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SUCCESSFUL ONCOLOGY PROGRAM DEVELOPMENT: OVERCOMING THE BARRIERS

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Changing patient care delivery systems is an important challenge for the health care organization that is cost conscious and quality sensitive. The development of a viable oncology program is one such delivery system change that can streamline services and improve patient care. But once a hospital has made the decision to develop a comprehensive oncology program, the work has only begun. Many hospitals underestimate the barriers that can, and often do, sabotage the best of efforts.

Time and time again, the same issues and questions arise. The following observations should help those institutions that are either contemplating or are currently developing an oncology program. This article provides an outline of a few key parameters that are essential to program success, and which every hospital should consider.

Pre-Planning Challenges

Which word describes your hospital's environment and agenda for change: dynamic or dynamite? There are typically five barriers to successful program planning and development in the hospital setting that need to be considered. Or, in other words, there are five structural requirements needed to create the environment in which program planning and development are most likely to succeed. The challenge to hospital management is to create an environment that will allow the necessary, comprehensive business planning process to take place, and to have long-term value.

The five barriers to successful program planning and development that will be discussed here are in the areas of:

- Hospital-physician relations
- Hospital corporate culture
- Hospital strategic planning
- Hospital business/program planning
- Hospital organization charts

Hospital-Physician Relations

The very terminology of "hospital-physician relations" is adversarial. It pits man (the physician) against the established institution (the hospital). It evokes cliches about not being able to "fight City Hall."

Physicians are identifiable personalities. They are usually relatively stable entities who tend to remain in the same community for the duration of their careers. Physicians build a community following that tends to remain loyal to them. This loyalty may provide political influence for physicians if some of their patients are influential members of the hospital board, auxiliary, or local political structure.

In contrast, the hospital is an organization or institution. It is faceless and lacks an easily identified personality. It has a reputation based on factors relating to patient carequality and its physicians. Moreover, hospital managers are typically transient, nationally averaging less than four years in their positions before moving on. Consequently, hospital managers may be viewed as less stable entities whose commitment is more allied with their overall career path than the well-being of the community.

Hospitals need a new terminology to change the chilling, subconscious perception of an imbalance between the institution and its physicians. They need to discard hospital-physician disparity in favor of terminology suggesting balance and parity. The proposed focus of the new terminology should be outcome-oriented, rather than participant-oriented. This shift in focus changes a negative impression to a positive impact, and an imbalance of interests to a unified interest.

An example of participant-oriented versus outcome-oriented planning is the hospital's once common "Physician-Nurse Liaison Committee." This committee usually is charged with trying to improve communications and cooperation between the medical staff and the nursing service. These two memberships are well aware of their adversarial history. They are reminded of this history every time they see a Liaison Committee meeting notice. But what would their conscious and subconscious perceptions be if the committee was renamed the "Collaborative Practice Committee?" Most likely, the focus of the committee would take a positive shift toward what they wanted to build, rather than what they are compelled to rehabilitate. Some hospitals have already made this transition, supporting an overall fundamental change in patient care delivery. But unless all hospitals embrace this concept, we will continue to see only sporadic success in the long-term, positive redesign of physician-nurse relations.

The disparity between hospitals and physicians creates a similar perceptual handicap or structural barrier to the development of positive models of cooperation. What if the hospital decided to develop a comprehensive oncology program partnership rather than a hospital-physician joint venture? Regardless of whether the program required joint planning or a more complex joint venture, the perceptual barrier of disparity is removed from the picture.

Corporate Culture

Changing terminology is a fairly easy step; changing corporate culture is a much

more difficult challenge. In an ideal environment, the attitude of the management team is collegial and collaborative. Management is viewed as a respected source for developing and maintaining hospital-based programs, as well as supporting physician practices. In this same ideal environment, physicians are viewed as indispensable customers, as well as partners in the planning and delivery of medical services to the community.

In an ideal environment, you can choose your partners. In the real world, management inherits the majority of its medical staff. If management does not get along well with a particular physician, it may believe there is little it can do about the situation. On the other hand, the medical staff is well known for its ability to displace administrators and members of middle management that they are unhappy with.

The path to management-medical staff harmony, as well as oncology program success, begins with re-defining or creating a new, more collaborative, corporate culture. The new corporate culture assumes membership by the medical staff. There must be a more enlightened attitude about the value and importance of collaboration and cooperation between management and the medical staff. Education may be required to change prevailing attitudes. Management and the medical staff must learn how to constructively manage the interpersonal relationships among all partners and constituencies. And they must demonstrate the value they bring to the settings in which they must share functions and responsibilities.

The corporate culture must reflect this positive attitude both in terms of personal behaviors and operational behaviors. This attitude must be fostered and constantly reenforced by the CEO and the chief of oncology. It is a choice between management changing the corporate culture for the better, or having the prevailing culture (dominated by antagonism toward the medical staff) change the management.

Therefore, when a hospital is developing a comprehensive oncology program, it is essential that the CEO and the chief of the service share the same goal of instituting and supporting a healthy work environment. This environment should be one in which change is embraced, risk taking is encouraged, and program "glitches" are viewed as opportunities for further development, rather than marks of failure.

Strategic Planning

How and when the hospital makes the decision to develop a program plan is too often a mystery to the medical staff. In most hospitals, the board of trustees annually reviews or approves a long-range strategic plan. The process is one in which management, often with the help of a board-level planning committee, prepares its recommendations for the plan. This is preceded by management planning retreats, research, and various internal committee meetings, all of which contribute to the gathering of information for decision making. Generally, these meetings are among various groups of senior and middle management.

The structural problem in many strategic planning processes is a matter of who is involved, when they are involved, and how they are involved. The term "strategy" too often connotes a secretive process that will result in a secret document, rather than a visionary process that will create a consensus of direction. This sometimes secret document is often viewed as something to be implemented to surprise "the enemy." But one must sometimes wonder if management perceives this enemy to be outside the walls of the institution or within the medical staff.

If the strategic plan is to contain recommendations regarding the oncology program, oncologists and other key program personnel should be involved in the development of those recommendations from day one. Furthermore, they should have access to, and fully understand, all of the literature research and market research that forms the basis for management's recommendations to the board.

The input of oncology program physicians and key personnel must go beyond their personal desire for a larger program. They must be allowed, encouraged, and required to participate in developing the substantive, quantitative support for creating or expanding the program. If management wants to form a joint venture with the medical staff, the implied partnership demands the full participation of physicians at the outset. The medical staff's understanding of the business planning process is important, and physicians may require intensive education at the beginning of the strategic planning process as to the required elements for effective decision making that will result in sound recommendations.

Business/Program Planning

The next structural imperative involves how the comprehensive business or program planning process is organized and carried out. The most common approach is to have the marketing or planning department, with the help of the finance department, develop the basic elements of the plan. At the same time, or after the elements are crafted, one or more planning committees are formed. The levels and membership of those committees may include the board, management, the medical staff, or joint management-medical staff.

Understandably, management reports information from the planning committee to a board planning committee. The purpose of this committee is to concur on policy issues and to evaluate the overall readiness of a plan for presentation to the full board. To overcome the structural barriers in this process, it would be best if the committees mentioned above were condensed into a single management-medical staff committee to encourage interdepartmental decision making and to reduce red tape.

The joint management-medical staff committee is typically organized to provide management updates to the medical staff concerning what management has so skillfully and knowledgeably created. Herein lies an important structural problem. If management does not want anything more than superficial medical staff participation, the involved managers need to make some important changes in their attitudes. If management has the perception that physicians are not interested in the details, this perception must be discarded. If the medical staff expresses a lack of interest in participating at this level, management should feel anything but relieved.

Interactive planning among all key players is essential to success. A lack of interest on the part of any member of the medical staff, in what should be a program of keen interest to them, suggests a passive resistance that will resurface in the future. Even if the medical staff has come to believe that management truly is working in its best interests, and is confident that management will develop a sound plan, management must nurture this confidence by insisting on ongoing management-medical staff collaboration on all key program planning efforts.

The ideal structure is to give the joint committee responsibility for crafting the

initial plan. The members of this committee should accept appropriate assignments to gather or analyze information, to keep each other informed about what information is being collected and what conclusions are being drawn, and to keep their respective constituencies abreast of program planning issues and directions.

Hospital Organization Charts

Although the organization chart is listed as a separate structural barrier, it also can be viewed as a common theme in the first four structural requirements discussed above. Physician involvement is a common thread that can create substantial management support or result in a management organization that is crumbling in front of the CEO.

The fact is, the positioning of a hospital organization on a pyramidal chart with its layers of bureaucracy ensures the retention of "old-time" politics. In such charts, the medical staff is usually included by means of a dotted line loosely connecting it to the board of trustees. The medical staff is usually positioned below the board and on a level with the CEO. Sometimes, the medical staff is positioned slightly above or below the CEO. Regardless, a hospital organization chart creates another perceptual or structural barrier to effective business planning. It makes explicit the perception that there is a management organization vying for power with the loosely-connected, but powerful, medical staff. These organizational structures encourage compartmentalization rather than collaboration.

The technical issue that members of the medical staff are not, in most cases, employees of the hospital makes it easy to justify the dotted-line relationship, both mentally and operationally. A better argument exists for throwing out chain-of-command organization charts in favor of functional organization charts.

It is counter-productive to produce charts that only symbolize formal superiority relationships. It is more productive for people to know what they are supposed to get done and with whom they are to do it. If hospital organization charts symbolized the real chain of command, as far as who is supporting whom, changes in the type of line and the location of the medical staff might be an eye-opener, both to management and to the medical staff.

Both the organizational set-up and the corporate culture must encourage team development and function, they should bridge all patient care areas, and they should eliminate traditional barriers. Decision making must occur in a "seamless" environment.

10-Point Checklist for Success

1. _____ The CEO has created a positive climate for change.
2. _____ Appropriate managers and members of the medical staff clearly understand the goals of the project.
3. _____ The managers, personnel, and members of the medical staff responsible for program development understand the essentials of team work and interactive planning.
4. _____ Key oncology program personnel responsible for program implementation are involved in all phases of planning and business evaluation.
5. _____ Management-physician relations are stable, and problem-solving is collaborative.
6. _____ Strategic planning is an "open" process that encourages the involvement of all affected parties.
7. _____ The business plan is crafted by a joint, interdepartmental committee which has, at hand, all of the information needed to make sound projections and decisions.
8. _____ The organizational structure facilitates quick decision making.
9. _____ There is a structure in place for ongoing follow-up and evaluation by the multidisciplinary committee.
10. _____ The oncology program philosophy identifies the patient as its focus.

Discussion

Management has an important role in directing the hospital environment in which the medical staff has the privilege and responsibility of caring for members of the community. Management must recognize that the medical staff is both a vitally important customer and an essential business partner.

On the other hand, physicians must recognize that they are not only care givers; they must accept responsibility for helping to plan and develop the environment in which they work. For the medical staff, management must be viewed as a vitally important provider of resources, and as an indispensable partner in planning and providing for additional resources. Physicians have a critical responsibility for doing everything they can to help their patients. One facet of that responsibility that must be greatly enhanced is the role physicians play in helping hospital management plan for the maintenance and growth of patient care in the hospital environment.

In the same manner that businesses are admonished to contribute to the welfare of the general community, physicians must contribute to the welfare of the hospital environment by participating in planning and program development functions. Management must contribute to the welfare of the community by creating a system of structures that allows their fundamental business partners to participate equally in planning for the future of the hospital.

To create and maintain these structural requirements, management and the medical staff must be re-educated regarding their roles and responsibilities for the future. Successful transitions may require one or more forms of guidance or "marriage counseling" to help the two groups better communicate and work together.

While some changes can be made more quickly and easily than others, enabling structures must be put in place. Otherwise, making minor changes only for cosmetic reasons—a facade that management and the medical staff will soon see through—will result in more frustration and, ultimately, a return to the traditional barriers confronting program development.

The commitment to create a barrier-free, seamless environment must come from the CEO first. The ultimate goal, and the ultimate outcome, should be the same: improved care, with the patient as the focus, and the team as the provider of services. ■