Marshall Hicks, MD

Interview Session Eight: March 21, 2019

Chapter 00H
Interview Identifier

T. A. Rosolowski, PhD
[00:00:01]
It is about seven minutes after eleven on the 21st of March, 2019, and I'm on the 16th floor talking to Dr. Marshall Hicks for what is our eighth session together. [laughs] So there we go. I don't know, you can put that in some book of your records, right?
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Marshall Hicks, MD
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Yes, definitely.
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Interview Session: 08
Interview Date: March 21, 2019

Chapter 28
Experiences at the Mallinckrodt Institute of Radiology and Their Impact on Later Leadership (1988-1998)
A: Professional Path;

Note: this chapter is a recapture occasioned by an equipment failure in Session 01.

Codes
C: Leadership; D: On Leadership;
C: Mentoring; D: On Mentoring;
A: Professional Path; C: Evolution of Career;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;
D: Technology and R&D;
B: MD Anderson Culture;
A: Influences from People and Life Experiences;
C: Professional Practice; C: The Professional at Work;
D: Ethics;

T. A. Rosolowski, PhD
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All right. Well, we strategized a little before and we had that homework to do from the last bit from session one, and so I wanted to invite you to just think about that time at Mallinckrodt, and what it was like working in a new program, setting up a new program from scratch.
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Marshall Hicks, MD
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Yeah, so that was my first job as a faculty member, first job right out of fellowship, and it was a prestigious radiology department, but they were really forming an Interventional Radiology Department. They had a guy there that had just finished his fellowship a year before and they basically appointed him section chief of interventional radiology. They were integrating it because it was very distributed to the different, really kind of organ systems. GI radiology did their own interventional, GU did their own interventional, musculoskeletal did, and they were consolidating it. Which is the way it was done really, at every other institution, because it's common techniques, and the field was evolving, and really staying on top of all the technical aspects was kind of challenging when you don't do it very frequently. So this was, How do you consolidate it into one group? And also I think to be competitive with hiring, the market being

people coming out of training and getting into programs like that. So it was an opportunity to really be on the ground floor and help develop a program over the ten years I was there. To help build a clinical service, to help build the education program, the training program. I ended up being a fellowship director for about eight years out of that time, maybe nine.
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T. A. Rosolowski, PhD
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And just for the record, the years were '88 to '98.
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Marshall Hicks, MD
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To '98, yeah, almost—it was, yeah, a month or two over ten years, so it was a great experience, but it was extremely busy, particularly when you're building a practice and you feel like you're—I was the third person hired. The other person that was hired had just finished her fellowship that year, so we were two of us right out of fellowship. One person a year removed, but I think a common [in audible] for the—you know, it was an institution where a lot of the textbooks in radiology were written coming out of there. So you're meeting all these people that you read their textbooks, you learned from them, they're kind of the legends in their field. Yet I went there and it's call me by my first name, helping, just really like I'd been there 20 years. So as a faculty member coming out of training, I just didn't expect that. Also it was a culture that was just very welcoming and also taught me how—you end up saying, "well that's what you expect, that's what you want a culture to be like when you go somewhere else."
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T. A. Rosolowski, PhD
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Okay.
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Marshall Hicks, MD
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And in training programs, I'd been in places that were friendly as well, but not with the reputation that this place had and yet, expecting that you were going to see a bunch of professors walking around that you had to call doctor and all that. It was like they were just very welcoming. I think also, the collaborative opportunity, because you're still learning when you're coming out of training. As one of three who were essentially right out of training, doing interventional, we kind of learned from each other, but we also learned from some of the more senior people that had been doing it historically but were no longer doing it. Just having them as a resource and having them as a resource on the imaging side too, it was really a great

atmosphere, it was kind of an interesting time.
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T. A. Rosolowski, PhD
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How was it different from what you had experienced? I get that there was an informality factor, but were there other surprises from your previous programs, the environments there?
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Marshall Hicks, MD
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I think in some ways, not so much, which was part of the surprise, because the quality of the residence was very strong, probably higher than where I did my residency and fellowship, but not incrementally higher that I thought well this --because I realized radiology is very competitive in general, so a lot of places got really good people. So there were just some surprises like that. Now what was an interesting thing that happened when I was there was Mallinckrodt owned the technical and professional side, so all the procedures, all the revenue from the technical side was owned by Mallinckrodt and then we would pay the hospital a piece of that. Over time, that piece was getting larger and larger, from negotiations, to the point where eventually it was sold to the hospital, and Mallinckrodt just became sort of the professional side. Our appointment was actually at Washington University, and so faculty members at Washington University, Mallinckrodt was the Institute of Radiology that was formed and may have been the first. It probably was the first in the U.S., to really establish a radiology department. So it was interesting on the business side, to see that transformation and learn a little bit about that, and then see some of how that transition worked. And then to be able to come here, which is more of a model like it was originally, where it was all integrated and so we all worked for the same employer. It became a situation where the physicians worked for Washington University, everyone else worked for Barnes Hospital. So it was more the classic sort of situation where you have the hospital and the university not being under the same umbrella.
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T. A. Rosolowski, PhD
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Right.
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Marshall Hicks, MD
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So it was kind of interesting to see that experience and how that transitioned to there, and then you could see sometimes, the interests that aren't aligned and some of how that gets worked through. But just being in systems that differ in understanding strengths and sometimes

challenges of those. So I think it was, that was a time also when you come right out of training, you're really focused on trying to get your career going and trying to figure where you're going and your way around, and develop in the specialty and start getting involved in that. Less involved in the politics of the institution or the governance of the institution. Most of that is you know you're kind of trusting that to others if you will and really focusing. I think that's natural. So I'm not sure. I just got interested in the education piece and became the fellowship director and focused a lot on that. And some of the research side, but it was very educational from the standpoint of building the practice, because we went from what were really three of us, to by the time I left six, about to become seven and eight. Then went from one fellow a year to six. So it was rapid growth in volume. It was very busy, but you learned how to really run a clinical service, what it takes to be successful. We would round once or twice a day at least and the hospital was right next door. You'd run over and see the patients. We developed a clinic to see patients ahead of time. It was really the things that were changing in radiology to make it more of a practice, clinical practice, rather than a consulting service that just saw the patient only when they came for the procedure and that was it.
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T. A. Rosolowski, PhD
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Right.
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Marshall Hicks, MD
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So learning about all that and learning about how you—to me, it was just common sense of taking good care of patients helps build the practice, and being responsible and responsive, and develop in those relationships. Also, what was interesting, I had mentioned this before, but Barnes is kind of shaped like a long, a wide T. So short top to bottom axis. Or like a capital T but short on the stalk, and this long hallway, and at the crossroads there was the faculty lounge, the physician lounge. It was a big lounge and it was a great place to go to get coffee in the morning and bagels, and they had lunch there, so you'd go in and grab a cup of coffee in the afternoon. Just get away or something, but you develop the relationships. And developed not only referrals clinically but collaborations on the research side, and that was something when I came here, I realize I missed. And it was probably something that was an opportunity, from a cultural standpoint to—I think here, the analogy was the Faculty Dining Room on the—which floor is it over there?
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T. A. Rosolowski, PhD
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In the Mayfair?
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Marshall Hicks, MD
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In the Hickey Auditorium, right where the executive offices were and there was a cafeteria there. There was like a center table that was really long and big, and people kind of would go there to commiserate and talk and discuss.
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T. A. Rosolowski, PhD
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Yeah, well those kind of the town square places, where people cross paths and things can happen.
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Marshall Hicks, MD
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And then when that went away --actually I think the same thing happened here. You know, people felt they missed that, a lot of people missed it. But that was one thing that I had that was new to that environment, that I hadn't had before. But again, I wasn't a faculty member before, so I don't know how much of that existed at the places where I trained. It was just that collegiality and the welcoming culture, and a high degree of professionalism that was there. The expectations of excellence in all areas, and respect. It was a great environment. I didn't know how great it was at the time. Looking back, I realized that it was really a pretty exceptional environment and I don't know if it's still like that, hopefully it is.
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T. A. Rosolowski, PhD
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Yeah, yeah.
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Marshall Hicks, MD
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Things can change over time.
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T. A. Rosolowski, PhD
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Was there anything that you, when you look back, you see yeah, I kind of learned how to do X there, you know? Maybe not, but I'm just wondering, since you went on to --so many of the themes that you mentioned with Mallinckrodt, are themes I've heard you talk about with what's an ideal environment.
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Marshall Hicks, MD
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Right. I think the big thing was the practice building and just what it took to provide great service and you're responsive and engaging. That's what we ended up doing here with interventional radiology. Because when I came here, I think I told you it was a rebuild. The former section chief had died and they were an old area. We were about to move into the new hospital, but that was a few months away, and it had just been kind of withering because they didn't have leadership. People were getting ready to retire, leave, and so to really build that kind of practice and respect within the institution. It just took a lot of the same things that I had learned, so it kind of came natural. I didn't have to figure it out.
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T. A. Rosolowski, PhD
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Yeah.
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Marshall Hicks, MD
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And as I brought people on and recruited people, tried to look for people that were similar, that were collaborative, that had sort of an aptitude for practice, development and responsible, that like kind of attracts like. And that's why you look today, Interventional Radiology is a very strong service with incredible people. It's just grown over time and it's really been almost nine years since I was really a major part of it, so it's just continued, but from that kind of nucleus that we built from the very beginning. It just grew from there, but it was the things that I learned at Mallinckrodt in terms of really just treating other colleagues, treating patients like you want to be treated --you know, the golden rule thing goes a long way. And then being willing to—you know part of what I learned there, too, was from a practice standpoint as a developing field, but learning your limits. Learning to understand the difference between really being a cowboy or a cowgirl and maybe being a little—exploring those boundaries in a wild way versus doing it in a collaborative way where you might be pushed to do something that is out of the ordinary or a little bit beyond, but it becomes the best alternative. So you're doing it understanding that there's a higher risk to a procedure in a certain type of situation, but that everybody has

understood and talked about it. You figured out that this is the best opportunity for success for that patient. That's something that I think you learn and you're able to translate into other colleagues as you're mentoring and developing them.
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T. A. Rosolowski, PhD
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Am I imagining correctly, this sort of cowboy mentality, it's kind of oh we can do it, therefore let's just jump in and do it. Kind of an ego-driven thing almost, really not entirely about patient benefit?
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Marshall Hicks, MD
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I think so, or the confidence, the kind of overconfidence that's there. You know that, yeah, we can do anything, this shouldn't go to surgery or this shouldn't go for another alternative. It's like we can take care of it, as opposed to this is a little bit out of—maybe it's using a device in a different way, but you're doing it because there isn't really another good alternative as opposed to yeah, we can do this because we can do anything, sort of mentality. In a new field, in an evolving field, I think you'll find those sorts of individuals. There were clearly --I would see it in our professional meeting --we talked about that coming up this weekend-- is you would start to see some of that at the meetings. You have to be careful in a specialty that's highly technologically driven and innovative. To make sure you're exploring those boundaries in a responsible way, I think is the best thing. So I was able to learn that and bring that here, with faculty members who are coming right out of training. To be able to try to help counsel them and help them understand that weighing the risk benefit and the alternatives and do it collaboratively.
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T. A. Rosolowski, PhD
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Interesting, yeah. It sounds like you had some concerning situations.
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Marshall Hicks, MD
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Well, I mean I think it was—oh, you mean of people maybe going beyond?
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T. A. Rosolowski, PhD
[00:18:00]
Yeah, doing that or just they were kind of the almosts?
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Marshall Hicks, MD
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Almost and maybe observing it in other places. Like when you go to meetings and you see people that you can—and you can see-- some people have a little bit more of a bent towards that. But I think good people, the best practitioners, know their limits and understand their limits and understand when it's appropriate sometimes to go beyond those limits. But it's always when you're considering the best interests of the patient. Sometimes that's not the primary interest in people who are very innovative and are exploring a new field. They're driving it because they want to drive the field. I think there's a good balance that you have to strike when you're pushing that edge. You really have to find it, because it's reputation, right? I mean it's one thing I learned at Mallinckrodt and brought here, is you earned your reputation every day on the clinical service and so you'll be mindful of that.
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T. A. Rosolowski, PhD
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And I'm sure that gets embedded into culture too and you've got people who can have a conversation about that and reinforce prudent behavior on both sides.
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Marshall Hicks, MD
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Yeah. And I think also, one of the things I was able to bring here was the collaborative side. I mentioned that there were senior faculty members there who treated me like I've been there forever. The relationship we had with our technologists and nurses as faculty physicians was a similar thing, where it was a team based approach. Nobody was above helping getting a patient on or off the table, or going and getting a patient. Helping if transport was tight or something. It was just that spirit of really trying to work together as a team. When I came here, again it just was natural. It's what I knew and it also was --to me seemed common sense. But I didn't realize until later here, that that had set an example, and how important that was. Because that gets back to reputation, but it also gets to creating an environment where people want to work, want to be there, be a part of it.
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Chapter 29
Transitioning out of the Interim President Role
B: Building the Institution;

Codes
A: Personal Background;
C: Leadership; D: On Leadership;
A: Professional Path; C: Evolution of Career;
A: Professional Values, Ethics, Purpose;
A: Influences from People and Life Experiences;

T. A. Rosolowski, PhD
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Well, would you like to talk a bit about the division now and in the future. I don't recall if I asked you about the whole coming down from the interim president, you know what was it like to come back to—you know let go of that role and then come back to being division head? Sometimes those shifts can be dislocating.
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Marshall Hicks, MD
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Yeah, it was more of an adjustment that I thought it was going to be.
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T. A. Rosolowski, PhD
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Oh interesting, how did you find that to be?
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Marshall Hicks, MD
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Well, I mean in that role at the level, a lot of what you're thinking about is institutional risk, is institutional decisions at a very strategic level and relationships, a lot of it external, with -- whether it's our Board of Visitors, whether it's our UT colleagues, whether it's the UT administration, a lot of external facing interfaces and decisions. So it's how you approach that and how you process that and how you approach it. Still you use the same skills and same approach that I used. That was … I think some advice that was given to me: don't do anything differently, because you were chosen to do this because of what you'd done and it's worked. So it was just at a different level; and frankly, fortunately, I found that it wasn't anything that to me

seemed magical about doing it differently. It was the same principles still worked. It was just different things you were dealing with, broader scale. I had great support and had developed a great team there. So coming back to the division where it's a more narrow focus and, you know, one of the things --it was like you realize that we are working within our own narrowness. Things that seemed very big to us at an institutional level are not nearly so big. So you sometimes ask yourself, Why are we spending this much time on this particular issue? Let's make a decision and move on. Or it's, we need to put this in the context of the bigger institutional decision or the bigger institutional framework. It was a little bit frustrating sometimes, to not think that people could see that, when in reality I knew that I had a perspective, fortunately developed, that I could hopefully bring back. But it wasn't always easy, you know?
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T. A. Rosolowski, PhD
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Yeah.
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Marshall Hicks, MD
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You're always, it's—because it would happen a lot. That's expected, I guess right, to some extent, because people didn't have that. Almost any issue we were dealing with, there was a broader issue at some level. It was really institutional, and trying to connect that and just really the energy of continually addressing that when you can't really explain maybe everything that's out there. For example, some of the internet security. Aspects like that. There are things going on and you kind of knew. Now that a lot of these have come to light, but at the time there was investigations, different things going on. I knew what we needed to do in DI [Division of Diagnostic Imaging], but it's hard when you're not as able to share as much information and so forth, about certain things. That was rare. It was more of the general aspects of how do you really deal with it at a fairly narrow level, and feeling like there was—you had been exposed to this, gotten a lot of the knowledge and workings and then now it's a much narrower focus. It was also an adjustment.
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T. A. Rosolowski, PhD
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Did people treat you differently or did you perceive any difficulties or changes in relationships from that?
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Marshall Hicks, MD
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Not so much that I'm aware of. I don't really—more people knew who I was, just from walking in the halls and stuff. People would talk to me or say hello that probably wouldn't have before, because they wouldn't know who I was. Some of these relationships I was able to develop across the institution in that role. I don't think it was all that different politically, and that's probably a good thing.
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T. A. Rosolowski, PhD
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What did you—were there any decisions that you made in coming back? Did you have a refreshed perspective on what the division needed to do, what direction?
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Marshall Hicks, MD
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I think it was a hard time for everybody, coming through all that. I think that for me, part of it too was just --particularly coming off of Harvey and kind of really getting on our feet again-- there was a bit of an emotional sigh of just saying we've got to take some time and regroup. So some of it for me was really figuring out where we were, because it had been about a year. What were some of the higher priorities? I think for us it was moving into the region, the HALs. We had continued our expansion at Memorial Hermann, on the breast imaging side, and it was how those fit into the larger context of where we were headed as an institution, were a couple of key things. From a clinical standpoint, we were doing well in terms of performance wise. But it was also a time when we were starting to ramp up out of Epic, to the point where we had not caught up on the staffing side. We're struggling with that a little bit. It's getting ahead of that, which is hard to do if you're still on a trajectory that's growing at a pretty significant clip. It's hard to ever get ahead of it, so we're trying to come up with some plan there. We were in recovery mode and a catch up mode if you will, for a lot of '18, and that's carried over into '19, which is a good thing, because it means we're going to come back pretty strong. People want to come here, but it's finding the balance on the staff side. So it was a little bit of what's next, you know? Just reflecting and then what's next. I was meeting with the CEO from one of our major vendors that I've known for about 20 years. He was visiting yesterday, and he was asking the same question: how are things, how was the adjustment and all that. I said something like, I kind of need to in some ways figure out how—it was a tough adjustment, you know? I'm still trying in some places to figure out how to adjust. He just kind of looked off for a couple seconds and said, "Well, is it you that needs to adjust or is it the eye that needs to adjust?" I thought that was an interesting perspective. I think what he was getting at is that there are things you do—like I said, he's a CEO, you know? He runs a large organization, and I think his point was when you're in a role like that you learn things. You can take them back but the expectation maybe is that the

vision needs to do things differently and can do things differently, that are a benefit to the institution, that you now know that maybe you didn't know before. I think that's where he was coming from out of it. But his comment caught me by surprise and I had to think about it and I'm still thinking about it. I think it was meant in a very positive way, you know? There are—as an example, because of spending a lot of time thinking about institutional risk and thinking of things from a broader picture, it's how do you introduce that into the conversation with leadership in DI? The "well let's elevate and think about this from an institutional perspective or think about the risk to the institution." Because it's often different from the risk that we see in the division, and it may cause us to make a different decision, allow us to make a different decision, putting that into the framework of the larger institutional perspective.
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T. A. Rosolowski, PhD
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Is there anything else you want to say about what was tough about the adjustment? I mean, I'm not trying to be intrusive, you know. These are aspects of leadership experience and I think it's an important record of what happens in that life cycle of leader.
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Marshall Hicks, MD
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It was a much tougher adjustment, and I think it's because you're used to things at a certain level. It's fascinating and it's stimulating, and then you come back to something that's much narrower and in some ways there were still some problems that were there when you left, and it's like why haven't these been solved? Why can't we move forward? I think some of them weren't solved for very legitimate reasons, or there was a focus on other things potentially, as we were going through all of this. But still, the natural instinct is well why are we still dealing with these things, and oh my gosh, don't you realize there's bigger issues we need to be dealing with? And then you start thinking, well is this the right role for me anymore, because you're thinking at another level and you're thinking differently about things. Is this now the best thing for the division, the best thing for the institution or the best thing for me, to be back in those role, and questioning it, and frankly still am.
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T. A. Rosolowski, PhD
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Sure, I mean it seems very natural. I mean I hate to put it in these terms but once you've been to the big city how can you go back to the little bitty town. [laughs] I mean it would be shocking if there weren't some of that. I mean honestly, for smart people who love to be intellectually stimulated and love to be making change and affecting things, to have the ability to have impact

on that scale and then okay, now I'm not doing that any more, well where is my purpose?
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Marshall Hicks, MD
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Yeah, and it was a struggle as well, because you think well, you just went through this experience. Hopefully learned a lot from it. Gained a lot that could benefit the institution and yet, you're back to a more limited role where you know people would say well, you're going to have a great perspective. And that's true. But it's still not the same and you're still, you find yourself asking that question.
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T. A. Rosolowski, PhD
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Have you kind of turned over any possibilities of next steps in your head, I mean really at a fantasy level, I know that this is early days.
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Marshall Hicks, MD
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I have, but on a personal level, what happened was my dad's health has been poor and struggling and in a slow decline with his Parkinson's. I didn't want to get preoccupied with exploring or committing or doing something. Frankly, it's just been a real struggle for him. I go up at least once a month now and I've been doing that really, since I remember in August of 2017 he was hospitalized with pneumonia. I really thought that was going to be the end, frankly, and that's been a year and a half ago. He's just been hanging on and it's great to have him but it's a struggle for him.
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T. A. Rosolowski, PhD
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Well and a struggle for the family.
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Marshall Hicks, MD
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And the family. So really, almost in some ways thought it would be selfish for me to try to not be able to help when I can and be distracted by something. On the other hand it's like you've got to still think about there's a window of time that I have left in my career and how do I work through that? I've found challenges as I've come back, and been able to help out, but I've been selective. I've been really pulled out of all my other commitments, while I became interim

president, so I wanted to allow other people, some of them might have been in those roles for a while as chairs of certain committees and things, so as I came back I was trying to be selective about which roles I can be in that I can really help, like with the Inpatient Planning Committee and different things like that that have come up. I want to make sure that it's something that was interesting to me, but also somewhere I thought I could add value. It is something that I keep thinking about too, what type of role, because this was when you compare us as an institution, to other institutions, we're so fortunate. So some of the issues --I love challenges but some of them are real challenges. Like when you look at what some of the other groups even in town are going through as healthcare institutions. There's a deanship or something like that, in an academic institution. Even that is very different than it is here, because we don't have a medical school. We don't have the sort of traditional thing. Then you're not dealing with the—and again, that's a more limited role, whereas something where—so it's really trying to find what will be a good fit. What would be something that would be stimulating but something where I would bring value as well, into a role like that? It's not been easy for me to think of those things. When you think of the role of this institution and the role of the CEO here, translating into something that could parley into another opportunity. You get into the CEO of a healthcare system, even if it's a small or moderate one, there's so many challenges in medicine right now that a lot of them are getting into cost cutting, cost reduction side of it, not how do we have opportunities to grow. So you have to look at roles, and even in deanships now, where resources are declining. There's other issues you're dealing with and some of these roles, I think could be pretty challenging. It could be there's opportunities, and then there's sort of setups for failure, and distinguishing those.
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T. A. Rosolowski, PhD
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Not a good move.
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Marshall Hicks, MD
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Yeah, exactly. [Interruption: Hi, excuse me, you left your phone in your office and it was ringing.] Okay, thanks, okay thank you.
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T. A. Rosolowski, PhD
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Should I pause this here?
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Marshall Hicks, MD
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No. Yeah, thanks. I purposely left it in there, bless her heart. [Tacey laughs] That's kind of it, I mean I've been—and to move. I mean it's a great institution but from a family standpoint too. It sounds like well yeah, it's got to be something else but if you look at it, it's like these are major life decisions and changes.
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T. A. Rosolowski, PhD
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Absolutely.
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Marshall Hicks, MD
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And I think probably also, when you're on a track where you're moving, I mean I've made one move as a career, as a faculty member. I think if you're in a mode where maybe you're doing it for five or ten years and you're moving up, it gets easier probably, to say well I'll take a chance on this. Then if it doesn't work out here, it's like yeah, I don't—I want to make sure it's something that is a good fit for me. So I purposely haven't been as active in putting my name out there, doing something until it feels like a good time.
[00:41:03]

Chapter 30
On Ongoing Strategic Planning and the Future of MD Anderson (2019)
B: Building the Institution;

Codes
C: Leadership; D: On Leadership;
B: MD Anderson in the Future;
B: Critical Perspectives on MD Anderson;
B: The Business of MD Anderson; C: The Institution and Finances;
B: The MD Anderson Brand, Reputation;

T. A. Rosolowski, PhD
[00:41:04]
That makes sense. Can I ask for a different sort of reflection now? I'm wondering about your view of the new strategic planning process. We have the McChrystal phase and now we've got segueing into this new phase with the *Play to Win* model by Lafley Martin, so I was wondering what your thoughts are about that transition.
[00:41:37]

Marshall Hicks, MD
[00:41:37]
Read the book. I'm familiar with it, and we've been having a couple exercises with it. I mean I like the approach. I think it will be interesting to see --this is coming out of more of a corporate, almost in a commodity area sort of approach-- and to see what we come up with is what's our aspiration or win, because I think that's a key question. A win for Proctor and Gamble is to dominate in a sector and crush the competition. For us a win is probably health, well being of patients and curing them of an individual cancer, not competitively necessarily against who is our competitor. That's one of the things we've been asking ourselves, is who are our competitors, and so how that approach translates and not. I think we've got to be careful --and I think we will-- not to have a perception be that we're turning into this sort of corporation that isn't more—isn't patient focused, humanistic about what our real goals are. That our winning aspiration is about the people, and P&G has customers that are focused but their customer is ultimately a transaction, meaning profits to the bottom line.
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T. A. Rosolowski, PhD
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What do you think of --I mean in the Division of Education and Training, which houses the library, there really has been an attempt to disseminate this model at every level of the

organization. I assume that's happening every place. What do you think about that method, you know is it new, is it different, what do you think is a prognosis for that?
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Marshall Hicks, MD
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You mean the actual trying to get it disseminated?
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T. A. Rosolowski, PhD
[00:43:56]
Mm-hmm.
[00:43:57]

Marshall Hicks, MD
[00:44:00]
I think so. I mean we did this with the pyramid thing and that was an attempt there with somebody I know within our division. We actually used that framework and we did concurrent strategic planning. I liked this framework in the sense that it asks questions, and I think if you're having people—if you're asking the same questions across the institution, I think that's a good thing. There are, in a sense, a lining over those questions, and beginning to think about what are these questions, what's important. We were reviewing yesterday at the new president's Advisory Council, it used to be the Shared Governance Committee, that from all the activity that's going on, whether it's online or the focus groups, that they're getting a lot of—they're getting strategic, focused suggestions for themes. But they're also getting —I'm blanking on what they call it-- but it's more tactical type things. They're talking about boxing, you know putting in a bucket rather. Things that we need to address but they're not things that are strategic. It's more like we need to reduce bureaucracy or reduce administrative burden and things that we do need to be taking care of but it's not really in following the realm of strategy. I think that's what happens, that we should be getting a lot more of those on a more strategic level, and that's probably natural because a lot of people tend to think about what's in front of them.
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T. A. Rosolowski, PhD
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Right.
[00:46:00]

Marshall Hicks, MD
[00:46:00]
It was interesting to me because the themes that are coming up strategically are probably fairly

predictable themes and many of them are things that as well, kind of came out of a political process. We called them priorities at the time. There's an overlap I think. Then some of the things that were in McChrystal, probably were more the tactical or operational stuff. I like just the framework of asking questions and really stimulating thought that way. Having its consistent but simple framework, which I think is the real strength of this. I think it's just perhaps managing perceptions to make sure that people don't think that we're trying to turn into a Proctor & Gamble.
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T. A. Rosolowski, PhD
[00:46:47]
Right. Mm-hmm.
[00:46:48]

Marshall Hicks, MD
[00:46:48]
And what is our real wining aspiration doesn't—that we're not trying to turn this into sort of a commodity based organization, or that we are not still losing sort of part of our secret sauce, which is that caring that we have for patients, that you hear over and over from people that come here. That it's the people that make the real difference, which is really our edge, what makes us distinguished from others. Even Carol Porter [oral history interview] brought this up at a meeting where we were talking about this, as who is our competition. Maybe you could say Memorial Sloan-Kettering, but most would argue maybe not, because they're so far away and they're dealing with a very dense population around where they are. But the caring aspect there, between there and here, is something that people who have experienced both places differentiate.
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T. A. Rosolowski, PhD
[00:48:02]
Oh really?
[00:48:02]

Marshall Hicks, MD
[00:48:03]
Yeah, just a different type of environment. That's the thing. When I hear patients that are friends, family, that come here, it's always about how well they were cared for. The breakthrough science and all that stuff is great, and the technology. But the thing that I hear that people really identify with is the caring of the people who work here. I like the framework, I think it's good. And I like the structure, because I think we need the structure and I think it needs to be simple enough that people understand and can focus on. Because if it's too much, they've got other things they're trying to do and distractions. I think this is something as well,

even though we tried to align with the pyramid, they were pretty broad. With this, we can all, within all of our divisions or departments, ask these same questions and say how do we align with now what is the institutional winning aspiration or support for it?
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T. A. Rosolowski, PhD
[00:49:18]
What do you foresee evolving? The what's in the future question, either for the strategic planning process or for the institution as a whole.
[00:49:27]

Marshall Hicks, MD
[00:49:31]
I think one of our biggest challenges is the changing healthcare environment and what that's going to look like, and there's a lot of uncertainty about it. It will continue down to some extent the political path. Where that's—there's a lot of conversation about Medicare for all, or single payer, or something, and who knows where that will end up. But those sorts of things will impact us for sure. Those are all concerns there. But --and like it or not, that's where a substantial part of our revenue comes from, so we have to pay attention to that. The science side, the research side, I think is jeopardized to the extent that it can't be supported. So where we're going is we need to look to see how we can make the research part less dependent on the clinical side. I think from the clinical side it's how do we develop a diverse portfolio to make us flexible enough to be sustainable and be able to continue to serve the mission. When I look at it, and I've been involved in this Inpatient Planning Committee, so it's how many inpatient beds do we need, do we continue to grow and where should they be, is the two simple questions out of it. As we looked at that, it's pretty clear that our region is still growing pretty phenomenally. Texas is still growing but Houston in particular is growing as a large city, getting even bigger. It's getting harder as a city being sprawled out as we are, more challenging for patients. One of the things we heard from patients out in the region is they want inpatient, they want inpatient facilities out there. Many of them will not come down here if that's the decision they have to make, because it's just too much, and it's going to get harder.
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T. A. Rosolowski, PhD
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Right.
[00:52:06]

Marshall Hicks, MD
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So I think if we want to be competitive in the region and continue to grow with our population

draw on the region, we're going to have to probably continue to expand. The HALs that we're building now are probably phase one. We'll probably end up with an inpatient facility of at least one of those, but as we continue to start planning, what's next.
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T. A. Rosolowski, PhD
[00:52:30]
I missed the acronym you used, HALs.
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Marshall Hicks, MD
[00:52:31]
HALs, Houston area locations. I think that just makes sense, because if you look, a third of our patients come from the Houston region, which right now is the surrounding counties. That may shrink if it gets harder for patients to come in even from the surrounding counties, but there's an opportunity to grow it as we get further out. So if we want to maintain that or even grow it, but right now we have about 25 percent of the Houston area market and it's not a lot really, when you think about it. So even if we increase that, even if we doubled that, which we really couldn't do as an institution, we still wouldn't have a majority of the market. We'd have right at 50 percent. But if we want to maintain that even as we grow out, we're going to need to grow. So when I think about the challenges that may come if there's a national network or as networks continue to narrow, the vulnerability we have nationally, of patients still being able to come here and even some of the Medicare –you know, the advantage plans, don't let people come here, they're becoming more and more popular. There are some risks nationally, as this continues to evolve. So it makes sense for us to position ourselves to where we're—to me it's the fixed cost concept and the variable costs. The fixed costs, the fixed revenue, can come from a region, as a portfolio. The more flexible variable piece is going to be probably what's outside of the region, whether it's international or national or in Texas. But also, as part of our responsibility as being part of the University of Texas System, is how do we work more closely with the rest of the institutions? This is something we started doing when I was the interim and even before it was Ron. It became much stronger as we actually formalized some of the affiliations, like San Antonio. I think there's an opportunity there for us to help in areas where cancer is not a strength, in some of these institutions, to really strengthen it and to reach more patients in Texas and to really kind of be the leading partner in oncology in the state. So I think that's part of the portfolio too. Then internationally, we're still trying to figure out what the best opportunity there is. It's a huge opportunity, but there's also huge risk there as we've experienced, when patients come and you end up with patients that really shouldn't be here and we really can't do much more. It's just impacting those that you really do want to serve. So how do we figure out how to really channel the right patients, the ones that can benefit, and get them here? The same thing nationally, to a lesser extent. That's a little bit easier to navigate through because of just the communications and the distances and time and all that being less. So I view it as we've got to

be flexible, we've got to be able to adapt to whatever changes happen in healthcare, policy and healthcare nationally, but that we have great opportunities. Our brand is so incredibly strong, as we found out when we were doing the focus groups and the interviews and surveys regionally. Patients will tell you that we're the place to be, but they're just not going to come down here.
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T. A. Rosolowski, PhD
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Well you've been very patient with all of this time, and I wanted to ask you if there's anything else you would like to add at this point.
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Marshall Hicks, MD
[00:57:08]
I don't think so, just that I appreciate the opportunity and it really was an honor to be in that role, which is the only reason I'm sitting here.
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T. A. Rosolowski, PhD
[00:57:12]
Not the only reason.
[00:57:16]

Marshall Hicks, MD
[00:56:16]
But no, it was quite an experience, and this has actually been very helpful, to just kind of put it all together, think about it, reflect on it, what I've learned, but also what we went through and how it can help better prepare us for the next chapters that happen. It was probably --the ultimate lesson was just the resiliency of our people and the commitment of the people that work here, because that was a major transition when you reflect on it, and it was a real credit I think, to everyone pulling together during that time. You wonder if other institutions, other organizations, how they would have weathered something like that. I think that we're just fortunate to have the kind of people --it gets back to the caring aspect, who not only care about the patients but we care about each other and care about the institution, and that's pretty remarkable.
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T. A. Rosolowski, PhD
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Well I want to thank you.
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Marshall Hicks, MD
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Oh, thank you, it's been a pleasure.
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T. A. Rosolowski, PhD
[00:58:40]
Yeah. So I want to say for the record, I am turning off the recorder at six minutes after twelve.
[00:58:46]