Leadership in the community oncology setting

The cancer center innovators survey

— Ronald Barkley, MS, JD

The findings of the Cancer Care Innovators Survey, a national survey of cancer care organizations that examines best business practices of innovative cancer care organizations, identified innovative business practices in cancer care delivery. The survey, conducted in 2007 by the Cancer Center Business Summit, was presented this past October at the Cancer Center Business Summit conference in Chicago.

One section of the survey posed questions regarding leadership in the community oncology setting. Respondents were asked to comment on whether they felt physician leadership or managerial leadership were characteristics that were critical to the success of a cancer center.

Leadership survey responses

The clear consensus among survey respondents was that two organizational attributes, physician leadership and managerial leadership, were important organizational success factors. Survey commentary on leadership offered by some survey respondents provides useful insight. Regarding physician leadership, respondents volunteered the following comments:

- At the core of any program is the passion and commitment of the physician champion(s)
- Physician leadership must define a compelling vision
- Governance is the real issue

And the following survey anecdotes were associated with managerial leadership:

- Management's job is to work with the physicians to implement the vision
- Lack of good management is a real weakness in the sector
- Physicians and management working together is key

Survey responses were representative of community oncology private practice as well as community hospital-affiliated oncology programs. And the commentary appeared consistent whether it was derived from independent medical practice or hospital-affiliated sources. The basic perception was that physician leadership should set the tone and generate the vision, managerial leadership should implement and carry out that vision, and physicians and management leadership should be working in tandem.

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Leadership defined

What might be a workable definition of leadership in the community oncology setting? Leadership seems to be an intangible and not easily defined characteristic, but one that can be felt when in its presence. If leadership is not present, it would be like an army with no general.

Futurist Joel Barker sees leadership as "the ability to take people where they otherwise would not go." Sometimes, there is no reason to go anywhere. What's wrong with stability?

Certainly in a stable, safe, and predictable environment, leading people to where they otherwise would not go is perhaps not all that useful. Organizational status quo can be comfortable. If there's nothing to be concerned about, then no external or internal threats will arise. There would seem to be no compelling need to be responsive to change if nothing is changing around you.

Health care costs as change catalyst

Health care in 2008 is hardly a stable, safe, and predictable environment. The mandate for change in the rising costs of health care is evident, whether expressed in terms of employer angst about rapidly increasing premiums for employee health insurance or in the presidential campaign platform mantras for change.

Costs for care are up while satisfaction with the delivery and payment systems is down. Patients, providers, and payers are pretty grumpy about it all. Topping the payment reform hit list is oncology, although there seems to be no empirical evidence that cancer care is outpacing general health care inflation—around 7% spending growth in health care compared with the economy's 2% to 3% general inflation rate. But with oncology drugs representing 40% of the Medicare drug spend overall, oncology is an attention-getter in the payer community.

Cost in this context is viewed from the perspective of the societal cost of care in the aggregate percent gross domestic product. The increases in cost of care from the oncology perspective include oncology-specific factors, such as the markedly increased cost of drugs and technology while servicing a higher patient volume, attributable in part to the successes of the past leading to increased survivorship and an increasing elder age cohort with its attendant higher incidence of cancer.

Despite "true cost" inflators in oncology, the popular view is simply that cancer care services are costing too much and must be reigned in. So, the high costs of cancer care will continue to be tinkered with through reduced reimbursement and perhaps eventually through a modernization of the payment system in some form or another. But make no mistake, the crusade to stomp out

the high cost of cancer care represents a very real change catalyst in community oncology today.

In a shifting sands environment, an organization that is responsive to change is in a stronger position to survive than an unresponsive one. Charles Darwin said, "It is not the strongest of the species that survive, nor the most intelligent, but the one most responsive to change."

Leadership and change

I believe this is where leadership comes in. Organizational leadership is about change sponsorship. It is about leading change, and leading change is a chaotic and messy business. More change always demands more leadership. And if leadership is lacking, then the organization is probably at risk with no direction, no clear vision, no one at the helm, leaving them adrift at sea with dangerous shoals in view.

Physicians and organizations

What is all this bother about organizational stuff anyway? In the medical group setting, it can be useful to examine whether the physicians in that group even see their practice as an organization, one with a life and character of its own. After all, medical group practice is all about good doctors working hard and doing their personal best—practicing alone together—to drive success and incomes, right? If this is the physician's perception of his or her organization, then it is understandable why he or she misconceives the role, the value, and the cost of leadership. There's simply no organization to lead, just good doctors doing their personal best with some unavoidable common practice overhead to be paid.

Physician leadership

Physicians are not always familiar with—or comfortable with—the role of leader. Physicians are trained to be independent thinkers and decision makers, not to be interdependent with common group and organizational goals in mind. There is frequently little value placed on physician leadership by other physicians. If a doctor does not believe this, he or she should try to get peers to agree on compensating a physician in a group-practice setting for management and leadership time. The physician's perception of a physician manager and leader is often not one of respect for his or her work.

In fact, in the typical medical-group setting, the common expectation of a physician leader by his or her peers is that the physician leader will be an advocate for the overall physician viewpoint and that he or she will protect the physician interests and be a good communicators. But that is not taking people where they otherwise would not go—that's not really leading. That's being a spokesperson for a position, a representative of a consensus viewpoint.

A bit of a catch-22 soon emerges. The organization needs physician leadership to sponsor change, but group physicians often do not accept the legitimacy of a leader's authority. Change is slow. It becomes stressful and painful for those who attempt to lead change and thus, few physicians aspire to fill the role if it means leading change. Typically, if an administrator or manager attempts to fill a hole in physician leadership, physicians see the manager as being controlling and resent such intrusion.

Governance and decisionmaking

Closely related to physician leadership is governance and the decisionmaking processes within a physician group. If the physician members of a group can entrust the authority and decision-making power to one or more appointed physician leaders, then it becomes possible to balance physicians' viewpoints and the practical need to make timely organizational decisions. Without an effective governance and decision-making process, organizational change and organizational progress can become stymied.

Strategic leadership and operational leadership

There are two different types of organizational leadership, both of which need to be present for organizational success. One type is the visionary leadership—the strategic leadership—that defines and assures the "what" for the organization, assuring everyone is going in the same direction. Strategic leadership includes such responsibilities as establishing a clear vision, maintaining a culture that aligns a set of values with that vision, and declaring strategic imperatives for the organization.

The other type of leadership is operational leadership that defines and implements the "how" for the organization—the implementation aspects of leadership. This includes policies and procedures; systems; organizational infrastructure; staff behavior or conduct; and day-to-day business operations.

Reconciling physician and managerial leadership roles

Maybe the roles of physician leadership and managerial leadership in community oncology can be reconciled by attributing strategic leadership to physician leaders and operational leadership to managers, as suggested in the responses in the cancer center innovators survey. That is, in a community oncology setting—private practice, hospital-affiliated or otherwise—physician leadership originates the organizational vision, setting the tone and the direction. Then managerial leadership steps up and implements, or operationalizes, the vision. Hopefully the two are working collaboratively with each other.

There are any number of successful community oncology cancer care organizations in which there is a physician and manager leadership team. The physician leader provides the vision and strategic direction and the managerial leader implements and manages the vision and strategic direction. There is a mutual respect and collaborative working relationship between the two roles; the physician leader still seems to have time to see patients, while the implementation of vision and operational matters are delegated and entrusted, to the management leader. In fact, where a functioning physician leader and managerial leader team is absent you are most likely looking at a less-than-optimally functioning community oncology organization.

Conclusion

The environment for community oncology organizations is changing, driven primarily by the economics of cancer care. An organization in a changing environment that can successfully adapt to change has a better chance of survival than one that will not adapt. Change is not easy and it is natural for organizations—community oncology organizations included—to resist change initiatives by leadership.

The objective is to achieve a balance. First there needs to be a balance among the group's physicians in the form of delegated authority or trust to physician leadership. Second, there should be a balance between physician leadership and managerial leadership so the organizational imperatives of strategic leadership and operational leadership can be accomplished for the betterment of long-term organizational sustainability and success. H

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