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Dr. Alma Rodriguez, MD

Video Supplement to Oral History Interview [2015]

Interview Session: April 17, 2017

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Chaper 00A
Interview Identifier

Dr. Rosolowski
[00:00:01]
All right. Well, thank you very much, Dr. Rodriguez, for coming in today.
[00:00:05]

Dr. Rodriguez
[00:00:06]
My pleasure.
[00:00:06]

Dr. Rosolowski
[00:00:07]
I just wanted to say for the record, that today is April 17, 2017, and we are doing the first of what I hope will be a few video interviews, with interview subjects for the institutional oral history project at MD Anderson. So, thank you for being our experiment this afternoon.

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Chapter 01
A: Overview;
Multidisciplinary Care at MD Anderson

Codes
A: Overview;
A: Definitions, Explanations, Translations;
B: MD Anderson History;
B: Multi-disciplinary Approaches;
B: Institutional Mission and Values;
B: Survivors, Survivorship; C: Patients, Treatment, Survivors;
C: Patients; C: Patients, Treatment, Survivors;
C: This is MD Anderson;
C: Discovery and Success;
B: Devices, Drugs, Procedures;
B: MD Anderson Culture;

Dr. Rosolowski
[00:00:07]+
I wanted to start by asking you about the tradition of multidisciplinary care at MD Anderson, and first if you could tell me a little bit about how you define it, how it's understood, and then maybe give an overview of how it has evolved at the institution.
[00:00:48]

Dr. Rodriguez
[00:00:50]
Multidisciplinary care is a framework for integration of all the relevant specialties that touch or have a significant impact on how a patient's condition is managed. It is intended to have all of these expert viewpoints integrating at an appropriate point in time, when the care planning is being made, and that these individuals, in a collaborative fashion, come to a consensus decision on how it is that the process of the care delivery is going to occur. This model traditionally includes of course, the medical oncologist, the radiation oncology specialist and the surgical specialist. Two other disciplines that are really critical to the treatment planning process are also the diagnostic specialties, and that is pathology and diagnostic imaging, because obviously, without the right diagnosis and without the appropriate staging of the tumor, it becomes very difficult to plan the appropriate care that is indicated for the patient's condition and stage of the illness. So for us, we view multidisciplinary planning really as that process that brings the knowledge of all these different disciplines to bear on the treatment planning.
[00:02:33]

[00:02:34]
I want to add, however, that there is another whole domain of supportive disciplines that also contribute significantly to multidisciplinary care planning, [ ]and that is psychosocial services, as well as rehabilitative services, nutrition, and other specialties that really enable the patient to reintegrate into a healthy state of being [ ] through their cancer care. The scope of supportive care is rather complex and very broad. To facilitate that, one of our prior leaders at the institution envisioned that all of these disciplines would work together in a single environment, and so that's how we designed our clinics. For example, the Connally Breast Center integrates, within the infrastructure of that center, the visits that the patient has with the medical oncologist, with the surgeons, with a radiation specialist, and even with plastics consultants at times. Within the center, there are also social workers. We have access to consultation by other specialists and we can also integrate their input into the care for the patient.
[00:04:05]

Dr. Rosolowski
[00:04:06]
I have a couple of questions. First is, does the patient ever meet with the entire team, or virtually the entire team?
[00:04:15]

Dr. Rodriguez
[00:04:17]
Not usually, simply because it's very difficult to coordinate everyone's schedule, but we do try to coordinate the patient's schedule so that all of those events, or meeting face to face with all of the relevant providers does occur, hopefully within the same day or within a very short span of time. Now, when the actual treatment planning is done, the clinicians come together in what are called Multidisciplinary Planning Conferences, and the patient's case is discussed and the relevant pathology is reviewed, the diagnostic imaging studies are reviewed, the planning from the perspectives of the oncologist, the surgeon and the radiation specialist are reviewed, and then if you will, a comprehensive plan is then agreed upon. This is really very important, again particularly for solid tumors and for certain categories of malignancies that are rare and complex in their management, it is absolutely essential. For example, in hepatobiliary malignancies that are rare but require very complex treatments or very complex planning of their care, these conferences are essential to arrive at an agreed upon plan. Head or neck surgery and head or neck chemotherapy and radiation planning, equally important for certain complex cases of colorectal malignancies. Again it's essential that this structure of planning must occur, in order for the treatment to be most optimum, because we know that outcomes, [ ] particularly for these complex malignancies, is very much driven by the level of expertise of the participants, but also the timeliness and sequential planning of each of the phases of the treatment.
[00:06:16]

Dr. Rosolowski
[00:06:17]
Now, you mentioned a period in the past when there were design decisions made about how to set up clinics. Could you say a little bit more about the history of the development of multidisciplinary care here?
[00:06:30]

Dr. Rodriguez
[00:06:32]
Well, I think that probably from the beginning of the institution, the vision of Dr. Clark was that patients would receive, of course, the optimum care for their malignancies. The institution has a very long history [ ], back to the 1940s, when surgery and radiation were essentially the only two therapeutics for malignancies that were effective at the time. He did develop [the process] of the Tumor Board, and discussion of the patient's care by the surgical and radiation specialists, but over time, the complexity of treatment management that then integrated [ ] meaningful chemotherapeutic strategies, it's become much more complex. In the 1990s, with awareness of how the complexity of the treatment planning was evolving, again the operations leadership of the institution made the decision to structurally plan the design of the clinics so that all of the important disciplines would be housed within a given specialty center for a disease category. That's why today we have the GI clinics, the thoracic clinics, breast center, et cetera.
[00:07:58]

Dr. Rosolowski
[00:07:59]
Was that an unusual decision at the time?
[00:08:01]

Dr. Rodriguez
[00:08:02]
Yes. I think it was a very innovative and visionary decision at the time and it has evolved [ ], progressively [ ]. I mean, I think at the beginning, probably there were some centers that were not as well coordinated as others, but over time, I think all the centers have made tremendous efforts to have not only a culturally accepted framework for how this works, but operationally, to facilitate for patients having appointments that are streamlined and [ ] well-coordinated . [This meant to avoid] waste of time unnecessarily, in moving from one treatment modality to the next, or to whatever the next step of the treatment plan would be.
[00:08:58]

Dr. Rosolowski
[00:09:00]

Now, you mentioned culture a little bit earlier and I wanted to follow up on that and ask, how do you see the providing a multidisciplinary care feeding or supporting the culture of the institution at large?
[00:09:17]

Dr. Rodriguez
[00:09:19]
Well, I think that the concept of multidisciplinary care being important in cancer, in essence levels the playing field if you will. We know that each of us plays an important role in this, in our mission, and to that effect, I think that we are a fairly democratic organization. We know the importance of anesthesia, of diagnostic imaging, of the medical oncology teams, you name it. Every one of those, every specialty really has a role to play, and we couldn't do it without each other. We couldn't achieve the outcomes that we achieve without everyone collaborating. One of the disciplines that, or one of the domains of care, that actually was brought into the institution after I joined MD Anderson, was [ ] internal medicine, [ ] to help us to manage the patients comorbid conditions that of course can influence how well the patient tolerates surgery, how well the patient tolerates chemotherapy, and therefore [ ]their outcome [ ]. I've seen that division grow over the years. Truly today, I don't think that we could say that we could function without the pulmonary service or without cardiology or without endocrinology or without general internal medicine or you name it, any one of the [internal medicine] specialties that we currently have onboard. We appreciate that they all contribute to our care of the patient [with] cancer, for the best outcome of the cancer treatment.
[00:11:21]

Dr. Rosolowski
[00:11:22]
It sounds like a recipe for healthy respect.
[00:11:26]

Dr. Rodriguez
[00:11:26]
I would say so, yes.
[00:11:27]

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Chapter 02
The Important of Clinical Leadership at MD Anderson
B: Overview;

Codes
C: Leadership; D: On Leadership;
B: MD Anderson History;
B: MD Anderson Culture;
D: On the Nature of Institutions;
D: Ethics;
C: Understanding the Institution;
B: Institutional Mission and Values;
B: MD Anderson in the Future;
C: The Institution and Finances;

Dr. Rosolowski
[00:11:28]
Well thank you, thank you. I wanted to talk a bit about leadership too and ask you first of all, why it is that physician leaders are so important to an institution like MD Anderson. I also wondered about your thoughts about leaders from basic sciences too.
[00:11:51]

Dr. Rodriguez
[00:11:53]
I think I can address best, the clinical leaders. It is very important that [not just] physicians, but [ ] pharmacists, nurses as well, be always at the table to make the decisions that will impact patient care. The reason for that is that we truly do know, those of us that are active in the frontlines, we do know what it is that we're facing, what it is that our patients are facing, and I think that we can guide [ ], if you will, the right strategies or the right priorities for the institution. There's a lot of literature today, with regards to the culture of safety and quality in clinical practice, [that] suggests that without physician engagement and support and championing of the principles of safety and quality, many organizations fail at that without physicians being up in front of those initiatives. So we know that it is important. For better or worse, we are seen as the people who are going to lead the charge, if you will, and if we are not fully engaged, if our input and our opinions are not part of the discussion at the highest level of the organization, then I think that we could have missteps in direction.
[00:13:42]

Dr. Rosolowski
[00:13:44]
Now, from the people that I've spoken with, interviewed for the oral history project, it's pretty rare to find someone who's had leadership training in medical school or real leadership experience during internship, residency, even fellowship. What are some observations that you've made, first of all about the qualities that are really needed in leaders right now in healthcare institutions?
[00:14:11]

Dr. Rodriguez
[00:14:14]
I think today, given the tremendous uncertainty, not just within our own organization but in the external environment, and even in the political arena of our country, [ ] we value [ ]in our leaders, first of all levelheadedness, [ ] a sense of steadfastness, [ ] a sense of steadiness, of staying on course, and not being derailed or not coming to hasty decisions without appropriate information. We're a very data driven institution and I think academic medicine in general, is very data driven, and the truth is that data matters. Making decisions that are well informed, or at least as well informed as possible given circumstances, will always be respected by those of us who follow the leaders. I think that in an environment, again, where there are few external markers that can guide our direction, I think internal direction is going to be the stronghold, and from a physician perspective, I think that the ethics of our profession should be our guide.
[00:16:08]

[00:16:08]
The ethics of our profession say that we should put our patients first, that we should collaborate and respect our peers, and that we must do the best in every possible situation that we encounter. Now, having said that, there are new dimensions being put into the equation today, and that is the larger needs of society as well. So traditionally, our professional ethics have been very driven by the dyad of the doctor-patient. We are being asked now to consider in the equation, the larger societal needs and how is it that we can deliver the best care for the most people, at the lowest cost. That is the triad of the last administration's quality initiatives and as far as I know, those have not changed. We are still driving towards the imperative of delivering care to the best value, and that is the best care at the lowest cost, if possible.
[00:17:25]

Dr. Rosolowski
[00:17:26]
And here you're referring to presidential decisions at the national level, not at the institutional level.
[00:17:32]

Dr. Rodriguez
[00:17:30]
Correct. That is correct, but of course those then, are driving a lot of forces, not only in the payment models, but also regulatory and legislative matters. All of these are now coming to bear on our day-to-day decisions.
[00:17:56]

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Chapter 03
Leadership in a Period of Change
B: Institutional Change;

Codes
B: MD Anderson History;
B: MD Anderson Culture;
C: Leadership; D: On Leadership;
B: MD Anderson in the Future;
B: Critical Perspectives on MD Anderson;
B: Growth and/or Change;
B: Institutional Politics;
C: Understanding the Institution;
C: The Institution and Finances;

Dr. Rosolowski
[00:18:00]
Well, I have a couple of other questions that I wanted to ask you about leadership, but we're kind of looking straight at this question of times of change and turbulence even.
[00:18:10]

Dr. Rodriguez
[00:18:10]
Yes.
[00:18:10]

Dr. Rosolowski
[00:18:11]
And just for the record, I wanted to say that we're having this conversation during a very unusual time at the institution. Ronald DePinho resigned his presidency of the institution after five and a half years of service. This was about a month ago, and so the institution is taking a hard look at itself and making some decisions. From what you've said, it sounds as though the healthcare environment is driving some of what the institution has been experiencing, and I'm wondering if you could comment on kind of the history of these moments of turbulence at the institution. Have we seen this before?
[00:18:51]

Dr. Rodriguez
[00:18:54]

Well, we certainly have seen times of financial crisis for the institution. In the history of the institution, we have never had a president resign. This is the very first time that has occurred, so that is new for us, that's a new reality for us to cope with. We certainly have had turbulent times where leadership has been challenged and our finances have been difficult. In those situations, there were also external forces; either disasters such as hurricanes, or changes in the healthcare market that were driving some shifts in how we were reimbursed. All of that has -- you know, we have experienced that before. We always have risen to the challenge, clearly. I mean we're still standing here today and in fact today we're much stronger, larger, much more advanced in our technologies and practices than we've ever been. So clearly, we have overcome those difficulties. We have in fact superseded them and excelled beyond those challenges.
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[00:20:14]
I hope that the same thing will happen this time. I think that we have many talented people in our faculty and our staff, that I know can rally to the challenge of bringing us through. What is not manageable or what is not predictable for us is really, what happens outside of our organization, but we certainly should have the ability to self-manage or to bring ourselves to facing the challenge. Like I said, we have done it before. In the past, however, it has been under very steady leadership, and that is one factor that at the moment, we have to acknowledge is a challenge, in that we have had these rather dramatic changes in our governance structure and so therefore, it makes it somewhat less predictable as to how we will weather the storm, but nonetheless, I'm certain that we have the talent to do it.
[00:21:32]

Interview Session: 01
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Chapter 04
Multidisciplinary Care and the MD Anderson Algorithms
B: Institutional Processes;

Codes
A: Overview;
A: Definitions, Explanations, Translations;
B: MD Anderson History;
B: Multi-disciplinary Approaches;
B: Institutional Mission and Values;
B: Survivors, Survivorship; C: Patients, Treatment, Survivors;
C: Patients; C: Patients, Treatment, Survivors;
C: This is MD Anderson;
C: Discovery and Success;
B: Devices, Drugs, Procedures;
B: MD Anderson Culture;
B: MD Anderson in the Future;
B: Beyond the Institution;

Dr. Rosolowski
[00:21:35]
I wanted to return, just briefly, to multidisciplinary care and kind of going to the issue of future, because I know that an outgrowth of multidisciplinary care, the MD Anderson algorithms of care, which you've been very involved in working on.
[00:21:52]

Dr. Rodriguez
[00:21:53]
Yes.
[00:21:53]

Dr. Rosolowski
[00:21:55]
I wonder if you could tell briefly what they are, and then talk about the fact that they're going to be used outside of the institution.
[00:22:01]

Dr. Rodriguez
[00:22:02]
Right. The algorithms of care, some other institutions are now calling pathways, have been part of our culture and [ ] the design of the multidisciplinary care planning model for years. The algorithms are essentially a map of care from diagnosis to, for some cases, unfortunately, end of life care. The map talks about each of the stages of the care delivery process, like I said from diagnosis, i.e. what are the appropriate tests to do, to arrive at the most correct diagnosis, to the treatment delivery based on staging or treatment planning based on staging, to evaluation, what we call surveillance, at each timepoint of the treatment plan, to decide what is the status of the tumor, how is the patient doing, and depending on the outcomes, whether it is a very good response, [ ] in remission and wellness, to unfortunately sometimes recurrences, and management of recurrences.
[00:23:15]

[00:23:15]
And if again, disease is not responsive to salvage treatments, then appropriate end of life care. So the algorithms essentially tell us from point A to point Z, this is what we consider the best decision tree, if you will. They're intended to guide people in the thought process, they're not directive. In other words, they don't say you must do this, but these are the best recommended or the best acknowledged processes for this particular phase of the illness. That should drive then, the decision-making process and the conversations with the patient, about you know, this is the recommended best strategy.
[00:24:10]

Dr. Rosolowski
[00:24:11]
And this is all based on data that has been collected.
[00:24:14]

Dr. Rodriguez
[00:24:14]
Correct. The algorithms are developed through a [ ] rigorous process of integration of multidisciplinary experts, to discuss the plan of care or to discuss the map of care, and then we also do literature searches to support those decision points. They are meant to be living documents. In other words, they change as the best evidence recommends that if treatment A was the best treatment ten years ago but it no longer is, then it needs to be removed. We have to keep updating these as new evidence emerges. Now, that of course served [ ] as kind of a collaborative map internally, but now that we are [ ] an organization that has other partners beyond our Houston address, one of the questions that the partners have raised is how do we know that we are delivering MD Anderson care, or how would we ensure that we are all delivering MD Anderson care. And of course, then these maps [ ] should be what then guides

each of [our] partners. Because the process has only been internal, we are now faced with an interesting, but I think exciting new challenge, which is how do we now engage our partners in true partnership?
[00:25:50]

[00:25:50]
That is, in the evolution and development of these tools that guide our practice. And the tools are not just the algorithms, but also order sets for example, that should be standardized in a certain fashion, to ensure that we have all the required elements for each episode of care. In particular, when it comes to chemotherapy, where certain chemotherapy regimens are rather complex, we want to ensure that they are safely designed, that they have integrated all of the components of prevention of side effects and/or appropriate management of side effects as they arise during the treatment, and so on. So designing the tools and collaborating towards the design and implementation of algorithms, I see as an exciting next phase of evolution in how we integrate not only multidisciplinary care, but now multi-institutional, multidisciplinary care.
[00:26:58]

Interview Session: 01
Interview Date: April 17, 2017

Chapter 05
Envisioning the Next Period of Leadership
B: Institutional Change;

Codes
B: MD Anderson History;
B: MD Anderson Culture;
C: Leadership; D: On Leadership;
B: MD Anderson in the Future;
B: Critical Perspectives on MD Anderson;
B: Growth and/or Change;
B: Institutional Politics;
C: Understanding the Institution;
C: The Institution and Finances;
B: Research;

Dr. Rosolowski
[00:26:59]
Very interesting, yeah. Well, I think I'm out of questions. Is there anything you would like to say about the institution right now, or an interesting next step for the institution that you envision?
[00:27:17]

Dr. Rodriguez
[00:27:19]
I think that at this point in time, obviously the next most critical step is to identify -- and this of course will be done at the level of the University of Texas system, [ ] who is it that we envision will be the best person to lead the organization as the [next] president of the organization. My personal hope would be that this would be someone who is both knowledgeable and sensitive to the culture of MD Anderson, which is very knowledge driven, very innovation driven, but at the same time is very knowledgeable and capable of maneuvering the new paradigm of healthcare from a national perspective, from a legislative perspective, from a financial perspective. There's no question that we have to revamp or redesign many of our infrastructure and our systems [ ] for accounting, for billing, for productivity, for so many other endpoints that in the industry of healthcare are considered important towards fiscal accountability and health of an organization. We also are committed and hopefully will remain committed, to education and prevention, as well as innovation and new discoveries.
[00:29:17]

Dr. Rosolowski
[00:29:18]
MD Anderson has always had a president who had MD after his name. Do you think that it would be valuable to continue in that tradition? I'm just, I'm saying that because all of the areas that you just mentioned are certainly not part of usual experience for physicians, in a deep experience in finances of institutions.
[00:29:43]

Dr. Rodriguez
[00:29:44]
Correct, but there are some physician leaders in the national arena who indeed are very expert. As I understand it, [the requirement of leadership by a physician is embedded] in the bylaws.
[00:29:59]

Dr. Rosolowski
[00:29:59]
Oh, I didn't realize that.
[00:30:00]

Dr. Rodriguez
[00:30:00]
I think it was part of the vision of Dr. Clark, that because patient care is a very essential and foundational mission of our organization, that we would be led by clinicians.
[00:30:19]

Dr. Rosolowski
[00:30:21]
And what do you feel, I mean what do you feel that's done for the organization?
[00:30:26]

Dr. Rodriguez
[00:30:28]
I think for us, it has grounded us and has made us very focused. Let me backtrack and say that at the time that this organization was founded, people didn't even speak about the word cancer, patients many times weren't even told by the doctors that they had cancer. And so he was creating an organization that was radical in its acknowledgement that we were here to treat cancer and our goal was that we would make cancer a treatable disease, rather than a fatal illness. So he was both an optimist and a visionary, as well as a very honest and forthright person, in saying this is our goal, cancer is our mission. So I think that it has grounded us very, very much, in [ ] our goal. Really, it's a very unified and very driven goal, to really make cancer a thing of

the past or make cancer a treatable illness that is not, like I said it's not a fatal condition but it's manageable, just like one manages diabetes, like one manages so many other chronic illnesses.
[00:31:57]

[00:31:58]
So to that end, I think that having physician leaders who were committed to that agenda has indeed made us the powerhouse that we are today, in terms of the development of so many new therapeutic strategies against cancer. But, this is not to say that there aren't other important domains in cancer care delivery, and I think Dr. DePinho had a vision of yet another aspect of that journey, [ ] that mission, which is the development of new and innovative [pharmaceutical] treatments, and that in itself, of course is a very worthwhile mission. It is very complex, however, and I think that the realities of the current fiscal environment make it very challenging to be able to manage both operations or both goals, because they're both very resource intensive, not just on the financial side, but also on the organizational, regulatory and human talent side.
[00:33:24]

Dr. Rosolowski
[00:33:26]
Well, I want to thank you very much.
[00:33:28]

Dr. Rodriguez
[00:33:28]
Oh, thank you, thank you for the opportunity.
[00:33:30]

Dr. Rosolowski
[00:33:31]
It's been wonderful talking to you again.
[00:33:33]

[End of Interview]