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THE ROLE OF THE PSYCHIATRIST AS MEDICAL DIRECTOR: A SURVEY OF PSYCHIATRIC ADMINISTRATORS

Jules M. Ranz, Ann Stueve, and Stephen Rosenheck

ABSTRACT: Previous surveys of public and community psychiatrists have demonstrated that medical directors perform a wider variety of tasks, and experience increased job satisfaction, compared to staff psychiatrists. Notwithstanding respondents' belief that clinical collaboration tasks contribute most to job satisfaction, the performance of administrative tasks is most highly correlated with overall job satisfaction. The current survey was undertaken to determine whether these findings could be replicated among hospital-based psychiatrists. Demographic and job characteristic profiles of hospital-based psychiatrists were clearly distinguished from those of community psychiatrists. Despite these differences, task profiles and job satisfaction parameters of hospital-based psychiatrists were comparable to those previously reported for community psychiatrists.

The position of medical director first appeared in the hospital literature of the mid-1960s. Since the early 1900s, a system had developed whereby a hospital's medical staff was typically led by a senior physician elected by colleagues as a part-time "chief of staff." Chiefs of staff tended to see themselves as representatives of the medical staff to the administration ("the medical staff's man"). But as hospital systems became more complex, hospital administrations began to appoint medical administrators to keep the medical staff informed of hospital decisions ("the hospital's man"). Thus,

Jules Ranz, M.D., is Director, Public Psychiatry Fellowship, and Associate Clinical Professor of Psychiatry, Columbia University, College of Physicians and Surgeons. Ann Stueve, Ph.D., is Associate Clinical Professor of Public Health, Division of Epidemiology, Columbia University, School of Public Health. Steven Rosenheck, M.S.W., is Training Coordinator, and Public Psychiatry Fellowship Instructor in Psychiatry (Social Work), Columbia University, College of Physicians and Surgeons.

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Address for correspondence: Jules Ranz, M.D., New York State Psychiatric Institute, 1051 Riverside Drive, Box 111, New York, NY 10032. E-mail: jmr1@columbia.edu.

in 1966 it was noted that "a new career in medicine—the Hospital Medical Director, is in its formative years" (Piercey, 1996). The position was generally held by a full-time administrator who did not have direct patient care responsibilities (Williams, 1965b). The medical director usually had line authority over medical staff, and sometimes over nursing staff as well (Foulkes, 1969). A discussion in the contemporary literature reflected considerable complexity and ambiguity in this newly emerging role (Ottensmeyer & Key, 1994; Williams, 1965a), especially regarding reporting relationships with senior administration.

The literature of the community mental health movement documents how a related process unfolded for psychiatrists in community mental health centers (CMHCs) (Knox, 1985; Pollack & Cutler, 1992; Ribner, 1980; Winslow, 1979). When CMHCs were developed in the mid-1960s the directors were originally psychiatrists (Winslow, 1979). But, as CHMC leadership migrated to non-physicians, the term medical director began to be used to describe the senior psychiatrist in the CMHC (Faulkner, 1987). In a 1978 survey of CMHC psychiatrists, 7 of 33 respondents were identified as medical directors (Reinstein, 1978). Even so, prior to the mid-1980s, the term medical director as a designation for psychiatrists in leadership positions in CMHCs and other community mental health service organizations barely appears in the literature. In fact, a 1981 comprehensive review of the history of psychiatric leadership since the mid-1800s refers to "superintendents" and "administrators" but not "medical directors" (Feldman, 1981).

In the mid-1980s the American Association of Community Psychiatrists (AACP) was formed by psychiatrists who were struggling to find a role for themselves, beyond medication management, in the community mental health movement (Breakey, 1996). The AACP developed guidelines for the position of medical director in organized service delivery systems ("AACP Guidelines for Psychiatric Leadership," 1995; "Guidelines for psychiatry practice," 1991). These guidelines outlined a role that encompassed a wide variety of medical, clinical, and administrative responsibilities. Following the publication of these guidelines, the role of the community psychiatrist as medical director has received increasing scholarly attention (Clark, 1991; Diamond, Stein, & Schneider-Braus, 1996).

Recent literature about hospital medical directors suggests that most of the ambiguities in the role that were noted in the 1960s remain unresolved (Baker, 1992). This ambiguity has been replicated for medical directors in community settings, especially with regard to line authority and reporting relationships with other senior administrators. Generally, in both hospital and community settings, the term is used to describe psychiatrists who function in an ill-defined relationship to a non-medical executive director. To the extent that the job has been described in the literature, the position

invariably includes responsibility for supervision of medical staff. Beyond that, many medical directors have varying degrees of clinical supervisory responsibilities. Others assume a variety of administrative responsibilities. Thus, in a survey of job descriptions of CMHC Medical Directors (Diamond, Goldfinger, Pollack, & Silver, 1995), almost all job descriptions listed supervisory responsibility over medical services and/or staff (94%). Conversely, fewer job descriptions noted supervision of non-medical (i.e., clinical) staff (61%), or administrative responsibilities such as policy development (69%) and quality assurance (63%).

The most recent version of the medical director job description developed by the AACP emphasizes clinical, in addition to medical, supervisory responsibilities. It indicates that the medical director should be responsible for "assuring that clinical staff receive appropriate clinical supervision" and "assuring through a multidisciplinary process, the appropriate privileging and regular performance review of all clinical staff" ("AACP Guidelines," 1995). In effect, breadth of supervisory responsibility can vary widely, to include both administrative as well as clinical staff (Psychiatric News, 1999). Notwithstanding the above, it is common for medical director responsibilities to be limited to only medical supervision (Community Mental Health Psychiatry Committee, 1992). As a result, there remains evidence that psychiatrists, even those in roles of medical director, continue to feel marginalized in CMHCs (Torrey & Noordsy, 1995).

RECENT SURVEYS OF THE ROLE OF PSYCHIATRISTS IN THE PUBLIC SECTOR

Since 1981, the Columbia University Public Psychiatry Fellowship (PPF) has been training young psychiatrists to take leadership positions in the public sector. When the fellowship was originally conceived, it was assumed that "leadership" meant, quite simply, directing psychiatric service programs. As noted above, it has proven to be not so simple.

Over the years, the faculty of the PPF noted that an increasing number of its alumni were assuming positions as medical directors in hospital and community based mental health services. In many cases, especially in community based agencies, they replaced "old line" medical directors whose positions were virtually unnoticed by the rest of the staff. It was apparent that nobody knew what to expect from a medical director who actually wanted to fulfill a function. Faced with alumni who were reporting lack of clarity as to what was expected of medical directors, the Fellowship began devoting an increasing portion of its curriculum to studying the role of the medical director. Part of this involved surveying its alumni on the roles they were fulfilling in public sector organizations.

In 1995, the PPF faculty conducted a questionnaire survey of its alumni

on the roles they play in the public sector organizations where they work (Ranz, Eilenberg, & Rosenheck, 1997). We asked the 70 respondents to classify their positions as either staff psychiatrist or medical director. A majority of respondents (n=42, 60%) were serving as medical directors (or a variety of equivalent positions). Respondents were asked to indicate how frequently they performed a list of 16 tasks, divided into three groups: direct service, clinical collaboration, and administration. These tasks were selected, in large part, from those listed in the CMHC survey noted above (Diamond et al., 1995), and an attempt was made to create a fairly comprehensive list of all activities regularly performed by psychiatrists in organizational settings. Both staff psychiatrists and medical directors performed direct service more frequently than clinical collaboration, which in turn was performed more frequently than administration. Medical directors reported performing a significantly wider variety of tasks and achieving significantly higher job satisfaction compared to those who were functioning as staff psychiatrists, performing direct service tasks approximately as frequently, while performing clinical collaboration and administrative tasks more frequently than staff psychiatrists. Respondents were also asked to what extent the performance of each task contributed to overall job satisfaction. Respondents rated clinical collaboration tasks as most contributing to overall job satisfaction (Ranz & Stueve, 1998). Interestingly, their perception proved to be inaccurate, as further analysis of survey results revealed that it was, in fact, the performance of administrative tasks that correlated most with overall job satisfaction, while clinical collaboration was not correlated with job satisfaction (Ranz & Stueve, 1998).

Noting that the majority of alumni respondents who identified themselves as medical directors were functioning at a program rather than agency level (e.g., as medical director of a day hospital), the PPF faculty concluded that the role of program medical director represented an important next step for young psychiatrists who wished to pursue careers as public sector leaders. Indeed, recent literature has noted the emergence of the program medical director as a recognized administrative position (Ranz & Stueve, 1998; Young & Clark, 1996).

After completion of the survey, the PPF faculty felt the need for a larger cohort, representative of psychiatrists in community settings throughout the country. We wished to survey psychiatrists functioning as both agency and program medical directors, to see if the same issues regarding job satisfaction applied. Furthermore, we wished to examine what we called breadth of supervision: the extent to which the medical director is responsible for medical staff only, for medical and clinical staff (e.g., other mental health professionals), or for all staff (medical, clinical, and administrative). We believed that psychiatrists functioning at the varying breadths of supervision were performing very different roles, and wished to examine such

differences. Toward this goal we obtained permission to survey the membership of the AACP because that organization is more representative of psychiatrists working in community mental health service organizations than any other group.

This expanded survey was distributed to members of the AACP in February 1998. When the data were analyzed, six distinct medical director roles were distinguished, based on the two levels of functioning (agency and program) and the three levels of breadth of supervision (Ranz, McQuistion, & Stueve, in press). Furthermore, the results allowed us to conclude that job satisfaction for AACP respondents followed similar patterns to those discovered among PPF alumni (Ranz, Stueve, & McQuistion, submitted for publication).

Within months of the conception of the AACP survey, we also decided to survey the membership of the American Association of Psychiatric Administrators (AAPA) using the same questionnaire. The AAPA is an organization representing administrative psychiatrists, most of whom function in hospital settings. Thus, in this article we compare AAPA and the AACP survey responses. We document the demographic and job characteristic profiles of psychiatrists who define themselves (by AAPA membership) as administrators, and contrast these profiles with those of community psychiatrists (AACP members). With this as a basis, we then ascertain whether task domain profiles and job satisfaction parameters for administrative psychiatrists are comparable to those noted above for community psychiatrists.

SURVEY METHODS

In March 1998, the survey was mailed to all members of the AAPA. The questionnaire was an expansion of that completed by PPF alumni, as noted above (copies of the survey are available from the authors and through the fellowship's web site at cpmcnet.columbia.edu/dept/pi/ppf/). The most important expansion concerned level of operation. We asked respondents to indicate their specific job title, as well as whether their level of operation is that of staff psychiatrist, program medical director (PrgMD) or agency medical director (AgMD). If they classified themselves as either of the two types of medical directors, they were also asked whether their breadth of supervisory responsibility included medical staff only (Med), medical and other clinical staff (Clin), or all staff—medical, clinical, and administrative (All). This produced six job types, PrgMD-Med, AgMD-Med, PrgMD-Clin, AgMD-Clin, PrgMD-All and AgMD-All.

Respondents were asked to indicate how often they perform each of 16 tasks divided into three domains: *direct service* (medication, psychotherapy,

overseeing medical care and negotiating care with other providers); *clinical collaboration* (supervising medical and non-medical staff, informal consultations, team meetings and formal training); and *administration* (policy development, routine administration, quality assurance, negotiating contracts, linkage to outside agencies, regulatory bodies and boards). Respondents were asked to rate each item on a 9-point scale ranging from 0=never, to 8=daily (two items were re-scored to that range). Scales for each of the three task domains were constructed using the means of the items in each domain. Internal consistency reliability (Cronbach's alpha) for the task domains was acceptable to good for direct service (0.77), clinical collaboration (0.67) and administration (0.87). Respondents were also asked to what extent the performance of each individual task contributes to job satisfaction (on a 5-point scale from seriously detracts to extremely helpful) and separately, to give a single rating for overall job satisfaction (on a 7-point scale from extremely dissatisfied to extremely satisfied). Internal consistency reliability (Cronbach's alpha) for contribution to satisfaction was acceptable to good for direct service (0.61), clinical collaboration (0.67) and administration (0.84).

RESULTS

Of 397 questionnaires mailed to AAPA members, 217 individuals returned forms, for a response rate of 61% (40 forms were undeliverable). Of these 217 forms, 62 were marked "not applicable" (i.e., not working in an organizational structure, or retired), and 15 were consultants, resulting in 140 respondents who were staff psychiatrists, program medical directors or agency medical directors. We merged these data with that of 251 AACP survey respondents in comparable positions, of whom 41 were members of both organizations who, for the purpose of this analysis, were placed in the AAPA category because preliminary analysis indicated that these respondents were very similar to those who were AAPA members only.

We first report the demographic and job characteristic variables for both the AAPA and AACP samples, in order to establish differences and similarities between hospital and community psychiatrists. Following that, we report task domain and job satisfaction results for the AAPA sample, to examine the extent to which results previously reported for public and community psychiatrists are replicated among hospital psychiatrists.

Demographics and Job Characteristics

The AAPA group is older than the AACP group, with a higher proportion of males, and a lower proportion of U.S. graduates (Table 1). The

AAPA group has worked a greater number of years at their current agency and works a greater number of hours per week. All the above differences are significant.

Based upon their names, organizations for which respondents work were characterized, if appropriate, as hospital-or community-based. It was not always easy to characterize an agency based solely upon its name, so the resulting categories must be taken as suggestive (more definitive information will have to come from future surveys). Of those classifiable as working in hospital or community based organizations, AAPA members are far more likely than AACP members to work in hospital settings compared to community settings: 72% of AAPA members were hospital-based (83 vs 33) compared to 35% of AACP members (62 vs 116) (Table 2).

Regarding auspice, AAPA members are more likely than AACP members to work in for-profit and federal agencies, as likely to work in state facilities and less likely to work in NFP agencies and municipal facilities (Table 2). AAPA members are more likely to work in small urban and suburban settings, as likely to work in large urban settings and less likely to work in rural settings. AAPA members are more likely than AACP members to function as agency medical directors and program medical directors, and less likely to function as staff psychiatrists. AAPA has a higher percentage of those who supervise all staff and those who supervise clinical and medical staff and a much lower percentage of those who supervise medical staff only. AAPA has a higher percentage of those who have their own budget and those who have input on budget, but a much lower percentage of those who have no input on budget. Finally, AAPA members make a significantly higher salary compared to AACP members. The median salary range for AAPA members is $125,000 to $150,000, while the median range for AACP members was $100,000-$125,000.

TABLE 1
ANOVA (one-way) on Demographic and Job Characteristic Variables by Organizational Membership (AAPA/AACP)

	AAPA (n=133-140)		*AACP (n=207-210)*				
	Mean	*SD*	*Mean*	*SD*	*F*	*df*	*p*
Age (years)	53.5	8.91	47.6	10.11	30.68	1,338	.000
Male (%)	83.1	0.38	70.5	0.46	7.19	1,344	.008
US grads (%)	78.2	0.41	89.3	0.35	6.98	1,337	.009
Yrs in agency	9.8	8.37	7.7	6.82	6.30	1,346	.013
Hours per week	39.2	11.63	36.8	10.86	4.00	1,346	.046

TABLE 2
Pearson Chi-Square Comparisons on Percent of Members in Each Organization

	% of AAPA Members (n=136–140)	*% of AACP Members (n=199–210)*	*Chi-Square*	*df*	*p*
Setting[a]			37.9	1	.000
Hospital-based	83	62			
Community-based	33	116			
Auspice			23.1	4	.000
State	29	28			
Federal	8	1			
Municipal	9	8			
Non-profit	40	47			
For-profit	14	4			
Locality			11.4	3	.01
Large Urban	50	50			
Small Urban	28	23			
Suburban	14	7			
Rural	8	19			
Level of Operation			25.8	2	.000
Agency Medical Directors	50	39			
Program Medical Directors	38	25			
Staff Psychiatrist	12	36			
Breadth of Supervision[b]			20.7	2	.000
All staff	44	28			
Clinical and medical staff	40	31			
Medical staff only	16	41			
Control over Budget			13.0	2	.001
Own Budget	27	18			
Input on Budget	44	33			
No input on Budget	29	49			
Salary					
<$75,000	3	2	26.6	5	.000
$75,000–99,999	7	15			
$100,000–124,999	17	35			
$125,000–149,000	33	29			
$150,000–199,000	30	16			
>$199,000	11	3			

[a] *N*=116 (AAPA), 178 (AACP)—includes only those with classifiable settings.
[b] *N*=122 (AAPA), 134 (AACP)—includes only medical directors.

As would be expected, for both AAPA and AACP members, staff psychiatrists have a lower salary than program medical directors, who in turn have a lower salary than agency medical directors. This difference is significant at p=.001 level for the both AAPA and AACP members (ANOVA). Pairwise comparisons show that for AAPA members the difference between staff psychiatrists and both program medical directors and agency medical directors is significant at the p=.05 level, but the difference between program medical directors and agency medical directors is not significant. For AACP members, all pair differences are significant (p<.05 level). Over the entire sample, staff psychiatrists median income is in the $100,000 to $125,000 range, while both program medical directors and agency medical directors median income are in the $125,000 to $150,000 range. However, agency medical directors have higher salaries than program medical directors, as reflected by the percent who record salaries about $150,000 (40% to 29%).

Task Domains and Job Satisfaction

In this section, results are primarily reported for the AAPA sample only. Results for the AACP sample were previously reported and referenced in the introduction to this article (Ranz et al., in press; submitted for publication). For AAPA members, the performance of direct service and administration task domains are significantly related to both level of operation and breadth of supervision, while clinical collaboration is not related to either. For level of operation (Table 3), direct service is performed by staff psychiatrists more frequently than by program medical directors, and by them more frequently than by agency medical directors; administration is performed by agency medical directors more frequently than by program medical directors, and by them more frequently than by staff psychiatrists.

TABLE 3
Relationship Between Level of Operation and Task Domains (one-way ANOVA)

	Staff Psychiatrists		*Program Medical Directors*		*Agency Medical Directors*				
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*F*	*df*	*p*
Direct Service	5.63	1.49	5.26	1.73	3.85	2.51	78.80	2,135	.000
Clin Collab	4.26	1.20	5.13	1.48	5.04	1.79	9.82	2,130	.154
Admin	1.69	1.38	3.52	1.27	4.79	1.32	137.7	2,132	.000

For breadth of supervision (Table 4), direct service is performed by those who supervise medical (MED) staff only more frequently than by those who supervise clinical and medical (CLIN), staff, and by them more frequently than those who supervise all (ALL) staff; administration is performed by ALL types more frequently than by CLIN types, and by them more frequently than MED types. As previously reported, results for the AACP sample are similar.

We also investigated differences in frequency of performing task domains reported by AAPA and AACP members. AAPA agency medical directors report significantly less direct service than AACP members (3.67 vs. 4.48, $p<.05$) and significantly more administration: 4.79 vs. 3.96, $p<.001$). No other differences between members of the two organizations are significant for performance of task domains by staff psychiatrists, program or agency medical directors.

AAPA respondents report that clinical collaboration tasks contribute more to job satisfaction than do direct service tasks, with administration tasks rated lowest. Paired sample *t*-tests reveal that all pair differences are significant ($p<.05$). However, it is in fact the performance of administration that is most highly correlated with overall job satisfaction ($p=.001$). Overall job satisfaction is not correlated with direct service or clinical collaboration. As reported previously, AACP respondents demonstrated the identical discrepancy between perceived and actual contribution of clinical collaboration and administration towards job satisfaction. AAPA medical directors report greater job satisfaction than staff psychiatrists, but the difference is not statistically significant. In the AACP sample job satisfaction was significantly higher for medical directors as compared to staff psychiatrists. For both AAPA and AACP members, salary is poorly correlated ($p>.05$) with job satisfaction.

A regression analysis was performed to further clarify the relationship among the predictors of job satisfaction (Table 5). Respondent's age and

TABLE 4
Relationship Between Breadth of Supervision and Task Domains Among Medical Directors (one-way ANOVA)

	MED		*CLIN*		*ALL*				
	Mean	*SD*	*Mean*	*SD*	*Mean*	*SD*	*F*	*df*	*P*
Direct Service	5.46	2.00	4.96	2.23	3.76	2.22	56.72	2,117	.004
Clin Collab	5.26	1.18	5.28	1.52	4.90	1.84	3.87	2,113	.483
Admin	3.62	1.33	3.94	1.32	4.74	1.41	24.05	2,115	.002

gender were entered in model 1, followed by full versus part-time status and years in current job in model 2, and level of operation, breadth of supervision, control over budget, frequency of performing each task domain and salary in model 3. This analysis reveals that the performance of administrative tasks is the only significant predictor of job satisfaction.

DISCUSSION

As expected, we have demonstrated demographic and job characteristic differences between members of the two national organizations that participated in these surveys: the American Association of Psychiatric Administrators (AAPA), and the American Association of Community Psychiatrists (AACP). These differences reflect their distinct mandates, the AAPA representing hospital administrators and the AACP representing community psychiatrists. Consistent with these mandates, 65% of survey respondents who are AAPA members work in hospital settings, while 65% of AACP members work in community settings. Since AAPA members work in settings with traditional physician-controlled hierarchies, they are more likely than AACP members to be male, older, have worked a greater number of years at their current agency, with wider breadth of supervision and more control over budget. Not surprisingly, since it is an organization for

TABLE 5
Regression Analyses of Job Satisfaction

	Model 1		*Model 2*		*Model 3*	
	B	*(SE)*	*B*	*(SE)*	*B*	*(SE)*
(Constant)	.29	(1.1)	−.21	(1.2)	−.64	(1.8)
Age	.02	(.02)	.02	(.02)	.02	(.02)
Gender	.10	(.39)	.12	(.39)	.20	(.41)
Full time/part time			.40	(.48)	.12	(.50)
Yrs in current job title			−.01	(.03)	.00	(.03)
Level of operation					−.15	(.32)
Breadth of supervision					−.10	(.23)
Control over budget					−.19	(.24)
Direct service					.03	(.08)
Clinical collaboration					−.03	(.10)
Administration					.31	(.12)*
Salary					.09	(.12)

Note. Dependent variable: overall job satisfaction.
*$p<.05$.

administrators, there are relatively few staff psychiatrists in the AAPA. AAPA members have higher salaries than AACP members at comparable levels of operation, although for both organizations staff psychiatrists have lower salaries than program medical directors, who in turn have a lower salary than agency medical directors.

Notwithstanding the above differences, the results regarding task domain profiles and job satisfaction demonstrate more similarities than differences. The only striking difference is that AAPA members who are agency medical directors do significantly more administration and less direct service compared to AACP agency medical directors, again reflecting the fact that AAPA members tend to work in physician-controlled hierarchies. For both groups, the performance of direct service and administration task domains are significantly related to both level of operation and breadth of supervision: regarding level of operation, staff psychiatrists do the highest amount of direct service and least amount of administration, while agency medical directors do the opposite; regarding breadth of supervision, those who supervise medical staff only do the most amount of direct service and least amount of administration, while those who supervise all staff do the opposite.

Members of both organizations believe that the performance of clinical collaboration contributes to overall job satisfaction significantly more than the performance of direct service, which in turn is perceived to contribute to job satisfaction significantly more than the performance of administration. However, again for both samples, it is in fact the performance of administration that is most highly correlated with overall job satisfaction. Overall job satisfaction is not correlated with the performance of clinical collaboration for either sample. One possible explanation for this interesting discrepancy is that clinical collaboration may serve as the necessary, though not sufficient, pathway to job satisfaction. Job satisfaction may depend on having the administrative power to ensure that clinical collaboration can bring about change in the organizational structure. A correlation between the frequency of clinical collaboration and the frequency of administration would support this argument, and, indeed, in the AAPA sample these two task domains are correlated with each other (r=.233, p<.01). A similar, even stronger, correlation was previously reported for the AACP sample.

AAPA members who are medical directors report higher job satisfaction than those who are staff psychiatrists, but unlike AACP members and PPF alumni, the difference does not reach statistical significance. We suspect this is due to the small number of staff psychiatrists in the AAPA sample. In any case, regression analysis demonstrates that level of operation was not a significant factor in job satisfaction, when the performance of administrative tasks was taken into account.

These findings for members of the American Association of Psychiatric Administrators are consistent with those previously reported for alumni of the Public Psychiatry Fellowship and members of the American Association of Community Psychiatrists. Both hospital and community psychiatrists, who function as agency and program medical directors perform a wider variety of tasks compared to those who function as staff psychiatrists. Psychiatrists in both hospital and community settings believe that the performance of clinical collaboration most contributes to job satisfaction, but these surveys demonstrate that overall job satisfaction is not high unless there is the opportunity to have an impact on the agency's functioning through involvement in administration activities. Notably, salary is not significantly correlated with job satisfaction for either sample.

Of particular interest is the recognition that psychiatrists can function as program medical directors. We have learned, while consulting with PPF alumni negotiating for jobs, that while agencies rarely recruit for program medical directors, it is often possible to convince an agency looking for a staff psychiatrist to hire the applicant as a program medical director. This is a desirable career move for staff psychiatrists, in that they will probably experience enhanced job satisfaction through the assumption of administrative responsibilities.

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