Leadership and Management in Times of Scarcity: The Internal Issues

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In the early 1970’s, John Kenneth Galbraith defined the prerequisites for a big reputation on Wall Street. In his view, being known as a genius in the stock market required only two things: a rising market and a short memory. Similarly, in our field in the early 1980’s, I would suggest that a reputation as an outstanding public mental health administrator requires only three things: a federal staffing grant, a compliant backup state hospital, and a short career.

Galbraith’s remark was made in the early days of a stock market slump, and it referred, of course, to the bright young managers of “go-go” mutual funds who had established their genius in an expanding economy. They knew how to ride and exploit a rising market but were lost when the market went the other way. Many of us in public mental health are in analogous circumstances. Despite our well-known—and successful—habit of pointing to funding limitations, we have been in a rising market since World War II. Although we have experienced short-term setbacks, our programs, staffs, and facilities have steadily increased in most areas of the country. Many of the persons with major administrative responsibilities for public mental health programs were trained in this expanding environment. Few, if any, have experienced the abrupt and catastrophic cuts that are forecast for the next few years—hence the theme of this annual meeting.

Only those of us who work in state- or city-operated programs in certain areas of the country have had a foretaste of management in a falling market. In Massachusetts we had a flick of the lash in 1975 when the state narrowly escaped bankruptcy. Since then times have been better, but we learned a great deal from that experience, which, I suppose, had something to do with the invitation to me to speak on this occasion.

I appreciate the distinction made in the title of this conference between leadership and management. Both are significant areas of concern, particularly in times of scarcity, and I have chosen to orient my remarks on internal issues around that distinction.

Leadership

According to Harry Levinson (1980), leadership involves the exertion of forward force to steer the organization into change. Stimulating and guiding that change requires, among other things, the generation of expectations based on the values and goals of the leader, which must resonate with the values and goals of the organization. This confluence of individual vision and group aspiration forms an organizational ego ideal, which expresses what the

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organization stands for (Levinson, 1972). Let me emphasize that this concept is not simply a clumsy verbal transposition from psychoanalytic theory; the most useful lesson that I have learned in leading a large, diverse, and decentralized organization in times of scarcity is the importance of the collective ego ideal. A primary function of leadership is constantly to affirm, personify, and redefine those collective aspirations in response to a changing world.

The collective ego ideal, like that of an individual, begins in the history of the organization—the myth of its founding—its roots. Most organizations, including departments of psychiatry, have a myth describing their birth, which almost begins, “Once upon a time.” Once upon a time there was a kindly general practitioner named Menninger in Topeka, Kansas, with two talented sons, who decided to go into psychiatry. Once upon a time a Philadelphia Quaker, Dr. Thomas Bond, who had visited Bethlem Hospital in London, discussed with his friend Benjamin Franklin the need for a place for Philadelphians “who unhappily became disorder’d in their senses, wander’d about, to the Terror of the Neighbors, there being no Place except the House of Correction) in which they might be confined, and subjected to proper management of their recovery” (Franklin, 1754).

Massachusetts Mental Health Center’s (MMHC’s) myth begins: Once upon a time there was an irascible and combative private psychiatrist, a Boston blue-blood named L. Vernon Briggs, who became incensed that indigent persons of Boston had no place to be promptly diagnosed if their behavior became disordered. He was concerned that they might languish for days on the “bare pine boards” of the Tombs, the city prison in Pemberton Square, until the court got around to deciding that they were mentally ill and sent them to the Boston Lunatic Hospital. After eight years of unsuccessfully fighting the medical establishment to put an observation unit in a general hospital, he finally succeeded in badgering the Massachusetts legislature to appropriate $600,000 to build the Psychopathic Branch of what was, by then, the Boston State Hospital. It was set up near Harvard Medical School with an informal but durable arrangement for joint responsibility so that psychiatry at the highest level of excellence could be brought to bear on the problems of the most disabled and most disadvantaged citizens of the city—the seriously mentally ill. To maintain that excellence in the service of the indigent requires research, teaching, a broad view of mental illness, a variety of services and sites, all the mental health disciplines, a sustained commitment to innovation and a disdain for conventional wisdom.

There, in brief, is our story: academic excellence, the poorest and sickest people, a constant fight against outside forces and innovation and growth within. It is a serviceable story because it is true, and because it speaks to something beyond us as individuals. Most important it provides for continuity of mission through the vicissitudes of history—from neurosyphilis, through schizophrenia, psychoanalysis, and the open door policy, to community psychiatry and whatever lies beyond.

It will serve us well in times of scarcity when my primary function as a leader is to interpret the present and future in terms of that enduring story. I have