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,

Building Cancer Programs: Budgets, Staff, and Administration Support

The recent AMA survey confirmed that private hospitals employed the largest number of physician administrators, closely followed by government and academic environments. There are good reasons for hospitals and physicians to join forces. Managerial positions offer physicians a means of influencing hospital programs, and an opportunity to merge the power of their clinical expertise with a legitimately defined organizational role.

On the other hand, hospitals are becoming more interested in integrating administrative and clinical decision making as strategies for providing health care change. Economic constraints, reimbursement procedures, changes in technology, rising medical costs and new, formal organizations of physician practices have made hospital management increasingly complex.

Part of the appeal of this new "physician executive" specialty undoubtedly stems from the evolutionary nature of the role. Hospitals vary the duties to suit their needs but in many instances, physicians have the opportunity to design positions that match their professional interests and talents. Evolution can be risky, however, and many potential pitfalls await the uninitiated executive. Not all administrators, or physicians for that matter, have a clear vision of the role and territory of this new specialist. Physician administrators perform a variety of roles, which differ according to the needs of the hospital, personal skills, and level of management. Job descriptions may be vague or left to the new administrator to prepare.

Balancing several roles may mean juggling conflicting sets of demands, while adjustments to a new non-clinical professional identity must also be made. Relationships with medical staff members and hospital administrators must be developed, or revised. In addition, the physician is now part of an organizational structure, not an independent entity, and must learn to operate within that structure. The executive's position within the structure is critical.

Gale Katterhagen has control over his budget and personnel, and reports directly to the president and CEO of the hospital. With open

A CEO Talks About Recruiting the "Physician Executive"

and not just know how to handle the problems as they develop. It is important that the physician be able to step back and see the organizational concerns."

5. Choose someone with people skills. "People skills are critical for leader ship," says Clarke, "particularly for the physician who will need to be able to give comfort to practicing members of the medical staff that the new leader will have no marketing advantage with respect to clinical practice." The medical staff can be reassured of the new physician executive's role in several ways.

First, review the job description with them and discuss it. "Let them know what you are planning," suggests Clarke, "explain how the leader will fit in and what the clinical practice elements will be." Next, eliminate or minimize the clinical practice portion of the executive's time, and make sure the staff understands that the leader will not be competing for patients. For example, Katterhagen works with residents in the outpatient clinic but does not carry a clinical practice. Finally, Clarke urges that you "assure them that the executive will not be arbitrary in dealings with the medical staff, and that the administration will not favor the leader." It is critical that "the new leader not be allowed to circumvent the normal working process of the staff, that they continue to be involved in clinical decision-making, and the their administrator does not pre-empt the established process designed to achieve medical staff consensus."

Of course, there may be times when the physician executive must override the medical staff position, and executives should have such authority. He exercised this option himself when deciding to recruit a physician for the Memorial position, but Clarke warns, "You must exercise this option rarely, and only in extreme situations. Otherwise, it defeats the purpose of the process, and you will pay a price for exercising that option." In fact, Clarke feels that the executive should be charismatic and persuasive enough to solicit agreement on changes without invoking this option. If not, he observes, "You may have picked the wrong person."

The length of the recruitment process is a consideration, too. What time frame should an administrator allow to identify and recruit a physician executive? It will vary, of course, but Clarke suggests allowing six months, including time for mustering political support for the idea, and as much as a year if the person you want must relocate from out of town.

And finally, where can administrators find physician leaders best suited for these leadership positions? Are headhunters any help? "Headhunters would be my second choice," said Clarke, "They are expensive, but you can consider them. Usually they are generalists, though, and really don't know who the leaders are in the field, or what skills are necessary for the position. I think the best way is to approach the leadership of the major clinical organizations in that specialty and ask them who might be right for the spot, and who might be available. The organization should be one that understands the field, like the Association of Community Cancer Centers." ■

access to the CEO (they meet weekly) and a staff of six, Katterhagen finds that he has great support and resources. He is responsible for all aspects of the cancer program, including the tumor registry, the oncology unit, cancer committee, and all educational programs. Surgical oncology falls under the auspices of the department of surgery, but Katterhagen is expected to include these oncologists and the staff radiation oncologists in planning, and to strengthen their relationships with the cancer program. To date, he has functioned well with the other administrators but says the support that exists for the cancer program, which is a recognized priority, has made the difference. Says Katterhagen, "It would have been easy to come in here and get buried because of all the other activities going on."

Bob Enck considers his primary role to be the "glue man," the person who glues all the pieces together. "Riverside has all the pieces, but some need to be enhanced, and links, or connections, need to be made," Enck explains.

"I enjoy putting together things and feel I am good at organizing. Right now, I am working on pulling together a network of services for smaller hospitals and enhancing the data management system. Riverside has 1100 beds, and as part of the U.S. Health Corporation, it is affiliated with four other hospitals and manages two more. My most important goal is to tie things together."

Given that competition is increasing, Enck wants to be "out of the blocks ahead of the others," and plans to develop strong ties with the smaller hospitals by using the cancer data system, tumor boards, and a series of clinics, manned by himself and medical staff, including house officers. "The hardest pieces to get started are the organizational and educational programs, but we have already established the outreach clinics and an indigent clinic is underway," states Enck.

Enck reports to the medical director of the hospital for issues related to the medical staff and to the vice-president of Clinical Services for all other responsibilities. He has no problems with this dual reporting system because the cancer program, along with the Heart Institute and the Women's Health Program, are designated priorities and have long term administrative commitments.

Rodger Winn draws funding from three sources: New development funds, maintenance funds, and a small travel budget. Based upon the recent CCOP competition, a fourth source of support may soon be coming his way. As principal investigator of the CCOP research base grant, he will have full discretion for signing off on these funds. Currently, Winn has a two-year start-up budget, including a full-time administrator who is a masters-prepared oncology nurse, a junior attending physician, and a secretary...but more will be coming with the research base grant. At Anderson, Winn reports to the Chief of Medicine, with whom he has a good relationship but notes that above the chief there are several different chiefs, some of which are easier to go through than others.

"In a private practice or small hospital, you are usually not concerned about reporting. But in moving into administration, it is critical to know how many layers are above and below you, who signs off on your budget and plans, and what steps you have to go through to get things done," cautions Winn.

Is the Move for You?

"I'm not sure the move is for everyone," says Katterhagen, "It's hard to uproot, and leave your home, family, and friends. While it can be challenging and stimulating, not everyone can take the trauma."

Bob Enck and Rodger Winn agree that the physical move can be traumatic but also rewarding. "The physical relocation turned out to be very difficult," says Winn, who moved from Essex County, New Jersey, to Houston.

"First, there were two careers to consider, my own and my wife's, and she had a senior position with a large bank in New York. Though we scouted the opportunities for her, we received unrealistic opinions regarding the economy and, as it turned out, the opportunities that everyone assured us were there for my wife did not exist." Unfortunately, their arrival in Houston coincided with the crash of the oil economy.

The Winns also found themselves re-examining their values. Faced with purchasing a new house, they gave serious thought to their true needs and wants, weighing such decisions as suburban versus urban living, the length of the daily commute, extra space, and the physical size of the house. They settled on a smaller house, just seven minutes from downtown Houston.

At first, the Katterhagens didn't really want to move and couldn't imagine ever leaving the Pacific Northwest. Gale recalls that he and Anne spent many hours assessing the pros and cons of their dual recruitment offer. Initially, he was more enthusiastic than she but after three or four visits to Springfield and lots of late nights talking over a bottle of wine, they decided not to move unless they both said yes. Anne's career and role was equally important as Gale's, and they essentially negotiated a package deal. The attraction of building a new program was ultimately what won out. "Anne did all the negotiating," says Gale, "and she did a hell of a job. She's very smart, a tough negotiator, and a better businessperson than I am."

Although the Katterhagens' three grown children were not thrilled with the idea of their parents leaving Tacoma, they told their folks they should "go for it." "Our three children are all adults now and didn't think their parents should live the last third of their lives for their children, especially since they felt free to accept jobs

outside the area themselves. They felt we shouldn't pass up the opportunity, and although we get homesick for each other, we have been able to visit frequently."

The Encks wanted to go to a place with potential, one that was growing, and that had a good quality of life. Still, the transition was rough. "It was a tough decision to make, but Martha and I both felt it was the time to make a move," says Enck. "The move itself was complicated by the slow sale of our house in Binghamton when IBM, the City's largest employer, went into a hiring freeze. We left in September but didn't sell the house until February. While it was difficult to leave our house and friends, we really like Columbus. Of course, the kids (boys 6, 8, and 10) weren't happy, but we involved them right from the beginning when we knew we would be looking outside Binghamton for a new job. And, they settled in fast. Within two weeks, the boys were in school, on athletic teams, and making new friends."

During the same period of time, Bob began coaching touch football. "The only time the boys want to go back now is when things aren't going well at school," says Enck. He suggests that the move was probably hardest on his wife, Martha, who left a close network of friends and community activities, and did not have a ready mechanism like school or work to help her develop new relationships.

Generally, however, the Encks are pleased with their new home town and have found it an easy place in which to make friends.

Stress and Education--Preparing for the Change

The stress of assuming new roles and relationships as a physician executive may be intensified by difficulties in applying their clinical skills to management situations. Many of the skills refined by years of clinical practice compliment administrative activities, but it's not unusual for physician executives to lack the business-oriented managerial training needed to operate effectively in their new position.

Eighty-one percent of the physician respondents to the AMA survey indicated that it was either "advisable" or should be a requirement for physician executives to seek additional, formal education. Recommended areas of study included computer applications, personnel and labor relations, accounting and finance, strategic planning, quality assurance, and management of other physicians and health professionals.

Several universities have recognized the growing numbers of physician executives and their particular needs, and they are starting to offer non-traditional courses and master's degree programs for clinicians. The University of Wisconsin currently offers a master's degree in administrative medicine.

Courses, educational seminars and workshops, and other resources are also available from the American Academy of Medical Directors (AAMD), the only professional association exclusively for physician executives. The wide range of educational programs, as well as journals, publications, and other resources are intended to help physician executives acquire or enhance administrative skills and stay up on trends in business and management. Also available from AAMD, which includes 2,300 members, are placement opportunities through a national registry, assistance in developing management positions and recruiting physicians, problem solving assistance, and a forum for the exchange of ideas and experiences.

The Academy certifies physicians by examination through its American College of Physicians Executives (ACPE), which was developed with the collaboration of the National Board of Medical Examiners. Fellowship in the ACPE is awarded to physicians who pass the certifying exam and have demonstrated excellence in clinical practice and administration. A committee is now pursuing the possibility of formal recognition as a specialty or subspecialty board.

Is it Worth it?

It is clear that the shift from a clinical to an administrative career may involve far more than just a new office or home telephone number. Katterhagen, Enck, and Winn made significant changes in their lifestyles and those of their families. Evjy, though he hasn't relocated, admits to virtually working two jobs, "100% clinical and 100% administration," which has caused him to re-evaluate his capabilities and priorities and work hard to balance his personal life. Personal as well as professional values and goals must be given careful consideration in the decision process, and even then, there are no guarantees that all bases will be covered.

Physicians considering a professional change and, thus, perhaps a physical relocation as well, may benefit from the advice of those who've taken the plunge.

Katterhagen emphasizes that "...you must really learn to know yourself. I'm convinced that I don't have a left brain. I wreck havoc with details, but I can see the big picture and develop the program." He points out that there are no how-to manuals on organizing programs, but he is constantly learning and working on new things. For Katterhagen, continually stretching his skills is exciting and challenging, but for someone else, it may be too stressful.

Bob and Martha Enck found it helpful to actually write out a list of pros and cons when they were evaluating their options. Though both felt it was time for a change, they were concerned about leaving behind close friends and parents. Ultimately, the need for change prevailed, but the process of relocation was still hard.

"Be honest with yourself--know your focus," advises Rodger Winn, "Don't take a job without knowing