be as important as reality and, as Trevino, Hartman, and Brown (2000) point out, depends on the two pillars of the leaders: visibility as a moral person and moral manager.

Leaders in many organizations are accountable to a board of directors. Some degree of transparency on both sides can prevent unexpected problems.

## Psychiatric Leadership

It is axiomatic that psychiatric leadership consists of the various layers of leadership necessary to lead to the completion of the tasks of psychiatry. Psychiatry in this sense consists not only of the profession of psychiatry, but also all the disciplines and healers working to improve mental health, as well as the consumers of services. The typical common denominator in all these aspects of psychiatry is the care of patients who have a diagnosable mental disorder, or, more broadly, the study, diagnosis, treatment, and even prevention of mental disorders. What is considered to be a mental disorder does change over time and across cultures. Moreover, as Sharfstein and Dickerson (2006) have warned, there are some consumer groups that dispute these conceptions of mental differences, sometimes to the extent of feeling oppressed or harmed by mainstream psychiatry.

Ultimately, the government of each country provides psychiatric leadership in the sense that it establishes and, if necessary, funds psychiatric services. The cultural values and social conditions of each country will influence these decisions. Just as McDonald's has spread around the world, in some ways, as Watters (2010) reported, so has USA psychiatry, especially in terms of diagnostic categories, psychopharmacology, and how post-traumatic stress disorder is conceived. Alternatively, there is much that psychiatric leadership in other countries can teach the USA, as presented by Eaton (2012). One example, as Goldstein and Godeman (2003) have reviewed, is how governmental and citizen leadership can successfully integrate the more seriously mentally ill into their communities, such as in the example of Geel, Belgium. The Hippocratic ethical ideal "to do no harm" applies to Calton and Spandler's (2009) call for psychiatric leadership in the United Kingdom to take into greater consideration the minimal or no-medication approach to schizophrenia used in other countries such as Finland, which, when successful, eliminates the long-term side-effect risks of antipsychotic medications.

What has been missing until recently is some literature that aims to begin to tie together the aspects of leadership in psychiatry. The first book to do so has recently come out under the editorship of Bhugra, Ruiz, and Gupta (2013), and it is written from an international perspective. Although this volume is not explicitly about “ethical” leadership in psychiatry per se, some ethical considerations are embedded more implicitly.

### **Ethical Principles for Psychiatric Leadership**

Ethical principles for clinicians treating patients have long been available and are updated periodically. For example, in the USA, the APA adapted the ethical principles of the American Medical Association (AMA) and added annotations for psychiatrists. There are mainly overlaps, but also some differences, in the ethical principles of other mental health care disciplines. Nevertheless, as Rosen and Callaly (2005) point out, all seem to agree that practitioners are accountable for those skills for which they are recognized to be competent from their training.

Business ethics, on the other hand, as Moffic (1997) illustrates in relation to managed care businesses, often emphasizes providing services to society that also produce financial well-being for the business. For the consumers of mental health care business services, the closest to a commonly accepted ethic is the motto “nothing about us without us.” As the book of that title by Charlton (2000) advocates, mental health care consumers are part of the worldwide disability rights movement, but are the most discriminated against and the most isolated. All vested interests have in common the desire to decrease stigma.

The World Psychiatric Association (WPA) has tried to develop ethical principles that can be accepted worldwide. These developed originally, and primarily, as a response to the perceived abuse of psychiatry in the former Soviet Union in the 1970s, where political directives skewed the determination and diagnosis of who was a patient. A major challenge, as Okasha, Arboledga, and Santorius (2000) indicate, is that ethics in psychiatry around the world has to be able to incorporate values ranging from the Islamic influence on Arab culture to the intersubjectivity characteristic of Japan. The essential WPA attempt at a universal psychiatric ethical principle seems to be: “Ethical practice is based on the psychiatrist’s individual sense of responsibility to the patient and his or her judgment in determining what is correct and appropriate conduct.”

However, even this principle can fall short in actual practice, as the WPA ethical principles go on: “External standards and influences such as professional codes of conduct, the study of ethics, or the rule of law by themselves will not guarantee the ethical practice of medicine.”

What, then, do clinicians and organizations need to be able to conduct themselves in an ethical way? For one thing, they need psychiatric leaders who will doggedly, courageously, and persistently fight for the resources necessary for competent care. However, until recently there were no formal ethical principles to guide psychiatric leaders and administrators in organizations on this sort of quest.

A unique capitalist business development was to end up stimulating a new set of ethical principles geared to ethical psychiatric leadership and administration. This was managed care. In the USA, private health insurance evolved as a fringe benefit of the workplace, as an alternative to raising salaries. At one time, health maintenance organizations (HMOs) evolved as an alternative way to provide health care, including preventive care, to defined populations. This concept was criticized as being too socialistic until President Nixon sponsored a law paving the way for the evolution of HMOs into managed care business organizations and corporations (MCOs) which would control costs for businesses, and later governments, by reducing care that was deemed not to be medically necessary. In psychiatry, that was deemed to be too-long hospitalizations and psychotherapy. Now MCOs are further evolving into the accountable health organizations (ACOs), which promise increased health and mental health coverage for those previously uninsured, albeit still largely under the management insurance companies. Though Moffic (2000) reported that no less a moral authority than Archbishop Desmond Tutu thought that managed care could be exported to poorer countries, this system never caught on elsewhere.

As for-profit managed behavioral health care escalated in the USA in the 1990s, Moffic (1997) depicted a very significant ethical conflict of interest emerging for psychiatric leaders of managed care. Such leaders had to decide how much to prioritize the financial needs of the organization, serving business ethics, versus the needs of the individual patients, which would serve medical ethics—let alone how to account for their own and the staff’s personal needs and ambitions. On what ethical basis could they do so?

One professional group, the American Association of Psychiatric Administrators (AAPA) tried to provide the answer to that question. The AAPA felt that a new set of Ethical Principles for Psychiatric Administrators was needed to guide such decisions. For a template, as presented by Saeed and Moffic (2004) and elaborated by Moffic (2004), it too used the AMA's Principles of Medical Ethics (as of the year 2000), but added Annotations Especially Applicable to Psychiatric Administrators. Perhaps this unique set of ethical principles geared to organizations, found nowhere else in the world will be the lasting global legacy of the uniqueness of managed care in the USA.

As in the AMA's ethical principles for clinicians, the key statement is in the Preamble. Compare the one for the clinician and the one for the administrator in the new AAPA principles. For the clinician, the AMA 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." Clearly, here, the patient comes first and foremost. The principles go on to state that the ethical expectation is for "competent" care. The clinical ideal, though not ethically required and not consistently obtainable, would be recovery.

For psychiatric administrators, these priorities are less distinct in the AAPA principles, 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 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 those principles, resignation would be an ethical option.

"Patients" in this organizational-based ethics refers to patients in the broadest sense of the term. Though most often patients are those served in clinical organizations, there are also would-be patients (the public), former patients, consumer advocates, and peer workers. Sometimes, patients are also called service users, survivors, members, or customers, among other designations. Ethically speaking, what term to use depends on the situation and personal preferences of the named. Ask!

The range of administrative ethical needs can be seen along a spectrum, akin to Slote's (2009) psychological spectrum of moral theory previously discussed. Bookended by the caregiver in solo practice and the leader of the large organization, varying degrees of ethical complexity will occur along the way. For example, as Moffic (2013) discusses, ethical decisions can range from the naming of a practice to selecting electronic medical record systems.

What makes the balancing of what can be a metaphorical seesaw of needs so ethically difficult at times, as Pearson, Sabin, and Emanuel (2003), Daniels and Sabin (2008), and Sabin and Daniels (2009) have all discussed, is, first of all, that the patients can't be served without the viability of the organization, large or small. However, fortunately, at times, there will be other alternative organizations for patient care, if need be. More difficult may be finding and keeping skilled clinicians, so much so that an ethical argument could be made that the needs of the staff, at least insofar as their skills and abilities go, should be the highest ethical priority of all.

If so, how should the psychiatric leader support those in the organization? Could it perhaps really be through a compassionate kind of love, sometimes called agape? Building on prior research on caring organizations by Green, Miller, and Aarons (2011), Barsade and O'Neill (2014) found that employees in a long-term health care facility, usually a stressful place to work, who felt that they worked in a "culture of compassionate love," had less absenteeism, better teamwork, more job satisfaction, and lower levels of burnout. Correspondingly, the facility's patients and their families were more satisfied with the care.

This kind of workplace compassion has to be modeled by leadership and, using emotional intelligence, expressed verbally and non-verbally through some degree of non-sexual affection, tenderness, and caring for one another. Some of the many mechanisms for establishing this "culture of compassionate love" are periodic staff parties, on-site times and places informally to decompress, the infusion of humor and laughter at inevitable mistakes, encouraging creative new ideas, and the support of important continuing education for advancement. Supplement this compassionate love with the "tough love" of appropriate rules and expectations, along with continuing



education, and you have a staff and organization that is more likely to reach its potential.

Almost 100 years ago, as Paul (1991) discussed in detail, Francis Peabody's famous statement (in a lecture) that suited that age of solo practice, was "the secret of care of the patient is in caring for the patient." That could be translated as a kind of compassionate, not passionate, love of the patient. Should that be updated in today's age of ever larger and more complex medical organizations to "the secret of the care of the patient is in caring for the caregivers"? If so, any new patient-care model should also include a clinician-care component.

### **Common Characteristics of Psychiatric Leaders**

Although there do not seem to be any studies that would either narrow or expand the expected traits of leaders in general to psychiatric leaders in particular, extrapolations perhaps can be made based on the nature of mental health care.

Psychiatry is a field that has always been surrounded by stigma. The stigma negatively affects the public, the patients, and the professionals. As a consequence, as Burns (2006) concludes, controversy has always surrounded psychiatry. That can range from doubts about its effectiveness, to anti-psychiatry groups, which, in their extreme, want to do away with psychiatrists and psychiatry. Therefore, the leader has to be able to bear criticism and the lack of admiration that most health care professionals receive. A strong sense of realistic self-worth may be essential.

Psychiatry is filled with ambiguity. Regarding treatment, although there are so-called evidence-based guidelines, they are numerous and can be inconsistent. Nevertheless, as Friedman et al. (2013) point out from a Rand study, leadership that supports quality improvement projects will increase clinician satisfaction. Given that, a leader in psychiatry needs to be comfortable with uncertainty, to be open-minded, and to embrace complexity. At times, ethics committees may be of practical value in resolving such ambiguities. Though consultants are sometimes hired, they have no clear authority to get things done.

Psychiatric care requires privacy. The paradoxical coupling of stigma with the importance of sharing private information makes confidentiality all the more ethically important. Therefore leaders and administrators need to be trustworthy and vigilant.

Psychiatry is multidisciplinary. Some of what the various mental health care disciplines do overlaps, such as providing psychotherapy, but much is unique, such as psychological testing by psychologists alone. In poorer areas, there are also paraprofessionals, who often come from the cultural backgrounds of those served. Therefore, to obtain potentially the best overall staff, embracing collaboration and respecting what each "discipline" can contribute is the most likely ethical way to a cost-effective system.

Psychiatry is emotionally draining. In order to be empathetic and understanding, we have to be able to hold the anguish of patients within ourselves and listen to the most troubling secrets. To do that year after year, establishing ways to replenish at work, after work, and with adequate time off is an essential administrative task for psychiatric leaders.

Many leaders and administrators will comment informally that taking care of staff problems is more difficult than treating patients. Leaders who feel this way have to be careful not to wildly psychoanalyze staff problems, or use their knowledge and power in an intrusive or vindictive manner.

### **Discipline Choices for Psychiatric Leadership**

In the early history of psychiatry, psychiatrists were indisputably the expected leaders and administrators because care was hospital-based and, in those times, always medically led. However, deinstitutionalization in the 1960s and 1970s required other disciplines to increase in numbers and eventually move into leadership and administration, as portrayed by Moffic and Adams (1982). Even more recently, as mental health care clearly became more business-like, more business knowledge and skills were needed. Consequently, business-trained professionals took more administrative positions unless clinicians were able to learn new business skills. As Rosencheck and Ranz (2012) have noted, the result is that psychiatrists in administrative positions have been decreasing over the last 50 years.

In regard to these disciplinary issues, Fulford, Stanghelline, and Broome (2004) pose the question of what philosophy can do for psychiatry. Not only are there differences in discipline training, but different disciplines work with very different implicit models, often contributing to difficulties in teamwork. Fulford's answer is that a philosophical approach can provide the "clear thinking" necessary to understand these complex situations.

Besides professionals and paraprofessionals, there has been the more recent emergence of patient peer involvement in mental health care. These are patients who are stable enough to provide unique education and support to other patients in a clinical system, as well as to act as a bridge to the professional staff. In certain large systems, some have taken on such leadership and administrative roles as Vice-President of Consumer and Family Affairs for a large managed care company. At times, such peers may disagree with professionals about the care of a patient, something that will need to be resolved by the psychiatric leader. Even more difficult are the dual needs of an organization that has peer staff who are also patients there, which is most likely to occur in rural areas with limited options. In those situations the psychiatric leader has to balance the needs of the patient peer carefully with the overall needs of the organization. Some of those problems can be avoided with careful consideration and explicit clarification of expectation before hiring.

All the variables considered, where does that leave us in mental health care? Does the discipline background not matter? Do we just rely on who has the most desired personality traits and enough knowledge to fit the setting?

For large organizations, given the variety of mental health disciplines needed and the variety of patient problems, a leader with the broadest education, including continuing education, should be preferable, all other things being equal. As Robinowitz (2006) argues, a strong case can then be made for psychiatrists, who combine medical, psychological, sociocultural and, in some instances, even some economic education, over at least eight years of basic medical school and residency education. Being physicians, psychiatrists are also exposed to leadership in medical school and residency. As Johnson and Stern (2013) point out, those who choose psychiatry often have relatively high EI. Leaders, by leading, learn to lead groups of people, and psychiatrists learn about group dynamics.

Whereas their background might justify psychiatrists being the preferred leaders, at least for higher positions, that may not outweigh the desired personal characteristics and needs of any given system. Moreover, from the business standpoint, psychiatrists usually expect the highest salary range—perhaps worth it, yet a potential drain on limited funds.

In addition, some of the basic educational benefits for psychiatrists can also be offset with continuing education for other disciplines. One form of that learning is from good mentors who are successful in their own right. Another, as Green, Miller, and Aarons (2011) discuss, is leadership training that can include didactics on leadership styles, 360-degree feedback from others in a given organization or training experience, and individual coaching. Needless to say, perhaps, any given aspiring leader and administrator can—and should—keep up on the relevant literature.

### **Choosing Ethical Leaders**

Given all the important leadership variables, choosing the right ethical leadership can be quite a challenge. A track record can help when available.

The tried and, sometimes, true process is to use word of mouth, familiarity, and on-site interviews. In business, besides often using recruiters, more subjective decision-making is usually supplemented by use of personality tests like the Myers-Briggs, psychometric questionnaires such as the Activity Vector Analysis, and Goleman's Emotional and Social Competence Assessment tool, among other tools analyzed by Kaplan and Saccuzzo (2009). Perhaps because the field of psychiatry has presumed expertise in understanding people, albeit mainly those with mental health problems, it has ignored these other tools. Without such tools, it may be more likely to choose the wrong leader, one chosen by the Peter Principle or because the candidate may be a leader in an area, such as bench research, that doesn't translate well to leading a clinical organization. More humility is needed.

### **Special Skills for Special Systems**

Harking back to situational leadership theory, leaders and administrators need to be a good fit for whatever system they lead. Occasionally, a system will be a “best fit” for a particular discipline; for example, a system that needs social and community assessments and interventions may best fit psychiatric social workers.

Managed care, as previously discussed in terms of its role in precipitating new ethical administrative guidelines, requires a unique kind of organization. As Moffic’s (1997) experience suggests, some ways to keep an ethical balance of business and health care ethics are for the leader to refuse bonuses based on profits, to see patients in the system and have that reimbursement count as part of their salary, and to recommend alternative services that would be adequate if treatment authorization is denied.

The term “thought leaders” in psychiatry often refers to individual psychiatrists determined by the pharmaceutical companies to be influential psychopharmacologists. Some were recruited and accepted the well-paid expectation to help sell a company’s product to colleagues through being on a speakers’ circuit. As Epstein et al. (2013) and others have noted, there is little question that these and other marketing tools do influence prescribing patterns, even if—as they often do—the individual practitioners deny that they can be so influenced (not surprisingly given the clinicians’ desire to feel that they are making good objective choices for treatment). Those psychiatrists so employed often have to face actual or potential conflicts of interest: promoting products whose effectiveness they may have doubted; delivering talks based on a company “script”; or feeling reluctant to disclose the nature of their financial relationship with the pharmaceutical company.

Then there is the unique system of academic departments of psychiatry, psychology, social work, and nursing. In some, research is a prominent ideal, with its ethical challenge to “publish or perish.” The leaders and administrators of such departments face the challenges of balancing and developing the three traditional priorities of education, research, and clinical care. Moreover, clinical care can be used for education and research. How they ensure that untrained students serve patients well and do not cause unnecessary harm while they are learning, and that research has appropriate informed consent, are complementary ethical challenges involving patients whose primary priority is competent care. There is one more challenge because of the greatly diminished outside funding of such education: nowadays, most departments in the USA have to be more financially self-sufficient and so economics becomes a fourth priority to balance on the academic seesaw.

A new attempt at integrating mental health care into medicine requires certain leadership characteristics. Such a psychiatric leader needs to be able to understand the culture of medicine; have a reasonably good fund of medical knowledge; respect that patients may be more comfortable seeking psychiatric care in general medicine settings; gracefully accept that primary care doctors are currently paid more than psychiatrists for the same treatment; and find ways to overcome the reimbursement problems that impaired such previous efforts, as described by Moffic (1979). If that can be accomplished, as Sederer (2014) indicates has begun to happen in New York State, the potential ethical benefits for patient care are immense. Most psychiatric medications are prescribed by general physicians, but often not well. Medical problems in psychiatric patients are common and, alas, frequently ignored, contributing to a significantly lower lifespan, at least in the USA. A more subtle benefit of integrated medicine is that having mental health professionals may benefit the mental wellness of all staff by establishing strategies to prevent burnout.

Some systems take care of significant numbers of ethnic minority patients. Culturally competent care is required clinically yet, as Santiago and Miranda (2014) conclude, the care of many ethnic and racial groups still falls short in the USA, and there are too few clinical leaders from minority backgrounds.

Besides racism, in some countries ageism is a barrier to competent care. As Agronin (2010) describes, there is now the paradox of knowing how to address humanely and therapeutically the special psychiatric needs of the elderly, but with increasingly inadequate resources to do so.

One unique subspecialty of psychiatry developed its own ethics guidelines: the American Academy of Psychiatry and the Law (AAPL) Ethics Guidelines for the Practice of Forensic Psychiatry. As Miller (2008) has reviewed, Alan Stone, Paul Appelbaum, and Ezra Griffith, the leaders of forensic psychiatry, have debated the ethics of the field for over 30 years. Ethical guidelines are clearest for psychiatrists working in correctional facilities, where the primary value is security. Psychiatrists, and other mental health caregivers must adapt to this priority while adhering as best as possible to the ethical principles incumbent on all clinical physicians. More problematic, as Stone emphasized in his 1982 presidential address to the AAPL, is lucrative courtroom testimony as an expert witness. Stone

emphasized the temptations, conscious and unconscious, of over-identification with the side that hires the forensic psychiatrists, leading Stone himself to decline testifying in court. Later, another president of the organization, Paul Appelbaum, declared that forensic psychiatry must have a different ethic than clinical psychiatry, one based on truth rather than beneficence. Later still, in 1997, in his own presidential address, Ezra Griffith emphasized the need to recognize the non-dominant status of an accused person from a minority group. Griffith (2005) then recommended using a cultural formulation to counter “an institution plagued by racism.”

There are also psychiatric services without the involvement of professionals. Clay (2005) describes some of the successful ones. These include drop-in centers, educational programs, peer support mentoring programs, and member-based clubhouses for socializing and job training.

### Measuring Leadership Success

Given that the ramifications of psychiatric leadership can be so significant, how do we know if it is successful or not? Certainly, leaders, including psychiatric leaders, can keep their position due more to power and connections than outcomes. Moreover, the very complexity of leadership in bigger systems would seem to defy analyzing the outcomes of that leadership. After all, the outcomes of a solo practitioner are hard enough to assess. Nevertheless, as Moffic (2012) recommends, there may be areas to focus on that can provide some useful information. They can include:

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. Employee well-being and turnover.
4. Leadership well-being and turnover.
5. Organizational development.
6. Relationships to other leaders and organizations.
7. Resolving conflicts between the areas above.
8. Influencing or advancing the field of psychiatry.

### Models of Psychiatric Leaders

As more psychiatric memoirs and autobiographies emerge among the growing popularity of memoirs in general, models of psychiatric leadership can be studied by everyone. As suggested by Lumsden (2013), the following vignettes tease out the leadership themes of the individual with reference to the autobiographical books that complete the picture of the person.

The first is Mel Sabshin's (2008), which is both an autobiography and a history of psychiatry in the latter half of the twenty-first century. During that period, following a time of conflict between biological and psychoanalytic psychiatrists, and the stagnation of the APA, Sabshin arguably became the most consequential leader in psychiatry, a clear example of a transformational leader. By leading the profession to focus more on a genuine scientific base, he fulfilled the AAPA ethical principle in Section 5: “A physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues, and the public.” Not only did he accomplish that in the USA, but referring back to the ethical principles of the WPA, Sabshin was also one of the leaders of the successful world psychiatric confrontation of the abuse and anti-semitism in the psychiatry of the former Soviet Union. That action exemplified Section 2, Annotation 4 of the AAPA ethical principles: “Whenever incompetent or inappropriate behavior on the part of the clinician or other administrators comes to the attention of administrators, the administrator must intervene.”

Some of Sabshin's personal characteristics reflect the trait theory of leadership: compassionate leadership, including high cognitive intelligence; the emotional intelligence to attract many successful mentees and staff; a brilliant strategizing; wonderful wit, warmth, kindheartedness, grace, and elegance.

As much as Sabshin contributed to world psychiatry, if there is an individual who could rightly be deemed the world's psychiatrist, it would be the award-winning Vamik Volkan (2013). As a participant-observer of conflicts

around the world, once traveling with USA President Carter, his goal was to develop a psychological “vaccine” to prevent such large-scale violence as terrorism and trauma. One of his colleagues, Peter Olsson, illustrated the essence of this complicated challenge in a poem, titled “Vamik’s Legacy,” which we have permission to reprint here:

Waving through the slalom course called world peace  
He has contributed the Tree Model to use as a guide.  
Allies and enemies can yield to the curiosity of neutral inquiry.  
Wisdom, humor and creative ways of learning to listen well,  
cooling “hot spots” of large group rage and shared traumas.  
Never forgetting applications of a people’s history to illumine,  
And thwart potential transgenerational enmity’s transmission.  
Volkan’s quiet work defines the essence of generativity.

Although there is growing criticism that psychiatry has become too biological, and that psychiatric medications may have more long-term side effects than realized, Karl Rickels (2011) became a pioneer in psychopharmacology when it was an advance on lobotomies, insulin shock, and ECT, let alone interminable psychoanalysis. In his heroic quest, he went from being a fervent anti-Nazi drafted into the German army to being an American POW, then returning to America to begin his psychiatric career.

Another psychiatrist, Barry Blackwell (2012), wrote a memoir which covered some other important leadership endeavors, including discovering dangerous and unexpected medication “side effects” that contravened the Hippocratic Oath to strive to “do no harm.” He worked with the homeless, managed care, and was in a marital partnership with a nurse who had leadership experience and skills of her own. After publishing this memoir, he wrote a poem to convey the possible personal moral challenge and cost of being an ethical psychiatric clinician and leader. An excerpt is:

What soothes an aching void?  
Kids compensate, choose who to be;  
social workers, nurses, doctors,  
care providers for a world of want.  
Tendering kindness for kindred souls,  
solace for unmet needs;  
“Mother Love” by other names.

Late in life some burn out,  
giving what they went without;  
wounded, healing others, not themselves.

A psychiatrist who exemplifies situational leader theory is Matthew Dumont. Dumont (1994) wrote about his work in Chelsea, Massachusetts, a community characterized by high population density, racism, poverty, substance abuse, and environmental hazards. After other psychiatrists had quickly come and gone, he arrived in 1975 and stayed for 17 years at the Chelsea Community Counseling Center, working with those in most need, until it was downsized and privatized. In this, he fulfilled the close of the ethical principle in the AAPA Preamble, Annotation 1: “If and when the psychiatric administrator can no longer follow those principles, then resignation would be an ethical option.” Dumont was a national model for community psychiatrists on how to build relationships with patients who were usually thought of as unreachable. He also was one of the rare psychiatrists who could fulfill the ethical leadership principle of educating the public, writing a successful column for *Mother Jones* magazine under a pseudonym.

T. Terry Brazelton (2013) combined the unusual dual medical specialties of pediatrics and child psychiatry. What he did with the knowledge of these two specialties, combined with personal psychotherapy, was to successfully and popularly communicate with the public on how to raise psychologically healthy children.

An even more diverse career of ethical psychiatric leadership is that of Norman Rosenthal (2013). After growing up in South Africa in the 1950s, he went on to a career of addressing adversity of all kinds, from climate to trauma, pursuing research into seasonal affective disorder, St. John’s Wort, and PTSD, concluding that the key is to find



something of value in the experience.

More women are emerging as leaders in psychiatry. An early example is Beulah Parker (1987), who wrote of the life experience of a troubled girl from a troubled family becoming a well-known psychoanalyst. More recently, Norris, Jayaram, and Primm (2012) have edited a book of personal perspectives, including those of a wide variety of women leaders in psychiatry.

A psychologist who has become an inspirational model for recovery is Kay Jamison (1995), whose memoir describes her personal and professional experience with severe bipolar disorder. She is a leading example of what some call a prosumer: both a professional and a patient in psychiatry.

Another prosumer is Elyn Saks (2007), who received a MacArthur's "genius grant" in 2009 after writing her courageous memoir of being a law professor struggling with schizophrenia. She expressed gratitude for both the right medication and psychoanalysis, both of which helped her, but is working on the ethical issues surrounding informed consent for psychiatric research and forced treatment.

It is rare for anyone to win a Supreme Court case. The patient activist Stephen Donaldson (1976) did so, and explains in his memoir how he did so. With the help of two lawyers, and after 15 years in the hospital against his will, Donaldson won a landmark decision, *O'Connor v. Donaldson*, 422 U.S. 563, against non-dangerous forced hospitalization. Today, whether the pendulum has swung too far, or not far enough, regarding involuntary treatment, is a matter of great and important ethical debate and decision.

If it isn't already clear that patients who "come out" in the role of consumer advocates will lend an increasingly important ethical leadership role in psychiatry, even to the extent of causing a cultural shift in the field, read Lauren Spiro's (2014) memoir. Whereas an inflexible anti-psychiatry attitude is unlikely to go far in advancing psychiatry, her more thoughtful approach as reflected in this memoir, along with Spiro's leadership work as Director of the National Coalition for Mental Health Recovery, has the capacity to improve our systems at every level. In a most humanistic account of her own heroic journey, and heroic journeys by women are less commonly reported, Lauren Spiro gifts us with a book of prose, poetry, poetry on paintings, and even a touch of mystery with a happy ending.

A portrait of a budding ethical leader in psychiatry is provided by Christine Montross (2013). In an Oliver Sacks sort of way, but substituting difficult and unusual psychiatric cases for neurology cases, Montross movingly uses her background of poetry and literature to convey the ethical dilemmas she faced. Each case is followed by personal reflections from her own day-to-day life, so the reader gets to know her as a person as well as a psychiatrist. That she seems to be heading toward ethical leadership for psychiatry is reflected not only in her writings, but also in her current positions as chief ombudsperson for student wellness and co-director of the medical humanities and bioethics concentration at Brown University.

Of course, there are controversial leaders in psychiatry such as R.D. Laing, the British psychiatrist who exemplified the leadership trait of empathy with the most disturbed patients. However, in the 1960s, perhaps brimming with overconfidence, he established a residential community in which there were experiments with LSD as part of his philosophy that insanity could be a sane response to an insane world. He was a charismatic speaker and writer, exemplifying charismatic leadership theory. Before he died, he took the most impressive, and unusual step of admitting that he had concluded that his treatments were ineffective and thereby not to be followed (Laing 2001), meeting the AAPA principle of Section 2: "A physician shall deal honestly with patients and colleagues."

Although the courageous confrontation between Robert Jay Lifton (2011) and the Nazi doctors was difficult enough, Viktor Frankl faced even worse. When a psychiatric leader despairs at obstacles to ethical leadership, his (2006) continually bestselling Holocaust memoir may be helpful and restorative. It shows not only how he kept himself from despair, but also how he creatively and effectively applied his skills as a psychiatrist to help his fellow concentration camp inmates find meaning in their lives, even in such dire conditions. A later, more general memoir by Viktor Frankl (2000) expanded on his earlier life and career after the concentration camp, including a return to the location of the belly of the Holocaust beast in Vienna, where he developed his ethical treatment advance of logotherapy. He spent the last 20 years of his life in America. Moreover, his brief 1972 TED video at [http://www.ted.com/talks/viktor\\_frankl\\_youth\\_in\\_search\\_of\\_meaning](http://www.ted.com/talks/viktor_frankl_youth_in_search_of_meaning) demonstrates so many characteristics of a great and ethical psychiatric leader: emotional intelligence, charismatic oratorical skills, rising to the occasion of the situation, service to others at risk to oneself, and using this experience to develop a new treatment.

These psychiatric portraits mirror in many ways, including an ethical outlier, the portraits in the 2013 *Time* Person of the Year selections. That correspondence should not be too surprising, given the common basics of effective leadership anywhere. In addition, despite the wide variety of careers of these portrayed psychiatric leaders, what emerges in most is a deep humanism, a kind of humanism that Kleinman and Brendel have found so distressingly uncommon in psychiatry nowadays.

### Conclusions

My goal is to become a global leader, because I believe we can change communities and impact the world in a positive way.

(Herold 2014, p. 107)

Our quest must consist, not in talk and meditation, but in right action and in right conduct.

(Frankl 2006, p. 77)

Leadership in psychiatry is ubiquitous, from solo practice to leading large organizations. Though the complexity of ethical leadership in psychiatry almost defies scientific study, we do know a lot about the variables that are most likely to produce ethical leadership in psychiatry. We do have ethical principles for psychiatric administrators, which all leaders should know, review periodically, and help revise as needs be. Decision-making in ethical leadership is rarely a clear-cut black or white, right or wrong. More often, it takes place in the ambiguity between ethical ideals and societal inequities. With all other variables being equal, psychiatrists would seem to have the best potential for leadership, at least of large organizations, but all things are rarely equal.

Where do we expect our future leaders to come from? Who will have enough emotional intelligence and other characteristics to be great ethical leaders for psychiatry? We've already had more women leaders in psychiatry, but that hasn't yet been enough. From where else might we get the fresh perspectives needed for innovation? The sociologist Becker (1997) studied leaders at inflection points in history, which might fit the current status of psychiatry. He concluded that the traditional leaders were too captivated by their own success to change. Rather, outliers who could compassionately and lovingly revise current traditions were needed. Given those criteria, one set of candidates might be prosumers, those who have recovered well enough objectively and subjectively to understand professional capabilities and consumer needs, and have the personal strength to endure the stress of such leadership. Or perhaps they might be psychiatric leaders who also come from formerly disenfranchised minority groups, such as Dinesh Bhugra. Bhugra (Bhugra, Ruiz, and Gupta 2013) has already started in that direction by being the first openly gay president of the World Psychiatric Association, taking office in 2014. Also needed are governmental leaders who are sufficiently concerned with psychiatry to produce laws to improve the systems of mental health care.

Whoever they are, if the CEO of a frozen yogurt franchise thinks yogurt culture can change the world for the best, as the former Israeli sergeant Amit Kleinberger was quoted as saying by Herold at the start of this section, why shouldn't psychiatric leaders feel that a psychological culture could also change the world? But, as Frankl cautioned, that will take more than just words, much more than just the words of this chapter. It will take action!

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