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The Leadership GAP and the Future of Cancer Care

Lee E. Mortenson (Senior Editor, ACCC Executive Director)

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Senior Editor
Lee E. Mortenson, M.S., M.P.A.
ACCC Executive Director

Managing Editor
Marilyn Mannisto

Production Editor
Carol K. Johnson

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FROM THE EDITOR

THE LEADERSHIP GAP AND THE FUTURE OF CANCER CARE

As I travel around the country speaking for the Association and consulting with programs, I am struck by the overwhelming need we have for clearheaded leadership in health care. Perhaps this is true of every profession and type of organization, but the needs in health care are extremely acute, and the number of individuals who are available to meet the challenge are few and far between.

You might note that I specified "clearheaded" leadership; people who are willing to do their homework, make a decision, and stick with it. This is extremely difficult at almost every level in health care. Think back for a moment about all of the critical decisions to proceed or not to proceed with an important, breakaway strategy or approach that you recall being made at your institution. How many of them got watered down, or fell apart, or were picked apart? With all of the well educated, sophisticated, self-interested individuals we have in health care we end up cancelling out decisions that are critical instead of taking bold, effective stands.

One of my academic colleagues in health care administration recently told me of three ways that hospitals are organizing according to product line. The first way is to organize on paper and then to cut costs by product line. This has no beneficial impact whatsoever. The second way is to invest heavily in the success of a specific product line for about 18 months and then, as other programs demand attention, waffle and invest in another product line. This does not work. The third way is to invest in a product line for three to five years and beat it to death. Back it to the hilt. Give it everything that it needs. Bend over backwards to make it the best thing on the block. This works like gangbusters! And, we have seen it work in a few great oncology programs.

So why doesn't it happen more often? The problem is that we have too many voices speaking against almost any new or radical move, even if it is positive. We have too many voices clammering for recognition. We worry a good decision to death and, too often, we don't stick to our guns.

When something does happen, you often see very strong leaders who take big-time chances and expect to get roundly criticized. Our incentives tend to promote accommodation rather than a "guns-on-the-table, let's take a vote, let's stick with it and take a chance" kind of leadership. Perhaps, it is not so surprising that we find reluctant, grudging praise for the hospital CEO or organizational leader who is somewhat autocratic. It is this type of individual who tends to get something done and to improve things.

Now, it may sound like I am advocating the kind of health care governance that we are seeing crumble in Eastern Europe. Well, yes, to a degree. The health care arena is so fragmented, with so many different forces at work, that we can barely afford the faint hearted. Health care is becoming more like the Gordian knot every day. We need hospital leaders, medical directors of cancer programs, and organizational leaders who are willing to back their convictions.

So, how do we get more of them? First, there is some truth to the fact that leadership is, in part, inherent. Some individuals have the ability to recognize patterns that others do not. However, pattern recognition is something that we all have as a potential skill. The problem is that not many people have exposure to a variety of decisionmaking situations and environments to enable them to see the patterns.

Second, it is easier to be a leader somewhere else. You are never a prophet in your own land. Most leaders start to put together programs in one institution, run into roadblocks, generate a great deal of scar tissue, and migrate to another institution where they tend to garner more respect (probably because they are more war-torn) and do a great deal better.

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ACCC APPROVES 18 COLLABORATIVE RESEARCH GROUP PARTICIPANTS

The Steering Committee of the ACCC Collaborative Research Group has approved the applications of 18 ACCC delegate institutions for participation in the ACCC Collaborative Research Group (CRG). (See box at right). More than 130 additional applications are in the midst of the review process.

The Steering Committee has also approved participation in two clinical protocols sponsored by Adria Laboratories. Approved participating institutions will be receive RFPs for these two protocols. Robert Enck, M.D., former ACCC President and now Medical Director for Adria Laboratories, presented an overview of the protocols at the Annual Meeting. In brief, the protocols are as follows:

- ADR-529 as a cardioprotective agent in a phase III randomized trial of FAC vs. FAC + ADR-529 in the treatment of disseminated carcinoma of the breast.
- Phase III efficacy and safety trial of toremifene vs. tamoxifen in postmenopausal patients with metastatic breast cancer.

ACCC Executive Director, Lee Mortensen, said that the Collaborative Research Group will provide many benefits to approved members, including the strengthening of individual indemnification clauses, consistent reimbursement for patients on trial, and the possibility for members that have no proven track record in clinical research to attain provisional status to allow for their participation in approved protocols.

PROSTATE CANCER AWARENESS WEEK

The Prostate Cancer Education Council is gearing up for its second annual Prostate Cancer Awareness Week, a national public education and screening effort scheduled for the week of September 16-23, 1990.

The Council hopes to screen 25,000 men nationwide at more than 200 sites in 1990. Last year, nearly 15,000 men received free examinations at 81 locations in 30 states and Washington, D.C. ACCC participation was invaluable, and delegate institutions have been asked, once again, to help fight the most common cancer among men.

ACCC involvement in the program is vital to the success of the 1990 campaign. As you know, the community goodwill and visibility generated by your screening. efforts can also be valuable to your institution. Information on how to get involved has been mailed to all delegate members with a May 30 deadline date. ■

ACCC COLLABORATIVE GROUP PARTICIPANTS

Centre Community Hospital, State College, PA
Community Hospitals of Indianapolis (IN)
Decatur (IL) Memorial Hospital
Frederick (MD) Memorial Hospital
Good Samaritan Regional Medical Center, Phoenix, AZ
Grand Rapids (MI) Clinical Oncology Program
Grand View Hospital, Sellersville, PA
Kalamazoo (MI) Community Hospital Oncology Program
Medical Center Hospital, Tyler, TX
Mercy Hospital Cancer Center, Scranton, PA
Mercy Medical Center, Cedar Rapids, IA
Mobile (AL) Infirmary Medical Center, The Cancer Institute of the South
The Reading Hospital & Medical Center, Beaver, PA
Schumpert Medical Center, Baton Rouge, LA
South Community Hospital/Central Oklahoma Cancer Center, Oklahoma City, OK
St. Luke's Hospital MeritCare/Roger Maris Cancer Center, Fargo, ND
Virginia Mason Medical Center, Seattle, WA
Winthrop-University Hospital, Mineola, NY

From The Editor

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Third, leaders tend to get to the point a lot quicker. After you've been a consultant to two or three dozen programs where everyone listened politely and then didn't do anything, you tend to be more direct and honest; you tell people what needs to be done, what the costs are, and whether there is any chance that they are going to be able to do it right. Of course, this is a lot easier to say if you are from somewhere else (see point number two)!

Fourth, leaders tend to have vision. This isn't so surprising if they have seen a lot of programs succeed and fail.

Fifth, leaders go for the right decision, rather than the easy one. They are willing to compromise or alter their position if new data emerges. They do not tie their ego to a particular position; they look to maximize the outcome by pressing for the "best" solution and then, if necessary, working for the next best accommodation. They tend not to become defensive if you challenge their position. They also tend to give others credit; usually their ego is big enough to allow others to succeed and get the glory.

Where do we find these individuals? That is a critical problem in cancer care. The first generation of cancer leaders has, with a few notable exceptions, passed out of the picture. This is true at the university level and in community cancer programs. These were the individuals who had an opportunity to build programs when money was plentiful and health care was on the high road (although many of them did not know it at the time). Now, as our situation becomes increasingly complex, and as tougher decisions need to be made, tough-minded leaders are required; individuals that still hunger to build quality programs, regardless of the costs of the battle, and who see how that can be accomplished.

Many of the individuals involved in ACCC are the type who have started down the leadership path within their own communities. Our task is to help them continue down the road so that, despite the forces against success, a number of truly great cancer programs, accessible to patients throughout the nation, emerge and survive.

Lee E. Mortenson, M.S., M.P.A.
Senior Editor,
ACCC Executive Director