

Wai-Kwan Alfred Yung, MD

Interview Session Four: July 7, 2014

Chapter 00D **Interview Identifier**

Tacey Ann Rosolowski, PhD

0:00:09

For the record, today is July 7, 2014 and the time is 2:37 and I'm on the 7th floor of the faculty center today in the Department of Neuro-Oncology talking with Dr. Alfred Yung, Department Chair. This is our fourth session together. So thank you very much for agreeing to this last session and with all of our re-schedulings and equipment questions and all of that we've --- we've powered through and we're at our last session, so thank you.

Interview Session: 04
Interview Date: July 7, 2014

Chapter 13

Focusing on Work, Faith, and Hope During Cancer Treatment

A: The Patient;

Story Codes

A: The Patient;
A: Character, Values, Beliefs, Talents;
A: Personal Background;
A: Overview;
A: Definitions, Explanations, Translations;
C: Faith, Values, Beliefs;
C: Portraits;
C: Formative Experiences;
C: Evolution of Career;
C: Patients, Treatment, Survivors;
C: Funny Stories;
B: MD Anderson Culture;
C: Dedication to MD Anderson, to Patients, to Faculty/Staff;
C: Healing, Hope, and the Promise of Research;
C: Human Stories;
C: Offering Care, Compassion, Help;
C: Patients;
C: Cancer and Disease;
C: This is MD Anderson;
C: Dedication to MD Anderson, to Patients, to Faculty/Staff;

Tacey Ann Rosolowski, PhD

0:00:09+

Well, I wanted to ask you today, we were talking before the recorder was on about some of your experiences as a patient at MD Anderson. So I wanted to ask you a little bit more about that. Last --- last time you mentioned that you were diagnosed in 1999.

Wai-Kwan Alfred Yung, MD

0:00:59

Yeah. I was diagnosed with cancer in 1999, transitional cell carcinoma in the prostatic duct which is kind of an unusual place for transitional cell carcinoma. Transitional cell carcinoma usually either in the bladder wall, you know, or in the bladder entrance but in the prostatic duct is very uncommon. But on the other hand I actually was symptomatic for a few years before finally the biopsy revealed the cancer cell. I had multiple biopsies because of the --- because of the symptoms of urgencies and bladder obstruction. So I used to have to go to the bathroom a

Interview Session: 04

Interview Date: July 7, 2014

lot. So we had multiple biopsies at time initially thinking it may be just the congenital problem of the --- of the bladder outlet, too narrow to open it up and make the symptoms go away, but it didn't. Until 1999 when they did some more tests and had some spontaneous bleeding. So the urologist took a much bigger biopsy and then discovered the cancer cell. At the time the cancer cell invaded some of the blood vessel. So we decided --- so the oncologist and the urologist decided that we should have chemotherapy first before radical surgery. So we did chemotherapy for five months I think and then followed by surgery. At that time, we decided to, David Swanson is the urologist, and David said, "Well do you want to have small surgery, just kind of scrape out the --- the wall or do you want to have more radical surgery to take out all your _____ (0:03:21.7) organ like the bladder and the prostate all at once. That would guarantee that there is no --- no tissue left for cancer to come back. Small surgery, you know, you keep your potency but you are leaving a lot of tissue for the cancer to come back."

Tacey Ann Rosolowski, PhD

Right hard decisions.

Wai-Kwan Alfred Yung, MD

0:03:43.9

So we choose to have the radical surgery with reconstruction.

Tacey Ann Rosolowski, PhD

0:03:53

So tell me about that shift. I mean, to go from being a cancer doctor to a person having cancer and seeing the disease and experiencing the disease in a totally different way. What was that change like for you?

Wai-Kwan Alfred Yung, MD

0:04:11

Well, I mean I think, I --- my wife and I, you know, we grew up in church and we have very strong faith in God. So when we were told with this diagnosis we really just, you know, take it in the way of this is just another hurdle that we need to put it in --- use our faith and put it on God's side and see what He's guiding us to do. I mean we didn't really go through a lot of anger and "Why me? Why me?" type stage. We really focused on next --- what next.

Tacey Ann Rosolowski, PhD

0:05:01

Well I think it's interesting that you, you know, you're saying that it was sort of a joint experience, you and your wife. So it sounds like you have a really strong --- you had a really strong support system at home, which is great.

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Interview Session: 04

Interview Date: July 7, 2014

Wai-Kwan Alfred Yung, MD

0:05:17

But when we were --- when I was deciding what to do, I mean, the first --- with the very first decisions that I don't, you know, want to leave Anderson system. I want all my treatment --- treatment for cancer, we're the best cancer hospital. I don't want to go elsewhere for the cancer treatment because I don't people to know that I had cancer. You know, so the first decision was to stay here whether it was chemotherapy or surgery. I trust my friends. So I talked to Logothetis and then talked to what's his name, the oncologist that left. It'll come back. I will have to find his name.

Tacey Ann Rosolowski, PhD

0:06:20

Okay and that first doctor's name was Peters? What was his first name?

Wai-Kwan Alfred Yung, MD

0:06:28

No. The Chief of GU Medicine now. Chris ---Christopher Logothetis.

Tacey Ann Rosolowski, PhD

0:06:38

Oh, Logothetis.

Wai-Kwan Alfred Yung, MD

0:06:42

Chris Logothetis.

Tacey Ann Rosolowski, PhD

0:06:43

Okay, got it. Uh-huh.

Wai-Kwan Alfred Yung, MD

0:06:44

But it --- But it was, you know, it was --- he assigned it to one of his deputies --- one of his faculty that specialized in bladder oncology. Logothetis himself is much more into prostate. So we have --- I had to go through five months of chemotherapy you know weekly times three, rest one week, and then --- and then --- so a total of 15 weeks of chemotherapy with three drugs.

Speaker

Wow.

Interview Session: 04

Interview Date: July 7, 2014

Wai-Kwan Alfred Yung, MD

But, you know, I was ama --- I was in pretty good health even though the chemo is pretty strong other than just losing all my hair and my --- my blood count dropped only one time and I have really --- you know, I timed the chemotherapy such that I get my chemotherapy Friday night. I check into my hospital room because it's overnight infusion. So I check into the hospital room Friday night, get my infusion done, and then Saturday morning I check out, go home and rest then come back to work on Monday. So for 5 months we go through this routine. But on the other hand that kind of experience was exactly how again like I said I wanted to behave like a patient, not a VIP, not a doctor. So I usually just go up to my room just like any other patient, check in, wait for my --- my chemotherapy and interact with the staff just like other patients.

Tacey Ann Rosolowski, PhD

0:08:54

Was there anything about that patient experience that surprised you?

Wai-Kwan Alfred Yung, MD

0:08:58

And I think it is. You know --- it is --- You get the feeling. At night it's pretty noisy in the hospital because the nurse comes in to check you. So you understand when patients say. "I don't want to stay in the hospital because it's so noisy at night. I cannot sleep." It's true. You cannot sleep. Because the nurse has to come check you sev --- several times a night and also if your room is close to the nursing station a lot of people are talking out there all night long. You know. So these are real people that go and the food is really lousy no matter what. Our food is pretty terrible. And you also have to, you know, --- you have side effects from the chemotherapy you know but I think that the experience of our staff, --- you know, I think at MD Anderson we have a wonderful team of nurses and support staff. And I think most of our nurses and assistants are very good, you know, very compassionate to patients. There are some who occasionally they are going to be that slacker but otherwise we have a very good team.

Tacey Ann Rosolowski, PhD

0:10:35

Did you observe? I mean did those observations and going through that experience, you know, from the inside, did that make you think differently about you know MD Anderson, about your own practice?

Wai-Kwan Alfred Yung, MD

0:10:49

Well I mean --- I think, you know, it did not change my mind about MD Anderson. I mean it

Interview Session: 04

Interview Date: July 7, 2014

helped me to --- to really be a better manager or to be --- to really be a better advisor when people --- when management asks me what we need to do and how we can improve MD Anderson and also as a Department Chair how we want to --- how we want to really change things in our clinic and the way that we administer care to the patients because I have seen first-hand, you know, what kinds of issues that you run into as a patient. I --- When my IV doesn't work, how fast do I get help? When I need to go to the bathroom, how fast did I get help? And when I have issues with one of the --- one of the drugs that I have is a steroid and steroid make you a nut, at night --- especially when you have steroids at nighttime --- especially when have steroids at nighttime you are agitated all the time. They make you feel like you pins and needles all the time --- pins and needles all the time, you know, and you cannot sleep. And when you go through that kind of experience you know what the patient goes through. When the chemotherapy makes you --- your stomach really queasy and you don't feel like eating anything or always want to --- want to throw up. You experience it and then when you talk to your patients you know what they go through and you understand what he is talking about. So in a --- in a way that experience really helped me. You know, I don't want to use the phrase "more compassionate" because I think I am compassionate enough without being a patient, but more understanding of what a patient goes through when you talk about or try to calm down their fears or trying to calm their nerves, you know, you can come in with more understanding there.

Tacey Ann Rosolowski, PhD

0:13.25

Do you tell your patients that you've --- you yourself have been a patient?

Wai-Kwan Alfred Yung, MD

0:13.29

Yes.

Tacey Ann Rosolowski, PhD

0:13.31

Does that help create?

Wai-Kwan Alfred Yung, MD

0:13.33

It does. I have many of my older patients, especially the patients who see me through those times. I still have a lot of patients that --- that, you know, saw me when I had no hair and up to this stage they say, you know, "Are you still okay?" No, I'm not --- I tell my patients I --- I know exactly what they are talking about because I am a patient. And, you know, I use my experience to encourage my patients that, you know, --- that you've got to have hope. We --- I am just a messenger. I always tell them I'm the messenger. I don't have the ultimate answer for you. I give you the medicine that I give everybody, but it may work on you and it may not work

Interview Session: 04

Interview Date: July 7, 2014

on you. He's the guy --- upstairs guy who is in control. You know, you just have to have the hope. This is a battle. you know.

Tacey Ann Rosolowski, PhD

0:14.44

I can imagine, I mean I think if a physician told me that you know he or she had experienced whatever I was going through I think that would really calm my --- you know calm me down and make me feel like, yeah this person kind of --- ki --- really knows.

Wai-Kwan Alfred Yung, MD

0:15:02

It depends on the patient. Some patients really, you know, have such a high anxiety level and high anger level that, you know, it's --- the anxiety and anger overcome everything else.

Tacey Ann Rosolowski, PhD:

0:15:27

Is that particularly the case in dealing with brain cancers? I mean I'm --- you know all cancer is so difficult to deal with. The diagnosis is so difficult, but I've --- I've always thought that a diagnosis of brain cancer has you know kind of a special urgency because the brain is so tied up with our identity, I mean who we are as a person.

Wai-Kwan Alfred Yung, MD

0:15:50

Well, yes. I mean I think --- I think the --- the anxiety level is higher mainly because it is so you know generally perceived that this is a --- you know especially a brain tumor is a deadly disease -- a hopeless disease. No one --- No one lives, you know. So --- But on the other hand, my observation is also --- depends on the makeup of the patient. Whether the patient is a control person or not a control person. I mean I think --- I don't think brain --- malignant brain tumor is any different from lung cancer or breast cancer you know. The only difference --- I think the only difference --- I would say there is a difference. The difference is that when you have cancer in the brain --- tumor in the brain, that the unfortunate thing is because the tumor is in the brain it kind of destroys your --- your cognitive function. It des --- destroys your --- your orientation, memory early. And so you lose your brain function early as opposed to cancer in the lung whereas you could be totally intact up here with the body being rotting away. But the problem with brain is that you lose your faculties. You become, you know, dependent on people and a lot of type A, high function people, really cannot handle that well. You know especially when high function people feel that they are only functioning at 70% because part of the memory is gone or part of the --- where they were able to function at 130% of their brain function and now they are only functioning at 70%. They don't like it. And also now they depend on what the doctors say, what my wife --- what the caregiver has to say and they used to give order. So it leads to a lot

Interview Session: 04

Interview Date: July 7, 2014

more anger especially on the high function people. You know a lot of anger and a lot of depression.

Tacey Ann Rosolowski, PhD

0:18:24

What do you do as a clinician for people like that?

Wai-Kwan Alfred Yung, MD

0:18:31

Not much you can do. You know hook them up with psychiatrist early or encourage them and say this is going to happen. The more you can give the more you can --- The sooner you can accept. My emphasis has always been the sooner you need to accept --- the sooner you can, the sooner the better for you. You need to accept that you are not the same person. Yes, you are CEO of the big company, you functioned at 130% of brain capacity but you know --- you --- now you only --- you only function at 90%. In general 90% is very good already so come on guy accept. 90% is better than a lot of people. Don't just keep drilling on that "Gee, I was 130% before, why can't I be 130%? I don't like 90%." So you are going to be depressed if you do not like your 90%. You've got to accept, 90% is just as good and function at 90% and not push yourself back to the 130 because you'll never get there. You'll get frustrated and you'll get depressed. Some people, you know, --- The people who do well is the ones that accept it. They say, "I'm stepping back. I accept this." Those who cannot do that they go into a deep depression and so some do not do well treatment-wise.

Tacey Ann Rosolowski, PhD

0:20:16

That's a very hard situation. I remember last time you also told me that when you were going through your treatment and all of this experience as a patient, I mean you were also really being jettisoned into an entirely new administrative role so your own administrative responsibilities had changed dramatically. How do you feel --- Was there --- What was that collision like? I mean here you were a patient and then suddenly, bang, you know you had this whole new role to take on. Did that help? Did it hurt? You know what --- what was that like?

Wai-Kwan Alfred Yung, MD

0:20:54

Well, the illness other than the you know the tumor and the surgery and the recovery from surgery, that five to six week period. We did not --- Even chemotherapy did not slow me down that much. But surgery and recovery from surgery, that five to six weeks of recovery time slowed me down. But as soon as I recovered from the surgery I was, you know, back to 100% active and my perspective at the time was that I'm given extra time so --- so now I have to use the extra time properly you know to the best of . . . God had given me the time I have. Because

Interview Session: 04

Interview Date: July 7, 2014

with the --- with the chemotherapy first and surgery later at the time of surgery the tissue that got removed showed almost no cancer cell left so what we call pathological res --- you know remission. The chemotherapy killed off all the tumor cells. So that was a good prognosis, a good prognostic factor that we were able to achieve pathology CR --- pathologic CR and then --- then the surgery becomes a cleanup job. And also the other thing is --- is that you know David, the surgeon, was able to --- to instead of when --- when you have to remove the bladder you know you either have to create a neo-bladder or use the bowel to create a bladder so that you can make internal --- you know have an internal reservoir or you have to wear an external bag if there is no --- not enough room to create. You know I told David I said "Try your best. Even though you may need to get rid of all the tissue but try your best and see if it's possible save enough room to put a bladder in so that my quality of life would be a lot better without dealing with the bag." Even though I have to deal with the incontinence but there is no --- no real sphincter control but it's still much better than changing a bag all the time. So we were able to have a neo-bladder so --- so I mean I function almost without much disability after the surgery. I'm really, you know I look like at it as God has given me the extra time, so I'm going to use it to do the program, you know.

Tacey Ann Rosolowski, PhD

0:23:53

What were some --- Were there some projects or you know pathways that you identified that you wanted to use with --- wanted to go down with that extra time? You know were there things that okay I've been given this time, I really want to do THIS. Was there anything like that?

Wai-Kwan Alfred Yung, MD

0:24:10

Well, I mean I wa --- Yes. I was going to --- to really build a world class brain tumor research program here you know and kind of continue what Dr. Levin, my previous boss, had started you know with Dr. Sawaya so I worked closely with Dr. Sawaya. We --- I --- I was given --- given positions and authority to expand the department, you know, and bring in more scientists and develop an area of drug development so that --- so that we have a team of people who develop new drugs and a team of people to look at creating virus for viral devel --- To create a laboratory and clinical program that can go you know back and forth in between it. What we call nowadays a translational program so that the clinicians and the scientists that work together. We go back and forth and we also perform more cohesive collaborations with Neurosurgery, Pathology, and Radiology to --- to really create this team so we go after the specialized center grant --- the SPOR grant.

Tacey Ann Rosolowski, PhD

0:25:50

Yeah we talked last night --- last time about how you were building those networks.

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Interview Session: 04

Interview Date: July 7, 2014

Wai-Kwan Alfred Yung, MD

0:25:55

So we --- we were finally successful at getting the SPORE grant after one trial. We were not successful with the first round in 2006. I think we were not successful there but we finally got our grant funded in 2009 --- no 2000 --- 2008. The second round was in 2008. We got funded in 2008.

Interview Session: 04
Interview Date: July 7, 2014

Chapter 14
Building the Advanced Practice Nurse Program
A: The Administrator;

Story Codes

A: The Administrator;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Offering Care, Compassion, Help;
C: Patients;
B: MD Anderson Culture;
B: Institutional Mission and Values;
A: Overview;
B: Institutional Processes;

Tacey Ann Rosolowski, PhD

0:26:27

Yeah, we talked last time about some of the research that --- that has come out of that too so it's really promising. I wanted to ask you about some of the other --- I have this little printout of, you know, the 'Where we were' in the department and "Where we are" in the department.

Wai-Kwan Alfred Yung, MD

0:26:45

Where did you find that?

Tacey Ann Rosolowski, PhD

0:26:48

I found it online. It has some --- some really interesting things, some of which we've already talked about but there were some that we hadn't and I was interested in the advanced practice nurses. You know the degree to which advanced practice nurses are kind of part of what is going on. There's also, I don't even know how to say this, ependymoma.

Wai-Kwan Alfred Yung, MD

0:27:18

Ependymoma.

Tacey Ann Rosolowski, PhD

0:27:19

Ependymoma.

Interview Session: 04

Interview Date: July 7, 2014

Wai-Kwan Alfred Yung, MD

0:27:19

Ependymoma.

Tacey Ann Rosolowski, PhD

0:27:20

What is that?

Wai-Kwan Alfred Yung, MD

0:27:22

Well there are --- So let's talk about the --- the --- the advanced nurse program. I think we --- we developed the advanced nurse program in the department sort of along the institutional direction. Now when I --- when I took over the Chair, you know, I --- I hired several you know more clinical faculty and recruited several more in an event to expand the clinical program and at that time it was also one way to expand the clinical care is utilize support from advanced nurse --- advanced practice nurse. Some departments use advanced practice nurse, APN. Some departments, especially surgical departments, might use physician's assistants, you know P.A.s. We --- We --- We in the medical side most of the medical departments use advanced practice nurse so they come up from the nursing rank. They have Master's degree training in --- in primary care nursing or advanced care nursing so they become --- they can perform the functions aside a physician you know and do physical exams and do history-taking and even are allowed to prescribe some simple drugs after they workup this --- the patient and find out that maybe this is an infection and we need to prescribe an antibiotic or the --- and/or this is just a cold or something like that. So the advanced nurse can be really very helpful. Some of them sometimes even can do independent followup, you know, follow up and check out the patient to see if blood count is good and we don't need actually physicians to see those patients. So they set up their practice line themselves. So we start --- You know when I became chair I recruited two or three faculty to expand our clinical load and at the same time we needed it so we recruited and started expanding our advanced practice nurse. I recruited **Ava Lou Lee (0:30:03.1)** from --- from the -- from the emergency room and she is wonderful. She worked with me and she help --- she is kind of in charge of hiring more APN. She became the APN Supervisor and we built a --- a --- a APN team, you know, to work with --- work with them. Early on the division of medicine has a kind of --- has a formula saying how many doctors, you know, we are allowed to hire, one APN for --- for two doctors unless --- unless the doctor is a full-time clinician then we can have one APN per doctor. So you work out that kind of matching. We also utilize APN to help them with the procedures. We train our APN to do lumbar punctures and/or **myotap (0:31.02.3)** so that we can give chemotherapy to the _____ (0:31.05.7) reservoir. We also use our APN sort of like medical doc --- interns in the inpatient service. Other services do the same, use APN to staff to -- with the doctor to really manage the inpatients. So the APN gradually --- have become not

Interview Session: 04

Interview Date: July 7, 2014

only just an integral part of the department, but a major piece in the level of care, you know, in the care team. Working with the research nurse, working with the clinic nurse. So in a way MD Anderson is blessed. We have the resources that --- we actually have these four groups of nurses in the department level. We have the research nurse that take care of the research studies. We have advanced practice nurse as the phys --- as the doctor's assistant and then in the --- in the clinic, we have the clinic nurse that kind of do the clinic and then you have the inpatient nurses. And in most --- most other places we do not have these --- that rich resources where can have that large group of research nurse as well as advanced nurse and some --- some of the other places, they have to use their advanced nurses to do a lot more research functions.

Tacey Ann Rosolowski, PhD

0:32:45

Interesting. I'm curious. I was talking to Barbara Summers [Oral History Interview], and she was talking about how there is move in nursing to talk more about patient-centered care and family-centered care and I'm wondering is there any way that that is also becoming part of --- of Neuro and what the nurses do in Neuro since you were talking earlier about these dependency issues with Neuro-Oncology patients.

Wai-Kwan Alfred Yung, MD

0:33:18

Yeah, I mean I would use like the --- the --- the --- the advanced nurse we provide, you know, the --- a --- a lot of help and assistance to --- you know to the caregiver, to interact with the caregiver. We also have --- You know, there are several research nurse --- several advanced nurses who are very much interested in quality of living --- quality of life and patient symptoms and so --- so that --- that is also there. Their research interest in how to you know to --- to work with the caregiver and the patient in the area of enhanced, you know, family care and family interaction and I think that's very important in terms of improving the quality of life of the patient.

Interview Session: 04
Interview Date: July 7, 2014

Chapter 15

The Collaborative Ependymoma Research Network (CERN); Funding Research A: Professional Service beyond MD Anderson;

Story Codes

A: Overview;
A: Definitions, Explanations, Translations;
A: The Researcher;
A: The Clinician;
D: Understanding Cancer, the History of Science, Cancer Research;
D: Business of Research;
D: On Research and Researchers;
B: Philanthropy, Fundraising, Donations, Volunteers;
B: Industry Partnerships;

Tacey Ann Rosolowski, PhD

0:34:23

Very interesting. Hmm... What about the uh ...?

Wai-Kwan Alfred Yung, MD

0:34:28

Ependymoma? You know, when it comes to primary tumor in the brain, the most common is astrocytoma. The second common is oligodendroglioma. Now in the brain if you re --- if you remember biology of the brain, there are four main types of cells in the brain. One is nerve cell, the neuron, nerve cell and then the nerve cell is actually supported by three groups of supporting cells. One is astrocyte. Astrocyte provides nutrients and spatial support to the --- to the nerve cell. Oligodendrocyte --- Oligodendrocyte is the cell that makes the lining of the nerve fiber to help conduction faster. And the third one is ependymocell. Ependymocell --- In the brain there is a reservoir called the ventricle and an ependymo --- ependymocell line the reservoir and make fluid and move --- propel the fluid. All three types of cells can become cancer --- become tumors. Ast --- When the astrocyte become tumor, it is astrocytoma. When the oligodendrocyte get transformed into tumor, they are called oligodendroglioma. When the ependymocell get transformed into tumor, we call it ependymo --- ependymocell --- sorry ependymoma. Ependymoma. So you have three --- But ependymoma is the least common in adults. Now in children --- in children --- the most common tumor in children is the nerve cell tumor, medulloblastoma, because it's sort of a, you know, --- there is --- the --- the --- the neuron is still dividing at an early age and that program had gone haywire so formed neural tumor called medulloblastoma. So most of the medulloblastoma is developed --- is developed early and gets discovered early. That's why it's a children's disease as opposed to adult disease. They pick up those tumors in children. Besides medulloblastoma, astrocytomas are very common, then

Interview Session: 04

Interview Date: July 7, 2014

ependymomas also are common in children more --- more than adults but it still is a very small disease. And now I recruited Dr. Mark Gilbert in 2004, you know, to --- to join us from Pittsburgh. Was it Pittsburgh? Yeah, Pittsburgh. And I forgot when maybe 2005 or 2006 or somewhere around there, maybe later in 2006 or 2007, he had a patient who had an ependymoma and the patient's brother had a foundation and the --- the patient's brother asked Dr. Gilbert "does this --- how much disease --- how much research is going on for this disease --- this small disease?" and Dr. Gilbert said "not much." Well then he said, "Well how can we create more research?" The Dr. Gilbert said, "Well we could do that if we have you a --- large sums of research funds." And the brother said, "Do it. Tell me how much." Dr. Gilbert said, "It probably takes about 20 million dollars." He said no problem. So they set up a --- a foundation or --- they set up a foundation and called it the --- The CERN. CERN is Collaborative of Ependymoma Research Network and that --- it is funded by this one family and probably a little more but --- but it is known as The CERN Foundation. This foundation single-handedly fund ependymoma research in adults and children. It's a joint --- It is a joint project with Dr. Gilbert and Dr. Gilbertson from --- from St. Jude Hospital.

Tacey Ann Rosolowski, PhD

0:39:25

So is this --- it sounds like maybe this is very unique, that there's not a lot of research.

Wai-Kwan Alfred Yung, MD

0:39:32

This is very unique and at least because the --- there's not a whole lot of research going there because it's such a small disease. Now if you think about --- about public funding from the government. So when you have a big disease, a big clinical need, and also big efficacy voice, you get more funding. When you have a small disease, not that many efficacy voice to raise, so you don't get much funding. So you know that if something happened to a rare disease most of the time you need, you know, private funding. And so this family and Mr. Clay, what is his last name? You could probably get his last name if you go on site --- go online and look up CERN, maybe you can find it. He's not that keen on announcing his name so everything is talked about CERN but --- but --- but this one piece of private funding has publicized the plight of patients with ependymoma because it stimulates a lot of --- especially more like tumor research and drug discovery research in this disease and it's --- is a model actually. I mean this is a model that we are following even with bigger disease like glioblastoma and I'm working with the National Brain Tumor Society to mount a national effort, you know, 50 million dollars along the same line that there is not enough public funding to really mount a big effort so you really can mount a --- a strong concentrated effort with private funding. We can seek out the --- the --- the talents, the strong scientists and high-impact program to get them to work together to --- to devote more time and more brain power into this problem and we'll --- we'll be able to make inroad faster.

Interview Session: 04

Interview Date: July 7, 2014

Tacey Ann Rosolowski, PhD

0:42:17

Is it the case too --- I mean I know when I was talking to Gabriel Hortobagyi he was raising certain issues that came up with private versus public funding for research and saying that even with certain private foundations and certainly with government, you know, there's a tendency to take a safer road in funding research whereas private funds can often be --- they have more freedom to fund things that --- that are innovative.

Wai-Kwan Alfred Yung, MD

0:42:46

I think he's right --- he's right. The system that we set up with NIH with the peer review system. It is --- It is a more conservative system because the peer review system, you know, utilized the view and take the view that "well tell me what you want to do" and this is what you want to do or why do you want to do it? What is the evidence that this is the right thing to do? So you --- they require a lot of preliminary data and it requires you know a --- a sort of --- a lot of safety valves, you know, check and balance to say you know I think of this but this has not worked as well. So it takes a more conservative way of thinking. In general because of the peer review system it's set up like this that the investigators do not really --- cannot take risks that much. You cannot say, "I want to do this even though I don't have a whole lot of data to support why I want to do this." You never get money from the public system when you say, "I want to do this just because of hunch. I don't have any data to support why that --- that it will work. Just a hunch." The public seminar gives you money to do this. The private systems works. If you --- If you say --- You know if you say that, "Gee, we need to take that risk." Especially you know if a group of advisors get together to say, "We have seen this. We --- We need to take this risk." And the private funding has the freedom because they don't --- they don't --- well they do have to answer to the constituents --- the ones who raise the funds, but they don't have to answer to a lot of government regulations that say, "Well did you use the money right?" You know? So I do believe that private funding allows you to take more risks which is what we need, to take risks.

Tacey Ann Rosolowski, PhD

0:45:14

I also wanted to ask you about the clinical research piece because I mean I was just talking to Robert Bast [Oral History Interview] this morning and --- and I've talked with other people who do translational research too, who you know have observed that there tends to be you know more emphasis on the pure basic research approach than a clin --- a more clinically based research. And I'm wondering if you feel that that's also a trend in funding. You know that I mean it's the basic research that gets into the high-impact journals that maybe attracts more --- more funding more quickly and that if private funding can be used for more clinical approaches, more translational approaches.

Interview Session: 04

Interview Date: July 7, 2014

Wai-Kwan Alfred Yung, MD

0:46:13

Well, I mean I think that there's --- there's a lot of NIH funding going to the clinical trials and I don't think there's enough private funding unless --- well there are s --- there are several high value foundations that they can --- they can fund you know clinical research in a way --- in a scale that the NIH is funding. Because doing clinical trials is very expensive. It's really very expensive you know and --- and that's either funded by the federal government or funded by the industry and private foundation funding unless you're talking about a big foundation like Coleman Foundation, you know, Ford Foundation those --- and Leukemia Foundation. Those big ones, they can handle multi-million dollar clinical trials. Many small foundations really cannot mount that kind of support for clinical trials. I think clinical trials require --- require a lot of --- if you can do it requires a lot of collaboration between the government and the drug industry and the private foundations for us to do more risky, innovative trials. The government funding tend to do, again, more conservative trials and --- and that's what the cooperative groups are doing, they --- conservative, you know, trials. Early --- But now even though the government and NIH are trying to fund the phase 1 and phase 2,, but phase 1 and phase 2 are traditionally still in the hands of the drug industry and the drug industry funds this kind of trial in big disease because they need to --- they need to get their money back. For a small disease like brain cancer, brain tumor, thyroid cancer, sarcoma they're always second fiddles or third fiddles when it comes to industry funding where there's --- this is where the foundation comes in.

Tacey Ann Rosolowski, PhD

0:49:01

If you had, you know, your wish granted, what would be one or two clinical trials that you would like to see handled in that way. You know, a risky trial funded by government, the drug industry, and private foundations all unifying their money. What would you like to see done?

Wai-Kwan Alfred Yung, MD

0:49:22

For brain tumor?

Tacey Ann Rosolowski, PhD

0:49:23

Yeah.

Wai-Kwan Alfred Yung, MD

0:49:24

Well we are actually doing some planning for that with a group of people and --- and thinking and planning and hoping that we can get these forces together. I mean what we --- what we have now to --- to --- that we need to take risks as we talked about in the research level we have a

Interview Session: 04

Interview Date: July 7, 2014

better understanding of the biology of a tumor. We know that, you know, glioblastoma can be divided in several subtypes with some clinical markings. So what we need to do then --- that --- is you know taking some of these molecular determinant and look at what drug could be matched with the molecular determinant and we can quickly test it. Getting one of drug A and drug B to treat disease A you know and disease B. Drug A and drug B if it does not work for C and D for disease A. Kind of doing these kind of mock-guided trials in a subgroup level. And --- And we can do this kind of trial in a very rapid changing fashion. A does not work, we go to B, B does not work, we go to C, C does not work, we go to D and there are technology for us to do that kind of design. The question is getting the company to allow us to use their drug which they are more happy --- you know, they would be more happy to give it to lung cancer and breast cancer but not as much to --- to --- to glioblastoma so we need to get the buy-in from the drug company saying, "Yeah we are going to come in to allow you --- to give you the drug." That's the collaboration you know and then we have money to --- and we share the risk with the company by going "You don't need to give us money to do the trial but just give us the drugs early enough or give a small amount of money for drug or foundation we could have more money to support the rest of the pot." That kind can allow us to really take this kind of risk. There's not a lot --- There's not a whole lot of preliminary data to say A should work with group A. There's not a whole lot of preliminary data to say B should work with A also. But what we do --- we carefully design the trial, monitor the patients carefully and we do a more very small number of patients. We can get the test in the patient itself without relying on testing of animals.

Tacey Ann Rosolowski, PhD

0:52:17

What's --- So this is the planning stages? Have you --- Have you had conversations at all with drug companies about this?

Wai-Kwan Alfred Yung, MD

0:52:24

We're beginning to through the foundation and through the National Brain Tumor Society.

Tacey Ann Rosolowski, PhD

0:52:32

Because it sounds almost like I mean it's reminding me a little bit of some of the --- the mindset of the Moon Shots, you know, that kind of view the short --- short. So I was right?

Wai-Kwan Alfred Yung, MD

0:52:44

That's kind of in the mindset of the Moon Shots. You --- You --- I mean in Moon Shot we --- we say you know what --- where's --- take the lower hanging fruit and materialize the lower hanging fruit first. And --- and here I would cause more risk taking and de-risking each other so

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

they would bring the company early de-risking them with foundation money and ---and also with the government comes in to also de-risk the company because you --- you allow some of the, you know, --- you allow the risks to be taken through the government red tape and also give the company that if we do this we may be able to forego some of the red tape and keep the registration down.

Tacey Ann Rosolowski, PhD

0:53:47

That's kind of adapting the Moon Shots approach to a situation which as you said the last time there isn't any low-hanging fruit for glioblastoma. So you kind of have to adapt the model to the reality of that situation. Yeah. Interesting. Very interesting.

Interview Session: 04
Interview Date: July 7, 2014

Chapter 16
MD Anderson's "Horizontally-Organized" Brain Tumor Center
B: Building the Institution;

Story Codes

A: The Administrator;
B: Institutional Processes;
B: Devices, Drugs, Procedures;
B: MD Anderson Culture;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
B: Obstacles, Challenges;
B: Controversy;
C: Understanding the Institution;
D: Technology and R&D;

Tacey Ann Rosolowski, PhD
0:53:47+

Well, I wanted to ask you too about the Brain Tumor Center, which is something that we've mentioned from time to time because you've been the co-director of the Brain Tumor Center from --- since 2001. And we sort of mentioned it a bit along the way but we haven't really talked about what the Brain Center means and what it encompasses, so if you could tell me a bit about that.

Wai-Kwan Alfred Yung, MD
0:54:29

Well the Brain Tumor Center basically is a, you know, horizontal organization bringing the department together.

Tacey Ann Rosolowski, PhD
0:54:43

And this is with the Department of Neurosurgery?

Wai-Kwan Alfred Yung, MD
0:54:442

Department of Neuro-Oncology, Department of Neurosurgery, and Department of Radiation Oncology with this brain group there and imaging --- predominately imaging with the neuro-imagers. That --- Because the well-defined department is the Department of Neurosurgery and Department of Neuro-Oncology. These two departments all focus on brain tumors, so we are the

Interview Session: 04

Interview Date: July 7, 2014

anchor departments for the center. But we cannot be a Brain Tumor Center without support from radiation, without support from radiology, without support from pathology and also laboratory researchers. So we have these people all working together under the umbrella of the Brain Tumor Center. And we --- we basically kind of started you know and we said now we are going to work together so that we can synergize each other and combine resources so --- and also --- and combine resources and synergize our talents so that we do not go off on a tangent and we need to do things as a group. And --- and I think we have done very well since we work together very well as a group. This has probably about more than 60 members in it and we work together to --- to --- to help each other to get individual investigator funding as well as combined multi-center --- multi-investigator funding like we are able to get the SPORE. I think that getting the SPORE is a triumph of the Brain Tumor Center coming together and we also --- it becomes a --- a program under the cancer program, --- you know, it's a clinical program under the cancer program and --- and support the cancer program. We get a outstanding rating you know. And we work together to develop drugs and the --- the viral program is also an outcome of collaborative effort among neuro-oncologists, basic scientists, and neurosurgeons. All three groups working together to really promote the oncolytic virus program.

Tacey Ann Rosolowski, PhD

0:57:23

Is the Brain Tumor Center and, you know, the thinking behind it, does that represent a special culture at MD Anderson, do you think? I mean, it --- does it have unique qualities?

Wai-Kwan Alfred Yung, MD

0:57:38

Not really. I think, you know, if you think about it it is a multidisciplinary approach to the cancer problem. I think is brain tumor may be more unique and that we, not the medical oncologist, not the neurosurgeon, not the radiation can really go independently to really create something for the patient. You know the treatment is so _____ (0:58:16.5) --- the treatment is so you know much dependent on all three things. You know you have to have good surgery, you have to have good radiation therapy, and you have to have good chemotherapy and all three things can be intermixed. So all three group of people really have to make --- work together to make advances. So we may be more dependent on each other if you want to build up --- if you want to build up strength as opposed to breast cancer. Breast cancer you can say, you know, there's a lot of chemotherapy that we can do with it. But on the other hand nowadays, you know, if we don't put the surgeon and the radiation doctor and the chemotherapy together in breast cancer they cannot make big advances either. You know? I think whether we call it a program, a breast cancer program, a brain tumor program, a lung cancer program or we call it the lung cancer center, breast cancer center, or brain tumor center, it is a multidisciplinary concept. Clinical and research people working together. It is a collaborative approach. It takes a village. We cannot go independent together. There is so much interdependency. For us to really make I

Interview Session: 04

Interview Date: July 7, 2014

think a center approach or a program approach is the only way to go so we can bring all the talents together.

Tacey Ann Rosolowski, PhD

1:00:04

And you're co-director is Ray Sawaya, M.D?

Wai-Kwan Alfred Yung, MD

1:00:09

Yeah. The question is how much of an independent infrastructure and mini structure that you want to create for the center or how loose a structure do you want, like many medical school or medical center they more use major loosely put together center or you know if we want to be more ri --- more --- more formal and say now not only you work together, administratively, you're together. You know the director gets to hire all the people and gets to control all the machinery. That's --- That's the definition _____ (1:00:50.7).

Tacey Ann Rosolowski, PhD

1:00:53

And what's your view of that? I mean I interviewed Dr. Sawaya and he, you know, provided his perspective on that. What's your perspective on what that might look like and what the pros and cons are of independent administration?

Wai-Kwan Alfred Yung, MD

1:01:05

I think it depends on where you are. I mean if you are able --- if you are able to --- I think, of course, it is --- It would be wonderful if you have --- if we can have an independent center you know independent center you know that the center controls the building and controls everything so. But on the other hand financially it is a very big undertaking, you know. So there is pros and cons to that approach you know es --- especially for the support. I mean if you think about radiation therapy, you know, can we administer and own our own radiation machine for brain and then lung own their own radiation machine, breast own their and split up our radiation department into 10-15 subgroup to house under each --- each unit. It becomes very costly. So we have to really look at this --- all these finance models. It's easier for us to group our neurosurgeons and neuro-oncologists, you know, together because we don't need to handle big machines, but when you have to handle big machines like radiation --- big machines like radiology the --- the financial model needs to be carefully thought out whether the --- this is economical.

Tacey Ann Rosolowski, PhD

1:02:50

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

Is there anything else you want to say about the Brain Tumor Center and maybe its future? Big directions that are being undertaken at this point?

Wai-Kwan Alfred Yung, MD

1:03:01

Well at --- at this point I mean the mixed levels. Presently I'm waiting for a --- a new chairman to come in to expand the group. I think it is time for us to bring in new talents to go into the next level. And --- and we have all the bells and whistles --- bells and whistles to do it and --- and I think we are pretty well set in terms of expanding the brain tumor program in a direction of the institution. You know not only to --- to put a lot more emphasis on immunotherapy and immunology which I think you know even though it has been employed for brain tumor treatment but I think the --- the --- the --- the new age of the emphasis of the T cell --- emphasis on T cell function you know is going to bring that into a new level also as opposed to the old --- the old way of depending on vaccine. Vaccine is not going to make a major impact other than you know coming back to look at this new --- the new knowledge of activating the T cell and that's how the brain tumor Moon Shots is pushing.

Tacey Ann Rosolowski, PhD

1:04:39

Now the brain tumor Moon Shot, has that become a reality?

Wai-Kwan Alfred Yung, MD

1:04:42

Not yet.

Tacey Ann Rosolowski, PhD

1:04:43

Not yet. That's what I thought I remembered from our last sessions but they're putting it together.

Interview Session: 04
Interview Date: July 7, 2014

Chapter 17

The Defeat Glioblastoma Initiative and the NCI Brain Malignancy Steering Committee

A: Professional Service beyond MD Anderson;

Story Codes

A: The Researcher;

A: The Administrator;

A: Contributions;

A: Activities Outside Institution;

D: Understanding Cancer, the History of Science, Cancer Research ;

D: Business of Research;

C: Professional Practice;

C: The Professional at Work;

C: Leadership;

Tacey Ann Rosolowski, PhD

1:04:43+

There were a couple other things I wanted to ask you about, your other roles. Your in --- involvement in the glioblastoma multiform research collaborative. Now I don't know --- Did --- I'm not sure we already talked about that, you know, the inter-institution organization. Yeah it's an inter-institution collaboration and data sharing under the auspices of the National Brain Tumor Society.

Wai-Kwan Alfred Yung, MD

1:05:22

That's the --- the --- the --- the new project that I'm setting up with National _____ (1:05:28.2). You know it's --- it's the initiative that we put together with several institutions including MD Anderson, you know, UCSD, _____ (1:05:46.1), UCLA, and Memorial-Sloan Kettering. We put the talents of the executive levels which we mentioned earlier about you know putting the talents together with a more concentrated funding and say --- then turn them loose and say now we want you to work on these directions. Develop new drugs, find out why -- - why the patient is resistant to the drug, find out --- keep --- find a marker that can divide the patient into a specific group, find out why the --- the --- the tumor escaped control, find out if there is any imaging way of --- if there is any molecular imaging to identify this patient without cutting open the patient. And these kind of --- giving these broad directions for this group of people. Do that and we're going to give you 20 million dollars or 10 million dollars to do it in the next three to four years. That is the initiative --- the goal of the initiative.

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

Tacey Ann Rosolowski, PhD

1:06:58

I see. Wow. So what's the timeframe for getting this underway do you think?

Wai-Kwan Alfred Yung, MD

1:07:04

We started the first year. The --- This group has started --- just started working the first year. So the --- next --- the next level is using to expand a national group into international collaborative. So whether we can divide up the topics and divide areas in terms of bringing in collaborators from Germany, from China, from Australia, you know.

Tacey Ann Rosolowski, PhD

1:07:41

Yeah. Wow. And I read the aim is to double the five year survival rate of glioblastoma patients within five years so that's a pretty Is that --- Is that bold?

Wai-Kwan Alfred Yung, MD

1:07:55

Well, that's bold. If you start with 10% and double it to 20% it's not that bold.

Tacey Ann Rosolowski, PhD

1:08:00

Yeah that's why I was asking the question.

Wai-Kwan Alfred Yung, MD

1:08:00

No, it's not that bold. Initially we were going to go from 10% to 40%. That's pretty bold.

Tacey Ann Rosolowski, PhD

1:08:09

But you scaled back?

Wai-Kwan Alfred Yung, MD

1:08:12

We scaled back to more reality or more realistic.

Tacey Ann Rosolowski, PhD

1:08:18

Interview Session: 04

Interview Date: July 7, 2014

Right. And it says that this group is relying very heavily on information from the Cancer Genome Atlas as well as immunotherapy approaches.

Wai-Kwan Alfred Yung, MD

1:08:27

Not really but --- but we learn from them and we --- we use utilize the cancer genome, you know, data as a starting point in terms of characterizing the patient's tumor as well as you know cell line that get generated from patients tumor but it's not totally relying on that.

Tacey Ann Rosolowski, PhD

1:08:59

Interesting. Okay. There's also your role on the NCI Brain Malignancy Steering Committee. Is that something that's --- you'd like to comment on?

Wai-Kwan Alfred Yung, MD

1:09:11

The Brain Malignancy Committee is --- is --- is a new organization feature of the NCI in response to the request from the Institute of Medicine. The Institute of Medicine asked NCI to reform their clinical trial network and put some more emphasis on collaboration among the network. So one way to do that is that they formed a steering committee on each cancer. So there is a Lung Cancer Steering Committee, Breast Cancer Steering Committee, Ovarian Cancer, and the Brain Malignancy Steering Committee. The -- The role of the steering committee is to reviewed proposals, review concepts and research trials with concepts from the big cooperative group when it involves a large number of patients or with even smaller cooperatives that rely on NCI resources. You know they need to be reviewed and was --- we're hoping that using the brain malignancy committee with a group of people sitting there to --- to look at these concepts who are able to really identify a high value concept versus lower value concept to encourage investment in the high value concept and also to avoid competition from one group or the other group when they are doing a similar concept. They say, "Why don't you guys work together?" Instead of two similar concepts, one concept and two groups work together.

Tacey Ann Rosolowski, PhD

1:10:52

So, just because you said that this was a new

Wai-Kwan Alfred Yung, MD

1:10:56

So it's kind of the committee -- the committee is look at the national trends.

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

Tacey Ann Rosolowski, PhD

1:11:01

Hmmm.. National trends. Because I was wondering I mean my question just to put it bluntly was what was wrong with the old system? You know weren't people doing that before?

Wai-Kwan Alfred Yung, MD

1:11:09

The --- The --- The old --- Without --- I think the committee plays a role in really looking at the national trend and the other idea is that usually a committee is able to chart national direction and then field it down to the cooperative group.

Tacey Ann Rosolowski, PhD

1:11:26

So it's --- So it's just taking a new perspective. That sort of integrative perspective was missing --- missing before.

Wai-Kwan Alfred Yung, MD

1:11:32

It's a new perspective, yeah.

Tacey Ann Rosolowski, PhD

1:11:36

Interesting. Now does that reflect kind of a new reality of what science is and doing --- doing biomedical research at this point?

Wai-Kwan Alfred Yung, MD

1:11:43

I think so. I think there is a new reality of bigger science, better team science, and you need better coordination when the resources is scarce. Especially you know because you have a fixed pot of money, now you have to do more work. How do you make --- use that money efficiently instead of you know allowing a lot of duplication. Because in the old system there's a lot of duplication. Even though it's --- it's competition but a lot of competition is self-centered competition and you --- you do a lot of duplication and a lot of wasting for a small thing.

Tacey Ann Rosolowski, PhD:

1:12:28

Oh I see what you mean by self-centered competition. It's like, well, I want to be the one to do it.

Interview Session: 04

Interview Date: July 7, 2014

Wai-Kwan Alfred Yung, MD

1:12:31

“I want to be the one to do it. I don’t want to work with you.” Or “I think my idea is good.” Even though it’s really trash. You know, this --- the third person looks in and say,s “This is trash, don’t do it.”

Tacey Ann Rosolowski, PhD

1:12:48

Interesting. I was thinking too about you know the --- an issue that’s come up in several conversations I’ve had about just the sheer volume of information now that people have to handle. Is there something in that as well you know that I mean you need an organization like this to kind of keep track. I mean it’s almost like this committee is --- is monitoring the groups that are producing information.

Wai-Kwan Alfred Yung, MD

1:13:20

Well the steering committee doesn’t really --- cannot deal with all proliferation of big data. That’s a separate issue. That’s a separate issue. All this big proliferation of data.

Tacey Ann Rosolowski, PhD

1:13:35

When did you start working with this committee?

Wai-Kwan Alfred Yung, MD

1:13:36

Well, the committee was formed in 2011. So I was appointed co-chair because the committee covered adult and pediatric. I’m co-chair for adult and Dr. Ian Pollock from Pittsburgh, Neurosurgeon, he is co-chair for pediatric. So basically the two of us started as the committee was formed. It’s a three year term. We’re just --- I’m just going in my second.

Tacey Ann Rosolowski, PhD

1:14:06

Secondterm. Is there anything that --- Is --- Are there any ways in which serving on this particular committee has, you know, changed your perspective at all or, you know, lessons learned from it? It sounds like a --- kind of a unique experience.

Wai-Kwan Alfred Yung, MD

1:14:24

Well I mean it gives me a nat --- gives me a chance to look at the national level is --- but on the other hand, it is a new experience in terms of kind of changing the mindset of how big group is

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

working together or whether they can work together.

Tacey Ann Rosolowski, PhD

1:14:47

That's the question.

Wai-Kwan Alfred Yung, MD

1:14:48

It is very difficult. I mean like I said it's --- it's a lot of self-interest even in a --- in a government funded group. "Well you fund me to be in charge. So I should be able to tell what science is good. Why --- Why are you creating another group on top of me to tell me I'm not doing the right thing?" Right? So a lot of this kind of thinking is still there. The --- The government funding for a big group or more than four company and then you have this size group. So each disease has many groups working, several cooperative groups and --- and trying to get these groups so each group has a certain amount of resources so now a level of consistency managed with medical school and center working together in this group, the other group work together and there is this competitive spirit. And now you say, "Well guys work together" and one group may say, "Gee why are you saying that my level of science is not good enough?" You have to really get people really able to break down the sides and start looking at the big picture together. It's -- - It's an interesting process.

Tacey Ann Rosolowski, PhD

1:16:08

How --- How do you do that? I mean, tell me about that process. How do you work with that?

Wai-Kwan Alfred Yung, MD

1:16:15

You know we have a lot of meetings together you know and some retreats, but it's the --- I think it is still too new. It's only two or --- about a three year process and to change the mindset takes more than two or three years.

Tacey Ann Rosolowski, PhD

1:16:39

Right. I mean it's kind of interesting when I was talking to Gabriel Hortobagyi [Oral History Interview] about just putting together the multidisciplinary reviews of cases in breast cancer and I said, "Oh well how long did it take you know before people really accepted that process?" and he said "Well about a decade." And I thought wow. It's not easy.

Wai-Kwan Alfred Yung, MD

1:17:04

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

It's not easy. Changing mindset is not easy.

Tacey Ann Rosolowski, PhD

1:17:07

Not easy at all. Especially you know with big egos. You know big talent, big egos.

Interview Session: 04
Interview Date: July 7, 2014

Chapter 18

Key Periods of Change at MD Anderson

B: Institutional Change;

Story Codes

- A: The Administrator;
- B: Institutional Processes;
- B: MD Anderson History;
- B: MD Anderson Culture;
- B: Building/Transforming the Institution;
- B: Growth and/or Change;
- B: Obstacles, Challenges;
- B: Controversy;
- C: Understanding the Institution;
- B: Critical Perspectives on MD Anderson;
- D: Understanding Cancer, the History of Science, Cancer Research;
- D: The History of Health Care, Patient Care;
- D: Business of Research;
- D: Fiscal Realities in Healthcare;
- D: The Healthcare Industry;

Tacey Ann Rosolowski, PhD

1:17:07+

I wanted to ask you about --- just some general questions about the institution. One of them is kind of, we talked about a big --- a key moment of change in the institution when the division system came in you know and how that got reorganized and you told me about that. I'm wondering if there are some other moments that you can identify in your career at --- at MD Anderson where there have been some really big changes in --- in the institution and you know how you saw that change?

Wai-Kwan Alfred Yung, MD

1:17:49

Well, I --- Dr. LaMaistre not only engineered the division concept. I think Dr. LaMaistre is also very instrumental in --- in handling you know the assault of you know the first healthcare change in terms of with the insurance changes from --- from the managed care. In '99 --- I mean I remember in 1992 and 1993 managed care concept comes in and says it's going to switch to Houston, Texas and we're gonna be --- MD Anderson is doomed. I think Dr. LaMaistre was really instrumental in --- in --- in preparing for that change especially getting the legislature to

Interview Session: 04

Interview Date: July 7, 2014

approve the new law that MD Anderson no longer functioned under referral system but MD Anderson can take patients directly. And this I see change law that allowed the survival of MD Anderson and allowed MD Anderson to grow and --- and --- and --- and that --- that gave MD Anderson new life. Then Dr. Mendelsohn came in in 1996 and bring that growth curve into the next level.

Tacey Ann Rosolowski, PhD

1:19:29

Can I ask you, I mean you mentioned Dr. LeMaistre [Oral History Interview] a number of times and I'm wondering did you have a working relationship with him?

Wai-Kwan Alfred Yung, MD

1:19:38

No. Not really. It was mostly just a --- a rapport as the president.

Tacey Ann Rosolowski, PhD

1:19:42

Right, right because I was wondering about your observations and what kind of a leader he was and what kind of a --- an individual.

Wai-Kwan Alfred Yung, MD

1:19:51

I mean I --- I get to know Mickey [LeMaistre] because he was very interested in the brain program and so I interacted with him eith the different levels in the department and the growth. But --- So --- And I especially in working with Dr. _____ (1:20:17.8) on the global expansion that was started by Dr. LeMaistre That's --- That's --- That allowed me to talk to him some more. But these are the observations in terms of the critical moments for --- of MD Anderson and what Dr. LeMaistre done and just like you know Dr. Mendelsohn pj[o . With Dr. Mendelsohn the --- the --- The clear change that Dr. Mendelsohn brought in is riding on the upswing and I think he skillfully bring that upswing --- continued upswing and actually changed the angle of the upswing even faster. And I mean the first 10 years of Dr. Mendelsohn's tenure was a rebuilding, one building after another building. I mean all these infrastructures is built by Dr. Mendelsohn.

Tacey Ann Rosolowski, PhD

1:21:22

Were there changes that you saw to the culture as a result of that enormous expansion?

Wai-Kwan Alfred Yung, MD

1:21:27

Interview Session: 04

Interview Date: July 7, 2014

There are certainly changes in cultures I mean I think whether we like it or not when the organization gets bigger more people come in and it becomes more of a corporation instead of a family business. You know when it was small it was a family business and we know each other and --- but when it becomes big, it becomes a corporation and now we have multiple layers, you know. So I mean that's the change. I mean with the increase of the size of the organization, the number of buildings, the number of programs, you have more administrators. Even though Dr. Mendelsohn say well we can limit our administration but there are unavoidable changes. There are also more vice presidents and more administration.

Tacey Ann Rosolowski, PhD

1:22:21

Right. What are the pros and cons of that?

Wai-Kwan Alfred Yung, MD

1:22:24

I mean you need growth. I think the --- the --- the challenge is that what we see you is a --- whether we are growing with a deviation from our base mission of research --- research-driven care as opposed to the growth of patient care for, you know, generating patient income to sustain the organization, which is --- which is a fine line. Because if we keep growing and we need to sustain the growth by patient income, when are we going to stop? Or is there a fine --- Or is there a fine line --- a moment where you sustain and say enough is enough because we really need to come back to say the kind of research knowledge that we have really has --- has to be --- has to have time to grow and have to have support so that we have the input into the pa --- clinical care and not to just grow in the clinical care without the research support.

Tacey Ann Rosolowski, PhD

1:23:58

What were some signs that you see or have seen, you know, as chair of the department that that fine line is --- that the institution is dancing around that line?

Wai-Kwan Alfred Yung, MD

1:24:12

It's dan --- dancing around the line all the time because we --- as Department Chair --- as the administration grows, the department becomes lower and lower in the administrative level. Department Chair is a midlevel manager just like you know director of the janitor. Not a whole lot more power. You know, now if I want to hire another faculty I need to go "Mother, may I? Give me the money. Give me the approval." So it's --- if you go up here it becomes smaller and smaller down here. As you move more emphasis on generating the number of patients which we are going to see every year as we see more patients and see more patients, then we have to say, "Well give me more faculty to see more patients." "No, you have enough faculty, you don't

Interview Session: 04

Interview Date: July 7, 2014

need any more.” And it’s always a constant argument. “No, I need faculty to research.” “No, you don’t need faculty to research.” Just you know we cannot afford it. I mean you have this constant back and forth argument. Sometimes it’s more successful because it’s, you know, if my voice is stronger than I get more but my colleague’s voice is not as strong as me, he get less.

Tacey Ann Rosolowski, PhD

1:25:48

Interesting, huh. What were some other --- have been some other moments? I mean John Mendelsohn brought in this expansion model. I mean I’m thinking obviously there’s been a big administrative change right now but maybe between you know and --- are there others between John Mendelsohn, you know, the big expansion. Were there other aspects of change in the department during John Mendelsohn’s administration that you could identify?

Wai-Kwan Alfred Yung, MD

1:26:14

No. I mean, I don’t.

Tacey Ann Rosolowski, PhD

1:26:15

That was a big one? The growth? Yeah. What about with --- now with Dr. DePinho [Oral History Interview] coming in? What have you seen or observed in the institution?

Wai-Kwan Alfred Yung, MD

1:26:26

Well, I mean I think you know you --- you hear all these noises internally as well as externally. I mean I think, you know, Dr. DePinho came in with a very good heart and very you know insightful observation that in --- that one way to really put Anderson in the next level is that we make some big impact in certain cancers. But the question is how do we do it? Whether there’s big advertisement on Moon Shot. Whether by recruiting some --- some well-known scientists. Whether by, you know, looking at the internal people, how many you know have been productive and not productive. These are you know necessary change and I think you know there is a certain level of complacency among the faculty as we grow you know with --- with --- with the golden era of Dr. Mendelsohn. And when you --- when --- when the new person like Men --- DePinho comes in and say now this is --- we are going to bring in some --- a --- a new group of scientists and laboratory scientists that are well-known in the country and replacing you know some of what he consider not very productive, it’s painful. You know I think that’s where the noise comes from. You know, the change comes in. And you know he may have done it in a way that has you know --- that --- that has opened himself up to a lot of criticism. But I think the change is needed. You know I think he went on realized that we had grown too complacent. We had a group of faculty that really not performing up to par. The clinical research you know

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

infrastructure needs more investment. I have not seen Dr. DePinho tackle that piece yet. He's tackling some more of the organization with some of the scientists bringing this --- and --- and Moon Shot but he has not really tackled the clinical research infrastructure. Not yet. But I think what he wanted to do, his vision, is correct vision. The way that he has been doing it in the last three years has generated a lot of pain in some group and a lot of un --- you know uncertainty in some group. But I think that's necessary pain.

Tacey Ann Rosolowski, PhD

1:29:52

Growth is --- always hurts.

Wai-Kwan Alfred Yung, MD

1:29:54

And I think both sides have to learn. He has to learn to how to really deal with the faculty. You know and get the faculty large support and so that he's get the faculty large support and not to be affected by the smaller faculty and the --- the unsettled ones.

Interview Session: 04
Interview Date: July 7, 2014

Chapter 19

Stepping Down as Chair; Accomplishments in Perspective; A Sunday School Teacher

A: View on Career and Accomplishments;

Story Codes

- A: Career and Accomplishments;
- B: MD Anderson in the Future;
- A: Faith;
- C: Faith, Values, Beliefs;
- C: Critical Perspectives;
- C: Leadership;
- C: Mentoring;
- D: On Research and Researchers;
- C: Personal Background;

Tacey Ann Rosolowski, PhD

1:30:26

Interesting. Well I have just you know a few tidying up kinds of questions and then I'll be done and I'll you know want to ask you if you have anything to add. But I wanted to kind of get you to reflect a little bit on --- First of all, you're stepping down as Chair. What are you going to be really focusing your attention on when that administrative piece is off your desk?

Wai-Kwan Alfred Yung, MD

1:31:00

Well, I mean I started a couple --- you know a couple of national projects, NBTS, _____ (1:31:06.7) projects externally. Internally, I will continue to promote the --- the --- the brain tumor research effort in the umbrella facet of the Brain Tumor Center and the --- the Moon Shot program. Before that though so --- that I will work with the new chair to help support the new chair to work on the --- to internally work on the brain Moon Shot, to support him and make sure that we are on the right track.

Tacey Ann Rosolowski, PhD

1:31:49

And when you kind of look back at your administrative role, what --- what are you very gratified to have set in place during that time?

Wai-Kwan Alfred Yung, MD

1:32:03

Interview Session: 04

Interview Date: July 7, 2014

Well, I --- I'm gratified to see how the department grew and how we maintain our you know different groups, are able to really grow in the area of brain tumor research, the area of cancer neurology and psychology. You know I think I'm gratified to see that the groups grow and work together well. I'm gratified to see that we work well with our neurosurgeons to strengthen our Brain Tumor Center. You know we grow and get these programs to be an example of a successful program among --- within the institution. I mean, on the other hand I think you know I could have done better in the --- especially in the level of mentorship and --- and helped in grooming the next level. I think we have not trained enough physician scientists which is one thing that I know.

Tacey Ann Rosolowski, PhD

1:33:20

What do you think are --- How do you see the challenges to doing that? I mean I've --- I've heard a number of people mention how difficult it is to do that.

Wai-Kwan Alfred Yung, MD

1:33:27

It's difficult. You know we also need a mindset --- mindset change within the institution because it --- it needs some culture shift in allowing the concept of physician scientists. How to support and how do we utilize institution support to foster physicians to spend time in the research lab? You know and that requires institution policy because --- mainly because where we are in Texas and where are not being a full-fledged medical school, it's a different environment than institution like Harvard Medical, you know, Johns Hopkins or Stanford or University of California. They have a different --- They already have a well set up mechanism of grooming physician scientists and we don't. We need to create that.

Tacey Ann Rosolowski, PhD

1:34:51

What are your big hopes for the Department of Neuro-Oncology in the future? You indicated some of it, but you know how would you define where you would like it to be in say 10 years?

Wai-Kwan Alfred Yung, MD

1:35:06

We are in --- the --- the place that you know the brain tumor patients will come to. We are the place that discovered the new treatment for brain tumor patients and the new science. We're the leader in terms of new thinking for this disease. I think the department also has a lot of room to grow and to attack the issue of brain metastasis not just find new tumor and we should be a participant or leader in conquering the issue of brain metastasis.

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

Tacey Ann Rosolowski, PhD

1:35:47

So that is an under --- that --- that area has not really been looked at? Is that what you're suggesting?

Wai-Kwan Alfred Yung, MD

1:35:55

The area is now beginning to look at but it's just the beginning. It's the tip of the iceberg. It's a big --- It's a big problem.

Tacey Ann Rosolowski, PhD

1:36:03

Really? Why has that been a neglected area?

Wai-Kwan Alfred Yung, MD

1:36:10

Well, a neglected area because it's difficult. It's very diff --- you know a very halogenous issue. Metastasis from lung cancer, metastasis from brain, from breast cancer are not the same and so we stay in the level --- because they are not the same. So it has been stayed in the level of just radiation therapy with physical force but now with better understanding about it. We are beginning to say, "Gee, we cannot win just by radiation only." We have to do more than radiation and that's where the science and treatment are going to meet. It's ready to be --- to be you know explored and deployed. I think we can play a role here in this institution because of the number of patients that we have.

Tacey Ann Rosolowski, PhD

1:37:14

I want to ask you a kind of odd question, which is what do you do in your free time?

Wai-Kwan Alfred Yung, MD

1:37:21

Oh! I don't know yet. My wife asks me a lot. I'm going to see my grandchildren. Or I may not have that much free time.

Tacey Ann Rosolowski, PhD

1:37:32

I kind of thought you might say that.

Wai-Kwan Alfred Yung, MD

1:37:35

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

But as much as I have, I will continue to teach Sunday School and go to see my grandchildren.

Tacey Ann Rosolowski, PhD

1:37:42

So you teach Sunday School? That's very nice. How long have you done that?

Wai-Kwan Alfred Yung, MD

1:37.45

Oh, for years.

Tacey Ann Rosolowski, PhD

1:37:46

Really? And why have you done that? Why s --- Why teaching Sunday School? Of all the things you could with your free time?

Wai-Kwan Alfred Yung, MD

1:37:55

I like teaching Sunday School because I mean I sort of like to train the next level of, you know, church leaders.

Tacey Ann Rosolowski, PhD

1:38.04

What is the age group that you teach?

Wai-Kwan Alfred Yung, MD

1:38:08

I teach --- I --- I teach you know the 40s and 50s or 30s --- the --- the --- the middle adult.

Tacey Ann Rosolowski, PhD

1:38.21

Interesting! So, leadership training?

Wai-Kwan Alfred Yung, MD

1:38.22

Yes.

Tacey Ann Rosolowski, PhD

1:38.24

Interesting. I mean what --- what kinds of things do you talk about in that? How do you train that next generation of church leaders?

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

Wai-Kwan Alfred Yung, MD

1:38:31

Well, I --- I have a co-teacher work with me together in the last few years so we you know thought --- the way to make church leader is --- Today, the most important thing for people is to really look at their belief, their faith seriously. And for a church to grow it has to grow solidly in their faith and what they believe. They need to know what they believe. They need to know who that God that they believe. Not just cavalier and say well "I'm a Christian, I'm a Catholic, I'm a Buddhist." But what does it mean?

Tacey Ann Rosolowski, PhD

1:39:19

So self-knowledge?

Wai-Kwan Alfred Yung, MD

1:39:22

Yeah. It's a real foundation of your belief.

Tacey Ann Rosolowski, PhD

1:39:26

Is that a process that you feel you've gone through yourself?

Wai-Kwan Alfred Yung, MD

1:39:32

Yeah, I have. I spent a lot of time in reading books and --- and think about the --- the --- the God and the constant. Who is God? Why do you believe in God? What is required where you believe in God? What kind of, you know, behavior or living?

Tacey Ann Rosolowski, PhD

1:40:03

Is there a meeting place between the work you do here at MD Anderson and your faith?

Wai-Kwan Alfred Yung, MD

1:40:12

Yeah. I use it. It --- It appears all the time in my interactions with patients.

Tacey Ann Rosolowski, PhD

1:40:22

How so?

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

Wai-Kwan Alfred Yung, MD

1:40:22

How I encourage them. You know how we look --- look at the battle that you're fighting together with conquering the disease or the daily --- daily trepidations up and down that patient goes through.

Tacey Ann Rosolowski, PhD

1:40:53

A lot of ministering. Absolutely.

Wai-Kwan Alfred Yung, MD

1:40:56

Psychology. Mostly it's encouragement.

Tacey Ann Rosolowski, PhD

1:41:07

Well, is there anything else that you would like to add Dr. Yung at this point?

Wai-Kwan Alfred Yung, MD

1:41:13

No. I think we had very fruitful sessions so I think if I look at the transcripts and there is anything else comes up I will let you know.

Tacey Ann Rosolowski, PhD

1:41:21

Okay, do! Yeah, sure. That would be great. Well I thank you very much for the time and I've really enjoyed talking to you.

Wai-Kwan Alfred Yung, MD

1:41:25.8

I've enjoyed talking to you, too.

Tacey Ann Rosolowski, PhD

1:41:29.9

Thanks very much.

Wai-Kwan Alfred Yung, MD

1:41:34.2

Great. Okay.

Making Cancer History®

Interview Session: 04

Interview Date: July 7, 2014

Tacey Ann Rosolowski, PhD

1:41:34.5

I'm turning off the recorder at about 17 minutes after 4.