

# The Psychiatrist's Role as Medical Director: Task Distributions and Job Satisfaction

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**Objectives:** Previous surveys of the alumni of Columbia University's fellowship in public psychiatry suggest that a large number of alumni fill positions as program medical directors. In contrast with agency medical directors, program medical directors work within team structures and maintain a high degree of clinical involvement. The fellowship faculty surveyed the alumni to catalog the tasks performed by program medical directors, agency medical directors, and staff psychiatrists and to determine the extent to which these tasks contribute to job satisfaction. **Methods:** A survey form was developed using a list of tasks derived from the American Psychiatric Association's guidelines for psychiatrists working in organized mental health care delivery systems and from a recent article that surveyed job descriptions of psychiatrists in community mental health centers. The survey form was distributed to all current fellows and alumni in active practice (N = 89). **Results and conclusions:** Seventy-two forms were returned, for a response rate of 81 percent. Respondents who were medical directors performed a greater variety of tasks and reported higher job satisfaction than those who were staff psychiatrists. Higher job satisfaction was related to a greater variety of tasks performed, especially tasks involving clinical collaboration. Most of the respondents were program medical directors rather than agency medical directors. The position of program medical director constitutes a relatively small and attainable step above that of staff psychiatrist. Agencies would do well to consider creating positions of program medical directors for their staff psychiatrists whenever feasible, and psychiatrists committed to public-sector careers should negotiate to have such positions. (*Psychiatric Services* 48:915-920, 1997)

The disaffection of qualified and capable psychiatrists from public-sector mental health care has been long noted (1,2) and constitutes a major public mental health

crisis in this country. How did this situation develop?

As the locus of care for psychiatric patients moved from the hospital to the community over the past 40 years,

psychiatrists lost the positions of leadership they held in state hospitals. In President Kennedy's landmark 1963 Community Mental Health Centers (CMHC) Act, it was assumed that CMHCs would be directed by psychiatrists, as had the state hospitals before them. Indeed, many early centers were established and administered by psychiatrists, and in 1971 more than half were headed by psychiatrist administrators (2). But the National Institute of Mental Health's original mandate that CMHCs be directed by psychiatrists was later broadened to include other mental health professionals, and subsequently the proportion of centers directed by psychiatrists declined to 22 percent by 1977 (3) and to 8 percent by 1985 (4).

As leadership passed into the hands of other mental health professionals, the appeal of CMHCs as practice settings for psychiatrists began to diminish. In the early 1980s many publications described the severe disaffection that psychiatrists working in CMHCs were beginning to experience (5,6). The reasons for the disaffection were myriad (2,3), resulting from many changes in the political, economic, and professional climates of mental health services delivery. Compared with other mental health professionals, psychiatrists are relatively scarce and constitute high-cost staff for fiscally constrained agencies, so service needs often force psychiatrists to devote their time almost exclusively to direct patient care. Nonbillable services, such as

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consultation, training, and supervision, are devalued.

Since funding cutbacks have adversely affected job satisfaction at CMHCs, psychiatrists have found it easier than other mental health professionals to leave these settings for more lucrative practices. This trend has resulted in a shift to more part-time employment by psychiatrists at the centers, pushing them toward peripheral roles as consultants. Meanwhile, other mental health professionals, who are more likely to be employed full time in CMHCs, are assuming leadership positions (7).

As psychiatrists' roles in CMHCs have become more marginalized, their dissatisfaction has grown. A 1985 survey of 220 psychiatrists working in CMHCs revealed that although many chose to work in those settings because of the desire for community service, role conflicts at the centers were the most frequently cited reason for leaving (8). When respondents were asked to identify the most critical variable that did or would cause them to leave a CMHC, 61 percent of all responses related to conflict over the psychiatrist's role, the psychiatrist's value, or both.

Indeed, many psychiatrists have complained that CMHCs often seem to prefer psychiatrists who will do little more than write prescriptions and sign insurance forms (9). They have reported feeling underappreciated, underutilized, underpaid, and clinically vulnerable. In a 1987 survey by Clark and Vaccaro (10), CHMC psychiatrists noted a decreased variety of tasks, responsibility without authority, lack of stimulation, and professional isolation. Other researchers have noted psychiatrists' concerns about pressures that compromise professional ethics (11).

However, notwithstanding the complaints of the psychiatrists who participated in Clark and Vaccaro's survey (10), 69 percent reported that they were generally satisfied with their work at CMHCs. The factors most often reported as contributing to job satisfaction included opportunities to perform a variety of tasks, especially those with clinical supervisory and administrative responsibilities. Clearly, psychiatrists who avoid

being marginalized and relegated to writing prescriptions experience greater job satisfaction. In keeping with this finding, Diamond and associates (12) identified four "nonessential but desirable" roles—assessor, generalist, teacher, and scholar—that psychiatrists could perform in CMHCs beyond the "essential" roles of medical expert and legal or medical authority.

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high-quality psychiatrists in the public sector. Pollack and Cutler (2) identified factors that improve survival of psychiatrists in public-sector settings. Among their recommendations were that psychiatrists should pursue relevant training programs in public psychiatry, seek roles that provide variety, and retain control over the relationship between responsibilities and authority. Pollack and Cutler noted that administrators are becoming aware of the need to recruit good psychiatrists into public-sector settings and suggested the following strategies: integrating the psychiatrist into the staff; negotiating a flexible and broad range of functions, including some administrative and teaching functions; and establishing the psychiatrist's responsibility to provide meaningful supervisory input into patient care.

Concerns about the lack of psychiatric leadership and psychiatrists' dissatisfaction with existing job roles led to the formation of the American Association of Community Psychiatrists (AACP) in 1985 (13). In 1991 the American Psychiatric Association adopted the guidelines established by the AACP for psychiatric practice in CHMCs (14). The guidelines have recently been revised (15).

The fellowship in public psychiatry at the New York State Psychiatric Institute and Columbia University College of Physicians and Surgeons, established in 1981, trains psychiatrists to assume leadership roles in public-sector mental health programs and is intended to improve retention of psychiatrists in these settings by enhancing their job productivity and satisfaction (16). Using the AACP guidelines, the fellowship has incorporated the following modules into its didactic curriculum over the past few years: a formal series of presentations on the role of the psychiatrist by fellowship faculty; a series of presentations by alumni and other psychiatrists functioning as medical directors in public-sector agencies; and a series of presentations by the fellows themselves on their role in their field placement agencies.

To monitor the success of its mission to promote leadership and retention, the fellowship surveys its alumni every year. These surveys have consistently demonstrated that more than 90 percent of fellowship alumni are pursuing careers in the public sector, with more than 50 percent working in management positions (16).

One intriguing survey finding is that a large proportion of the management positions are for program medical directors. In contrast with agency medical directors, who fulfill a myriad of administrative functions for large systems of care, program medical directors work within a team of clinicians and administrative support staff and maintain a high degree of clinical involvement. Thus the title of medical director may apply to psychiatrists who head agencies and to psychiatrists who lead treatment teams, such as day treatment or mobile crisis teams. The title may also

be used by psychiatrists who collaborate with directors of nonmedical agencies or leaders of nonmedical teams. In such collaborations, the medical director assumes some degree of clinical or medical leadership, at least on paper.

However, whether medical directors feel they actually have the opportunity to exert leadership remains questionable. Diamond and colleagues (17), in a recent survey of job descriptions of psychiatrists in community mental health centers, found that "most CMHCs want fully trained psychiatrists involved in a variety of activities in addition to prescribing medication." In particular, agencies expected psychiatrists to be involved in training and consultation or linkage to outside agencies or providers; they also expected psychiatrists to have authority over medical and nonmedical staff. Moreover, agencies described an even higher expectation for medical directors to perform a greater variety of tasks, including policy development and quality assurance.

However, Diamond and colleagues cautioned that "a job description may have little to do with how the psychiatrist is really spending his or her time." They emphasized the need to assess what psychiatrists actually do in public-sector settings and to determine whether comprehensiveness of the job description is correlated with job satisfaction.

To pursue these issues, the faculty of the fellowship in public psychiatry at Columbia University decided to survey its alumni to ascertain what tasks they actually perform in their roles as staff psychiatrists, program medical directors, and agency medical directors and to assess to what extent each task contributes to job satisfaction.

## Methods

A survey form was developed using a list of tasks derived from the AACP guidelines and from the survey of CMHC psychiatrists by Diamond and colleagues (17). (A copy of the survey form is available from the authors and through the fellowship's Web site at <http://cpmcnet.columbia.edu/dept/pi/ppf/>. See the box at the

end of the paper.) The survey requested information about the number of hours the respondent worked at his or her primary work site, the respondent's job title and degree of involvement in the budgeting process, and the number of staff the respondent interacted with regularly.

The survey form listed 16 tasks divided into three subgroups—direct service, clinical collaboration, and administration. Direct service included four items: prescribing medication, providing direct psychiatric services such as evaluation and psychotherapy, overseeing medical care, and negotiating care with other providers. Clinical collaboration included five items: supervising medical staff, supervising nonmedical staff, providing informal consultation, participating in team meetings, and providing formal training. Administration included seven items: policy development, routine administration, linkage to outside agencies, quality assurance, interacting with regulatory agencies, negotiating contracts, and interacting with the board of directors or community board.

For each item, respondents were asked to indicate how often the task was performed (on a 9-point scale ranging from 0, not at all, to 8, daily) and to rate the extent to which the task contributed to job satisfaction (on a 5-point scale ranging from -2, seriously detracts, to +2, extremely helpful). Overall job satisfaction was rated on a 7-point scale from -3, extremely dissatisfied, to +3, extremely satisfied.

The survey form was distributed to all alumni and current fellows in the fellowship in public psychiatry ( $N=100$ ) in spring 1996. The survey was also placed on the fellowship's Web site. We anticipated a high response rate because we maintain yearly contact with our alumni through surveys and because response rates to previous surveys were high. The primary author followed up with phone calls to potential respondents who did not respond to the first mailing.

Our hypothesis was that medical directors would report performing more tasks and report higher job satisfaction than staff psychiatrists. We also predicted that both groups

would report higher satisfaction from clinical coordination tasks than from direct service or administration tasks. Accordingly, one-tailed  $t$  tests were used to establish statistical significance for these predictions. The level of significance was set at  $p<.05$ .

## Results

Of the 100 current fellows and alumni, six were not currently in practice due to maternity leave, engagement in nonmedical activities, retirement, or death, and an additional five were lost to contact. From the remaining 89 potential respondents, 72 forms, including five from the Web site, were returned, for an 81 percent response rate. Three respondents were in full-time private practice, leaving 69 in public institutional settings. Of these, 42 identified themselves as medical directors, and 27 as staff psychiatrists.

As a group, medical directors worked a mean  $\pm$  SD of  $38 \pm 8$  hours per week, compared with  $34 \pm 9$  for staff psychiatrists, a significant difference ( $t=-1.92$ ,  $df=54$ ,  $p<.05$ ). Medical directors also interacted with a larger number of staff regularly, a mean  $\pm$  SD of  $31 \pm 26$  staff members, compared with  $18 \pm 11$  for staff psychiatrists ( $t=-2.19$ ,  $df=52$ ,  $p<.05$ ).

Of the 42 medical directors, 38 reported that they were program directors and four reported that they were agency directors. Agency medical directors reported interacting regularly with a much larger number of staff, a mean  $\pm$  SD of  $77 \pm 27$ , compared with  $25 \pm 20$  for the program medical directors ( $t=-3.25$ ,  $df=3$ ,  $p<.05$ ). Program medical directors performed direct service tasks more frequently than agency medical directors, but the difference was not significant, nor were any other differences in task frequencies or job satisfaction between agency and program medical directors.

Twenty-six medical directors headed their agency or program, and 14 collaborated with nonmedical leaders. Two others indicated minimal contact with nonmedical leaders. The medical directors who headed their agency or program did more formal training and policy development and reported more satisfaction from di-

**Table 1**

Mean frequency with which medical directors and staff psychiatrists perform selected tasks and contribution of the tasks to their job satisfaction

Task	Frequency <sup>1</sup>					Contribution to job satisfaction <sup>2</sup>				
	Medical directors (N=42)	Staff psychiatrists (N=27)	t	df	p<	Medical directors (N=42)	Staff psychiatrists (N=27)	t	df	p<
Direct service	6.4	6.4	0.6	59	ns	1.1	0.8	-2.6	64	.01
Prescribe medication	6.6	6.3	-0.7	49	ns	1.3	0.7	-2.6	64	.01
Provide direct psychiatric services, such as evaluation and psychotherapy	7.1	7.9	2.2	47	.05	1.4	1.4	0.2	60	ns
Oversee other medical care	6.2	6.2	0.0	55	ns	1.0	0.8	-1.0	60	ns
Negotiate care for individual patients	5.6	6.2	-0.4	53	ns	0.6	0.3	-1.0	52	ns
Clinical collaboration	6.4	4.9	-3.4	36	.001	1.4	1.2	-2.5	39	.01
Supervise medical staff	6.8	4.3	-3.4	36	.001	1.5	0.9	-2.5	39	.01
Supervise nonmedical staff	6.8	5.0	-3.0	37	.01	1.5	1.0	-2.6	44	.01
Provide informal consultation	7.4	6.4	-2.8	43	.01	1.5	1.3	-1.0	47	ns
Participate in team meetings	6.3	5.4	-1.0	56	ns	1.1	1.3	0.2	65	ns
Provide formal training	4.5	3.3	-2.0	43	.05	1.5	1.3	-1.7	42	.06
Administration	3.5	1.4	-6.5	41	.001	0.8	0.4	-4.3	34	.001
Policy development	5.8	2.2	-6.5	41	.001	1.5	0.7	-4.3	34	.001
Routine administration, including program design, strategic planning, and fund raising	5.8	2.4	-5.7	42	.001	1.1	0.8	-2.5	42	.01
Linkage or consultation to outside agencies	3.8	1.6	-3.7	58	.001	1.0	0.4	-3.1	52	.01
Quality assurance	4.0	2.4	-3.0	46	.01	0.8	0.7	-1.1	64	ns
Interact with regulatory agencies	4.0	0.4	-9.9	67	.001	0.0	-0.1	-0.1	66	ns
Negotiate contracts	1.6	0.5	-2.3	62	.05	0.4	0.0	-1.6	67	.06
Interact with boards of directors or community boards	1.0	0.0	-4.4	41	.001	0.6	-0.3	-3.2	63	.001

<sup>1</sup> Rated on a scale from 0 to 8. A rating of 0 indicated not at all; 1, annually; 2, semiannually; 3, quarterly; 4, monthly; 5, twice monthly; 6, weekly; 7, twice weekly; and 8, daily.

<sup>2</sup> Rated on a scale from -2, seriously detracts from job satisfaction, to +2, extremely helpful to job satisfaction.

rect service tasks than did the medical directors who acted as collaborators with nonmedical leaders. The collaborators provided more informal consultation and reported more satisfaction from clinical collaboration tasks. However, none of the differences between the two groups on task frequency or job satisfaction measures were significant.

As Table 1 shows, of the 16 tasks listed on the survey form, 11 were performed significantly more often by medical directors than by staff psychiatrists. Medical directors did clinical collaboration and administrative tasks significantly more often than staff psychiatrists. However, staff psychiatrists provided direct psychiatric services such as evaluation and psychotherapy significantly more often than did medical directors. Medical directors reported per-

forming ten tasks, primarily direct service and clinical collaboration tasks, at least weekly, while staff psychiatrists reported performing only four tasks, primarily direct service tasks, at least weekly.

Staff psychiatrists performed direct service tasks significantly more often than clinical collaboration tasks ( $t=3.9$ ,  $df=52$ ,  $p<.001$ ). Both groups performed clinical collaboration tasks significantly more often than administration tasks ( $t=8.2$ ,  $df=51$ ,  $p<.001$ , for staff psychiatrists;  $t=10.2$ ,  $df=82$ ,  $p<.001$ , for medical directors).

Table 1 also shows that medical directors prescribed medication as often as staff psychiatrists, but medical directors rated their satisfaction with prescribing much higher than did staff psychiatrists. Not shown in Table 1, all respondents reported a

mean of 33 direct patient contacts per week for medication and psychotherapy. This number was somewhat lower than the mean of 37 reported by public psychiatrists in a 1994 survey of professional practice patterns of U.S. psychiatrists (18).

As for job satisfaction, Table 1 shows that seven of the 16 tasks listed in the survey made a higher contribution to job satisfaction for medical directors than for staff psychiatrists. For only one item—participation in team meetings—did staff psychiatrists reported a higher contribution to job satisfaction than did medical directors, and the difference was not significant. Medical directors reported that five tasks—primarily clinical collaboration tasks—were extremely helpful in contributing to job satisfaction, while staff psychiatrists did not report that any tasks were ex-

tremely helpful in contributing to job satisfaction.

As for overall job satisfaction, the mean  $\pm$  SD rating on the scale from -3, extremely dissatisfied, to +3, extremely satisfied, was  $2 \pm .8$  for medical directors and  $1.2 \pm 1.5$  for staff psychiatrists, a significant difference ( $t = -2.7$ ,  $df = 35$ ,  $p < .01$ ). As Table 1 shows, medical directors reported a significantly higher contribution to job satisfaction for all three task subgroups—direct service, clinical collaboration, and administration. Both groups reported that clinical collaboration tasks contributed significantly more to job satisfaction than did direct service tasks ( $t = -2.6$ ,  $df = 73$ ,  $p < .01$ , for medical directors;  $t = 2.8$ ,  $df = 52$ ,  $p < .01$ , for staff psychiatrists) or administrative tasks ( $t = 4.7$ ,  $df = 72$ ,  $p < .001$ , for medical directors;  $t = 3.6$ ,  $df = 40$ ,  $p < .001$ , for staff psychiatrists).

### Discussion and conclusions

Our most important findings are that survey respondents who are medical directors perform a greater variety of tasks and report higher job satisfaction than those who are staff psychiatrists. Furthermore, both medical directors and staff psychiatrists report higher contribution to satisfaction from clinical coordination tasks than from direct service or administrative tasks. These findings are consistent with other reports in the literature showing that job satisfaction is related to the variety of clinical and supervisory tasks in the job description (2,8,10,12).

Staff psychiatrists perform direct service tasks more often than clinical collaboration tasks, and both groups perform direct service and clinical collaboration tasks more often than administrative tasks. Contrary to expectations, program medical directors did not perform direct service tasks significantly more often, or administrative tasks significantly less often, than agency medical directors. However, the very small number of agency medical directors in our sample ( $N = 4$ ) precludes meaningful analysis of this finding.

Most of the survey respondents were program directors who supervised smaller clinical operations than

did agency medical directors and who were heavily involved in direct patient care. A surprising finding was that respondents who were medical directors performed as many direct service tasks as did respondents who were staff psychiatrists. This finding is undoubtedly related to the sample's small number of agency medical directors, who in general tend to have restricted direct clinical responsibilities. Although program medical directors had the same amount of patient care responsibilities as staff psychiatrists and additional supervisory and administrative duties, the program medical directors reported increased job satisfaction compared with staff psychiatrists.

This seeming paradox merits further contemplation. Because clinical caseloads are not lower for program medical directors, one might wonder whether creating such a position amounts to little more than having the title of medical director on paper, but not in reality. In fact, the position of medical director legitimizes and facilitates the performance of collaborative activities that are associated with higher job satisfaction. Nonetheless, it is worth considering that some of the increased satisfaction may indeed come from the title alone. The perceptions created among staff by a job title such as "medical director" include an expectation of leadership, and if the person filling the position has true leadership and administrative skills, he or she will almost certainly be looked to for guidance.

We are not sure how program medical directors find time for the added duties that are crucial to their job satisfaction. They reported working an average of four hours per week more than staff psychiatrists, and this extra time may allow for clinical collaboration and administrative tasks. Their supervisory functions may introduce job efficiencies by training team clinicians to be more clinically effective.

It is also possible that agencies willing to hire program medical directors are more likely to assign them smaller caseloads or provide them with other administrative supports than are agencies that hire only staff psychiatrists. Alumni of the public

psychiatry fellowship may seek out agencies that are more "psychiatrist friendly." Our finding that their caseloads were slightly lower than those of public psychiatrists as reported in national survey by Olfson and colleagues (18) is consistent with this hypothesis.

We recognize that psychiatrists who participate in Columbia University's fellowship in public psychiatry are a self-selected group and probably do not represent the typical psychiatrist now working in the public sector. The fellows have made a conscious decision to work in the public sector and to obtain the training that imparts the conceptual orientation and practical knowledge needed to function well in the public sector. The characteristics of the study sample thus limit the extent to which we can generalize the findings. We cannot conclude that staff psychiatrists in general would experience enhanced job satisfaction with increased administrative and supervisory responsibilities. We suspect that many would feel burdened if their duties and responsibilities were increased. However, we can infer from the findings that committed public psychiatrists, particularly those starting their careers and those with relevant fellowship training, are more likely to experience enhanced job satisfaction and to stay in public-sector careers if they are given a wider breadth of job duties and more pivotal leadership responsibilities in their programs.

These relationships are particularly noteworthy because the study sample represented primarily program medical directors rather than agency medical directors. The position of program medical director is a relatively small and attainable step above the position of staff psychiatrist. In fact, many of the fellowship alumni who participated in the survey negotiated with potential employers to create program medical director positions, with the encouragement of fellowship faculty, in the course of applying for jobs as staff psychiatrists. The survey results suggest that these negotiations generally did not involve a reduction in caseload or other direct care duties.

Of further interest to agency administrators, the survey results suggest that both medical directors who independently headed an agency or program and those who worked in collaboration with a nonmedical leader performed a similar constellation of tasks and enjoyed equal job satisfaction. These findings should be encouraging to agency administrators who may fear that nonmedical leadership would have to be dismantled to accommodate more satisfying and powerful roles for psychiatrists. Anecdotally, we have observed that some of our alumni who are thriving as medical directors report that collaboration with nonmedical leaders makes a crucial contribution to their job satisfaction.

This survey raises questions for future study. For example, more detailed information about the direct clinical care activities of medical directors and staff psychiatrists would help us understand how program medical directors have time for additional responsibilities beyond direct clinical care. We would also like to survey other agency and program medical directors to achieve a sample size large enough to draw meaningful distinctions between these two categories.

### Conclusions

The survey finding that program medical directors report an increased variety of tasks and increased job satisfaction has exciting implications. Public-sector managers would do well to consider how these findings may lead to improved recruitment and retention of psychiatrists without added expense. Both agency administrators and psychiatrists should take notice that creating positions for program medical directors does not require a reconfiguration of an agency's table of organization. Young psychiatrists interested in public-sector careers should consider negotiating for the position of program medical director whenever feasible. ♦

### Acknowledgments

The authors thank Hunter McQuiston, M.D., Susan Deakins, M.D., and David Pollack, M.D., for their helpful comments on manuscript revisions.

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## Fellowship Faculty Seek Additional Survey Responses

The faculty of Columbia University's fellowship in public psychiatry seek additional respondents for their survey on psychiatrists' job tasks and their contribution to job satisfaction. Practicing psychiatrists who work in public institutional settings are invited to visit the fellowship's Web site at <http://cpmnet.columbia.edu/dept/pi/ppf/> and complete a survey form on-line. Information about the survey and a copy of the survey form are also available from Jules Ranz, M.D., Public Psychiatry Fellowship, Columbia University College of Physicians and Surgeons, New York State Psychiatric Institute, 722 West 168th Street, Box 111, New York, New York 10032; telephone, 212-960-5655; fax, 212-960-2356; e-mail, [jmr1@columbia.edu](mailto:jmr1@columbia.edu).