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Cancer Program Medical Directors: Results of a 1997 ACCC Survey

by Charles H. Nash III, M.D., F.A.C.P., and Donald Jewler

In May 1997 the Association of Community Cancer Centers conducted a national survey of cancer program medical directors. A questionnaire was mailed to 936 cancer program medical directors in the United States. The goal was to collect information on duties, reporting structures, compensation, participation in managed care and alliances, and job satisfaction of physician managers. A total of 113 responses was received—a response rate of 12 percent. Responses were anonymous; there were no follow-up mailings.

This article presents the results of this survey and provides some comparisons with the results of ACCC's 1992 survey of 143 medical directors. Percentages presented in this article are derived by including only the medical directors who responded to a particular question.

A BROAD SCOPE OF RESPONSIBILITIES

The ability to interpret the meaning of survey responses from oncology medical directors is dependent in part on a clear understanding of their perspective. The medical director is so titled not because he or she obtained a medical director degree, took a medical director training course, or learned through experience all the right moves to make in the arena of cancer management. The medical director is chosen mainly because he or she possesses medical knowledge important to the organizational and fiscal management of a cancer program. The physician's medical degree, experience in the field of cancer therapy, good reputation in the community, and excellent leadership and communication skills are necessary prerequisites to aspire to the position and then succeed. Without the contributions offered from the studied clinical viewpoint of a physician, hospital-based cancer programs might to their detriment ignore many considerations vital to the care of human beings.

Always keeping the welfare of patients and families in mind, the medical director must understand the pitfalls involved in dealing with and sometimes negotiating with fellow physicians. The director might have occasion to line up with or against colleagues on certain issues. Due to the major impact of cancer-related illnesses on hospital costs and revenues, oncology medical directors in particular must be able to function in a hospital's organizational structure as well as in physician circles. The medical director's scope of responsibilities is very broad and might easily encompass coordination of clinical oncology practices at the hospital or cancer center, oversight of research activities, and supervision of nursing personnel. In addition, he or she may provide necessary input on strategic planning and the setting of goals and objectives for cancer program matters, including acquisition of new technology. Almost certainly the director will be expected to represent the cancer program to outside organizations on local, state, and national levels, and may participate directly or indirectly in fund-raising efforts. Many directors oversee implementation of a quality improvement program for the cancer program and may help sponsor educational symposia to improve the general level of cancer care in the community.

In this era of increasingly managed oncology care, the medical director must stay abreast of recent developments in national legislation affecting oncology care delivery, patient access to care, payment policy, and competitive challenges. Most directors also maintain an active clinical practice, with the apportioning of time to clinical versus administrative matters always at issue, given the rigors of the specialty and the expectations of the parent institution.

OVERVIEW OF SURVEY RESPONDENTS

Table 1 shows a breakdown of survey respondents by bed size and geographic region. Median bed size is 400-499. Median population of the community and primary market area in which the institution is located is 250,000-499,000. An average of 1,110 new cancer patients are seen annually. About four out of five cancer programs have an administrative director.

Market competition, the growth of managed care, and decreased funding for clinical research are causing some medical directors to re-evaluate current programs and, in some cases, to downsize their centers. However, survey results show that the majority of respondents, regardless of the size of the institution, offer a wide array of multidisciplinary services, especially psychosocial services (89 percent), prevention/screening programs (83 percent), and home care (80 percent), as well as clinical research (69 percent).

Although institutions that have a medical director tend to have established cancer programs or an institutional commitment to develop a quality cancer program,

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Table 1. Distribution of Respondents by Bed Size and Geographic Region*

Bed size	NE	MAT	ENC	WNC	SAT	ESC	WSC	PAC	MT
0-49			1		1				
50-99				1				1	
100-199	2	4		2	2			2	1
200-299	2	4	5		1		1	3	2
300-399		3	7		5	1	2	4	2
400-499		5	4	2	1	1		3	
500-999	2	5	5		6	2	4	4	1
1000+		1			3			1	
TOTAL**	**6**	**22**	**22**	**5**	**19**	**4**	**7**	**18**	**6**

* The nine census regions include: Northeast (NE) (Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, and Connecticut); Middle Atlantic (MAT) (New York, New Jersey, Pennsylvania); East North Central (ENC) (Ohio, Indiana, Illinois, Michigan, Wisconsin); West North Central (WNC) (Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas); South Atlantic (SAT) (Delaware, Maryland, Washington, D.C., Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida); East South Central (ESC) (Kentucky, Tennessee, Alabama, Mississippi); West South Central (WSC) (Arkansas, Louisiana, Oklahoma, Texas); Pacific (PAC) (Washington, Oregon, California, Alaska, Hawaii); Mountain (MT) (Montana, Idaho, Wyoming, Arizona, Colorado, New Mexico, Utah, Nevada).
**3 of 113 respondents did not indicate state of origin.

a surprising number of respondents already offer progressive, innovative services, such as dedicated pain management (48 percent) and outreach programs (61 percent). Almost half offer site-specific services, most often a breast center.

EXPERIENCE AND BACKGROUND

The predominant, official title of responding physician managers is "Medical Director" (77 percent). The only other title mentioned with any frequency was Director of Oncology [Services] (4 percent).

A significant percentage of medical directors have held their current position for five or more years (39 percent, compared with 31 percent in 1992). Just 15 percent of respondents have been medical directors for less than one year, compared with 20 percent of respondents in 1992. The remaining respondents indicated that they have been a medical director for one to two years (26 percent) or three to four years (20 percent).

Most respondents work in a community teaching hospital (44 percent) or in a community nonteaching hospital (37 percent). About 9 percent of respondents work in a consortium or multihospital system. In the 1992 survey most respondents worked in a community nonteaching hospital (59 percent).

None of the respondents indicated that they hold a business degree in addition to their medical degree. The majority indicated they had *not* previously held a hospital management position (86 percent, versus 78 percent in 1992). However, almost half have previously held an administrative post in a hospital (department chair, chief of staff, etc.).

When medical directors were asked how they obtained their current position, 58 percent stated that they were approached by the management of an institution with which they were already affiliated. Nineteen percent were approached by an institution with which they were not affiliated. Only two respondents answered an advertisement for the vacancy, while nine respondents used the services of a recruiting firm.

About 78 percent of physician managers are medical oncologists, 56 percent of whom specialize in both medical oncology and hematology. Other specialties include radiation oncology (14 percent) and surgical oncology (8 percent). Most physician managers (85 percent) still maintain a private practice, of which a majority are members of a group practice. Just 12 percent of respondents indicated they are in solo practice. More respondents reported their practices are hospital-based than private office-based.

Competition remains a fact of life, although mergers and alliances have changed the hospital landscape over the past five years. Today about 47 percent of the respondents compete with four or more hospitals, compared with 84 percent of respondents in the 1992 survey. About 14 percent of today's respondents compete with three hospitals.

REPORTING STRUCTURES

Many medical directors report directly to the CEO of the cancer program's affiliated institution (33 percent) or to the vice president of

Table 2. Duties of the Position

Primary Responsibilities	Level of Time/Effort		
	High	Medium	Low
Keeper of the vision	51%	34%	15%
Obtaining participation/cooperation of physicians	50	36	14
Maintaining an effective cancer committee/tumor board	50	34	16
Strategic planning	49	32	19
Developing/promoting clinical research	48	35	17
Fundraising for the cancer program	12	25	63
Helping to develop budgets and financial plans	10	30	60
Third-party reimbursement and managed care issues	8	34	58
Monitoring/managing contracts with physicians	8	20	72
Monitoring/managing contracts with nonphysician employees	1	13	87

medical affairs (30 percent). Other reporting relationships include the chief operating officer (16 percent). About 20 percent of respondents report to the Board of Directors or to "other" structures in the hospital.

In some cases (15 percent of respondents), the director has a dual reporting structure—for instance, the CEO regarding administrative matters and the Board of Directors regarding medical policy.

Medical directors tend to have more employees under their indirect supervision than their direct supervision. About 31 percent of respondents directly supervise eleven or more employees, while 63 percent indirectly supervise eleven or more employees. In fact, 29 percent of all responding medical directors do not have direct supervision of more than one or two employees.

Positions within the cancer program that most frequently report to the medical director include:

- tumor registry staff (52 percent)
- administrative secretaries (51 percent)
- nurse data managers and/or cancer program administrator (44 percent)
- tumor board (41 percent)
- oncology-related department managers (38 percent)
- hospice director (15 percent)
- radiation therapy staff (13 percent)
- marketing director (13 percent).

DUTIES OF THE POSITION

Medical directors view leadership responsibilities as the position's main role (94 percent). Few of the responding medical directors view their position as consisting primarily of management duties (6 percent).

The areas in which medical directors noted they spend the most time and effort varies. About half the respondents said they spend a high level of effort functioning as a keeper of the vision for the cancer program and in obtaining the participation/cooperation of physicians. On the other hand, most medical directors stated they spend a low level of time and effort monitoring/managing contracts with nonphysician employees or physicians (Table 2).

About three of four responses indicated that the cancer program has its own budget and resource allocation authority. Sixty-six percent of the responding medical directors have budget and resource allocation authority for their cancer program, close to the 71 percent in 1992. The most frequently cited areas for which the medical director has budget authority include travel (81 percent), education (77 percent), supplies (71 percent), research staff (64 percent), salaries (63 percent), and tumor registry staff (61 percent).

A large number (64 percent) of cancer programs obtain 95 to 100 percent of their funding from hospital operating expenses. About 17 percent of programs obtain 5 to 10 percent of their funding through endowments. In 14 percent of programs, community fundraising accounts for 5 to 10 percent of total funding.

Respondents cited cancer

Table 3. Full-Time Medical Director Salary Distribution by Hospital Bed Size*

Bed Size	$50–90K	100–199K	200–299K	300–399K	400K+
0–49					
50–99					
100–199					
200–299	1		1		
300–399			1		
400–499		1	2	1	
500–999		3	2		
≥1,000				2	

*does not include bonuses

program budgets ranging from $51,000 to $88 million with an average budget of about $6.55 million. Forty-eight percent said their budgets include patient care expenses. Finally, a modest number of directors (twelve) reported that their programs receive resource allocations in place of a set budget. The budgets include an average of fifty FTEs, with a minimum of four FTEs and a maximum of 400 FTEs.

COMPENSATION

Twenty-nine percent of responding medical directors are employees of the hospital, compared with 60 percent in the 1992 survey. Fifty-six percent have individual contracts, compared with 7 percent in 1992. About 15 percent are part of a physician group contract, the same percentage as in the 1992 survey.

The number of medical directors with a written contract has increased only slightly from the 1992 survey (79 percent versus 76 percent). For directors who have a written contract, the most common contractual provisions are the duties of the position (98 percent), reporting relationships (76 percent), and periodic performance reviews (68 percent). Twenty-seven percent of the responding medical directors receive additional compensation in the form of incentives/bonuses—up considerably from the 11 percent in the 1992 survey. Average bonus of all respondents is $24,000.

The length of medical directors' contracts varies: 37 percent report one-year contracts; 16 percent have two-year contracts; and 24 percent have three-year contracts. The remainder have contracts lasting four or more years.

Just fourteen full-time medical directors provided salary information (Table 3). Average salary of these respondents is $221,000, and their average bonus is $15,500. For those respondents in hospitals of bed size 400-499, the average yearly salary is $244,000. For those in hospitals of bed size greater than 1,000, the average yearly salary is $350,000.

Sixty-six percent of medical directors are paid a set fee for their management duties, compared with 85 percent in the 1992 survey. Seventeen percent receive an hourly rate, compared with 7 percent in 1992. Fifteen percent indicated their salary is based on percentage of time. Most part-time medical directors earn about $100,000/year, and they spend an average of twelve hours per week on their duties.

The most common fringe benefits are travel, health insurance, education, pension, and vacation.

CAREER DEVELOPMENT

Most medical directors are either satisfied (43 percent) or very satisfied (40 percent) with their decision to become a physician manager. The physicians who are somewhat dissatisfied (14 percent) or very dissatisfied (3 percent) are primarily part-time directors who view their role as medical director as a token position. They are also more likely to work in institutions in which the cancer program is not one of the top three product lines.

Satisfied directors point to the challenges of developing and expanding a cancer program, and having a greater voice in hospital management decisions as the main reasons for feeling fulfilled. Those who are dissatisfied express frustration with their lack of authority within the institution, their ill-defined duties as medical director, and the fact that they enjoy "patient" care more than "paper" care. Nevertheless, only 6 percent of respondents indicated that they intend to leave management altogether. Seventy-five percent of respondents intend to maintain their status quo as either a full-time or part-time physician manager, and 6 percent of part-time directors plan to seek full-time employment.

THE FUTURE

Medical directors believe that market competition poses the greatest threat to the future of their cancer

programs, followed by lack of organizational consensus and competition among product lines. Issues that do not seem to greatly concern physician managers include physician credentialing and conflict of interest/fraud and abuse regulations.

Regarding particular reimbursement issues, 36 percent of directors believe that reimbursement by private insurers and managed care programs will cause the greatest dollar losses to their programs over the next two years, followed by RBRVS (25 percent) and DRGs (16 percent). Only 6 percent of respondents believe that APGs will be responsible for large reimbursement decreases in the near future.

When asked what new programs or projects they were planning to implement during the next year, 45 percent cited outreach clinics (compared with 33 percent in 1992) and 42 percent cited initiating or expanding clinical research activities (compared with 60 percent in 1992). Whereas 60 percent of all respondents in the 1992 survey cited they were planning prevention/screening programs, only 37 percent noted so today. A significant number of directors will also be initiating marketing efforts (38 percent), site-specific activities (37 percent), and development of new technology (33 percent).

SUMMARY

The position of oncology medical director continues to mature and evolve as an important management component of the cancer treatment landscape. While previously it existed as a rather loosely defined, hospital-centered physician bonding tool, the typical medical director now appears to be more seasoned in the role with increased longevity of the position. Fewer persons are new to the role, and a larger percentage of community teaching hospitals now use such a person. Most directors still continue to work for or with a single institution, and hospitals continue to demonstrate their inclination to work with local oncologists to provide programmatic leadership. Medically savvy individuals are sought, with management degree training not required in any instance. The rigors of balancing a clinical practice with administrative duties make a group practice setting a must for directors desiring to maintain an active patient load.

The sample size addressing compensation of full-time medical directors was too small to reach any definitive conclusions. However, if the overall survey of 113 respondents is representative, the direct hospital employment of physician directors is decreasing, giving way instead to other innovative compensation strategies, including hourly pay, performance-based or time commitment-based models.

Not surprisingly, medical director satisfaction in the position is tied to feelings of empowerment and responsibility, with the lowest satisfaction ratings realized in situations where the director is only a token figure. Most physicians function poorly with such constraints.

As the need to effectively manage the costs and revenues attendant to an increasing oncology patient population expands, the assistance of a dedicated and empowered oncology medical director working in conjunction with hospital administrative personnel is invaluable. Complicated issues of treatment, cost control, and outcome must be carefully considered by specialists skilled in the intricacies of compassionate care delivery for these patients. The visionary physician leadership now accepted by hospitals on a part-time basis might well evolve into a more critical, financially important position in the future. Considering the staggering cancer prevalence rates in our aging population, it seems inevitable that the demand for effective oncology medical directors will only continue to increase.

A MEDICAL DIRECTOR PROFILE

If you were to create a profile of an average cancer program medical director, many of the following characteristics would be evident, based on ACCC survey results:

- Medical specialty: medical oncology
- Official title: medical director
- Reports to: CEO or Vice President of Medical Affairs
- Average annual salary: $221,000 (full-time)
- Average annual bonus: $24,000
- Time spent on management duties: twelve hours per week for part-time medical directors
- Number of years experience as a medical director: three or more
- Number of employees under direct supervision: less than ten
- Previous hospital management experience: none
- Business degrees: none
- Maintains a private practice: yes