ONCOLOGY PROGRAM MEDICAL DIRECTORS
Moving From Practice To Administration

Catherine A. Novak, R.N., M.S.

The Enck family, standing in front of their new home in Columbus, Ohio, on moving day, exemplifies more than just a change in geographic location. The Encks and many other oncology families are changing careers, communities, roles, and expectations. Whether it's mid-life crisis, burn-out, the need for a new challenge, or the chance of a life time...a growing number of oncologists are taking on new careers as administrators in hospital and university settings. And with these new careers come fresh opportunities and frustrations for the whole family.

Some physicians leave private practice for full-time administrative posts, but many take on a part-time role as a cancer program administrative director and then are lured into full-time administration, often by hospitals out of town. Gale Katterhagen, M.D., former president of the Association of Community Cancer Centers and the first community physician to serve on the National Cancer Advisory Board, had been a part-time administrator of the cancer program at Tacoma General Hospital for more than a decade when the call came from Bob Clarke, CEO of Memorial Medical Center in Springfield, Illinois.

"For a couple of years before the move, I had been thinking of doing something different, something new and challenging," relates Katterhagen, executive director of the Comprehensive Cancer Center at Memorial. Restless and alert for new opportunities, he even considered going back for another residency but couldn't decide what to do. "I didn't want to retire, put on the polyesters, move to Sun City, and shoot shuffleboard," he says, "I always want to be contributing, and I want the last third of my life to be as productive as the first two-thirds."

In Katterhagen's case, he never really looked for a position. "One day, out of the blue, Bob Clarke called and said he wanted us to quit our jobs, sell the house, and move to Springfield. Frankly, I thought he was crazy, but the idea of the opportunity and challenge intrigued us, and we couldn't dismiss it."

Intense competition, new technologies, predictions of a physician surplus, and threats of institutional closures have created an atmosphere in which the line between clinical and managerial decision making is no longer clearly delineated. As a result, increasing numbers of hospitals and physicians are seeing an advantage in combining clinical expertise and managerial responsibility, giving rise to a new type of "physician executive."

Rodger Winn, M.D., now director of the Community Oncology Program at M.D. Anderson Hospital, was first aware it was time to move on when a younger partner enthusiastically told him about a "great case of Hodgkins disease." "Five years earlier I might have agreed with him, but I was too familiar with the implications this disease has for a young person, and there was just nothing great about it," says Winn. The realization helped motivate him to look for new challenges. "I had been thinking about looking for something different and had even enrolled in a master's program in

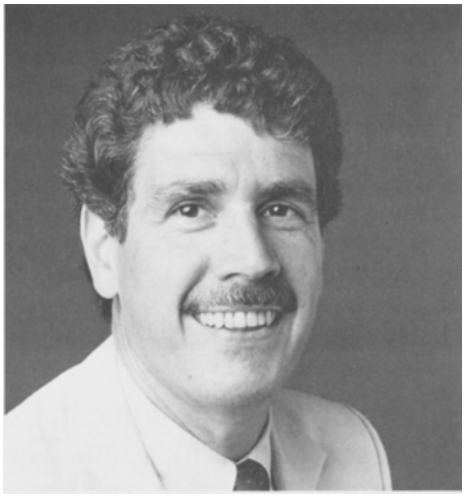
J. Gale Katterhagen, M.D.
Memorial Medical Center, Springfield, IL

environmental toxicology. I also considered a position as Chief of Medicine at a county hospital in Brooklyn, a position as a full-time cancer program director at a smaller hospital, and even looked at a job with NCI, but felt it was more administration than I was ready for."

One of his colleagues suggested his name to M.D. Anderson when Winn decided not to take the job at NCI. The M.D. Anderson call was also "out of the blue," like Katterhagen's offer. Winn reviewed the Anderson position, which was an entirely new one with only a two sentence mandate. He interviewed, listened to the broad outline of the position, and wrote a 20-page proposal describing his plan for development of the program. It was accepted as written, and Winn was on his way to Houston.

Bob Enck almost didn't take the call from the headhunter with the position opening for a cancer program director at Riverside Hospital in Columbus, Ohio. Enck had joined Lourdes Hospital in Binghamton, New York, in 1979, as a full-time hospital-based oncologist, carrying a substantial case load as well as management responsibilities. He implemented a full range of cancer program activities, including NCI-funded CHOP and CCOP grant awards, for which he served as Principal Investigator. But as support for the cancer program declined at Lourdes, Enck sought other opportunities.

"The first thing that impressed me was that the Riverside administrative team knew what they wanted. They had a written job description with clearly described responsibilities, and a strong, obvious administrative commitment to the cancer program, something that I was concerned about," says Enck. He noted that several attractive offers for cancer program development actually turned out to be primarily practice building positions, with program development "on the side," relegated to spare time status.



Robert E. Enck, M.D.
Riverside Methodist Hospital
Columbus, OH

Frustrated by his previous experience and wary of offers with sizable clinical requirements, Enck checked out the Riverside job carefully. He placed his first call to ACCC Executive Director Lee E. Mortenson, then talked to people in and outside of Columbus about the hospital, its reputation, and its future. When he interviewed, Enck made a point of talking with people within the administration who could have been a potential source of resistance to the development of the cancer program, but could find no evidence of opposition.

In the end, Riverside had everything he wanted...a teaching institution, an academic appointment with a clinical component, a clear job description, a strong administrative commitment to the cancer program, adequate resources and control, a quality oriented organization, and a good offer.

"In Binghamton, we had three CEOs in seven years, what I characterize as 'turnstile management,' which, in turn, fostered an ambivalence about supporting programmatic efforts and gradually began to squeeze the program's resources," said Enck. "The administrative continuity at Riverside was an important factor in our decision making process."

While Enck, Katterhagen, and Winn have moved into full-time cancer program administration, Jack Evjy, M.D., is teetering on the verge. After 16 years in practice, Evjy is president of the Greater Lowell Cancer Program, a non-profit program of three hospitals, administers his own group practice, and still maintains his full share of an extremely active practice. Moreover, he is guiding the transition to product line management in three hospitals.

"I'm ready to cross over," says Evjy, discussing the possibility of moving to full-time management. "The number of hours and the amount of effort required to manage three different types of enterprises has become overwhelming, and I've come to realize that I have access to more resources, there are more opportunities, and I am more comfortable managing than I was."

The Challenge of Managing a Cancer Program In Competitive Times

At first glance, it may appear that the "physician executive" is merely a re-invention of the wheel. But anecdotal reports and recent surveys suggest that the emerging "physician executive" is indeed a new breed.

According to a recent membership survey by the American Medical Association (AMA), "physician executives" today are more likely to be in the job by choice and spending almost 21% of their time in clinical settings. Only 18% of survey respondents found management unrewarding, while just 4% had chosen a managerial position to get way from clinical practice. Even fewer (3%) gave income security as the motivation for choosing administration. The vast majority had chosen management positions for positive reasons: To make a broader impact on health care, assure quality of care, tackle new opportunities and challenges, fill a need in the organization, or because they enjoy applying their expertise to managerial activities.

These findings are almost exactly the reverse of previous

study findings and lend support to signs of change reported by other observers. In a membership survey published last fall, the American Academy of Medical Directors (AAMD), found that their members, on average, were younger than the AMA members, newer to management positions, and holding jobs that are relatively new to the health care scene. Involvement and accountability of physicians in hospital management has also been increasing in the areas of cost containment, priority and goal setting, program development, and utilization review. The number of hospital-compensated-physician administrators has also increased in recent years, along with physician membership and participation on boards.

Gale Katterhagen says that developing cancer programs used to be easy, but now it's a real challenge. "There are so many forces working on health care now, like money constraints and intense competition," he says, "but all of this makes the work challenging and exciting. I don't consider myself a program director, but rather an oncologic developer."

Notes Katterhagen, "We are beginning to see 'onco wars,' with pitched battles and frequent border skirmishes" because of the extreme competition for patients. With a larger supply of physicians and a shrinking pool of patients, the consequent competition for the remaining patient population is intense.

The announcement of his appointment and position came at a time of tension in Springfield, and rumors about his "real" purpose in coming to Springfield were rampant. One rumor claimed that he was coming to town with two other oncologists to set up a practice at Memorial to steal all the patients. The most imaginative reported that he would be appointed dean of the School of Medicine, and then admit his wife and children to the school, from which they would automatically graduate because he wouldn't fail them. "In retrospect, my wife, Anne, thought it would've been a clever way to pick up an M.D. degree."

Because rumors were running wild, Katterhagen made an effort to get to every kind of committee and medical meeting, since "everyone wanted to see this animal." Once the medical community was reassured that he did not plan to start a practice subsidized by the hospital and would only be consulting and teaching, many of the initial rumors dissipated. Having completed his first year in Springfield, he feels that his relationship with the medical staff is now on solid ground.

Clinical Care? How Much or How Little?

Although interested in medical management as a profession, Katterhagen, Enck, Evjy, and Winn are all adamant about keeping a clinical component in their careers. Katterhagen estimates that he spends approximately 85-90% of his time developing the cancer program, and 10-15% teaching in the medical school, consulting, or seeing patients with interns and residents. Every other Thursday, he staffs the outpatient clinic. While he says he misses some aspects of patient care, he definitely doesn't miss being on call or working weekends.

Evjy remains fully involved in his group practice, while coping with the management responsibilities that he has been rapidly accumulating. He doesn't want to leave the clinical setting and thinks it would be wrong to do so, but he feels that he is running out of hours in the day. "My administrative responsibilities developed as a parallel process," he observes, "which is not the best way to move into management." Evjy considers himself a coordinator, facilitator, and decision-maker, and he places a high priority on team work. "Team building is really the key ingredient, to get the program to emerge from your people, and essentially to lead by following. Physicians sometimes don't understand the people problems."

"Sometimes you have to help people see that conflict is often the result of ignorance and misunderstandings, not malice," says Evjy. And how does he cope with the proliferating demands of his responsibilities? "You have to learn how to say no without turning people off, how not to be in a hurry, and try to have fun." He has also learned how to get to the essence of a problem and to know what constitutes a good decision, as well as when not to decide and just leave things alone.

Finally able to have the time to devote to program development, Enck still feels strongly that physician administrators should continue to commit some part of their time, even if it is only several hours per week, to clinical duties. "It's important that I continue to appreciate the clinical considerations and requirements. I doubt that I can be a good administrator if I don't have a direct view of the clinical setting," he says.

Enck points to key program decisions that he would find difficult to evaluate, such as biological response modifiers, if his clinical skills weren't current. He also feels responsible for participating in the assessment of quality of care delivered by others and by the institution, and he feels his credibility in this area would be seriously compromised without clinical credentials. "How can I assess the quality of care provided if I don't know what state-of-the-art care is?" he says. As busy as he is, Enck acknowledges that it's tempting to drop clinical duties, yet he feels it is too important to stop. When he did stop seeing patients, for about three months while settling in at Riverside, he admits to missing the patient contact. Like Katterhagen, however, he doesn't miss the on-call weekends and interrupted nights.

Winn also made certain that in his new capacity, he spends approximately 15-20% of his time

in the clinical settings of a second opinion clinic and high risk screening clinic, both of which he initiated. Remaining in touch with the clinical side of oncology was a high priority for him, particularly after investigating some other administrative positions with no clinical involvement. In Winn's opinion, abandoning all clinical involvement for a purely administrative position can actually be "dangerous."

"There are three good reasons to keep seeing patients," says Winn, "First, it increases your credibility with your peers and with other patients. Second, you will miss it if you stop entirely. Third, it gives you a wedge when talking with hospital and other administrators. You can say you're actually out there and know what is going on in the clinical arena."

Still, clinical practice can be significantly different for the administrative physician. Winn, for example, admits that the arrangement at M.D. Anderson is unusual, even "a little unreal," but it contributes greatly to his enjoyment of practice. Since he is completely salaried, Winn doesn't worry about managing a private practice, which delights him. Nor are patient expenses a problem, as Anderson is a state institution and accepts all Texas patients regardless of their ability to pay. The removal of these constraints has resulted in a dramatic change in the practice aspect of his work.

After residencies at Harvard and Jefferson, Winn went into solo private practice. While in practice, he participated in community oncology programs as chief of oncology at St. Barnabas, won a CCOP award for the program, and helped to found the Memorial Adjunct Oncology Group. In private practice for 13 years, Winn saw the number of oncologists in the area mushroom from one (himself) to nearly 70 medical oncologists in 10 years. Competition and the restraints of a state DRG program significantly constrained the practice of quality cancer care.

Winn's work in the second opinion clinic has also required a shift in his previous manner of practice. At the clinic, he does not just express his personal opinion of a case, but applies the M.D. Anderson approach to managing particular patient problems. He is still in the process of learning the fine details of the Anderson approach to cancer management, but in general, he judges that Anderson is more aggressive than he was in private practice.

VIEW FROM THE TOP

A year and a half ago, Robert Clarke, CEO of Memorial Medical Center in Springfield, Illinois, decided to recruit Dr. Gale Katterhagen to build a cancer program at MMC. He obviously did something right. Today, Katterhagen is finishing his first year as executive director of the Comprehensive Cancer System, and the cancer program is off to a fast start. Since his plan of action seemed to work so well, we asked Clarke to offer some advice for hospital administrators wrestling with the question of recruiting a "physician executive" to manage a cancer program.

In Clarke's opinion, when you recruit a cancer program director, you are choosing a leader, not just an administrator for your program. The decision to recruit a leader, he says, should be "the second strategic planning decision you make." The first decision is to determine the needs your program is going to meet, which is accomplished by conducting a marketing analysis of regional health needs. Once those decisions are confirmed, Clarke stresses, "recruit your leader as soon as possible, because they should be involved in everything that takes place after that point."

Robert T. Clarke, M.H.A.
Memorial Medical Center
Springfield, Illinois

But how do you know when you need a "physician executive" for your program? "Any major clinical program that has been designated as a priority program should, in this competitive environment, have an effective change agent as a leader. You should have a leader in charge of every major product line that is considered a priority at your institution," says Clarke.

Leaders don't necessarily have to be physicians, but physicians bring unique traits to administration. If you think your program needs the clinical expertise of a physician, Clarke suggests keeping several things in mind:

1. Choose someone who is an "effective, charismatic change agent." Clarke particularly feels that the leader must be experienced in implementing change, and functioning in a changing environment.
2. Make sure the person you recruit has a broad awareness of where the specialty is headed, particularly on the national level. Otherwise, your long range planning may be off target.
3. Insure that your candidate "knows who the players are in the specialty, the organizations involved, and how to influence them."
4. Assess whether this person can make the switch from a case management approach to an organizational problem solving viewpoint. This switch may be especially difficult for the clinician who is accustomed to focusing on individual patient problem solving. Clarke points out, "Your leader must know how to set up the organizational systems to prevent problems,