

Alma Rodriguez, MD

Interview # 61

Interview Session One: 20 February 2015

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Chapter 00A

Interview Identifier

Tacey Ann Rosolowski, PhD

[00:00:00]

OK, so we are recording. And I'm Tacey Ann Rosolowski. Today is the 20th of February, 2015, and I am interviewing Dr. Alma Rodriguez for the Making Cancer History Voice Oral History Project run by the Historical Resources Center at MD Anderson Cancer Center in Houston, Texas. Dr. Rodriguez came to MD Anderson in 1986 as an instructor, laboratory research and clinician in the Department of Internal Medicine. I have that correct?

Alma Rodriguez, MD

[00:00:31]

Yes, well, I actually don't recall what it was called at the time.

Tacey Ann Rosolowski, PhD

[00:00:36]

Oh, OK.

Alma Rodriguez, MD

[00:00:37]

It was in the section of lymphoma and myeloma.

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:00:39]

OK. OK.

Alma Rodriguez, MD

[00:00:43]

I believe it was called Cancer Medicine, actually.

Tacey Ann Rosolowski, PhD

[00:00:51]

OK. And since 2005, she has served as Vice President of Medical Affairs.

Alma Rodriguez, MD

[00:01:00]

That is correct.

Tacey Ann Rosolowski, PhD

[00:01:03]

OK. She has a primary appointment as internist and professor of medicine in the Department of Lymphoma/Myeloma, Division of Cancer Medicine. OK, great. I'll also say that Dr. Rodriguez contributed a chapter to the book *Legends and Legacies*, produced by Women Faculty Programs, and I say that just for reference purposes to anyone listening to the interview.

Alma Rodriguez, MD

[00:01:21]

Mm-hmm.

Tacey Ann Rosolowski, PhD

[00:01:24]

This session is being held in Dr. Rodriguez' office and the Office of the Executive Vice President and Physician in Chief in Pickens Tower on the main campus of MD Anderson, and this is the first of two planned interview sessions. The time is twenty-seven minutes after ten. Thank you, Dr. Rodriguez for agreeing to take the time to do this interview.

Interview Session: 01

Interview Date: February 20, 2015

Chapter 01

Growing Up in a Migrant-Worker Family

A: Personal Background;

Story Codes

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Influences from People and Life Experiences;

Tacey Ann Rosolowski, PhD

[00:01:24]+

Well, I wanted to start kind of with regular background information and I wanted to ask you where you were born, and when.

Alma Rodriguez, MD

[00:02:00]

I was born in Robstown, Texas on September 11th, 1953.

Tacey Ann Rosolowski, PhD

[00:02:07]

And tell me a little bit about your years growing up.

Alma Rodriguez, MD

[00:02:14]

Well, I grew up in a migrant family. We used to move from place to place, following, if you will, crops. As a child, one of my first memories is of following my parents around in the cotton fields. There were no babysitters, so they would take us with them. I thought about that as I've grown older, and as I'm more familiar with the risks of pesticides and herbicides, which I'm sure we were exposed to as children, both my sister and I. But that was our childhood, following our parents as they were doing their jobs in the fields.

Tacey Ann Rosolowski, PhD

[00:03:03]

Now, did you stay within Texas? Or, did you—

Alma Rodriguez, MD

[00:03:05]

Yes. Early on, yes, we were in Texas. Later on, during my junior high to high school years, somehow my parents got wind of the crops in California, the agricultural business in California,

Interview Session: 01

Interview Date: February 20, 2015

and that it paid better than in the State of Texas. And it was seasonal, so we could leave. By that time, we were much more settled, and we would attend school for the full school year, but in the summer, we would drive all the way to California—

Tacey Ann Rosolowski, PhD

[00:03:47]

Wow.

Alma Rodriguez, MD

[00:03:49]

Spend the summer working there, usually in the grape fields, and come back for the start of the school year.

Tacey Ann Rosolowski, PhD

[00:03:59]

Wow. Wow. You know, as I read some of your story about that in the essay that you did for *Legends and Legacies*, I wondered, you know, as you reflect back on that time, was there anything about that experience of work, you know, the context, that influenced how you thought about healthcare later on, or that gave you some particular insights that affected the delivery of care?

Alma Rodriguez, MD

[00:04:29]

Not particularly, not the migrant working experience. But actually, my neighborhood, in my experience with relatives and friends of my family, when I went to medical school, I was astonished as I thought back of the huge range of illnesses that I had observed, growing up. There was someone in our neighborhood who now, I retrospectively could say, he was a paranoid schizophrenic, there was a family who lived next to us that all had a genetic disorder of degeneration of muscles. And one by one, all the male children—this was a dominant inherited condition—and one by one all the male children over the years would begin to show weakness in their gait, and eventually would become paralyzed, and all of them died as young teenagers.

Tacey Ann Rosolowski, PhD

[00:05:35]

My God.

Alma Rodriguez, MD

[00:05:37]

When another lady, who was a neighbor, I remember after her pregnancy began to develop a

Interview Session: 01

Interview Date: February 20, 2015

very large abdomen, which apparently was from fluid retention related to a valve that was dysfunctional. So I vaguely remember all of these stories, and she died also very young. And her children were very young, and were left orphaned. I just of all that. And one of my grandparents died of COPD [chronic obstructive pulmonary disease], another one died of diabetes at home. One of my cousins died in a fire from burnt skin. So one of my childhood playmates had what now I retrospectively know was tetralogy of Fallot, his face was purple all the time. And I wondered about that, why his color was so different from the rest of us. And now I know he must have had a cardiac deformity, a congenital cardiac deformity, and couldn't oxygenate his blood. And so he looked purple all the time. And he died when I was six years old.

So, I'm just thinking I did have an experience going through childhood. Death was not an uncommon event in our lives. And people had a whole slew of different illness manifestations, not to mention infectious illnesses; as a child I suffered from some sort of infectious illness, I don't know what it was. But I do know it probably was a form of meningitis, because I was unconscious for several days. And it was only as an adult that my parents told me that they thought I was going to die. So, you know, that was my experience growing up.

Tacey Ann Rosolowski, PhD

[00:07:34]

Right.

Alma Rodriguez, MD

[00:07:34]

My exposure to health, or poor health, I should say.

Tacey Ann Rosolowski, PhD

[00:07:36]

Right. Or poor health. No, I assume that in not every case where these individuals that were close to you, they were treated by physicians or not? I mean, very little healthcare—

Alma Rodriguez, MD

[00:07:46]

Very little healthcare.

Tacey Ann Rosolowski, PhD

[00:07:50]

Yeah, I assume that. Yeah. Yeah. So interesting that you remember, recall all that. I mean, did it have—I mean, how do you think about that now? I mean, what does it—did it have an effect

Interview Session: 01

Interview Date: February 20, 2015

in your selection of specialty and any of that, do you feel? Or was it really just back context that was—

Alma Rodriguez, MD

[00:08:07]

I think that it's just back context. I mean, my selection of specialty really came more from my direct experience taking care of patients, as I was doing my training.

Tacey Ann Rosolowski, PhD

[00:08:16]

Yeah. That's a really astonishing experience, you know, to have that in your background. Tell me a little bit more about your family. How many kids were in the family?

Alma Rodriguez, MD

[00:08:22]

Just two of us.

Tacey Ann Rosolowski, PhD

[00:08:24]

Oh, really? Wow. So that's a pretty small family.

Alma Rodriguez, MD

[00:08:26]

Yeah.

Tacey Ann Rosolowski, PhD

[00:08:28]

And what—were there—what were lessons learned? You know, tell me a little bit about the character of your parents and kind of how they maybe influenced you as a person.

Alma Rodriguez, MD

[00:08:44]

Well, they were survivors. I mean, that's the best I can describe of them. They were very committed to family, I mean, that was one thing I learned from them. Not just to us, but they were committed to their own elderly parents, to the care of their own elders. We had a very large extended family that we were in communication with. They were very frugal, so being cautious about how, when to use the small resources that we had. Obviously, we were poor given their occupation. But retrospectively, you know, I never did lack anything. I never—I was never conscious of lacking in essentials. I mean, we always had food, we always had shelter, we

Interview Session: 01

Interview Date: February 20, 2015

always had clothing. And obviously, we had a family. So to us, you know, growing up, I never knew that there was anything else different from that.

Tacey Ann Rosolowski, PhD

[00:10:01]

Yeah. And your sibling, brother or—

Alma Rodriguez, MD

[00:10:03]

My sister? A sister.

Tacey Ann Rosolowski, PhD

[00:10:05]

Sister. And tell me your parents' and your sister's names.

Alma Rodriguez, MD

[00:10:11]

My father's name was Ricardo. My mother's name was Olivia, and my sister is also Olivia.

Tacey Ann Rosolowski, PhD

[00:10:17]

Oh, is she older?

Alma Rodriguez, MD

[00:10:20]

She's younger.

Tacey Ann Rosolowski, PhD

[00:10:20]

Younger.

Alma Rodriguez, MD

[00:10:21]

I was the older child. And by the way, my sister was also born with a cardiac defect, with a septal defect that sealed over time, it was a transitory event, but—

Tacey Ann Rosolowski, PhD

[00:10:34]

Did they know that at the time?

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:10:35]

Yes.

Tacey Ann Rosolowski, PhD

[00:10:39]

Your parents had some real scares with their children.

Alma Rodriguez, MD

[00:10:42]

Mm-hmm.

Interview Session: 01

Interview Date: February 20, 2015

Chapter 02

Support from Teachers and Family Leads to a College Education

A: Educational Path;

Story Codes

A: Personal Background;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

A: Experiences Related to Gender, Race, Ethnicity;

Tacey Ann Rosolowski, PhD

[00:10:44]

Yeah. So tell me about your educational experience. When did you know that you were going to focus in the sciences, and perhaps even medicine?

Alma Rodriguez, MD

[00:10:52]

Well, I didn't know that I would focus on the sciences, really, until high school, and my exposure to chemistry and physics, and biology. For whatever reason, I just was drawn to those. And I was a very good student; I had always outstanding grades. And my teachers always encouraged—I mean, I do recall this even from very young in elementary school, I was encouraged to study. I really have no idea what my IQ is, but I know that we took some form of IQ test in elementary school, and that my parents were told that I should—that they should always encourage me to stay in school. I guess I did well compared to the rest of the students, would be my guess.

Tacey Ann Rosolowski, PhD

[00:11:55]

Yeah. Yeah.

Alma Rodriguez, MD

[00:11:57]

But I do remember that. I also remember being asked had I cheated on the test. I mean, I am, I was, like, I don't know, five or six years old. I had no concept of what cheating was. I guess now that I think about it retrospectively, I think, that was really unskillful! (laughter)

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:12:22]

But obviously they did [inaudible].

Alma Rodriguez, MD

[00:12:24]

Yeah, to ask a young child, are you cheating on your IQ test? Are you serious?

Tacey Ann Rosolowski, PhD

[00:12:29]

How did that happen?

Alma Rodriguez, MD

[00:12:30]

How did that happen? (laughter)

Tacey Ann Rosolowski, PhD

[00:12:32]

That's whacky! Well, obviously they believed you when you said, "No," or looked dazed at the question.

Alma Rodriguez, MD

[00:12:39]

Yeah!

Tacey Ann Rosolowski, PhD

[00:12:41]

And your parents encouraged you, so that's really—

Alma Rodriguez, MD

[00:12:42]

Yes.

Tacey Ann Rosolowski, PhD

[00:12:42]

—really cool.

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:12:43]

Yeah, they were supportive.

Tacey Ann Rosolowski, PhD

[00:12:44]

Yeah. Right, yeah. And I mean, that's not always the case in families when they feel that their children may be having an experience that will separate them from family experience.

Alma Rodriguez, MD

[00:12:53]

Correct.

Tacey Ann Rosolowski, PhD

[00:12:55]

Yeah.

Alma Rodriguez, MD

[00:12:56]

Well, you know, honestly, my mother did not want me to go to college, whereas my father said he would support whatever I wanted to do.

Tacey Ann Rosolowski, PhD

[00:13:04]

OK.

Alma Rodriguez, MD

[00:13:05]

And so, I just said, "OK, good, I like father's opinion."

Tacey Ann Rosolowski, PhD

[00:13:16]

Well, what was your mother's reservation about that?

Alma Rodriguez, MD

[00:13:16]

Oh, fear that, you know, going away, etc., separating from family like you said—

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:13:21]

Right.

Alma Rodriguez, MD

[00:13:23]

—and so on.

Tacey Ann Rosolowski, PhD

[00:13:27]

Yeah.

Alma Rodriguez, MD

Always having lived in a small town, and life is very sheltered, or relatively sheltered. There's no such thing as a safe place on the planet entirely, but—

Tacey Ann Rosolowski, PhD

[00:13:39]

Yeah, when you have a small—

Alma Rodriguez, MD

[00:13:39]

Right.

Tacey Ann Rosolowski, PhD

[00:13:40]

Yeah. Well good for dad, you know?

Alma Rodriguez, MD

[00:13:43]

Yes. Yes.

Tacey Ann Rosolowski, PhD

[00:13:44]

For supporting you.

Alma Rodriguez, MD

[00:13:45]

Yes.

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:13:45]

So tell me about your—that process of applying to college, and then, you know, that’s—

Alma Rodriguez, MD

[00:13:51]

That was really, I mean, again, thinking about it retrospectively, it was sort of a kind of miraculous thing. So I went to a very small high school.

Tacey Ann Rosolowski, PhD

[00:14:03]

What’s the name of the high school?

Alma Rodriguez, MD

[00:14:06]

In Roma. Roma, Texas, Roma High School. And we had a counselor who did meet with each of us in the senior year, and encouraged us to apply to college. But sort of was the extent of the assistance we got. You know, we were told, here’s the registrar for UT [University of Texas], you know, we were given some information and then—but we were pretty much left on our own. And again, having had no exposure in my family ever to anyone going to college, I had no idea what that entailed.

Tacey Ann Rosolowski, PhD

[00:14:40]

Right.

Alma Rodriguez, MD

[00:14:40]

Now, so the one thing that was helpful is, they advised me to apply for some scholarships. And one of them was from a small, private—or not so small, but a foundation called a Minnie Piper Foundation. And it provided for scholarships at any one of three, of the three Catholic schools in San Antonio at the time, the Incarnate Word, St. Mary’s and Our Lady of the Lake [College]. And one would go and interview with this panel of people for the scholarship. And that was the first time that I flew in an airplane. They provided travel, so I flew from the Valley to San Antonio in a small propeller airplane. (laughs)

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:15:36]

Did you have the turbulence?

Alma Rodriguez, MD

[00:15:36]

Actually, no, it was a very pleasant experience.

Tacey Ann Rosolowski, PhD

[00:15:39]

Good.

Alma Rodriguez, MD

[00:15:41]

Yes. (laughter) It was my first time being alone in a large city, San Antonio being relatively large to where I grew up. And meeting with this panel, you know, I'd never had had such an experience either, before. And needless to say I probably was shy, or perhaps not as fluent or verbally convincing as the other candidates, but I did not get that scholarship. Nonetheless, one of the nuns on the panel from Our Lady of the Lake apparently was impressed enough with me or my presentation that I got a separate offer from Our Lady of the Lake for a scholarship and financial assistance, if I attended Our Lady of the Lake. So it happened to be a small college, it happened to be Catholic, and it sort of was aligned with, more or less, the values of my family. So my parents that I could go. So that's how I ended up—

Tacey Ann Rosolowski, PhD

[00:16:51]

Wow! And women supporting women, yay!

Alma Rodriguez, MD

[00:16:55]

That's how I ended up at Our Lady of the Lake. Which—

Tacey Ann Rosolowski, PhD

[00:16:55]

Of the Lake, yeah. Huh. So that must have been a really big deal, packing up and going away to college.

Alma Rodriguez, MD

[00:17:05]

Interview Session: 01

Interview Date: February 20, 2015

Yes, it was.

Tacey Ann Rosolowski, PhD

[00:17:05]

Yeah. Well, tell me about how your education and perspective evolved when you got there.

Alma Rodriguez, MD

[00:17:12]

Well, initially, you know, every student was assigned to a mentor, and every student is asked to declare—was asked to declare what their major would be, or what their primary area of interest would be. And despite my liking sciences, actually, I was just being pragmatic. I thought, oh, I'll get a Spanish—I'll get a major in Spanish, because I could read and write fluently in Spanish. And I'll say that I'm going to be a teacher, because realistically, that did seem like a very good career at the time.

Tacey Ann Rosolowski, PhD

[00:17:49]

Right.

Alma Rodriguez, MD

[00:17:49]

And so that's what I declared. So I was assigned to a mentor from the Department of Second Languages, Spanish—specifically, one of the Spanish teachers. They had French as well. But I was assigned to one of the faculty in the Spanish curriculum, Dr. Rigual. And so he started asking me some questions, just what do you like, what do you—you know. I said, well, I liked science, I liked this, I liked that. So I signed up for a full—I don't know, the maximum number of hours I could take that first year. And I did very—in fact, I think I placed out of one of the basic sciences, and he was very impressed for that. And he said, well, you should consider being a science major, which was interesting, because he was supposed to be my Spanish mentor.

Tacey Ann Rosolowski, PhD

[00:18:53]

Right. Well, good for him—

Alma Rodriguez, MD

[00:18:54]

Yes.

Tacey Ann Rosolowski, PhD

Interview Session: 01

Interview Date: February 20, 2015

[00:18:55]

You know, for really looking at the student's gift.

Alma Rodriguez, MD

[00:18:59]

Yes. So in any event, I also did very well in my science curriculum at the end of the—so at the end of the year, when we went over my performance, he saw that I had done very well. He says, “You know, you really need to consider going into the sciences.” And from that—and even at the beginning, he said, “You need to consider going to medical school.”

Tacey Ann Rosolowski, PhD

[00:19:19]

Wow!

Alma Rodriguez, MD

[00:19:20]

Which I really didn't think that was a good idea; I thought I don't have money. That's really hard to get into medical school, from what I've heard. And it will be a long time before I will have a real job, that was the other thing I was concerned about, because I needed to have a job.

Tacey Ann Rosolowski, PhD

[00:19:35]

Sure.

Alma Rodriguez, MD

[00:19:36]

So, it really was not the first choice that I had in my mind as to what I was going to do with my life. But in any event, I declared then, I changed my major to chemistry, and then, and second major in biology, I believe. It was two sciences; chemistry and biology. So that's what I devoted the rest of my focus on that, for the rest of my college education.

Tacey Ann Rosolowski, PhD

[00:20:15]

Now, how were you visualizing your career future at that point? You know, did you—

Alma Rodriguez, MD

[00:20:19]

Oh, I thought I would be a teacher.

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:20:19]

OK.

Alma Rodriguez, MD

[00:20:21]

Or, I would possibly, again, as I got towards my junior or senior year, my chemistry mentor, Sister Jane Ann [Slater], encouraged me to go to graduate school.

Tacey Ann Rosolowski, PhD

[00:20:36]

Mmmm [affirmative]. I mean, I was thinking, you know, I was just thinking about the time, the timeframe when you were in school. I mean, this is still the era when being a teacher was the nice profession for a woman.

Alma Rodriguez, MD

[00:20:50]

Yes.

Tacey Ann Rosolowski, PhD

[00:20:51]

You know, so it was kind of—and you really—

Alma Rodriguez, MD

[00:20:51]

Well, it was one of the optimum professions at the point.

Tacey Ann Rosolowski, PhD

[00:20:54]

Right. But it was very cool, actually, that Dr. Rigual, and then Sister Jane Ann were really thinking beyond that scope.

Alma Rodriguez, MD

[00:21:04]

Correct. Yes.

Tacey Ann Rosolowski, PhD

[00:21:05]

You know, not being limited by those more traditional or conventional ideas—

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:21:08]

Correct.

Tacey Ann Rosolowski, PhD

[00:21:08]

—of what women might do.

Alma Rodriguez, MD

[00:21:09]

Correct.

Tacey Ann Rosolowski, PhD

[00:21:11]

So lucky you, and that's very cool.

Alma Rodriguez, MD

[00:21:11]

Yes, it was very fortunate that it was an environment where people could really pay attention to the students, look at the, if you will, the gifts of the student, the talents of the student and encourage them to follow their talent, if you will.

Tacey Ann Rosolowski, PhD

[00:21:29]

Absolutely. So tell me about that process. Well, and where the research interest. You know, it was obviously going to assert itself really strongly. Was that something you had experience in college at all?

Alma Rodriguez, MD

[00:21:44]

Well, again, this was another—because I was in the sciences, the college, and because the consortium of schools, of those Catholic schools, had a very high percentage of minority students. They received a grant at the time, and I'm not sure from which foundation. But they had received a grant from one of the national science foundations to encourage students to, first of all, go into the sciences, and then second, to learn about research, involvement in research. And so there were several small research projects that were available through the three colleges. And I applied to one of them, and I had been accepted to it, so I had an exposure of laboratory design, carrying out the project, analyzing data—or collecting data, analyzing data, and even

Interview Session: 01

Interview Date: February 20, 2015

presenting at a college level research symposium, which was very exciting, of course. (laughs)

Tacey Ann Rosolowski, PhD

[00:22:59]

Yeah.

Interview Session: 01

Interview Date: February 20, 2015

Chapter 03

Going to Medical School

A: Educational Path;

Story Codes

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

C: Patients;

C: Cancer and Disease;

Alma Rodriguez, MD

[00:23:01]

So yes, that was my exposure to research, which sort of was why I was thinking, really, that I wanted to go to graduate school to pursue that further. But in the meantime, between my junior and senior year, usually I had done either summer courses or summer research work, or something like that, the prior two years, but in between my junior and senior year, I really didn't have anything planned, job-wise. And sometime in the spring of my junior year, two African American students from Baylor College of Medicine showed up on the campus. And there was a flyer on the elevator, I remember, as I was in the science building, that said, "Learn more about summer internships," or "Summer research projects at Baylor College of Medicine."

So I thought, oh, well, I need a job for the summer, so maybe I should go look into this. (laughs) And it really wasn't so much that it was just a research project, it was that this was an effort from Baylor to also recruit minority students for medical school. So it was a program that was supposed to prepare students to take their medical—or the medical school entrance exams, the MCATs [Medical College Admission Test]. And there was a curriculum that was associated with it, and they were recruiting students throughout various schools in the State of Texas to come there, now, and so I thought, well, OK, I need a job, so I applied. (laughs) And I got in. Now, I thought it was going to be only for students in the State of Texas. It turned out when I actually did come for the program, there were students from all over the country there.

[00:25:12]

Tacey Ann Rosolowski, PhD

Oh, wow.

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:25:12]

There were people from Stanford [University], NYU [New York University], as I recall. The only other person from San Antonio was a young lady from St. Mary's. I was at Our Lady of the Lake, she was attending St. Mary's. So the two of us had gotten accepted. So in any event, that was my summer experience between the junior and senior year. And we got—we used to have all of these rehearsals for how to study for the test, and I really had not, again, even up to that point, I had not consciously thought I am going to go to medical school. But then they took us around and showed us—these medical students would take us to their clinics, we would be observing alongside them. We even observed a heart surgical procedure.

Tacey Ann Rosolowski, PhD

[00:26:05]

Wow!

Alma Rodriguez, MD

[00:26:07]

At Methodist [Hospital] from the gallery. So it was very exciting. So when I went back, I talked to, again, my chemistry advisor and Dr. Rigual. And I said this was very exciting, what do you think? And Rigual just said, "Are you kidding? I told you, take the MCAT!" You know? (laughter) So, I took the MCAT that fall, my senior year. If you speak to medical students now, they would have thought that is a bizarre, insane trajectory, or way to approach getting into medical school. Nobody does it that lackadaisically, you know?

Tacey Ann Rosolowski, PhD

[00:26:42]

Yeah. Yeah.

Alma Rodriguez, MD

[00:26:43]

If you will. It's not that I was being lackadaisical in my studies, but I never—it wasn't—I wasn't, I think the term probably still is a "gunner." I wasn't one of those gunners that are pre-med, and you know, do or die, I have to get into a medical school. That was not the trajectory of my life.

Tacey Ann Rosolowski, PhD

[00:27:01]

But the way you were thinking about it completely makes sense, I mean, given your background.

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:27:04]

Right.

Tacey Ann Rosolowski, PhD

[00:27:06]

I mean, you had real pragmatic, logistical concerns. I need to work. I mean—

Alma Rodriguez, MD

[00:27:07]

Right.

Tacey Ann Rosolowski, PhD

[00:27:08]

I mean, my parents worked, I need to work.

Alma Rodriguez, MD

[00:27:10]

Yes.

Tacey Ann Rosolowski, PhD

[00:27:10]

You know, and you were just really lucky that making your practical decisions led you and opened up your life in amazing ways.

Alma Rodriguez, MD

[00:27:17]

Right. Right.

Tacey Ann Rosolowski, PhD

[00:27:20]

Yeah.

Alma Rodriguez, MD

[00:27:21]

But even, so even after taking the MCATs, my worry—well, first of all, will I get accepted or not?

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:27:26]

Right.

Alma Rodriguez, MD

[00:27:28]

And secondly, if I get accepted, how will I pay for it? And again, my choice was made strictly on pragmatic grounds. I got an offer from the University of Texas here in Houston for a full tuition scholarship. And of course, student loans. So that's where I went.

Tacey Ann Rosolowski, PhD

[00:27:54]

Yeah.

Alma Rodriguez, MD

[00:27:56]

Because they offered me all of that.

Tacey Ann Rosolowski, PhD

[00:28:00]

All the money, yeah. You're certainly not the only person who's made those decisions.
(laughter)

Alma Rodriguez, MD

[00:28:04]

Yes.

Tacey Ann Rosolowski, PhD

[00:28:06]

So, I mean, this is maybe a bit of a digression, but I'm curious. You know, as you were going through all of these exciting experiences, and you're seeing kind of a new world from the world you grew up in, you know, how was that—how did you bring that information back to your family? You know, how did that affect kind of how they saw you in your relationship with your parents and with your sister, Olivia?

Alma Rodriguez, MD

[00:28:30]

Well, again, they were concerned principally because again, I was going to be moving in, and further, as you said, it's further than San Antonio from Roma. So there was that concern.

Interview Session: 01

Interview Date: February 20, 2015

Secondly, of course, that medical school would take me even further in terms of incurred debt, in terms of education, but also that they realized that it is a very difficult profession. And so their concern all along was, are you sure you want to do this, because life is very difficult for doctors. So really, that was their primary objection, if you will. They didn't really tell me don't do that, they just wanted me to be sure that's what I wanted to do.

Tacey Ann Rosolowski, PhD

[00:29:34]

So how did you answer their concerns at the time? Those dinner table conversations? (laughs)

Alma Rodriguez, MD

[00:29:40]

Well, honestly, I was just taking it one step at a time. The time that I made the application, I said, well, I have just applied. I don't know if I'm even going to get in. And if I don't get in, I'm going to come back and teach chemistry probably, or biology, at the high school, you know? That's what's going to happen, you know.

Tacey Ann Rosolowski, PhD

[00:29:50]

Yeah.

Alma Rodriguez, MD

[00:30:00]

And so I sort of had Plan A, Plan B strategies.

Tacey Ann Rosolowski, PhD

[00:30:12]

So you began medical school—I'm just checking the dates here—

Alma Rodriguez, MD

[00:30:17]

In 1976.

Tacey Ann Rosolowski, PhD

[00:30:18]

Nineteen seventy-six, yeah. So tell me about that process.

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:30:24]

Well, at the time, the University of Texas medical school here in Houston was unique in that it had a very compressed curriculum in three years. So their four-year curriculum was compressed into three years. And so we literally had absolutely no time off. It was—at the end of those three years, and reflecting back on it years later, is, like, I have no idea what was happening in the world at that time. Honestly, I lived at the library, I lived in—initially, I lived in an apartment building that was across from the medical school. It was called Favrot Hall. It's been demolished since then. (laughs) But I lived in Favrot Hall. I went to the medical school, and I went to the library, so that was my triangle. You know, medical school, classes, library, Favrot Hall. Favrot Hall, medical school—that was my life throughout my first years. And then when I went into my clinical years, then I moved out of Favrot Hall because it was so confining; the environment was too confining. But in any event, on to clinical rotations. But it was more or less the same thing, you know, apartment, hospitals and of course MD Anderson was one of the hospitals we would rotate through. So hospital rotation, back to the apartment, hospital, back to the apartment. (laughs) That was basically life.

Tacey Ann Rosolowski, PhD

[00:32:06]

So how were your interests evolving at that time? Did you get a sense of your specialty? Your coming specialty at the time?

Alma Rodriguez, MD

[00:32:11]

Well, yes. I mean I think the rotational experiences through the various specialties gives the students a bit of a flavor of what, first of all, of what the physical demands of that particular specialty will be, a bit about the personalities, if you will, and obviously about the tasks themselves. So from the very get-go, I think my first rotation was in pediatrics. While it was really—it's really lovely to interact with children, I love the Well Baby clinics and all of that, but it was very stressful dealing with the parents. And because it's a triad relationship, it's the parent, the child and the doctor, and at the time, that level of my psychological development, I really found that very stressful. So I knew although I loved the children and learning about their childhood illnesses and all of that, I could not handle the parental—the parents were either anxious, angry—or even worse, some of them were indifferent. And any and all of those emotions were a bit too much to handle on top of taking care of the child. So that was out.

When I did psychiatry, I actually excelled at psychiatry. But for some reason, it really did not grab me as something I was passionate about. It was interesting, but surgery was physically too demanding, getting up—the medical students were expected to be the first ones on the wards, at

Interview Session: 01

Interview Date: February 20, 2015

least at that time. Things have changed radically since then, in how students are treated. But we had to be there really early in the morning, 5:00 or so, so we had to see all the patients before the residents arrived. We had to report to the residents where the patients—how the patients were doing. Then the residents, of course, in turn reported to the attending. And then you went into the OR and spent the whole day in the OR, then you had to come back and do the rounds all over again. And then you had to close the day, went home, slept, up at 4:00—

Tacey Ann Rosolowski, PhD

[00:34:45]

Yeah.

Alma Rodriguez, MD

[00:34:47]

It was a very, very physically demanding—very exciting, being in the operating room is probably one of the most exciting environments in medicine. But I knew I didn't have the physical stamina to sustain that for my life, for a lifetime career.

Tacey Ann Rosolowski, PhD

[00:35:08]

Right. Right.

Alma Rodriguez, MD

[00:35:09]

And obstetrics and gynecology, similarly very exciting to deliver the babies, but the physical pain that the mothers endured was really too difficult for me to just be comfortable with. It was amazing how the nurses in labor and delivery would just—it was like they had earplugs or something, I mean, really, the screams didn't bother them very much.

Tacey Ann Rosolowski, PhD

[00:35:36]

Wow.

Alma Rodriguez, MD

[00:35:36]

But it bothered me a great deal.

Tacey Ann Rosolowski, PhD

[00:35:38]

Yeah. (laughter) So what was grabbing your interest at the time?

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:35:47]

Well, so eventually, through my internal medicine rotation, internal medicine is a very intellectual discipline. You have to do a lot of thinking, it's almost a bit doing detective work, if you will. You gather a lot of information, put the pieces of the puzzle together and make a diagnosis. So that was very interesting to me. So along the course of all these rotations, I knew I had the personality and mental inclination to be an internal medicine specialist, but even within internal medicine, there's so many sub-disciplines; cardiology, gastroenterology, pulmonology, endocrinology, etc. So the sub-specialty choices come later.

But one of the rotations we had as medical students was at MD Anderson, and taking care of cancer patients was challenging, as well as intellectually stimulating, and more importantly, comparing the personalities. I know that it's difficult to generalize, but in general, cancer patients were so much kinder and appreciative of the care that the medical team, you know, offered them. It was not as traumatic, for example, as dealing with patients in the emergency room, or even dealing—one of the specialties that I found very, very challenging, for example, was pulmonary medicine, where so many of the patients had self-induced illness from smoking. And I'm not judging here, I know it's really, really hard. But many of them couldn't help themselves. So how can the doctor help them if they can't help themselves? In a self-induced situation. Whereas with cancer, although many cancers are linked to environmental factors, including cigarette smoking, but so many of them have absolutely no explanation. I mean, it's certainly not a choice people—it's not due to—the majority are not due to a self-determining choice, if you will. So it's a different, how shall I say, it's a different relationship that one establishes both with an illness as well as with the individual who's suffering the illness.

Tacey Ann Rosolowski, PhD

[00:38:44]

So were you thinking at that time, even during medical school, that oncology was where you were going to focus?

Alma Rodriguez, MD

[00:38:53]

I thought I might, although I still wanted to do primary care.

Tacey Ann Rosolowski, PhD

[00:38:59]

OK.

Interview Session: 01

Interview Date: February 20, 2015

Chapter 04

A Revealing Internship and Residency

A: Professional Path;

Story Codes

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

A: Influences from People and Life Experiences;

A: The Researcher;

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

Alma Rodriguez, MD

[00:39:00]

At that point, I still wanted to do primary care. And I chose my training in internal medicine in San Antonio, one, because I had been there in college, and I liked San Antonio, but also because the population base for the medical school in San Antonio and for the training in San Antonio is largely Hispanic. And I sincerely wanted to learn more about healthcare in the Hispanic population, the Hispanic community. Diabetes is a very major issue, very major health problem. I thought I might veer in the direction of diabetes-related care and illnesses. But again, as I did my oncology rotation, I again found that very interesting. I also had a very dynamic attending. It makes a very big difference.

Tacey Ann Rosolowski, PhD

[00:39:58]

And what was your attending's name?

Alma Rodriguez, MD

[00:39:59]

Daniel von Hoff.

Tacey Ann Rosolowski, PhD

[00:40:04]

OK, that's right, I do remember that name. Yeah. What was so inspiring about him?

Alma Rodriguez, MD

[00:40:09]

Well, he was very energetic. He was a clinical and laboratory researcher, and he had come to—he was young in his career. He had come to San Antonio from the National Cancer Institute, and he was very passionate about what he did, and he was an enthusiastic and engaging individual,

Interview Session: 01

Interview Date: February 20, 2015

and very supportive of residents who expressed interest in oncology. So he sort of took me under his wing and I did a year's fellowship in his lab.

Tacey Ann Rosolowski, PhD

[00:40:42]

Oh, wow!

Alma Rodriguez, MD

[00:40:45]

After my residency.

Tacey Ann Rosolowski, PhD

[00:40:48]

OK, yeah. So just for—so, for the recorder, the dates. So you did your internship from 1979 to 1980, and the '80 to '82 was the residency in that system as well.

Alma Rodriguez, MD

[00:40:58]

Correct.

Tacey Ann Rosolowski, PhD

[00:41:02]

Yeah. So tell me about the research project that you did during that. Did you do research during this first residency? Or was it during your fellowship period afterwards?

Alma Rodriguez, MD

[00:41:10]

It was afterwards.

Tacey Ann Rosolowski, PhD

[00:41:11]

Afterwards. OK. So from 1982 to '83, you had the cancer research fellowship at the Cancer Therapy and Research Center.

Alma Rodriguez, MD

[00:41:20]

Correct.

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:41:19]

So but you—and was that Dr. Hoff's lab?

Alma Rodriguez, MD

[00:41:21]

It was in Dr. Hoff's lab, yes.

Tacey Ann Rosolowski, PhD

[00:41:22]

OK. But so the first couple of years you were kind of getting to know him, and making your selection.

Alma Rodriguez, MD

[00:41:29]

Correct.

Tacey Ann Rosolowski, PhD

[00:41:29]

So tell me about the process of selecting the focus on oncology. You know, when did you know that you were going to kind of separate and pay more attention to the area of oncology?

Alma Rodriguez, MD

[00:41:41]

My senior year in residency, the second year of residency I really was sure about that. And that's what I approached Dr. von Hoff about during the year of—in his lab, simply because I wanted to really cement that in my mind. Also, quite frankly, it had been, like, six years from medical—if you include the three years of medical school, the three years of residency and internship, it had been six years of really relentless, unending, go-go-go-go without pause for reflection, if you will. And so I wanted that year to both familiarize myself more with the work that he was doing in the lab, but also to do some self-reflection about whether this was really what I wanted to do.

Tacey Ann Rosolowski, PhD

[00:42:41]

What were the issues you were weighing in your mind at the time?

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:42:45]

Well, certain—I mean, for one, it's not a trivial decision to make—so select a sub-specialty, because then one has to commit to further training in a fellowship.

Tacey Ann Rosolowski, PhD

[00:43:00]

Yeah.

Alma Rodriguez, MD

[00:43:01]

So that's additional time. It also, depending on where or what type of fellowship, that would mean yet another geographic change, interviewing all over again, going through the round of interviews, going through the rounds of selection and waiting to hear are you accepted or not. I mean, it had been sort of that process from college, medical school, the residency and now again fellowship. So it felt like I had been under the scope and for so many years now, in my life. So I had to think about that carefully. Did I really want to go again through another round of— But, you know, it turns out life is an endless round of interviews! (laughter) But anyway, and I just wanted to be certain of what it was that I wanted to do. And I also wanted more time to spend with my parents, because they had moved to San Antonio, actually. Along the way, they had decided that they did not—they wanted to closer to a place where they had access to airports, because they knew both my sister and I likely were never going back (laughs) to Roma. So they wanted to have—be closer to access to travel that would be easier for them. And they had moved to San Antonio, so I spent that year with them, as well. So anyhow, that's how I really cemented my decision for oncology.

Tacey Ann Rosolowski, PhD

[00:44:49]

What was the research that you were doing?

Alma Rodriguez, MD

[00:44:51]

Well, at that time, he was—at that time, there was a concept that one could—it's interesting to me how ideas sort of come around, they cycle. So the idea that Dr. von Hoff had, and still has—he's still conducting research along these lines—was that one could personalize the treatment, depending on the sensitivity of the tumor to certain drugs.

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:45:31]

Wow!

Alma Rodriguez, MD

[00:45:32]

So his concept for how one did that was that one would take the cells from the patient's tumor, grow them in the lab in petri dishes, or some other medium, and then test pretty much similarly to one how tests bacteria. You grow them in the lab and then you apply the antibiotic to the plate where the bacteria are growing, and then you observe whether the bacteria die or not. And to what degree do they die when they're exposed to the antibiotics. Well, he had the similar concept for cancer cells and chemotherapeutic agents. So if one grew the cancer cell successfully, and that's a big barrier, first of all, getting the cancer cells to grow. Secondly, one would test specific drugs, Drug A, Drug B, Drug C, and whichever one of those drugs give the highest level of tumor kill, that would be the appropriate treatment for that individual patient. That was his model, or his concept.

Tacey Ann Rosolowski, PhD

[00:46:42]

Now, what did he believe made the difference between patients? Why did he believe that tumors were slightly different in different patients?

Alma Rodriguez, MD

[00:46:52]

Well, there's just a clinical observation, that's a fact.

Tacey Ann Rosolowski, PhD

[00:46:54]

OK.

Alma Rodriguez, MD

[00:46:55]

You know, some patients respond very well to chemotherapy, others don't. And yet, they have the same diagnosis, right? Assuming that physiologically these individuals are not that different—and that's a big assumption, in reality that's a big assumption—but let's say that both individuals supposedly will metabolize the drug in the same way, then the only explanation for why they get different responses is that the tumors are different.

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:47:29]

Yeah.

Alma Rodriguez, MD

[00:47:31]

The tumors are biologically different. And at that point, was the beginning, as well, of genetic testing in tumor cells. So along with the drug testing, there were also cytogenetic analyses that were done in parallel. Now, I was not doing the cytogenetic testing, I was more doing the laboratory processes, testing various laboratory processes. So my involvement at the time was primarily just to test different media, design different environments for the growth of the tumor cells to see which ones would be best, and so on. So it was more of a cellular biology project that point, and that we were investigating the techniques by which one would grow the cells and which one was successful.

Tacey Ann Rosolowski, PhD

[00:48:18]

Did this view affect your own conceptualization about cancer? I mean, it's a very, you know, interesting and kind of avant-garde way of looking at it.

Alma Rodriguez, MD

[00:48:30]

Right. Right.

Tacey Ann Rosolowski, PhD

[00:48:32]

How were you affected by that intellectual environment?

Alma Rodriguez, MD

[00:48:34]

Well, intellectually, I think I've always understood that, you know, cancer in individual A is not the same as cancer in individual B. I've always understood that there are unique characteristics of the biology of the cells that, despite appearing similar under the microscope, there are other inherent characteristics of the cells that will make the malignancies different from individual to individual. I think that we're beginning now with the genome project and looking at exquisite analyses of the profile, genomic profile of each tumor, we're now beginning to appreciate what those subtle differences are— What are the similarities and what are the differences, as well. But that was philosophically, if you will, and empirically we had observed that for many years.

Interview Session: 01

Interview Date: February 20, 2015

We've known that for many years.

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:49:42]

So what turn did life and research take next? I mean, when during this fellowship period, you know, what was the next step?

Alma Rodriguez, MD

[00:49:52]

Well, that was only a one-year experience. I then did a formal fellowship in hematology and oncology at the University of Arizona in Tucson. And specifically, the focus of my research was in multiple myeloma. That's how I ended up in the Department of Lymphoma/Myeloma.

Tacey Ann Rosolowski, PhD

[00:50:17]

Oh, OK. Yes. Why did you choose to go into blood diseases?

Alma Rodriguez, MD

[00:50:22]

One of the reasons is, you know, hematologic malignancies are much easier to culture in the laboratory, or at least at the time. It was simpler to obtain tumor samples of blood cell malignancies than it is for cell—it's still true today. I mean, a patient with leukemia, one can do a blood draw, and the malignant cells will be in the blood sample. One doesn't have to invade the body any more than that. Whereas in solid tumors, you know, usually it will involve having to do some deep cavity biopsies. And that can be traumatic for the patient, as well as difficult, and costly, etc. So hematologic malignancies have been traditionally model for cellular and biological investigation of malignancy processes. So that's what makes it, in part, attractive. The other is that the biology of cancer, the studies of the biology of cancer, have been also more advanced in hematological malignancies. Hematological malignancies have been always, you know, a couple of jumps ahead of the biology analyses of solid malignancies, precisely simply because they're easier to study and analyze. And thirdly, because there were two individuals; specifically Dr. Salmon and Dr. Durie in Arizona, who were world-renowned at the time for their work in multiple myeloma, so—

Tacey Ann Rosolowski, PhD

[00:52:07]

Could you repeat their names again? Dr.—

Alma Rodriguez, MD

[00:52:09]

Salmon, S-A-L-M-O-N.

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:52:11]

S-A-L-M-O-N, OK.

Alma Rodriguez, MD

[00:52:12]

And Durie, D-U-R-I-E.

Tacey Ann Rosolowski, PhD

[00:52:15]

D-U-R-I-E. OK. So you went specifically to study with those individuals?

Alma Rodriguez, MD

[00:52:18]

Yes.

Tacey Ann Rosolowski, PhD

[00:52:19]

You know, and let me just backtrack a tiny bit, because I realize I neglected to ask about another dimension of that experience in San Antonio. Because you said you had gone there because you wanted to also provide some—do you need to take a check on that?

Alma Rodriguez, MD

[00:52:33]

I need to just check—

Tacey Ann Rosolowski, PhD

[00:52:35]

OK, let me just pause the recorder really quickly.

[The recorder is paused]

Interview Session: 01

Interview Date: February 20, 2015

Chapter 05

The Problem of Diabetes among Hispanics

A: Overview;

Story Codes

A: Professional Path;

A: Character, Values, Beliefs, Talents;

A: Personal Background;

A: Professional Path;

A: Inspirations to Practice Science/Medicine;

D: Cultural/Social Influences;

Tacey Ann Rosolowski, PhD

[00:52:35]+

OK. You said you had gone to San Antonio to—with also the intention of providing some kind of medical care for the Hispanic community. And I'm wondering where that piece, how that evolved over the course of your increasing interest in oncology.

Alma Rodriguez, MD

[00:53:03]

Well, it didn't evolve. And I can't say exactly why. But I did not meet anyone who was particularly, if you will, engaging, or interested in bringing the residents into their projects, or their research or their initiatives. A lot of the work that we would do, or the training that we received in the management of diabetes was largely in the clinics, in the ambulatory clinics. And diabetes is a very difficult illness. It's a chronic illness. It's very difficult, because it is so directly linked, or at least adult onset diabetes is so directly linked to lifestyle and diet. And I've come to appreciate, as I've grown older, how much we are, if you will, defined, or married, for lack of a better word, to habit in diet. It is one of the most—I think next to cigarette abuse, dietary changes are another very challenging and difficult aspect of health. And, you know, despite all of the recommendations of the food pyramid and despite all the models being very thin on television, and despite the entire obsession of our culture with being thin, etc., etc., we are growing more obese as a nation, which is a very interesting disconnect, if you will, of what is presented on the surface of the culture, versus what is the reality of the culture. And the same is—so, in Hispanic culture it is very hard to shift dietary habits. We love to eat, and I speak for myself as well, we love to eat, first of all. Food is an important part of our daily family rituals. Certain types of foods are very engrained in our history as a culture. And most of them taste very good, and most of them are not very good, if you're a diabetic.

Interview Session: 01

Interview Date: February 20, 2015

Tacey Ann Rosolowski, PhD

[00:55:47]

Yeah.

Alma Rodriguez, MD

[00:55:48]

So, I felt, honestly, in my diabetes clinics week to week, I felt like I was just holding hands and telling my patients, well, your blood sugar is high again. There was very little that changed from visit to visit. You could change the medications, we could change the dose of insulin, the timing, etc. But they still work with—they work where they were.

Tacey Ann Rosolowski, PhD

[00:56:26]

Right. And they were going to go home to families.

Alma Rodriguez, MD

[00:56:28]

And they were going to go home to the same pattern of behavior.

Tacey Ann Rosolowski, PhD

[00:56:35]

So making a move into something you could really have an impact on, then?

Alma Rodriguez, MD

[00:56:38]

Correct.

Tacey Ann Rosolowski, PhD

[00:56:39]

Yeah, makes sense. Makes a lot of sense. OK, well, I just wanted to kind of pick up that piece, because it seemed like such an important motive. And we kind of lost track of that long the way.

Interview Session: 01

Interview Date: February 20, 2015

Chapter 06

Fellowship Research and the Move to MD Anderson

A: The Researcher;

Story Codes

A: The Researcher;

A: Joining MD Anderson;

B: MD Anderson History;

C: Mentoring;

C: Understanding the Institution;

Tacey Ann Rosolowski, PhD

[00:56:52]

So tell me about the research that you undertook when you were at Arizona.

Alma Rodriguez, MD

[00:57:00]

Well, at this time, was—this was an exciting time in the evolution of cancer research in that molecular biology techniques were being introduced. The whole field of analysis of DNA, to the level of unique genes that you could run on a certain—not as whole chromosomes, but rather as analyzing unique patterns of the gene distributions; whether some were over-expressed or under-expressed, and so on. That was happening at that time. So I learned how to do some of those DNA analyses technologies, PCR [polymerase chain reaction] analyses were just coming on. You know, that's the famous technique that analyses paternity as well as in criminal cases identifies (laughs) whether the criminal's DNA is in the victim, etc.

Tacey Ann Rosolowski, PhD

[00:58:06]

And what does PCR stand for?

Alma Rodriguez, MD

[00:58:08]

What does it stand for now? I have forgotten, I did it for so many years.

Tacey Ann Rosolowski, PhD

[00:58:13]

Oh, I can look it up, it's all right.

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:58:14]

Polymerase chain reaction—

Tacey Ann Rosolowski, PhD

[00:58:16]

Oh, OK.

Alma Rodriguez, MD

[00:58:18]

—technique.

Tacey Ann Rosolowski, PhD

[00:58:19]

Yeah, I just—I had never heard “PCR analysis” before.

Alma Rodriguez, MD

[00:58:21]

So anyway, so that was very exciting. So I was doing that level of analytic work with tumor samples in myeloma, specifically, recognizing—and one of the analyses that we did at that time was also looking for viruses in the cells. So it was all very exciting work.

Tacey Ann Rosolowski, PhD

[00:58:54]

Yeah.

Alma Rodriguez, MD

[00:58:55]

And so I knew at that time I would want to stay and continue to work in an environment that was still linked to research, that delivered cancer care, but also was linked to research. And it so happened at the end of my fellowship that my mentors at the University of Arizona had been contacted by somebody from MD Anderson, I don’t know who it was exactly, saying we’re looking for people in the Department of Lymphoma/Myeloma.

Tacey Ann Rosolowski, PhD

[00:59:32]

Wow.

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[00:59:33]

They knew Dr. Durie and Salmon, because they were known as myeloma researchers, so they contacted them and said, are there any fellows in your program who are looking for jobs? We have openings. So—

Tacey Ann Rosolowski, PhD

[00:59:45]

Wow.

Alma Rodriguez, MD

[00:59:46]

That's how I ended up here.

Tacey Ann Rosolowski, PhD

[00:59:49]

Wow. That's an amazing story! I'm sure people who are looking for jobs now think of that and go, "Wow!" It ain't like that now. (laughs)

Alma Rodriguez, MD

[00:59:55]

Yes.

Tacey Ann Rosolowski, PhD

[00:59:56]

So tell me about coming here. You know, how did the interview process go? I mean, how were you recruited? Did you make an application just cold? How did that all work?

Alma Rodriguez, MD

[01:00:09]

I think I came for one interview.

Tacey Ann Rosolowski, PhD

[01:00:13]

Uh-huh?

Alma Rodriguez, MD

[01:00:15]

It wasn't traumatic, I mean, I was certain I wanted to come here. I—honestly, I don't remember

Interview Session: 01

Interview Date: February 20, 2015

the interview very well.

Tacey Ann Rosolowski, PhD

[01:00:25]

I can just imagine.

Alma Rodriguez, MD

[01:00:26]

All I know is I had a job.

Tacey Ann Rosolowski, PhD

[01:00:28]

Yeah, great!

Alma Rodriguez, MD

[01:00:31]

And I moved here.

Tacey Ann Rosolowski, PhD

[01:00:31]

So you came and—you came in 1986.

Alma Rodriguez, MD

[01:00:36]

Mm-hmm [affirmative].

Tacey Ann Rosolowski, PhD

[01:00:37]

Yeah. So tell me about the department at the time. You know, who were the people who were there who were really significant for you? And what was the climate like?

Alma Rodriguez, MD

[01:00:45]

Well, it was a difficult time for the entire Cancer Medicine group. I'm trying to remember all the exact organization, you know. Obviously, I was a lowly faculty member. I wasn't in the governing structure of the department, all I knew is that there were changes happening. It actually—Lymphoma/Myeloma was not a department, it was a section. It was a section of a department of hematology, if I recall. And hematology was yet another part of the larger group that was called Cancer Medicine [Division of]. And there was a transition happening at the level

Interview Session: 01

Interview Date: February 20, 2015

of leadership, and there were several transitions, really, that I went through before it all settled, which then made it very, very difficult—you know, for a junior faculty member starting out without a defined grant, you know, as a junior faculty member, you're not bringing in big grants, right? You're going to start to work under someone's mentorship so that you can build your research portfolio and then get your own grants. But because of the continuous movement of leadership, actually my mentors kept changing year to year. And at some point, I think it was into my fourth year or so, I realized that I wasn't going to be successful, that I wasn't going to be successful in the lab, simply because I did not have a solid anchor for the work that I was doing. And I wanted to have an anchored perspective in my career. The chair of the—or, the chief of the section at that time was Dr. Fernando Cabanillas. We were later made into a department, and he became the chair of the department. He was very influential in my work. I mean, he really was truly my mentor.

Tacey Ann Rosolowski, PhD

[01:03:08]

What did you get from him?

Alma Rodriguez, MD

[01:03:13]

Well, he was very passionate about moving forward the treatment of lymphomas. He was convinced we could cure lymphomas. And at the time that he had trained as a fellow here at MD Anderson, actually most lymphomas, with the exception of maybe Hodgkin's lymphoma, most other lymphomas were not curable. And he was a participant in the seminal early work that showed the first curative regimen for large cell lymphoma. And he was very committed to the development of new chemotherapy protocols and regimens that could lead to cure.

Interview Session: 01

Interview Date: February 20, 2015

Chapter 07

Shifting Focus from Research to Administration

A: Professional Path;

Story Codes

A: Professional Path;

A: The Administrator;

C: Evolution of Career;

D: On Research and Researchers;

Alma Rodriguez, MD

[01:03:13]+

So most of my career, really, was about designing drug combinations, testing them in clinical trials to define or determine efficacy. So that really was the, if you will, the defining perspective of the work I did for many years. And then sort of in a surreptitious way, I started doing administrative work.

Tacey Ann Rosolowski, PhD

[01:04:40]

Why do you say “surreptitious”?

Alma Rodriguez, MD

[01:04:42]

(laughter) Well, it was one of those things—see, in academic medicine, people want to avoid getting assigned responsibilities that are in no way, shape or form going to lead to some new project or protocol, or discovery, OK? But Dr. Cabanillas asked me if I would take on the responsibility for being the Director of the Lymphoma Clinic, and it meant sort of helping the nursing administrator of the clinic to create or come up with room assignment schedules, and doctor schedules, distributing dates of the clinic, and distributing personnel and that sort of thing, which most of my peers consider to be terribly boring work and not interesting. But I took it on, and I actually learned I have a knack for administration. Or, at least I liked, or enjoyed, working with people who were committed to trying to make things better for the patients. And so I got to interact with Patient Advocacy, with social work, nursing staff, and very importantly, clinical pharmacists, which were a new specialty in the organization. And these were young men and women who wanted to not just be in the pharmacy dispensary but wanted to be in the front lines of the clinic, and to interact with the Physicians and advise on drug safety, and help us to standardize protocols and standardize the chemotherapeutic order sets, and so on and so forth. And I learned tremendously from them; I hoped they learned from me.

Interview Session: 01

Interview Date: February 20, 2015

But we standardized the structure of orders sets in our clinic, we began to develop, if you will, standard operating procedures for how we would control nausea, how we would hydrate patients, and how we would use certain kinds of catheters to facilitate patients getting chemotherapy, and so on. So this was a multi-disciplinary effort from nursing and the pharmacist and myself, and some of my peers contributed to that as well. But in any event, it was exciting to sort of think of ways in which we could make our work life and the patients' treatments a little bit more structured and predictable, if you will.

Tacey Ann Rosolowski, PhD

[01:07:49]

So you held that—this was the period 2000 to 2003, when you were a Medical Director? Or is this actually prior to that?

Alma Rodriguez, MD

[01:08:00]

Yes. It's that time. And then afterwards, we also were—well, even prior to that. There were several iterations of the clinic and several iterations of the title.

Tacey Ann Rosolowski, PhD

[01:08:12]

Oh, was it? Oh, OK. Yeah, here it may be. Clinic chief lymphoma—

Alma Rodriguez, MD

[01:08:17]

Yes.

Tacey Ann Rosolowski, PhD

[01:08:19]

—and myeloma. And that was 1994 to '96.

Alma Rodriguez, MD

[01:08:21]

Yes. Yes.

Tacey Ann Rosolowski, PhD

[01:08:22]

OK.

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[01:08:22]

Yes.

Tacey Ann Rosolowski, PhD

[01:08:23]

Wow. I mean, you know, it's funny, because when you said that you found psychiatry interesting, you know, but didn't have a passion for it, I thought, huh, I wonder why that was. And it seems like that requires kind of a knowledge of people, and maybe getting people together, getting people to work together. So those skills suddenly reasserted themselves even in more complicated ways during that period of being clinic chief. So that must have been exciting to discover kind of an entirely new skillset.

Alma Rodriguez, MD

[01:08:57]

Yes.

Tacey Ann Rosolowski, PhD

[01:08:59]

Yeah. So how did your thinking about that change? I mean, when he asked you to take on that position, did you have a plan? Or was it kind of learn on the job?

Alma Rodriguez, MD

[01:09:06]

It was just he asked me to do that, he needs help, I was grateful that he had supported my shift in career orientation from the lab to the clinical research, and—

Tacey Ann Rosolowski, PhD

[01:09:25]

That was it.

Alma Rodriguez, MD

[01:09:25]

And that was it.

Tacey Ann Rosolowski, PhD

[01:09:26]

You had a kind of a new thing. Now, just so I understand that period of shift, you said about after four years here, you began to see the handwriting on the wall, that it was going to be really

Interview Session: 01

Interview Date: February 20, 2015

difficult to build a real research career. Now, during those first four years, were there some landmark studies you participated in, or feel you made a major contribution to, that we should talk about here?

Alma Rodriguez, MD

[01:09:50]

Well, not really.

Tacey Ann Rosolowski, PhD

[01:09:51]

OK.

Alma Rodriguez, MD

[01:09:53]

I mean, that was part of the problem, that I felt I was spinning my wheels.

Tacey Ann Rosolowski, PhD

[01:09:53]

OK.

Alma Rodriguez, MD

[01:09:54]

And, I mean there were a couple of clinical—there were a couple of projects that did ultimately get published. But they were not ground—majorly ground-breaking—

Tacey Ann Rosolowski, PhD

[01:10:04]

Right.

Alma Rodriguez, MD

[01:10:06]

—number one, and secondly, it took a great deal of effort to get them done, and it wasn't enough to move to—it wasn't enough, or solid enough, that it was a good foundation for grantsmanship.

Tacey Ann Rosolowski, PhD

[01:10:18]

Right. Right.

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[01:10:20]

And to really be successful in research, then as now, one has to have the skill of grantsmanship. And foundational to that, of course, is good data. But beyond good data, you also have to have excellent writing skills. You have to have perseverance. You have to keep sending, amending, revising, redoing your applications endlessly. And after a certain number of those redos, rewriting, resending, some of us really don't have the psychological strength to keep doing it. Some people do. I forget it was where I read where Arthur Miller sent off *Death of a Salesman* to I don't know how many publishers and got rejected, like, thirty times. So I don't know where I get that number, thirty, but he was rejected, like, an enormous number of times and he still kept sending it out.

Tacey Ann Rosolowski, PhD

[01:11:15]

He kept sending, yeah.

Alma Rodriguez, MD

[01:11:20]

So, you know, some people have that level of resilience of continuing to do—for me, it's, like, I—if I have done something several times, and I think I've done my best at it, and it still doesn't work, why keep doing it?

Tacey Ann Rosolowski, PhD

[01:11:37]

I think it was W. C. Fields who said, "Try, try, and then don't be stupid." (laughter)

Alma Rodriguez, MD

[01:11:44]

Yes, something like that. Yes.

Interview Session: 01

Interview Date: February 20, 2015

Chapter 08

Research on Lymphoma Treatments

A: The Researcher;

Story Codes

A: The Researcher;

C: Discovery and Success;

Tacey Ann Rosolowski, PhD

[01:11:47]

Yes. OK, so that was really the watershed moment, it's, like, OK, I'm moving on. And then this Medical Director opportunity comes, and you excelled in that area. So what were you thinking about now? You know, you're kind of redirecting your MD Anderson career. So how did you begin to think about that? What was the next opportunity you looked for?

Alma Rodriguez, MD

[01:12:11]

Well, like all other junior faculties, you look at what is it that's going to get me to my promotion. To the next promotion. And essentially, you know, you have to write papers, you have to collaborate in research protocols, get some funding for your work, and whether it's from pharmaceutical grants, or NCI [National Cancer Institute] funded research protocols, so essentially that's what I really focused a lot of my attention to; how am I doing, who am I collaborating with.

Tacey Ann Rosolowski, PhD

[01:12:49]

Because you shifted your research focus at this time. So how long did it take you to settle on a new research project, or do an arena of research projects?

Alma Rodriguez, MD

[01:13:01]

Well, that wasn't difficult, because Dr. Cabanillas, like I said, really was passionate.

Tacey Ann Rosolowski, PhD

[01:13:04]

OK.

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[01:13:04]

So we were literally turning out protocols after protocol after protocol.

Tacey Ann Rosolowski, PhD

[01:13:06]

Wow.

Alma Rodriguez, MD

[01:13:07]

That was not difficult at all, I mean, we were short-handed in terms of the number of people who could do all the clinical studies.

Tacey Ann Rosolowski, PhD

[01:13:19]

Wow.

Alma Rodriguez, MD

[01:13:20]

It was a very rich time in terms of the development of new combinations of chemotherapeutic agents that were successful. So that's what we did, write protocols, conduct the clinical trials, report out, present at the national meetings, etc.

Tacey Ann Rosolowski, PhD

[01:13:39]

And what were some key studies that you worked on there, on things that would be relevant to talk about here?

Alma Rodriguez, MD

[01:13:47]

Well, at the time, so Dr. Cabanillas had done some early work with a drug called ifosfamide, and shown that in some patients with large cell lymphoma who, unfortunately, their tumors might not respond as well as they should to the best front-line regimen, which at the time was a regimen called CHOP [Cytosan, hydroxy doxorubicin, Oncovin, Prednisone]. It still is, actually, the golden standard today. It hasn't shifted much, it still is one of the golden standard regimens. So if the patients didn't do so well with CHOP, if they were treated with this drug called ifosfamide, some of them responded further and went on to achieve complete remission. So we did a number of studies using ifosfamide base combinations. At that time, we were also starting to do stem cell transplants, so we explored the use of ifosfamide in high doses as what we call an

Interview Session: 01

Interview Date: February 20, 2015

induction regimen for stem cells. And actually, ifosfamide base combinations are still—are today still the pre-stem cell transplant induction regimens of choice for large cell lymphomas. There's been some tweaking to them. But they still are, at this point in time.

Tacey Ann Rosolowski, PhD

[01:15:10]

And that's at other institutions here, and at other institutions?

Alma Rodriguez, MD

[01:15:11]

Mm-hmm [affirmative].

Tacey Ann Rosolowski, PhD

[01:15:13]

Yeah? Wow.

Alma Rodriguez, MD

[01:15:16]

So some of that seminal work was at that time. We also showed the benefit of a combination of a drug called Cytarabine and Cisplatin, and that's another regimen that's still in use today. So that was in the early—in that face of shifting focus in my career. Later on, and even to today, the attention now is more to the introduction of very new investigational agents into the trials. It's ironic, but relatively more attention is being paid to new drugs versus exploring, perhaps, optimization of old drugs. Now, let me say that one person who has done just that is at the National Cancer Institute, Dr. Wyndham Wilson. He actually took the exact same combination of the CHOP and he altered it in ways that we had advocated before. We had said, you know, drugs by continuous infusion do better. Dr. Cabanillas had been pooh-poohed for that. Dr. Wyndham Wilson took that to heart, and he redesigned the protocols. And he has shown that really, continuous infusion of certain drugs really does yield better results.

Tacey Ann Rosolowski, PhD

[01:16:53]

Wow. Why was that not seen as a good idea before?

Alma Rodriguez, MD

[01:17:00]

I really don't know. Perhaps we didn't design the studies well enough to be convincing, but we had tried—in fact one of our—to this day, I consider the continuous infusion of certain medications to be much safer than the bolus administration. And that's been shown in studies.

Interview Session: 01

Interview Date: February 20, 2015

But in the community of oncology, because the bolus—the rapid flush administration is much more efficient, less time-consuming, it can be done in the clinic, that sort of has stayed as the standard. But infusional administration of particularly some of the very toxic drugs can be safer for the patients. Very interesting—

Tacey Ann Rosolowski, PhD

[01:17:52]

Yeah. Yeah.

Alma Rodriguez, MD

[01:17:52]

Issues going on in research, but—

Tacey Ann Rosolowski, PhD

[01:17:58]

Huh. What makes sense to talk about now? I mean, we've kind of, you know, have been following the theme of your research, and I know that your research kind of shifted some direction, or maybe you added new dimensions to it as you began focusing—your career took its shift to administration. Would you like to talk about some of those studies? Or would you like to talk about some of the new administrative promotions that you had?

Alma Rodriguez, MD

[01:18:27]

Well, I have to go give a presentation at noon.

Tacey Ann Rosolowski, PhD

[01:18:29]

Oh, OK, so—

Alma Rodriguez, MD

[01:18:30]

And so we have only about, what, ten minutes, fifteen minutes?

Tacey Ann Rosolowski, PhD

[01:18:31]

Right. Right. Would you like to stop now? Do you need some time to prep? Or—

Interview Session: 01

Interview Date: February 20, 2015

Alma Rodriguez, MD

[01:18:40]

I just probably am going to need some time to travel.

Tacey Ann Rosolowski, PhD

[01:18:41]

OK.

Alma Rodriguez, MD

[01:18:41]

Because these days we have to go from one place to another.

Tacey Ann Rosolowski, PhD

[01:18:44]

Right, I mean, because we're kind of at a natural stopping place right now. Does that make sense?

Alma Rodriguez, MD

[01:18:50]

Yes, that'll be fine.

Tacey Ann Rosolowski, PhD

OK, well, then I want to thank you for your time today.

Alma Rodriguez, MD

[01:18:51]

Oh, you're welcome. Thank you.

Tacey Ann Rosolowski, PhD

[01:18:54]

That's a very neat story. And I am turning off the recorder at about quarter of twelve.

Alma Rodriguez, MD

[01:19:00]

OK.

Tacey Ann Rosolowski, PhD

[01:18:56]

All right.

Alma Rodriguez, MD

Interview # 61

Interview Session Two: 6 March 2015

Chapter 00B

Interview Identifier

Tacey Ann Rosolowski, PhD

[00:00:00]

OK, we are officially recording. And today is the 6th of March, 2016. The time is about twenty minutes after ten.

Alma Rodriguez, MD

[00:00:08]

Two thousand and fifteen.

Tacey Ann Rosolowski, PhD

[00:00:08]

Two thousand and fifteen. What did I say?

Alma Rodriguez, MD

[00:00:09]

Sixteen.

Tacey Ann Rosolowski, PhD

[00:00:09]

Oh, my gosh! That—I usually don't do that one.

Alma Rodriguez, MD

[00:00:12]

You're time traveling.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[00:00:12]

(laughs) I know! I am time traveling. Thank you for catching that. And I'm on the eighteenth floor of Pickens Academic Tower today in the office of the Executive Vice President, talking my second session with Dr. Alma Rodriguez. So thank you very much for making time for me again today.

Alma Rodriguez, MD

[00:00:32]

Not at all. Thank you.

Interview Session: 02
Interview Date: March 6, 2015

Chapter 09

Learning Administrative Approaches by Leading the Myeloma Clinic

A: The Administrator;

Story Codes

A: The Administrator;

A: Professional Path;

B: MD Anderson History;

B: Building/Transforming the Institution;

B: Devices, Drugs, Procedures;

Tacey Ann Rosolowski, PhD

[00:00:36]

And we strategized a little bit beforehand, and decided it would make a lot of sense to start now talking about your administrative experience. And I know that last time you mentioned your first experience with administration, which kind of let you know that you had a gift in that area. So if you could tell me about your next significant experience, which I believe was in 2005, you were Director of Clinical Investigation for Lymphoma/Myeloma?

Alma Rodriguez, MD

[00:01:09]

Right. So, before getting to that—

Tacey Ann Rosolowski, PhD

[00:01:13]

OK.

Alma Rodriguez, MD

[00:01:14]

There were several stages, if you will, in the evolution of the Lymphoma/Myeloma clinic.

Tacey Ann Rosolowski, PhD

[00:01:22]

Oh, OK.

Alma Rodriguez, MD

[00:01:23]

Because initially, we were included in or jointly managed with leukemia and stem cell

Interview Session: 02

Interview Date: March 6, 2015

transplantation. We were a single, if you will, operational unit, and we shared resources. We shared space, nursing assignments, funding, etc. And it was very interesting, quite frankly, to be in an environment of shared resources where each one of the participants felt they were entitled to more than the other.

Tacey Ann Rosolowski, PhD

[00:02:03]

Huh. What did you, what did—

Alma Rodriguez, MD

[00:02:03]

So, and this was a very—pardon me?

Tacey Ann Rosolowski, PhD

[00:02:08]

What did you learn from that experience?

Alma Rodriguez, MD

[00:02:08]

Well, what I learned from that experience was that one had to be very well-prepared, first of all, in understanding the fundamentals of how resources are allocated and distributed, according to need. So you had to—so I learned how to assess patient volumes, patient flow, how to assess nurses to Physician ratios, hours of operation, etc. And being well-informed certainly lends credibility to one's claims on, or requests for, resources. And that's a very fundamental principal in operations. You have to justify cost for the operation.

Tacey Ann Rosolowski, PhD

[00:03:09]

And just to refresh the memory of the listener, this would have been when you were Medical Director of the lymphoma section?

Alma Rodriguez, MD

[00:03:17]

Correct.

Tacey Ann Rosolowski, PhD

[00:03:18]

From 2000 to 2003.

Interview Session: 02
Interview Date: March 6, 2015

Alma Rodriguez, MD

[00:03:19]

Well, it was even earlier than that—

Tacey Ann Rosolowski, PhD

[00:03:22]

Oh, really? OK.

Alma Rodriguez, MD

[00:03:21]

—when we were still joined. Now, we were eventually, if you will, divorced, or separated. Each of the clinics was then separated, which then comes to the period of 2000 to 2003 when we are our own freestanding clinic.

Tacey Ann Rosolowski, PhD

[00:03:33]

Oh, OK. So the joining that you were talking about had always—I mean, that was pretty much how it was conceptualized.

Alma Rodriguez, MD

[00:03:37]

Mm-hmm. Mm-hmm.

Tacey Ann Rosolowski, PhD

[00:03:43]

In that joint operation.

Alma Rodriguez, MD

[00:03:45]

But as we were the separated, and each of us were allocated our own resources, it was interesting because there's always—at every level, there are different challenges. So now it was not so much paying attention to how we competed, if you will, for resources with the other two groups, but in fact it was the competition within the group. I want to work with this nurse, I want my clinic on these days.

Tacey Ann Rosolowski, PhD

[00:04:14]

Right.

Interview Session: 02

Interview Date: March 6, 2015

Alma Rodriguez, MD

[00:04:16]

You know, I do not want to be here on Fridays—so the process then became more one of analyzing internal utilization; how is work distributed internally within our own work group? By this time we were a much larger operation, as well within lymphoma.

Tacey Ann Rosolowski, PhD

[00:04:38]

How had it grown in terms of faculty numbers and provider numbers?

Alma Rodriguez, MD

[00:04:43]

I can't tell you the exact numbers. But we certainly—I can tell you by this time, we had probably nearly doubled the number from when—way back when, we had been joined with leukemia and stem cell transplant, which is one of the reasons why the three clinics were separated, because the operation had gotten so large. It was not possible to efficiently manage all three together. And so in internal resource management, people are much closer to you, if you will. So it becomes necessary to be far more transparent. So I began to create reports that would display how many patients were seen by each of the providers, what their clinic days were. Back in those days, we would also be provided with sheets of downstream revenue that the whole clinic had generated, and at some point, those disappeared, and I'm not sure why. But it used to be that we would know how many—you know, what the revenue to lab, what the revenue to diagnostic imaging and the chemotherapy areas had been from our referrals to those areas, or generating, if you will, business for those areas, for lack of a better word. How many x-rays we ordered, how many chemotherapy cases we had treated, and so on.

So it was a learning period for me as well, obviously, in that I began to understand then the effect that the work of individual has on the whole. I mean, we, in essence, like all other clinics, we were driving downstream benefits and work and workload. So, for example, we became aware that we were one of the biggest customers, again for lack of a better word, of the CT scan unit, I mean patients with lymphoma for staging purposes require that you image the entire lymphatic system. So we had to do CT scans from head or neck, thorax, body. And so we were a big customer of theirs. So we then began to ask that they participate more actively in helping us to plan and strategize for the growth of the clinic. If we're going to generate so many—if we're going to be asked to increase the number of new patients that we're seeing by so many percents, what is that going to mean for CT scans? And if you can't manage that volume, what are we going to do? So, for example, sometime in this period of time, somewhere in this period of time, there were not enough CT scan machines in the organization to handle the volume that not just us, but the entire clinical operation was generating for diagnostic imaging. So we had to think of

Interview Session: 02
Interview Date: March 6, 2015

alternatives, such as negotiating with St. Luke's at the time. They had started to build some of their external or ambulatory CT scan units. If we send our patients there, will you send us the reports in a timely fashion? How will we communicate with you? So thinking strategy for care delivery under stress of low resources, I mean, that's very challenging. And that was another learning point for me.

Tacey Ann Rosolowski, PhD

[00:08:45]

Yeah, after we turned off the recorder last time, you were saying that every time you reached another administrative level, you realized that you were operating in an entirely different institution. And I—

Alma Rodriguez, MD

[00:08:59]

Correct.

Tacey Ann Rosolowski, PhD

[00:08:59]

—can kind of see how this is an example of that.

Alma Rodriguez, MD

[00:09:02]

Correct.

Tacey Ann Rosolowski, PhD

[00:09:03]

And you'd just seen an entirely new—it's like putting a different lens up to the Institution.

Alma Rodriguez, MD

[00:09:07]

Correct. Correct.

Tacey Ann Rosolowski, PhD

[00:09:10]

Yeah.

Alma Rodriguez, MD

[00:09:11]

And, you know, being in that particular scenario, for example, of the CT scanners, understanding

Interview Session: 02

Interview Date: March 6, 2015

who else needs the CT scanners, the sarcoma, thoracic, GI service—you know, understanding how the other services whose clinical work demands that they also have access to the same imaging resources makes one aware of how we're not the only fish in the pond, if you will.

Tacey Ann Rosolowski, PhD

[00:09:40]

Right.

Alma Rodriguez, MD

[00:09:42]

And I can tell you that the individual Physician providers do tend to be very ingrown, if you will, and view the world only as within the boundaries of their own life. Like I said, you know, it can get fairly—it can get into a sibling rivalry situation, almost, where people are competing for the same day, or I want to work with Nurse So-and-So, well, so do I. So-and-so is my mid-level provider, well, I want to work with them, too. You know. And so, the management and distribution of work internally, but then also proceeding how the internal work affects the external operation of the organization. That was an important learning curve for me.

Also, sometime around this time, and I have to look at all my different diplomas, some of which are hidden by now, were put away. I attended so many administrative educational courses this time to learn more about operations, to learn more about how budgets are done, how forecasting of business is done, how or why third party payers view services rendered, why documentation is so important, why the appropriate billing structure was so important. I know that it astonishes many people when I tell them that when I first arrived at MD Anderson, we didn't even drop bills. We never filled out a charge form, ever. As a Physician, I never saw a charge form, probably until the '90s, the late '90s, the mid to late '90s. We became aware that, oh my gosh, we get paid for what we do! (laughs) And we introduced the billing forms, and oh my God, you would have thought that this was a revolution. People were not used to seeing those forms, so they conceived of that as just more added paperwork. And then even within the forms, the rules about how we were reimbursed changed, and you had to explain the complexity of the visit. And there were rules about how you calculated the complexity, etc. So there have been many evolutionary changes that have occurred.

Interview Session: 02
Interview Date: March 6, 2015

Chapter 10

The Role of the Physician-Leader at MD Anderson

A: Overview;

Story Codes

A: The Administrator;

A: Overview;

A: Definitions, Explanations, Translations;

B: Building/Transforming the Institution;

C: Leadership;

D: On Leadership;

D: On the Nature of Institutions;

C: Understanding the Institution;

Tacey Ann Rosolowski, PhD

[00:12:26]

It sounds to me like a good part of what you're describing is also a communication problem; you know—

Alma Rodriguez, MD

[00:12:33]

Yes.

Tacey Ann Rosolowski, PhD

[00:12:33]

—you have the individual providers and then you have a person like you who's in the administrative function, and has a much broader, more nuanced perspective on these operations. What have you discovered about communicating across that gap, to try to ease some of this?

Alma Rodriguez, MD

[00:12:53]

Well, I think that that's—I mean, you've hit on a key issue about administration. I think one of the most important roles of physicians and administration, but administrators in general, is that you have to communicate in a way that is relevant to the listener why it is that change—how and why certain changes are important, and why it is that the individuals who are affected by the change must engage in the change. So for example, when—and it's also important to listen. So for example, the issue with the CT scans, initially, my perception was that I was just hearing, because I started to hear from one or two individuals how hard it was for them to get their CT

Interview Session: 02

Interview Date: March 6, 2015

scans. They happen to also be very busy, have very large patient numbers, and they were very vocal individuals. So my thought was, OK, they're having a bad day, you know?

But then, and again, this is another one of the important reasons why I think Physicians who are in administration have to have some sort of toe hold, if you will, into clinical work. I began to notice I was having trouble getting my CT scans scheduled, as well. So having a shared experience does give one a more realistic perspective on why there's dissatisfaction, or why the complaints are coming up. So I began to realize, look, I'm not one of the busiest clinicians, and yet I'm having difficulty with this. So these individuals, who have many more patients than I do, must be desperate, trying to get these results back and trying to get the tests scheduled in a timely fashion for their patients. So there's then a shared reality, if you will, a shared experience, and a validation of the reality of what the individuals are saying. And I think that that's important. So it's important—so if the individual—so if the administrators are not clinicians, they at least need to do experiential rounds, for lack of a better terminology. They really should go to the front lines, spend time experiencing what it is that people in the front lines are experiencing, because I don't think that—there is really a difference in the perceived urgency, I think, of complaints, when you are experiencing the problem yourself. So that one aspect of communication that's important; being there, experiencing it, so that one understands the reality of what is happening. But then there's the other side; the explanation of the larger reality. And in general, Physicians are very data-driven. We understand information that is, if you will, factual, informational, graphic.

Tacey Ann Rosolowski, PhD

[00:16:36]

Mm-hmm.

Alma Rodriguez, MD

[00:16:37]

So, sharing that information with people is very important. So, saying to my colleagues, well look guys, we had X-number of CT scans, these five or six CT scanners have to fulfill the needs of not just lymphoma but thoracic oncology department, the Sarcoma Department, the X, Y and Z department, the neurosurgery, etc. So when you add up all the numbers, then you begin to realize, if you total up the number of cases per day that these six machines are handling, it's not possible for them to fulfill. And if you take into account that each test will take a minimum of X-number of minutes or hours, there are not enough hours in the day for them to fulfill the needs of all of these demands. So let's talk about alternative solutions. So that's when we came up, OK, let's start to talk organizations outside of MD Anderson. Now, here comes the rub though—I had to have approval from the higher ups to say it's okay to go outside of the organization, to negotiate for your patients to get tests, because obviously, that's a revenue loss

Interview Session: 02

Interview Date: March 6, 2015

for our organization. So again, appealing and making the case known to higher level administrators on behalf of the group one is representing is also—you know. So it's up and down. So in a way, you know, if the mid-level or mid-tier administrators, particularly if they are Physicians such as the Medical Directors, their role is really to advocate up and down. You know, to sort of be the conduit from the larger group to the front-line group, and from the front-line group to the larger group. That's really the key to the job, in my opinion.

Tacey Ann Rosolowski, PhD

[00:18:45]

There's so much discussion now about the importance of having physician leaders.

Alma Rodriguez, MD

[00:18:53]

Yes.

Tacey Ann Rosolowski, PhD

[00:18:54]

And I can see that, you know, the contours now of why that's so key. Are there other things besides being able to create a shared reality, you know, understand the clinical needs? What are some of the other reasons why Physician leaders are so important in an organization like this?

Alma Rodriguez, MD

[00:19:14]

Well, I think it's just the psychology of groups. I mean, we tend to trust the people who are more like us, right? So I think gaining trust from Physicians is perhaps, to some degree, not always, but again it depends on the skills of communication and other interpersonal qualities. But it is much easier for a Physician to have credibility with Physicians than a total stranger, in the eyes of the Physicians, a total stranger that comes and tells them this is how it is. And it's no mystery that there is a dichotomy in the culture of hospitals; there are the suits, those are the administratives and the coats, and the coats are the Physicians. So there's that perceived dichotomy of culture. So the coats would listen to another coat. More than they'll listen to a suit. That's the bottom line.

Tacey Ann Rosolowski, PhD

[00:20:16]

And, I mean, traditionally, there has been—or maybe I've not been asking that question correctly, you know, what has been the kind of history of having physician leaders in a setting like this? Is it a new thing? What are the impediments or challenges of getting people to take on that role?

Interview Session: 02
Interview Date: March 6, 2015

Alma Rodriguez, MD

[00:20:41]

Well, I mean, it's not a new thing. Obviously, MD Anderson was established by a Physician, a surgeon, specifically. And of course, he had to assume administrative responsibilities once he came on board as the leader of the enterprise.

Tacey Ann Rosolowski, PhD

[00:20:57]

And we're talking here about R. Lee Clark [MD].

Alma Rodriguez, MD

[00:20:57]

R. Lee Clark, yes. And then, of course, he on-boarded other individuals that to whom he then delegated responsibilities and authorities, and in turn, they became leaders of other operational aspects of the organization. So, it's not unknown. But there are distinctions, if you will. And these are—and again, looking in from the outside, they may seem subtle or irrelevant, but they're really critical and key. And that is that most Physician leaders assume responsibility or take on that leadership role under the auspices of academic titles; the provost, the dean, the chair, the deputy chairs. Those titles in those designations are under academic format. And those are individuals that are assumed to have gained that title and that authority through the acquisition of knowledge of that specialty, or that area of work. You know, so the chair of radiology will be seen as an expert, an utmost expert in radiology, right? But in today's reality where—at least in our organization—where we are really one entity, the academic and the operational and [inaudible] enterprise, they're one big pot. We really have to do both well. But the truth is, one cannot do both well. It is not possible to be an expert and the leader, and the most grant-driven leader in a specialty, and at the same time be the most expert and best at safety, quality, financial, organization, operational expertise, that is required to run the organization well. That's—it's not possible. Those are two huge jobs, in and of themselves. So—

Tacey Ann Rosolowski, PhD

[00:23:23]

And that's aside from, you know, the problem of assuming that just because a person has acquired great knowledge and specialty, that they will, therefore, have a great ability in admin.

Alma Rodriguez, MD

[00:23:36]

Exactly.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[00:23:36]

Yeah.

Alma Rodriguez, MD

[00:23:37]

Exactly. That's a huge and inappropriate assumption, we're learning, now, in the current reality. That might have been very feasible and workable twenty years ago, like I said, in the early 1990s, where we didn't even know about billing. (laughs) But it's not an acceptable reality today. And so this is why now you're beginning to see more titles for Physician leaders that are different, such as Chief Medical Quality Officer, such as myself, the Vice President of Medical Affairs, and so on. The Directors of the various clinics who progressively now are being relied on much more by our Executive Vice President for Operations, because that's where the rubber meets the road in the clinics. So you have to have somebody who understands how the clinic runs to help run it. So—

Interview Session: 02
Interview Date: March 6, 2015

Chapter 11

Today's Medical Paradigm Shift

A: Overview;

Story Codes

D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;
D: On the Nature of Institutions;
D: Technology and R&D;
D: The Healthcare Industry;
C: Understanding the Institution;
C: The Institution and Finances;
C: Research, Care, and Education;

Tacey Ann Rosolowski, PhD

[00:24:41]

I have another general question. When I was doing my background research, I read somewhere that you had said that medicine—the entire environment of medicine and healthcare was really poised for what you referred to as a “paradigm shift.”

Alma Rodriguez, MD

[00:24:58]

Yes.

Tacey Ann Rosolowski, PhD

[00:24:59]

And I wondered if you could talk to me about what that involved, and how it connects up with this issue of physician leadership that we're discussing.

Alma Rodriguez, MD

[00:25:05]

Yes. OK. Well, so I'm going to digress for some time—

Tacey Ann Rosolowski, PhD

[00:25:13]

Sure.

Interview Session: 02

Interview Date: March 6, 2015

Alma Rodriguez, MD

[00:25:15]

Just so that we have the perspective of what I'm speaking of today. So, up until the 1800s, for example, when scientific inquiry began to revolutionize, truly revolutionize medicine and to make a scientific inquiry into the cause of diseases, and we discover microbes, and we discover principles of immunization, for example, and principles of hygiene and epidemiology, and how those are very critical in illness, up until that point, throughout history and up until the middle ages in Renaissance, medicine was taught pretty much as an apprenticeship, you know. Yes, there was a period or a face of didactic learning, where the physicians would go to a university and learn about anatomy, and whatever was known at the time about physiology, was a great deal of herbology, and techniques of how to excise tumors, etc. But truly, it was an apprenticeship, and one would seek a practice, a Physician in practice; one would go and be mentored by that individual, who would take the young Physician under their wing, and the Physician would then learn through the older individual and learn their practice. In the 1800s, hospitals became a reality.

And by the way, hospitals, for a long time, were place to go die, not places to go live. And it was the revolutionary changes, again in the 1800s, that were brought about by nursing, you know, when nursing was developed finally as a distinct, professional pathway, if you will, a distinct profession that helped to sustain patients staying alive after surgery, and it was not just, you know, removing their waste and bringing them plates of food when it really became a care profession. Then physicians and nurses could partner, and then hospitals became the training, the better training places for Physicians to learn acute medicine. So this is the period of the 1800s into the early 1900s, when we see, if you will, the scientific basis of medicine begin to take root. So medicine transitions from an apprenticeship, really, to a more systematically learned practice. I mean, that's where the term "intern" comes from; an intern was somebody who would literally live in the hospital. They never left. They were left twenty-four hours to take care of the patients. And that's where the word resident comes in as well, because one would reside in the grounds of the hospital to be available to the hospital.

And so that was the paradigm shift, from an apprenticeship to a truly learned profession, in given environments with a more scientific basis. And then we transition, then, in the twentieth century to highly technical developments; to the introduction of hemodialysis that allows people with chronic renal disorders to live. Heart bypass and organ transplants, bone marrow transplants. So the twentieth century was like an explosion of technical and further scientific evolutions. In fact, medical oncology, as a discipline, isn't really born until the mid-twentieth century. So we're a relatively young profession, or arm of medicine. So that's yet another paradigm shift, you know, our ability to manipulate physiology and technology in such a way that we are now transforming the life expectancy of individuals.

Interview Session: 02

Interview Date: March 6, 2015

But the new paradigm now is no longer focused so much on the technology, but actually how we deliver care, because for the longest time, again, the assumption has been that medicine's about the patient-doctor relationship. But the truth is that health and well-being and the management of illness which, by the way, are different issues—everyone thinks that healthcare is health care. No. There are different paradigms and faces within that, as well. There's the health maintenance, there's the chronic illness management and then there's acute illness management. They're all different. So, but in any one of those faces, it really is no longer about just the patient-doctor relationship. It really is about the patient and medical team, or clinical team relationship.

Tacey Ann Rosolowski, PhD

[00:30:51]

And about an institution.

Alma Rodriguez, MD

[00:30:51]

And institutional relationships.

Tacey Ann Rosolowski, PhD

[00:30:54]

Yes.

Alma Rodriguez, MD

[00:30:55]

And so, what is now, if you will, under what really should become the important analytical—let me backtrack. What really we need to look at critically now, what we need to learn about now, I mean, we were learning—in the 1800s, we were learning about microbes. In the twentieth century we were learning about how to manipulate technology and alter human physiology. This time, we need to learn how we manage ourselves and our systems; how we best deliver in a system. How do we deliver the most optimum care? So medicine itself, the delivery of care itself, is now the subject of inquiry, in my opinion, that's most fascinating and most challenging. I understand that MD Anderson is still under the paradigm of let's investigate illness down to the genetic level; but frankly, that is not what's going to solve the problem of cancer. And I don't mean that disrespectfully. That is going to solve the problem of certain cancers. But the problem of malignant disease in the larger community is going to be solved by how we address population behaviors, how we address education of individuals, how we engage the individuals to be accountable and to manage their own health most optimally. I truly cannot be at the bedside, or at the table, I should say, in the home of my patients watching to be sure they don't

Interview Session: 02
Interview Date: March 6, 2015

eat carcinogenic foods. I can't do that. That's not possible. I can't be watching them while they sneak out to have their cigarettes, right?

Tacey Ann Rosolowski, PhD

[00:33:08]

Yeah.

Alma Rodriguez, MD

[00:33:09]

That's not possible. So the most meaningful preventive health measures are entirely within the domain of individual control.

Tacey Ann Rosolowski, PhD

[00:33:21]

It sounds like in some ways you're revisiting the scenario you confronted in San Antonio, I believe it was, when you were interested in diabetes.

Alma Rodriguez, MD

[00:33:29]

In diabetes. Correct.

Tacey Ann Rosolowski, PhD

[00:33:30]

Yes. And it really now providing mechanisms to support management of individual behavior—

Alma Rodriguez, MD

[00:33:37]

Which is another health disorder that is within the scope of individual—largely. Not entirely. There are some individuals who, unfortunately and regretfully, the pancreas just quits working.

Tacey Ann Rosolowski, PhD

[00:33:52]

Right. Right.

Alma Rodriguez, MD

[00:33:52]

But for most people it's not that the pancreas doesn't work at all, it's just that the metabolism in their body has been so altered by their dietary and lifestyle habits.

Interview Session: 02

Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[00:34:00]

So what impact—I mean, how is MD Anderson engaging what you see as this new paradigm in any way?

Alma Rodriguez, MD

[00:34:18]

Well, we are to some degree. I mean, so remember that I said that, you know, within what people consider to be healthcare, there really are different—there are different domains of healthcare. There is true health management where one does what I just spoke about, one motivates and engages one's patience as partners in the care delivery. And that's predominantly a primary healthcare issue, and frankly, I don't think Physicians are necessarily the best at that. I mean, I think that nutritionists, exercise experts, even behavioral medicine specialists are far more expert at doing that. We're not trained to do that. We're not trained to maintain health. We are trained to take care of disease. We are trained to be disease management experts. So for Physicians, chronic illness management and acute illness management are the domains of our education.

So to answer your question, how do we engage people? Well, we don't do that very well. Nonetheless, we have accumulated a large body of evidence that supports our moving, if you will, the needle towards the domain of prevention, progressively more. And we can do that at two ends. We can do that before people get cancer, but we can also—we also need to do it after people get cancer, because actually, we're getting so good at the management of cancer that if you look at the statistics for the American Cancer Society and the National Epidemiology Database, the SEER [Surveillance, Epidemiology and End Results] database, you will see that nearly seventy percent of patients who are diagnosed with cancer today will be alive five years or longer from today. So these people are going to have further opportunities for other cancers, OK, so it's equally important, not just for the people who are pre-survivors, that terminology is now being used, previvors. Previvors, I think, is the actual term. Previvors. And then the survivors of cancer.

So how do we influence those groups, is now coming into our consciousness. There are people who now—you know, there are fellowships now that are being focused more towards prevention, as well as post-cancer management. We are, in fact, engaging with Baylor University to develop a residency program for along the track of internal medicine with a focus on cancer management. And that means helping patients manage their illnesses, such as diabetes, heart disease and so on, probably go through the challenge of being treated for cancer, but then post-cancer as well. So those are changes that I foresee in the future. So one of the ways in which as an organization we're doing that, for example, is that, you know, we are

Interview Session: 02
Interview Date: March 6, 2015

committed now to the—we have been for a long time committed to a tobacco-free environment, but we didn't necessarily require that our employees were tobacco-free.

Tacey Ann Rosolowski, PhD

[00:38:24]

Right.

Alma Rodriguez, MD

[00:38:24]

Now we do. We have—

Tacey Ann Rosolowski, PhD

[00:38:29]

And that was instituted when? Was that earlier this year, or was it last year?

Alma Rodriguez, MD

[00:38:30]

Correct. I think it was—well, probably it was last year.

Tacey Ann Rosolowski, PhD

[00:38:33]

Yeah.

Alma Rodriguez, MD

[00:38:34]

Sometime last year. You know, we're also taking that message in our international relationships, that coalition that was established with the National Institute in Mexico, National Cancer Institute in Mexico for prevention of tobacco-related illnesses and tobacco-related malignancies. I mean, sadly, worldwide, the rise of tobacco-related illness and malignancies is rising. But one country at a time, I guess.

Tacey Ann Rosolowski, PhD

[00:39:13]

Yeah.

Alma Rodriguez, MD

[00:39:15]

So that's another strategy. But I think, going back to the larger community, we also collaborate with other institutions across the state in what is called the Texas Cancer Control Plan and, you

Interview Session: 02

Interview Date: March 6, 2015

know, our cancer prevention program is part of that. And we assume a leader—we have, I don't know exactly how many years, but I know that Dr. Lewis Foxhall, who's in the Cancer Prevention Department, has a leadership role in that initiative. So those are some of the ways in which we are starting to take some responsibility for that. And then, of course, on the post-cancer arena, we are developing, or we have over the last several years, been developing the survivorship program. And we are—we make ourselves available to anyone who wants to reach out to us who wants to learn how we're doing it, we freely share our lessons learned. We've been developing the program, we share the model that we've developed.

Tacey Ann Rosolowski, PhD

[00:40:30]

I mean, I know that that's been a major initiative since 2006, and probably even—maybe even earlier, that was also part of your role as Director of the Office of Medical Affairs.

Alma Rodriguez, MD

[00:40:44]

Yes.

Interview Session: 02
Interview Date: March 6, 2015

Chapter 12

The Survivorship Initiative

B: Building the Institution;

Story Codes

B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Patients;
C: Patients, Treatment, Survivors;
C: Dedication to MD Anderson, to Patients, to Faculty/Staff;

Tacey Ann Rosolowski, PhD

[00:40:43]

And would you like to talk about survivorship in detail now? I mean, that's certainly a really important topic.

Alma Rodriguez, MD

[00:40:48]

Sure.

Tacey Ann Rosolowski, PhD

[00:40:48]

Or, would you like to continue with the administrative story? Up to you.

Alma Rodriguez, MD

[00:40:53]

No. I'm happy to do that.

Tacey Ann Rosolowski, PhD

[00:40:54]

Talk about survivorship? OK, great. So how did—how did that survivorship initiative begin?

Alma Rodriguez, MD

[00:41:04]

Well, for—I'm not quite sure how the Institute of Medicine—where it began for the Institute of Medicine. But as an organization, one of our prior leaders, actually our first female leader at the executive level, Dr. Margaret Kripke, was appointed to the President's Commission on Cancer.

Interview Session: 02

Interview Date: March 6, 2015

And at that level, she began to interface with other leaders at the national level, and became aware of the issue of cancer survivors. Mr. Lance Armstrong, at the time, was a member of that commission as well. And he has been—was a much well-known advocate for cancer survivors at the time. So Dr. Kripke was very intrigued by this concept, brought it back, shared it with our President, Dr. [John] Mendelsohn, and shortly after that, the Institute of Medicine report was published. It was published in 2005, and it's called, *From Cancer Patient to Cancer Survivor: Lost in Transition*, and that's a heading, *Lost in Transition*, really is the main message of that report, and that is that patients felt they were lost as they transitioned from having been under the care of an oncologist and being treated for their cancer. Once that experience was over and they tried to reintegrate into a more normal life, they felt that they were lost and excluded, because the health community did not want to take them on as patients. Sometimes the primary care providers were afraid of assuming responsibility for the care of these individuals, because they felt, you know, once you've had cancer, God only knows what will happen after that.

Tacey Ann Rosolowski, PhD

[00:43:10]

Right.

Alma Rodriguez, MD

[00:43:11]

They didn't want to take responsibility for that, for the care of that individual. Or the patients, worst yet, had lost their insurance, which, by the way, was very common, and therefore, they could not access health services, even if they wanted to, even if there was somebody willing to take them on as patients. They couldn't. They didn't have insurance. Many lost their jobs, and that's very well-documented. A diagnosis of cancer is one of the medical conditions that's most likely to result in bankruptcy. It is one of the conditions that has the highest rates of divorce as the consequence, and therefore, sometimes in a marriage, one partner was the insured partner and if the other individual, the uninsured partner was the cancer patient, well, there goes the insurance once they're divorced.

So there are many—there were many difficulties that cancer survivors were facing. So this was made public knowledge, so therefore, again, our President, Dr. Mendelsohn at the time, felt that it was important that we integrate cancer survivorship as into our care delivery system. So he charged a committee to take this on. I was not part of that initial committee that formulated the proposal to him. But I was asked to take it on when the implementation phase was deemed to be the right time. Dr. Burke was the Physician in Chief at the time, and he asked that—he delegated that responsibility to me.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[00:45:08]

And that was in 2006?

Alma Rodriguez, MD

[00:45:08]

Correct. So we formed a steering committee, first of all, multi-disciplinary. We began to map out how we would do this. Certainly it was far more than I could handle on my own, so I requested that I have a true operations expert person to help develop this. So we did. And the person who really was instrumental in doing the front-line work, if you will, the operations work, her name is Fran [Frances] Zandstra, she just retired.

Tacey Ann Rosolowski, PhD

[00:45:46]

Fran—

Alma Rodriguez, MD

[00:45:49]

Zandstra. Z-A-N-D-S-T-R-A. She had been the clinical administrator for several clinics; she then had been a Director for Patient Affairs. She was very knowledgeable about how the Institution worked. She had a network of friends and colleagues in the Institution that knew her and respected her. She was very patient, centered in her approach to things. So she and I partnered in this initiative, and kind of building the model and the implementation of the process. And what seemed to work best, again, part of the listening mode and being in the front lines, part of what we learned to work. So we held focus groups, we got input from providers, we got input from patients and their families. In the end, what we heard both the providers and the patients tell us was, the patients were accepting of the idea that maybe their focus—the focus of their care was no longer going to be necessarily the cancer itself. And in fact, many of them welcomed that it would now be more wellness and prevention.

But they did not want to separate from their clinics. They wanted to feel that their oncologist, or the community of oncologists who were expert in their disease, were still linked to that survivor care. So we built the survivor care clinics in the same way that we built the acute care clinics; in other words, the Breast Center had their own breast survivor clinics, the Gynecological Oncology Center has their own gynecologic survivors clinic. Head and Neck has their own head and neck survivor's clinic, etc. We did find, however, that some clinics really were pressed for space; so, for example, the Thyroid Center felt that they were very cramped for space, and they would welcome transitioning their survivors to a different space. They still wanted to remain linked in providing the services, so they would assign who would go to the survivor clinic, but

Interview Session: 02
Interview Date: March 6, 2015

they couldn't do it in their own space. So they transitioned their patients to the Cancer Prevention Center, which had a lot of space at that time.

Tacey Ann Rosolowski, PhD

[00:48:39]

Can I ask a question?

Alma Rodriguez, MD

[00:48:40]

Mm-hmm [affirmative].

Tacey Ann Rosolowski, PhD

[00:48:40]

When this report came down, and John Mendelsohn and then the committee kind of began working and the Institution began to understand this was going to be added to the pallet of care delivery, was it controversial? I mean, what—

Alma Rodriguez, MD

[00:48:57]

Yes.

Tacey Ann Rosolowski, PhD

[00:49:00]

Why?

Alma Rodriguez, MD

[00:49:02]

The controversy was that we were, first of all, we were saying the care for these patients is no longer about their primary cancer. So first of all, having had cancer A doesn't mean that you're under the threat of cancer A for the rest of your life. In fact, you maybe at higher risk of cancer B or cancer C as you grow older. So that was one message, you know, bringing to awareness of the primary oncologist that, you know, guess what? The disease that you treated and the care for this patient is no longer the focus of this patient's life, or should no longer be the focus of the care of these patients, moving forward. So that's a little bit of a threat, right?

But the other more important issue is that we were asking people to, for lack of a better word, divorce themselves from their oncologist. And so, there is, you know, the reason the so-called model of the dyad of the doctor-patient relationship has lasted for such a long time is that that is very inherently basic to human psychology; you know, the healer-healed person relationship.

Interview Session: 02

Interview Date: March 6, 2015

You know, it's been talked about extensively in psychiatry and psychology, and it's real. I mean, there is a bond that forms between the Physician and the patient, and particularly in a situation where the patient perceives that their lives have been saved by this individual. And so it is very emotional, it can be very emotional. It can be difficult, both for the patient and the Physician. We found that in some cases, it wasn't necessarily so difficult for the patients, again, as long as they knew it was within the same clinical environment where they were cared for before, but in fact, it was more traumatic for the Physicians because they felt that seeing these patients who are well from the perspective of the cancer, who had survived the cancer and were still free of the cancer, that that was the height of their day, that was the most enjoyable part of their day, and we were going to deprive them of that. So that was a challenge, the psychological separation.

The other challenge was, like I said, the operations, you know, where do we find the space? Where do we find the rooms? Who is assigned—who is going to be assigned now to do survivor clinic? Will it be one of the Physicians within the clinic, or will it be mid-level providers? Or will it be a Physician supervising several mid-level providers? In the end, it really was more of a model of a supervisory Physician with multiple mid-level—with mid-level providers; sometimes multiple, sometimes one or two at most, depending on the volume of patients' transition. But it became clear that really, one of the benefits of the survivor care model is that you can deescalate the intensity of the visit to being more health-oriented. And again, remember what I said about Physicians are not always the most well-trained in health and motivation training. Sometimes the mid-level providers and nutritionists and social workers—so we built partnerships of this other tier of providers, who could then help the patients maneuver through these others issues.

Tacey Ann Rosolowski, PhD

[00:52:56]

So tell me about the stages in setting that up, I mean, like, kind of—I'd like to get kind of more of a portrait of how the survivorship initiative at MD Anderson works.

Alma Rodriguez, MD

[00:53:13]

So we started off, of course, doing pilots in a couple of clinics, first of all to test the model to see if it was feasible.

Tacey Ann Rosolowski, PhD

[00:53:24]

And just for clarity, was this a model that you adopted from somewhere else and then tweaked, or—

Interview Session: 02
Interview Date: March 6, 2015

Alma Rodriguez, MD

[00:53:30]

We designed it.

Tacey Ann Rosolowski, PhD

[00:53:31]

You designed it. OK.

Alma Rodriguez, MD

[00:53:31]

We designed it to fit, like I said, the psychology and the structure and the operations of our own organization. And being that we have multi-disciplinary disease-specific clinics, and that the patients felt most comfortable in that closeness to their primary clinic, we built the survivor clinics for each disease group for patients with certain categories of disease within that same group. So in gynecology, for example, we built a gynecology survivor clinic in the Gynecology Center. How we would start off is simply by looking at their patient populations and saying, you have X-number of patients who come to your clinic on a yearly basis. We notice that X-number of these patients have not had any treatment for the last three to five years. Would you not consider these patients to be well?

Tacey Ann Rosolowski, PhD

[00:54:32]

Oh, OK.

Alma Rodriguez, MD

[00:54:32]

And to be survivors? We didn't say immediately upon completing chemotherapy you must transition them to survivor, that's not what we said. We said at what point do you, the clinicians, consider it safe to transition to survivorship? So remember I said that we took into account both patients' opinions and the doctors' opinions; the doctors' opinions were, OK oncologic care does not end, really, cancer care doesn't end until the patient has reached a point at which the risk of relapse is fairly minimal to nil. That's when it's safe for me to say, "You're a survivor." So that's what our community said. You know, and I can talk about what the national discourse is from the Affordable Health Care Act perspective. But from our providers' perspective, it was, we're not done until we're sure that your risk of cancer is minimal.

[00:55:33]

We want to continue to follow you through surveillance. So again, the cancer care continuum—

Interview Session: 02

Interview Date: March 6, 2015

and there's my little diagram—what we're speaking of is, once treatment ends, it ends here. But we have to keep watching for potential risk of relapse. You're under what we call a surveillance period for potential recurrence of your illness.

Tacey Ann Rosolowski, PhD

[00:55:55]

Would it be possible for me to have a copy of that?

Alma Rodriguez, MD

[00:55:59]

Sure.

Tacey Ann Rosolowski, PhD

[00:56:00]

I can put it right into your transcript.

Alma Rodriguez, MD

[00:55:59]

Oh, OK.

Tacey Ann Rosolowski, PhD

[00:56:02]

Yeah.

Alma Rodriguez, MD

[00:56:03]

And you know, for some cancers, that period of risk of relapse may be very short. It may be a year. So maybe the patient can be considered well, and we can bless that they can transition to survivorship in a year. But for other diseases, it might be five years. For some it might be ten years. We don't know. I mean, so which is why we delegated that responsibility and accountability for determining the time point of appropriateness of transition to the primary providers. And we said it has to be risk-based. So to do that, they built what we call algorithms of transition. So for disease X, when would be the appropriate time point to transition? For disease Y, what would be the appropriate time point for transition? And then we built the actual care model. So in other words, you're not just going to toss your patients out there. You have to tell us what are the key care domains, or elements without four domains—we built the domains based, again, on the Institute of Medicine report.

So first of all, you have to do some aspect of surveillance for second cancers. You also have to

Interview Session: 02

Interview Date: March 6, 2015

do prevention in early screening. You have to monitor for late effects of the chemotherapy or radiation or surgery, because unfortunately, those will happen and some patients may be at higher risk than others. So we call that a late effects monitoring. And then lastly, psychosocial health. Did these individuals get back to work? Are they OK mentally? Are they chronically depressed? Chronically anxious? What is going on in their lives? So those four domains of surveillance, late effects management, cancer preventions and psychosocial health, those four key areas had to be addressed in every single algorithm. But it was up to the disease sides to tell us what do we put in those boxes. So in breast, for example, under the psychosocial domain, body image was one of the aspects of psychosocial health that sometimes can emerge as an issue in the patient's mental health. I treat patients with lymphoma patients, they sometimes, particularly if they had radiation in the chest area or in the neck area, they sometimes can develop hypothyroidism later on. So monitoring thyroid function as a late effect was really important, and so on. I'm just giving you those as examples, that each disease category has its own potential late risks, potential consequences from the treatment and from the disease itself. Patients who have had head and neck cancers, for example, are at risk for developing other head and neck cancers. So they have to have a certain type of exam done on a yearly basis, so that they get completely checked to be sure they are not developing other late second or third oral cancers. So there's all of these disease-specific knowledge that we built into these models of care. So the providers feel comfortable, I'm not just sending these patients to a clinic where somebody's going to say, "Eat vegetables." That's not it. They're going to have, you know, a delivery of care that is aligned with these concerns that need to be addressed downstream.

Tacey Ann Rosolowski, PhD

[00:59:47]

I'm kind of seeing, and tell me if this is the case, that charging each one of the disease areas with this kind of activity also perhaps meant it was asking them to regularize and accumulate their knowledge in a systematic way—

Alma Rodriguez, MD

[01:00:10]

Correct.

Tacey Ann Rosolowski, PhD

[01:00:11]

—that maybe was different than what they had done before.

Alma Rodriguez, MD

[01:00:11]

Correct.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[01:00:13]

Did the individual disease area see this as valuable? Has that activity itself had an impact on the Institution?

Alma Rodriguez, MD

[01:00:23]

Well, as many years as now we're in this process, we really didn't begin to transition patients in significant volumes until 2010.

Tacey Ann Rosolowski, PhD

[01:00:33]

Oh, OK. Wow. So there was a long set-up time—

Alma Rodriguez, MD

[01:00:36]

Correct.

Tacey Ann Rosolowski, PhD

[01:00:39]

—exactly to create all that body of information.

Alma Rodriguez, MD

[01:00:39]

Correct. Correct. So since 2010, however, we now have, I think, a significant body of patients, volume of patients transition that we—that's my next agenda item, if you will.

Tacey Ann Rosolowski, PhD

[01:00:56]

Sure.

Alma Rodriguez, MD

[01:00:58]

Let's start to strategically utilize this information, this data, to assess where are we today? What have we learned from our survivorship model of care? And what should we change? Or is it optimum as it is? Or how can we continue to improve it?

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[01:01:22]

Do you have any inklings of this at this time?

Interview Session: 02
Interview Date: March 6, 2015

Chapter 13

Aimed Toward an Interest in Survival; Survivorship Care and the Affordable Care Act

A: Overview;

Story Codes

D: Fiscal Realities in Healthcare;
D: The Healthcare Industry;
C: Discovery and Success;
C: Patients;
C: Patients, Treatment, Survivors;

Alma Rodriguez, MD

[01:01:23]

Well, I know—so I said that I wanted to talk about the Affordable Health Care Act.

Tacey Ann Rosolowski, PhD

[01:01:29]

Yeah.

Alma Rodriguez, MD

[01:01:31]

OK. So there's a movement nationally now that says, well, oncologists are very expensive, and they order too many tests for surveillance. So let's transition everybody to primary care after treatment.

Tacey Ann Rosolowski, PhD

[01:01:51]

Oh, OK, right.

Alma Rodriguez, MD

[01:01:57]

And that may be appropriate in some, for some diseases, for some types of malignancies. According to our providers and according to our—what I think we're learning is that that would be premature for patients who have had very aggressive treatment, or who have had very aggressive tumors. And so, if that kind of concept of how care will be delivered in the future for cancer survivors takes hold, I think we will see a lot of patients who, regrettably, will not do well. I think there is merit to having oncologic care still continue for the period of time at which,

Interview Session: 02

Interview Date: March 6, 2015

or during which, the survivor may be at risk for recurrence of the same disease simply because they already have the relationship with the oncologist if early detection of relapse happens, perhaps a more reasonable—more reasonable options of treatment. Perhaps a what we call a first-line salvage treatment strategy would be workable and feasible, versus patients showing up with very late metastatic recurrence. So pros and cons for both strategies. Obviously on the con side of transitioning the patients, psychologically, maybe, it's an earlier separation from their identity from the prior cancer. I mean, there could be that psychological benefit. From the healthcare account's perspective, perhaps the primary care providers are going to do less tests. Maybe, I don't know. To me, the solution is simply to say the oncologists, you're accountable for the number of tests you do. (laughs) Justify why you're doing the tests, rather than saying, you know, don't see the patients. Anyway—

Tacey Ann Rosolowski, PhD

[01:04:24]

So, I assume that the, you know, frustration about this is that the Affordable Care Act hasn't been in place long enough to actually accumulate the data—

Alma Rodriguez, MD

[01:04:32]

Correct.

Tacey Ann Rosolowski, PhD

[01:04:32]

—to provide evidence about that.

Alma Rodriguez, MD

[01:04:34]

That's correct.

Tacey Ann Rosolowski, PhD

[01:04:34]

So is this office, or other groups or initiatives within MD Anderson positioned to collect this information? Keep track of it?

Alma Rodriguez, MD

[01:04:47]

Not yet. Because, quite frankly, I think that there's a great deal of consternation and there's huge variability as to how people are interpreting this whole process of transition. In fact, I was invited to speak at the American Society of Clinical Oncology this year about our model of care,

Interview Session: 02

Interview Date: March 6, 2015

and to share with other organizations how we had been doing it. We fully acknowledge that, you know, obviously we are quite unique; we have a huge number of resources. We are very blessed to have all of the number of resources we have. But nonetheless, I think that the model of the domains of health that are relevant to healthcare of the providers—of the survivors, rather—is relevant no matter where the survivor is taken care of. People need to pay attention to cancer prevention. They need to pay attention to the psychosocial health of the patient. They need to pay attention to the late effects that are going to happen. And if you don't know how to do this, then go learn. And whoever it is who's going to be providing the care, whether it's an internist or a family practitioner, or even the oncology practice itself, perhaps, may hire on an additional staff member, and they'll say, OK, now this is the survivor, so your charge—whoever it is that's doing the care, however you built the model in your own practice, whether it's a small practice or a large practice, whatever it is, those four domains of health have to be taken care of. It's just like saying, if you're monitoring diabetics, guess what? You have to monitor their fasting glucose or hemoglobin A1C. You have to send them to the ophthalmologist and the podiatrist. You know? It's the same issue. There are certain aspects of health that have to be paid attention to.

[01:06:57] And you have to understand which are most important, based on the disease and the type of treatment the patient received. Which is why there is resistance among the internists or the primary care providers, because they said, we don't know about chemotherapy or radiation. You do. You, the oncologists, do. You are the ones who really should be doing this. And from our perspective, you know, we're happy to take care of the survivors. It's just that the pressure is mounting that we not take care of the survivors. And there are pragmatic reasons for that, one, of course, being you're more costly.

Tacey Ann Rosolowski, PhD

[01:07:39]

Right.

Alma Rodriguez, MD

[01:07:41]

But the other being that there will be fewer of us in the future, it's predicted that the number of, the ratio of oncologists to the number of patients with cancer diagnoses is going to dramatically shift, and there will be much fewer of us.

Tacey Ann Rosolowski, PhD

[01:07:55]

Right. I mean, not only are there fewer doctors, but there are increasing numbers of survivors as—

Interview Session: 02
Interview Date: March 6, 2015

Alma Rodriguez, MD

[01:07:59]

Correct.

Tacey Ann Rosolowski, PhD

[01:07:59]

—treatments become more and more effective.

Alma Rodriguez, MD

[01:08:01]

Exactly. Exactly. Exactly.

Tacey Ann Rosolowski, PhD

[01:08:04]

Right. Huh. Well, I did interview Lewis Foxhall, and he spoke a lot about the community, the education programs for community Physicians, and kind of even attempts to integrate education about oncology care in medical school curricula so that Physicians would have that survivorship and cancer treatment on their radar from the very beginning.

Alma Rodriguez, MD

[01:08:29]

Correct.

Tacey Ann Rosolowski, PhD

[01:08:32]

It sounds like that the initial steps to being able to put oncologists in partnership with physicians in the community.

Alma Rodriguez, MD

[01:08:38]

Correct.

Tacey Ann Rosolowski, PhD

[01:08:40]

Yeah. Really interesting issue, a whole new dimension of activity. Was survivorship—how did you personally become interested in survivorship?

Interview Session: 02

Interview Date: March 6, 2015

Alma Rodriguez, MD

[01:08:51]

Well, I take care of lymphoma patients. And lymphomas are a group of diseases that, actually, from the early days of medical oncology, were one of the first categories of malignancies to be cured by chemotherapy. And so over the years, I have had a large population who were long-term survivors. And so I just noted these problems, so I'm familiar with the issues of, you know, prevention, second malignancies. I can't tell you how many second malignancies I've diagnosed or picked up on routine monitoring and visits, surveillance visits for my patients. You know, having survived lymphoma which, by the way, is not one of the most common malignancies, it usually ranks fifth or sixth for both men and women, but far more common are breast cancer, colorectal cancer, lung cancer, thyroid cancer in women. All those are more common in women, and breast cancer being, of course, the most common. Breast, colon, lung if they're smokers, gynecologic cancers, thyroid cancers—all of those rank above lymphomas in women. So being aware of those as possible occurrences over the lifetime of my patients was important. They're not risk-free, just because they were treated from lymphoma. And it's amazing how many patients would tell me, "Well, I had chemotherapy, don't you think that would have taken care of all those cancers?"

Tacey Ann Rosolowski, PhD

[01:10:37]

Oh, yeah.

Alma Rodriguez, MD

[01:10:34]

And I go, "No. Actually, unfortunately and sadly, it might even exacerbate your risk for getting those cancers, because the chemotherapy itself, of course they're toxic chemicals. We don't know how much they might influence a late effect risk of getting other malignancies."

Tacey Ann Rosolowski, PhD

[01:10:52]

There's actually an article today in the *New York Times* about, there was a study done of patient and provider's perceptions of—actually, patients' perceptions of the relative health or relative benefits versus risks of having certain procedures done, and how pretty much across the board, patients had no clue of how much value—

Alma Rodriguez, MD

[01:11:12]

Risks.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[01:11:14]

—of how much value they were getting and what the risks were, you know? And, you know, most of it was an emotional component that they were bringing to the evaluation of that. So cancer's certainly on that list, too. Not in the article, but clearly that's at work—

Alma Rodriguez, MD

[01:11:32]

In general.

Tacey Ann Rosolowski, PhD

[01:11:34]

—in these assessments. Well, would you like to continue with your story about administration at this point?

Alma Rodriguez, MD

[01:11:42]

How are we doing with time, because I—

Tacey Ann Rosolowski, PhD

[01:11:44]

We're doing well.

Alma Rodriguez, MD

[01:11:44]

OK. Great.

Tacey Ann Rosolowski, PhD

[01:11:45]

We're at 11:30 now. What time do you ideally have to break today?

Alma Rodriguez, MD

[01:11:50]

Let me see, I think the meeting I have to go to starts at twelve—

Tacey Ann Rosolowski, PhD

[01:11:54]

OK.

Interview Session: 02
Interview Date: March 6, 2015

Alma Rodriguez, MD

[01:11:54]

—something. Twelve fifteen, twelve—I know we start with lunch, so it's probably sometime around 12:00, and then we sit down and really do business.

Tacey Ann Rosolowski, PhD

[01:12:05]

OK, so what time would you like to break off today?

Alma Rodriguez, MD

[01:12:06]

Let's break off at noon.

Tacey Ann Rosolowski, PhD

[01:12:07]

At noon? OK. Sounds good. So we've got about a half hour, that's great.

Interview Session: 02
Interview Date: March 6, 2015

Chapter 14

Lessons in Administration as Ad-Interim Chair of Lymphoma/Myeloma

A: The Administrator;

Story Codes

A: Professional Path;
C: Leadership;
D: On the Nature of Institutions;

Tacey Ann Rosolowski, PhD

[01:12:07]+

Well, tell me about, well, there's the Director of Clinical Investigation and then there's the Office of Medical Affairs. How do you want to continue your story? You kind of gave me the background about the change in your perspective. What really was kind of a next big landmark in the evolution of your administrative work and perspective?

Alma Rodriguez, MD

[01:12:38]

Well, around the time, around 2000, yes, around 2000, Dr. Cabanillas retired, who had been my mentor and so on. And I stepped in in an interim role as chair of the department. And that was yet another whole dimension of MD Anderson, because although I had had experience in the administration of the clinic, running a department on the academic side, because the chair of the department, as I said, remember I said those titles are aligned with academic responsibilities, then brings in a whole different set of dimensions to the responsibility, which is the funding for research, the oversight of the staff in the office, the administrative staff, the research support staff, of course the Physicians as academicians, not the Physicians necessarily as professionals, which is what I had been doing before in my role as Director.

But as the interim chair I also had to look at them as academicians, and how are they doing in their career progression, who is ready for promotion or not, who thinks they're ready for promotion but really don't have the qualifications to be promoted in their academic title, and then how do we talk about that; behavior issues, etc., etc. In addition, of course, now there is a whole set of different peers. You know, as a Medical Director, I and others would interact with each other more on the operations side, you know, I knew the administrative Directors, the nurse managers, etc. On the administrative side of the department, you interface with other department chairs, the division head, the provost. So it's an alignment of leadership that is different than the alignment of the operations of the organization.

Interview Session: 02

Interview Date: March 6, 2015

And there is also competition for resources, in a different way. There's—in addition of the competition for office space, there's the competition for lab space, for position—for the number of positions, how many Physicians, if you want to hire somebody else you have to justify it on the grounds of this, that or the other, and if you're onboarding them as scientists then they have to have X-number of qualifications, whatever their level of title is, is how much square feet of space they get, and on and on and on. So that's yet a different level of administrative responsibility that has its own different view of what MD Anderson, or who MD Anderson is. You know, in that world, MD Anderson may or may not have good standing in the national societies; you may or may not get published by certain journals. You may or may not be excluded, perhaps, by certain funding mechanisms. You may or may not be highly successful at philanthropy, etc. So all of these are metrics that are looked at—

Tacey Ann Rosolowski, PhD

[01:16:30]

Interesting.

Alma Rodriguez, MD

[01:16:33]

—as a point of evaluation of the performance of that department. So in that realm, then, one sees the organization from the perspective or the world view of, well, for lack of a better word from the academic world, from the knowledge world of medicine. You know, are you credible? How credible is your research? How much have you contributed to the knowledge of the larger community of medicine and science?

Tacey Ann Rosolowski, PhD

[01:17:22]

So what did you take from that—how were you interim?

Alma Rodriguez, MD

[01:17:26]

Until 2003, when the new chair—

Tacey Ann Rosolowski, PhD

[01:17:28]

Until 2003, OK.

Alma Rodriguez, MD

[01:17:30]

—came on. I think those are the years.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[01:17:35]

I don't actually have—

Alma Rodriguez, MD

[01:17:36]

Yeah, 2003, 2004, actually, I think.

Tacey Ann Rosolowski, PhD

[01:17:39]

OK.

Alma Rodriguez, MD

[01:17:39]

Two thousand and four, somewhere in there. Anyway, he, you know, a new chair was brought on board, so therefore, I stepped down in my interim role. One of the things that I learned that was very valuable from that experience is that the people who are chairs of the departments, the traditional model, up until recent years, the traditional model or the historical model of who became a chair was this erudite expert, you know, best-known, highly-glorified individual. However, again, you know, we have been in a transition period where to really be a successful chair, it's ironic that the people who are selected for those positions indeed still are the people with the thickest CV. But the irony is that once you step into that role, you have to let go of that ego persona, because the job of the chair really is not to continue to aggrandize your own identity, but rather to bring forth the future leaders of the field, and to ensure that the people who are reporting to you themselves have the opportunities to become great people, great leaders in the future.

So managing other people's careers is your primary job. Ensuring that they have the opportunities, that you champion them, that you mentor them, or if you can't, then you find the right mentors for them, that you stay on top of pushing them. Like I said, one of the toughest conversations to have is with people who are not going to make the next promotional step, and they think they deserve it. But what if they don't meet the watermark? I mean, in some ways, and in some ways, that is not the chair's decision; it's going to be a committee that's going to decide that. But the chair has a pretty good perspective, because you know what the career path is for everyone else. And if this individual falls significantly short of his peers, then you know that they're not going to get promoted. I mean, the committee's going to look at everybody else's performance and compare. So it's an interesting job in that sadly, most people who step into the chair job think that they're there to get further glorification, but no. They've got that job

Interview Session: 02

Interview Date: March 6, 2015

so they can make other people great. And that can be a challenge, if the individual who steps into the role does not have that perspective, the department can falter significantly. Because it's not about the chair, it's about the department. It's about the staff in the department, not the peers within the department. So that's what I learned from that job.

Tacey Ann Rosolowski, PhD

[01:21:24]

Sounds like a very important lesson, indeed.

Alma Rodriguez, MD

[01:21:27]

So it makes me appreciate how tough the job of the chair is, quite frankly.

Tacey Ann Rosolowski, PhD

[01:21:32]

Yeah.

Alma Rodriguez, MD

[01:21:32]

I think it's one of the toughest jobs.

Interview Session: 02
Interview Date: March 6, 2015

Chapter 15

Vice President of the Office of Medical Affairs; the Value of Faculty Credentialing

B: Building the Institution;

Story Codes

B: Institutional Processes;
A: The Administrator;
D: Fiscal Realities in Healthcare;
D: On Texas and Texans;
D: Ethics;
B: MD Anderson Culture;
B: Institutional Mission and Values;
B: The MD Anderson Brand, Reputation;

Alma Rodriguez, MD

[01:21:32]+

So I sort of came to this, my current job, in a roundabout way, and that once I stepped down, you know, after having been in this very intense furnace of the interim chair role, and I suddenly was—they hired the new chair, although I did become the Director of Clinical Research, and that in itself was—clinical investigation within the department, that in itself was another set of lessons. I really have always had my heart in the hospital side, in the operation side, and the professional aspect of medicine side. So I simply had had a conversation with a person who, at the time, was the Physician in Chief. And I had said, you know, there are opportunities for operation leadership. Keep me in mind, I'd like to step back into leadership in operations.

Tacey Ann Rosolowski, PhD

[01:22:38]

And was this still Tom Burke at this time? The Physician in Chief?

Alma Rodriguez, MD

[01:22:42]

Well, it was kind of a—that was yet another transition period.

Tacey Ann Rosolowski, PhD

OK.

Interview Session: 02
Interview Date: March 6, 2015

Alma Rodriguez, MD

[01:22:47]

The person actually was David Callender [MD, MBA, FACS].

Tacey Ann Rosolowski, PhD

[01:22:50]

OK.

[01:22:50]

Alma Rodriguez, MD

[01:22:47]

But he knew he was leaving, so he introduced me to Tom Burke.

Tacey Ann Rosolowski, PhD

[01:22:54]

OK.

Alma Rodriguez, MD

[01:22:55]

Who he knew was probably going to be—so that was a very interesting transition experience as well, because Tom Burke's role was an interim role. And he just asked me to take on some of his responsibilities so that I could help him do both jobs.

Tacey Ann Rosolowski, PhD

[01:23:11]

I'll be interested to hear about that! (laughter) So, I mean, just let me ask you question. So you had this conversation with Dr. Callender. You know, obviously, he was very open to the idea of you taking on this role. And why, what did he see in you? I mean, because obviously, I'm sure there could be any number of people interested in this role. So why you at that time?

Alma Rodriguez, MD

[01:23:37]

Well, I can't answer for him. But I can tell you that one of the things that I did, you know, and my relationship with Dr. Callender had been in my job as the Medical Director—

Tacey Ann Rosolowski, PhD

[01:23:48]

OK.

Interview Session: 02
Interview Date: March 6, 2015

Alma Rodriguez, MD

[01:23:50]

Of the lymphoma section. I think I was the only Medical Director that would, on a yearly basis, send him a report. (laughter)

Tacey Ann Rosolowski, PhD

[01:24:00]

The importance of documenting.

Alma Rodriguez, MD

[01:24:05]

Yes. I mean, I still have some copies of those reports. I mean, I took my job of, you know, observing what—remember I told you I would prepare these reports for my own peers.

Tacey Ann Rosolowski, PhD

[01:24:13]

Right.

Alma Rodriguez, MD

[01:24:15]

So-and-so, so many patients, so-and-so saw so many patients, this is how many, you know, on Mondays the clinic is overwhelmed with patients, but on Friday we don't have enough utilization of rooms. So let's try to reassign people, you know. So I would send yearly reports to him of, you know, this year we met the goal of blah blah, however, we fell short of blah blah. Next year we need more of this, you know, so I was always sending him reports that sort of justified whatever it was we were calling—we were asking for. I kept track of what I did. So I don't know if that had any influence, but certainly my name was known to him because I was sending him those reports.

Tacey Ann Rosolowski, PhD

[01:24:59]

Well, so it shows you're kind of on the wavelength—

Alma Rodriguez, MD

[01:25:04]

Yes.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[01:25:05]

—of sort of seeing things in a big perspective, and understanding the need to document of a wide variety of activities from different perspectives.

Alma Rodriguez, MD

[01:25:13]

Yes.

Tacey Ann Rosolowski, PhD

[01:25:15]

Very interesting.

Alma Rodriguez, MD

[01:25:17]

So my guess is perhaps that's what he thought. I truly don't know. Also, in my interim role as the chair, the transition for the department was really very challenging. There were lots of disruptions; I kept him and Dr. Kripke, who at the time was a provost, I met with both of them, apprised them of who were being difficult. We had had a challenge in the entire, well, the Leukemia Department had been shut down because their research protocols had been shut down because of some problem. So that brought the big light on lymphoma.

Tacey Ann Rosolowski, PhD

[01:25:58]

Oh, wow.

Alma Rodriguez, MD

[01:25:58]

(laughs) So suddenly all the hematology services are being looked at really critically. So I met with everybody, we sent reports. If there were things that were found wanting, we corrected them. I mean, I was, I think by my directorship role and my obsession for reports served me well in that role, because, you know, I wouldn't let things just sit. You know, if a response was needed to a certain thing that was brought to our attention, we would respond. I had a good administrator that was also helping me very much, certainly it's not just me. But we tried to keep things afloat through that transition period of a few years. And the department survived. (laughs) So I think that was—he was also aware of that.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[01:27:00]

Yeah. Yeah.

Alma Rodriguez, MD

[01:27:02]

So my guess is those qualities served to bring me to his attention.

Tacey Ann Rosolowski, PhD

[01:27:12]

It's always good to be a cool head in an emergency! (laughter) So you stepped in as interim Director of the Office of Medical Affairs in 2004.

Alma Rodriguez, MD

[01:27:19]

Correct.

Tacey Ann Rosolowski, PhD

[01:27:19]

And what did Medical Affairs look like at that time? Because I assume that in the last ten years, it's gone through significant changes.

Alma Rodriguez, MD

[01:27:33]

It has changed significantly, yes.

Tacey Ann Rosolowski, PhD

Yeah. So in 2004, was it—

Alma Rodriguez, MD

[01:27:34]

Well, essentially, I mean, the only charge that, or the aspects of the office that Dr. Burke delegated to me because he actually stepped in an interim role, when Dr. Callender left. He stepped in as the Physician in Chief. He still had the title of Vice President of Medical Affairs. I was only a Director, he delegated to me the title of Director, meaning I wasn't quite him. But I mostly focused—or he asked me to focus most of my oversight responsibilities to the credentialing privileging of Physicians to the Office of Credentials, and oversight of the Physician Assistant programs, which really there was no such thing as an office of Physician Assistant's programs, they actually all reported to me directly. And I learned a tremendous

Interview Session: 02

Interview Date: March 6, 2015

amount about Texas law, of which I was very ignorant, I must say. Not mostly, but I had huge gaps in my knowledge; I knew some, I knew enough, of course, to run the department and the clinic. But I learned much more in-depth all the regulations of medical practice, particularly in a hospital setting, which are huge, enormous. I mean, I was just overwhelmed. To this day, I'm still over—I am amazed that we float. (laughs) We float, despite all the regulations. So I did a very in-depth learning of the laws and regulations that govern medical practice, I familiarized myself with what Physician Assistants were, the rules and regulations that govern them. I learned also a great deal about Advance Practice Nurses, because they were also privileged to practice at the hospital, so oversight—they are governed by a totally different board. Both Physician Assistants and Physicians are governed by the Texas Medical Board. But the Advance Practice Nurses are governed by the Board of Nursing. And oh my God, if the Medical Board has complex rules, the Board of Nursing is unbelievably more complex.

Tacey Ann Rosolowski, PhD

[01:30:16]

Can you give me an example of a rule that's complex? Sort of amazingly so?

Alma Rodriguez, MD

[01:30:19]

For nursing? No, I can't—

Tacey Ann Rosolowski, PhD

[01:30:21]

Either one. (laughter)

Alma Rodriguez, MD

[01:30:24]

I do not even want to remember reading all of that.

Tacey Ann Rosolowski, PhD

[01:30:26]

OK.

Alma Rodriguez, MD

[01:30:27]

OK? But so, in medical practice, for example, there is a whole list of rules about how Physicians or who is worthy of getting a license in Texas.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[01:30:41]

Oh, OK.

Alma Rodriguez, MD

[01:30:43]

OK? You had to have gone to a medical school that's recognized by the Board, you have to have had training, post-graduate training completed. You have to have confirmation of that training. In fact, you even have to have transcripts all the way back to high school to confirm you are who you are. You have to be in good standing. You cannot have any criminal activity, you know, etc., etc. It becomes really convoluted for people who come from outside of the state, and most—and largely so for people who are trained outside of Texas, outside of the U.S., OK? There are different kinds of licenses. And each of them has a different set of forms that need to be submitted. We have a number of people who want to come as visiting professors—well, they have to go through a certain set of paper trails that we have to manage for them. On and on.

Tacey Ann Rosolowski, PhD

[01:31:50]

I mean, I'm sure the legislature has one answer to this question, but I want you to answer this question. Why is that important?

Alma Rodriguez, MD

[01:31:59]

Well, it's important to safeguard the larger community, to ensure that, frankly, we're not quacks. Because anyone can falsify documents, right? And in fact, it has happened. So I see why they have built all of those rules and regulations; I think in today's environment of electronic databases and so on, it might make it simpler for the physicians to jump through all those hoops. But it has been rather difficult. I mean, I'm not kidding about you have to have your transcripts, your grades, your original diploma, your etc., to show the Board to get your initial license. Now, once you've gotten your initial license, then it becomes much easier. You simply submit a whole pro forma every so many years. It's still a very large, long document. But thankfully they keep a template of what you submitted the last year, so you can copy it all over again, because things don't change that much from year to year, right?

Tacey Ann Rosolowski, PhD

[01:33:20]

Right.

Interview Session: 02
Interview Date: March 6, 2015

Alma Rodriguez, MD

[01:33:22]

So but yes, so all of that. Now, internally, hospitals have to have, and it's not just from the state, but it's from the federal government. We have to have oversight of the credentials of individuals. So the state has its own rules for granting licenses and renewing licenses. Internally, each hospital has to have what is called a credentialing process. So that's the office that I was overseeing, the Office of Credentialing. And we, ourselves, have to do due diligence. We have to track on national databases, the national provider database has to have any actions, lawsuits, loss of privileges, and other adverse events being reported for this particular person. We have to search criminal databases, has this individual been charged, not only criminal in terms of the state, for example, but also at the federal level. We have found cases, for example, where the FBI is investigating someone for fraud, or because of violations of narcotics prescriptions, or etc. You know, so we do occasionally find those. It's rare, thankfully. It's rare, but it does happen. We have had people send us false documents, and we confirm all of that. So somebody sends us a certificate for their board certification, we confirm that by going to the Board and saying, is provider so-and-so, certificate number so-and-so, certified by you?

Tacey Ann Rosolowski, PhD

[01:35:10]

Wow.

Alma Rodriguez, MD

[01:35:10]

I this particular case, they said, "Oh my God, we've been looking for that certificate for years. Send it to us immediately."

Tacey Ann Rosolowski, PhD

[01:35:20]

It was a stolen certificate? Wow!

Alma Rodriguez, MD

[01:35:25]

So, you know, it does happen. So that's the reason why there are rules like that. We wish humanity was peerless, and we wish physicians were above misconduct, but, you know, we're humans.

Tacey Ann Rosolowski, PhD

[01:35:43]

Right.

Interview Session: 02
Interview Date: March 6, 2015

Alma Rodriguez, MD

[01:35:42]

So it happens.

Tacey Ann Rosolowski, PhD

[01:35:44]

And it does seem like it's remarkably rare.

Alma Rodriguez, MD

[01:35:44]

So and then, of course, we also look at the Texas Medical Board to see if any complaints have been filed by patients or peers against that individual. So we do all of that on a continuous—well, not a continuous basis, but on a yearly basis to ensure that everyone's information is up to date. Now, it is then up to me, if those issues float up, then I communicate that, share that with the chairs of the departments and say, "Are you aware that this is going on?" Because remember I said it's one of the toughest jobs, it'll be that chair's responsibility then to say how they're going to address that issue. Now, some of those issues may, because of the bylaws or the rules and regulations of the state, or whatever, may end up in termination. That, again, is extremely rare. But it could be a consequence. So we don't take this as a trivial exercise at all.

Tacey Ann Rosolowski, PhD

[01:36:48]

Right. Right. And a lot of states—

Alma Rodriguez, MD

[01:36:50]

It's very serious.

Tacey Ann Rosolowski, PhD

[01:36:53]

—in the United States. Yeah. Well, Dr. Rodriguez, we're almost at noon, and I want to make sure you get to your lunch and meeting.

Alma Rodriguez, MD

[01:36:58]

OK, thanks.

Interview Session: 02
Interview Date: March 6, 2015

Tacey Ann Rosolowski, PhD

[01:37:00]

So why don't we close off for today, and then I'll look forward to continuing our conversation at a later time.

Alma Rodriguez, MD

[01:37:05]

OK.

Tacey Ann Rosolowski, PhD

[01:37:07]

Thank you very much. And I am turning off the recorder at about 11:58. Thanks very much.

Alma Rodriguez, MD

[01:37:10]

Thank you.

Alma Rodriguez, MD

Interview # 61

Interview Session Three: 1 May 2015

Chapter 00C

Interview Identifier

Tacey Ann Rosolowski, PhD

[00:00:00]

All right. OK, so our counter is moving, and we are recording. And it is 10:23 on the 1st of May, 2015. And I'm Tacey Ann Rosolowski. Today I'm on the 18th floor of Pickens Tower in the Office of Medical Affairs, or actually in the Physician in Chief's Office.

Alma Rodriguez, MD

[00:00:21]

Suite.

Tacey Ann Rosolowski, PhD

[00:00:21]

Suite, yes, interviewing Dr. Alma Rodriguez. This is our third interview session together. So thanks for making the time.

Alma Rodriguez, MD

[00:00:26]

Oh, not at all. My pleasure.

[00:00:31]

Interview Session: 03
Interview Date: May 1, 2015

Chapter 16

The Office of Medical Affairs: Credentialing, Quality Indicators, and Building a Culture of Improvement and Quality Care

B: An Institutional Unit;

Story Codes

- A: The Administrator;
- B: Building/Transforming the Institution;
- B: Multi-disciplinary Approaches;
- B: Growth and/or Change;
- B: MD Anderson and Government;
- C: Understanding the Institution;
- D: The History of Health Care, Patient Care;
- D: On Care;
- C: The Life and Dedication of Clinicians and Researchers;

Tacey Ann Rosolowski, PhD

[00:00:31]

We started talking last time about—well, we talked about the survivorship program, which I guess is part of the Office of Medical Affairs. But we hadn't really talked about the office in general. And so I wondered if you could start off that discussion by telling me what's the mission of Medical Affairs, and what's your philosophy, what was your philosophy as you took the office as a Vice President.

Alma Rodriguez, MD

[00:00:58]

Well, the core, really, the core responsibility of the Office of Medical Affairs is to oversee that the Physicians and Physician Assistants, as well as other licensed independent providers who provide the care for our patients are truly competent individuals; that they indeed have the appropriate—that they're legitimate, that they have the appropriate credentials that they say they do, and that they have a track record of competence. So part of our job, a very core part of our job is to perform the function of credentialing, what is called "credentialing," and that is to confirm and verify that individuals who are working at this organization, MD—and who are what are called independent providers, that is, the professionals who are licensed to provide medical care, Physicians, mid-level providers, psychologists, physicists, etc., that they're all, indeed, well-trained, that they meet the competent standards of the organization. That's step one. And secondly, added onto that, since 2009, we also established a process of what we call ongoing professional evaluation. And so we had to build the infrastructure, measurement of

Interview Session: 03
Interview Date: May 1, 2015

metrics, decision on metrics across the organization to follow and monitor performance, etc.

Tacey Ann Rosolowski, PhD

[00:02:32]

Why was that—why did that happen in 2009? What was going on at the time?

Alma Rodriguez, MD:

[00:02:38]

Well, the Joint Commission, which is one of the main accrediting bodies for health organizations in the United States, as part of an over—really, it's a national movement that began even before 2009, even further back. The issues of quality of healthcare were being discussed, that it wasn't enough to simply provide healthcare, but that we should look at what is the quality of the healthcare we provide. And there are a number of national indicators that apply to general hospitals, cancer care hospitals were somehow exempt from that and still are; some cancer centers are still exempt from that, although that's changing as well.

Tacey Ann Rosolowski, PhD

[00:03:23]

Why is that? I mean, I don't, I hope that's not too much of a [inaudible].

Alma Rodriguez, MD

[00:03:28]

Well, cancer hospitals are not general hospitals.

Tacey Ann Rosolowski, PhD

[00:03:31]

Oh, OK.

Alma Rodriguez, MD

[00:03:32]

We have a very unique and different category of patients, or sub-type of problems with our patients that are not common in the general population. I mean, and general hospitals deliver services that are mostly directed at the more common illnesses; cardiovascular disease, diabetes, infections and other conditions of aging, as well as healthcare for delivery of babies, etc. So we are sort of a bit off the beaten track. And also you must remember that until the 1960s, most patients who had cancer died of the disease, so it was considered a terminal condition anyway. And how do you build quality indicators around terminal conditions, you know, and so on. So for the longest time, now that we are successful, and now that we know that there is a significant probability of survival for many, many patients with cancer, now the question is, are you doing

Interview Session: 03
Interview Date: May 1, 2015

curative treatments, you know, what are the best standards for curative treatments? Are you doing them according to the standards, and so on and so forth. So in any event, they are now—there's now this movement to apply what are called "quality indicators" to all providers across all professions, regardless of the specialty, and we are not exempt from that. So we monitor, like I said, ongoing professional performance indicators. It's one of our requirements for credentialing from the Joint Commission. That's part of our job, as well. That's one of our tasks. And it sounds very simple, but it's not. It's rather complex.

Tacey Ann Rosolowski, PhD

[00:05:26]

What are some of the complexities that arise in that kind of valuation?

Alma Rodriguez, MD

[00:05:28]

Well, where do you get the data? That's complexity number one. How do you measure these endpoints? Which are the valid endpoints to measure? What are the appropriate endpoints to each specialty? What are appropriate endpoints that apply across the board to everyone? So a very simple measure that applies to everyone across the board is, do your patients complain about you? (laughs) And how often, how many times? That's one, for example. So in any event, so there's—another one is, what's the—for surgery, what's the mortality of your surgical interventions? How many of your patients die from the surgical interventions? How many of your patients have infections after surgery? How many of your patients—in general, across the board, how many of your patients that you admitted to the hospital that are discharged, how many end up coming back into the hospital within forty-eight hours, meaning probably there was a bad judgment call on their readiness to leave the hospital. So those are—I'm just explaining, you know, the—but it takes a lot of dialog, a lot of discussion, a lot of soul-searching, quite frankly, on our part, as well as the part of administrators, to say what really does matter.

Tacey Ann Rosolowski, PhD

[00:06:56]

Yeah.

Alma Rodriguez, MD

[00:06:57]

What is the—you know, what matters when you give healthcare?

Tacey Ann Rosolowski, PhD

[00:07:00]

Well, I was going to ask you, because it sounded, with some of the issues that you were raising,

Interview Session: 03

Interview Date: May 1, 2015

that by asking those questions, you're starting to create kind of a cultural change in an organization that delivers healthcare. And I'm wondering, you know, has there been resistance to that? Have there been philosophical discussions? You know, what's been the reaction, you know, of different generations of care providers here at MD Anderson, as they have engaged with those questions?

Alma Rodriguez, MD

[00:07:25]

Right. Well, it depends, as you said, on the specialty and on the generational boundaries, if you will, of the groups that are engaged. Some sub-specialties have been, by the nature of their specialty, are very familiar and very engaged, and in fact welcoming of indicators. One specialty that, for really decades, has been striving to improve its outcomes is anesthesia. You know, they have to shepherd the patient, if you will, through the whole process of the surgical intervention. They must keep them free of pain, but yet they must keep their vital signs and their vital organs functioning properly and appropriately. They must bring the patient out, hopefully with not too many side effects from the anesthetic. So they've been monitoring that for a long time, I mean, literally decades, have had internally-driven quality endpoints that they measure.

But for other organizations, for example, medical oncology, it's very difficult to determine, or it has been difficult to determine what are best measures. One of the national organizations called the American Society of Clinical Oncology recently, over the last ten years, finally started to establish some endpoints of quality through a program they call the Quality Oncology Performance Initiative. And they've, again, had their own committees internally to decide what might be indicators and so on, but it's not a widespread practice. And some institutions have embraced that, others have not. For us, for example, we have not been following those indicators for medical oncologists for the main campus, whereas in the community clinics, our outreach clinics, do follow those indicators. So even within an organization you can have subsets of individuals who embrace the culture, if you will, of self-measurement, versus others resist it. Our surgical colleagues, there's been a national movement to measure surgical endpoints, and again, initially, very resistant. Our internal culture was very resistant to it.

But we had some young people within the organization who had had experience with the national indicators at their own training programs outside of MD Anderson, and they championed it. They said, "Oh, this is good for us." And now that we've had the so-called National Surgical Quality Indicator Program, the NSQIP program, embedded in the organization, now everybody wants to know what their NSQIP indicators are in the surgical world. So it's interesting. I mean, it does take time. It takes having champions, people who understand the objectives, the goals of such processes, and who are able to speak to them and speak about them in a way that is not threatening, in a way that is supportive of the practitioners, in a way that

Interview Session: 03

Interview Date: May 1, 2015

really empowers the practitioners to look at their own practice. The whole field of quality endpoints is supposed to have underlying it a culture or a philosophy of improvement, not of punishment. Not of punitive measures, or rather self-assessment and self-improvement. Having said that, the tradition in medicine for many generations has been one of, for lack of a better word, you know, of shaming and punishing those that don't perform up to standards. And so, I mean, it's also embedded in our culture, the whole litigious environment of malpractice. It's not about 'let's learn from this unfortunate adverse event,' it's 'let's see how much money we can milk out of the hospital and the doctor' kind of attitude. So it's not, for better or worse, a culture in the United States does not support, you know, this whole movement of self-improvement and quality. Having said that, there have been some—in some states, there have been seminal legislature that is helping to support that. And Texas is one of those states. It's not well-known, but it is one of those states; it has tort reform, it limits amounts of malpractice. For example, it limits—in general, it has moved towards a culture of supporting physicians' improved practice, rather than just have punitive outcomes. But nonetheless, that still has not left us, I mean, it still exists. You know, the whole negative attitude still exists.

Tacey Ann Rosolowski, PhD

[00:13:04]

When I was doing your background research, I'm trying to remember, I know I was doing some work with someone's background, and I read the phrase "appreciative inquiry." Were you the person who was work—were you working at all with appreciative inquiry, and—I was just curious because that's obviously very much based on self-improvement—

Alma Rodriguez, MD

[00:13:22]

Correct.

Tacey Ann Rosolowski, PhD

[00:13:25]

—and self-evaluation moving to self-improvement.

Alma Rodriguez, MD

[00:13:25]

Correct. I mean, that essentially the intent of, we hope, of the entire, if you will, culture of medicine, moving forward. It has to shift, really, from this adversarial relationship between society, the environment, the patients and the Physicians. And what is most—what is really tragic and what is very paradoxical is that most patients do not want to have an adversarial relationship with their Physician or with the healthcare institution that provides care for them. And but it always—it's just the negative few, or the few rotten apples, so to speak, that can spoil

Interview Session: 03
Interview Date: May 1, 2015

the entire barrel.

Tacey Ann Rosolowski, PhD

[00:14:26]

Right.

Alma Rodriguez, MD

[00:14:26]

You know, so—

Tacey Ann Rosolowski, PhD

It's also a mindset, you know?

Alma Rodriguez, MD

[00:14:30]

It's a mindset, yes.

Tacey Ann Rosolowski, PhD

[00:14:32]

I think there are some people who, just as individuals, you know, don't have that mindset to say, well, I'm going to take some kind of negative event and then turn it around and learn and move forward from it.

Alma Rodriguez, MD

[00:14:42]

Correct.

Tacey Ann Rosolowski, PhD

[00:14:42]

They process that information differently.

Alma Rodriguez, MD

[00:14:46]

Differently.

Tacey Ann Rosolowski, PhD

[00:14:46]

Emotionally, in terms of data, I mean, all kinds—

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[00:14:47]

Intellectually, and so on.

Tacey Ann Rosolowski, PhD

[00:14:47]

Yeah. Yeah.

Alma Rodriguez, MD

[00:14:48]

Yes, of course.

Tacey Ann Rosolowski, PhD

[00:14:51]

Yeah, very interesting. Now, I kind of derailed you with that discussion about culture. Were there more things evolving from that initiative that this office has taken on to create those measures, just so we complete that story at the administrative level?

Alma Rodriguez, MD

[00:15:04]

Well, so we created—I mean, to do all of that requires, you know, really a large infrastructure; you have to have, as I said, data sources. So we had to look at our data sources. I had to build partnerships with the Office of Performance Improvement, because the measurement engineers are in the Office of Performance Improvement; they don't report to me. So looking, or building alliances with the right groups of people was important, and then realizing again that there is no one individual that can truly understand the complexity of each of the domains of medical practice. Essentially, within each of the domains of practice, there have to be internal content experts, or experts in what matters to that profession. So we also developed policies and processes and established, implemented, the development of a Quality Officer role within each of the clinical departments, so that those individuals would carry out, then, this function of oversight of specific indicators.

Now, some departments again have taken it on very, very seriously, versus others. Some departments have extremely robust processes to share the data internally, discuss it amongst themselves if there are adverse events, that there's a methodology for, if you will, [inaudible], doing a tracer for the events, what happened here, where did things go wrong, what needs to be fixed so it doesn't happen again. And usually, those have been the procedural departments, if you will, like [Department of] Pulmonary Medicine, [Department of] Gastroenterology, because they have to understand the methodology—you know, what occurred during the procedural care

Interview Session: 03
Interview Date: May 1, 2015

delivery that maybe can be done better. Others have taken a more lackadaisical attitude, and have said oh, well, that's just a Joint Commission requirement, it's not about us. You know? (laughs) So we have a very divergent, at this point in time still quite divergent group of quality officers, some of whom are extremely and highly engaged and knowledgeable about what it means to have self-assessment and quality oversight and others that are very peripheral to the process. (pager is heard)

Tacey Ann Rosolowski, PhD

[00:17:49]

Should I pause for a moment?

Alma Rodriguez, MD

[00:17:53]

Let me just see if this is a critical page or not. Message, oh—they're just telling me I'm covering someone. OK. Somebody else's pager is being dropped onto my pager. So anyway, so that was another initiative, so getting the department chairs engaged in appointing such an individual. Some department chairs have said this is a waste of time, others have said oh my gosh, it's about time we did this. So again—

Tacey Ann Rosolowski, PhD

[00:18:30]

Huge range of reactions.

Alma Rodriguez, MD

[00:18:31]

Yes. A whole range of reactions. But slowly, slowly I'm seeing a shift towards a—the number of individuals who say this is important is becoming larger and larger. So that's encouraging. And it's very timely, because on the national scale, like I said, you know, starting this year, we will be required to report what are called the Physician Quality Report Indicators, PQRIs. And it will be publicly reported in a federal domain on one of the federal Websites, anybody can go and look at their Physician's quality scores.

Tacey Ann Rosolowski, PhD

[00:19:32]

Wow. Wow. Wow, I'm sure that's making some people mad and leaving them shaking in their boots—

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[00:19:38]

Yes.

Tacey Ann Rosolowski, PhD

[00:19:39]

—or saying OK, huh, good shift—

Alma Rodriguez, MD

[00:19:43]

A lot of them are annoyed. It's going to be a very big challenge. So they're starting off, of course, first of all, with organizations that have large numbers of physicians in their organization, because they understand that those are the organizations that are likely going to have the measures or the numbers or the data sources to measure. But it's gradually moving to every single physician in the United States, even if they have a single office, single physician, single office practice. They're going to have to figure out how they're going to track their own measures of practice quality—

Tacey Ann Rosolowski, PhD

[00:20:12]

Interesting.

Alma Rodriguez, MD

[00:20:16]

—to report.

Tacey Ann Rosolowski, PhD

[00:20:16]

Wow.

Alma Rodriguez, MD

[00:20:17]

So, more to come.

Tacey Ann Rosolowski, PhD

[00:20:21]

Yeah.

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[00:20:22]

It's a shift in the national healthcare scene, as well as a change in the internal environments of all organizations that deliver healthcare.

Tacey Ann Rosolowski, PhD

[00:20:38]

Very interesting story.

Alma Rodriguez, MD

[00:20:40]

So that's, you know, that's a core function of our organization, do we have the right people delivering the right care? And are they doing it well?

Tacey Ann Rosolowski, PhD

[00:20:49]

Yeah.

Interview Session: 03
Interview Date: May 1, 2015

Chapter 17

The Office of Medical Affairs: Patient Concerns, Patient Advocacy, Conflict Resolution

B: An Institutional Unit;

Story Codes

A: The Administrator;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Understanding the Institution;
D: The History of Health Care, Patient Care;
C: Offering Care, Compassion, Help;
C: Patients;
C: Cancer and Disease;
C: Patients, Treatment, Survivors

Alma Rodriguez, MD

[00:20:51]

That's our responsibility. Secondly is to ensure that we are also providing our patients with the opportunity to voice their complaints or their dissatisfaction, and that we also support patients when they have concerns about whether their care has been appropriate or ethical. So to that end, I also oversee the Clinical Ethics Group, the Physician Advocacy Group—

Tacey Ann Rosolowski, PhD

[00:21:33]

And that's all part of this office?

Alma Rodriguez, MD

[00:21:37]

Mm-hmm [affirmative]. I have a Conflict Resolution Advocate. And we also formed a group called—a council called the Psychosocial Council that brings to the table, really, all the domains of practice that somehow touch on psychosocial care. For example, psychiatry, psychologist or behavioral medicine, social workers, patient educators, integrated medicine services, etc. So we bring all these individuals to the table and we talk about, you know, what would be important processes for us to improve; what's a key issue that we should be addressing. And again, from the national perspective, one of the endpoints of quality, actually, that organizations are going to be asked to report is on whether we are assessing patients for distress, and how we are addressing

Interview Session: 03
Interview Date: May 1, 2015

distress. Now, that's a very—the word “distress” is very general. I mean, people can be distressed due to physical symptoms, but they can also be distressed due to emotional issues or economic issues or social issues, or their transportation—so it is so broad, that it is very hard to put one's arms around it. But nonetheless, you know, there's some—there's some initiatives that have attempted to build, if you will, boundaries around what—how do you ask patients about distress, and what might be some of the domains of distress that are most common that should be addressed? It turns out the most common domain of distress is usually the patient has anxiety about their test reports. And once they've seen the doctor and gotten their test reports, they feel better. But then there's the others that have true emotional distress or spiritual distress, or socioeconomic distress. And those domains of care really are not—you know, the Physicians are not going to be the best to provide support for those initiatives, or for that category of distress. So integrating what we call psychosocial services into the delivery paradigm in cancer care is important. So—

Tacey Ann Rosolowski, PhD

[00:24:24]

Have you seen, with the issues of patient distress and psychosocial issues, have you seen changes in the issues that are stressing patients over the course of ten years that you've been with the office?

Alma Rodriguez, MD

[00:24:39]

Not really. So, I'm going to talk about the complaints more than the distress issue, because the distress question is something we push out to the patients. The complaints are something the patients initiated.

Tacey Ann Rosolowski, PhD

[00:24:56]

Yes.

Alma Rodriguez, MD

[00:24:59]

So those are more, if you will, objectively measurable. So the most common, and still persistent issue with patient complaints is communication. And despite the fact that we now have all kinds of devices to communicate, it still remains the same thing. And part of it is—paradoxically, I think what may be happening is that the expect—people, the expectation that people have now, given that everybody emails and texts everyone everywhere on the planet, the expectation is almost that there will be an immediate response. Well, we wish we could respond to everyone, but the truth is, I am sitting here right now talking to you. If this had been somebody just

Interview Session: 03
Interview Date: May 1, 2015

wanting to know am I going to be at such-and-such a meeting at such-and-such a time, I'm not going to call them back.

Tacey Ann Rosolowski, PhD

[00:25:54]

Yeah.

Alma Rodriguez, MD

[00:25:54]

I'm not going to answer to them. I'm here to talk to you. I'm here for you. You're here. They're not. They're home or at another office, or whatever. So the social expectation of what is appropriate timeliness to communication has eroded. I mean, people used to be patient and thoughtful, I think that that's eroding. (laughs) I think patients and thoughtfulness are eroding in our culture. And so how are we going to resolve that? I don't know. I don't think that there are any good solutions to that. And what is unfortunate is that this continuous barrage of asking, asking, asking puts those individuals who truly should be listened to immediately, puts them at risk.

Tacey Ann Rosolowski, PhD

[00:26:53]

Yeah, because they're just lost.

Alma Rodriguez, MD

[00:26:55]

They're lost in the noise, OK?

Tacey Ann Rosolowski, PhD

[00:27:01]

Yeah. Yeah.

Alma Rodriguez, MD

[00:27:00]

And we have not yet come up with a good solution to the true triaging, if you will, of what requires immediate response, versus not. I think this will only—I mean, this will take some time, some evolutionary process, I think, that we'll leave the communication experts to tell us, to look, perhaps, for certain clues, certain terminology. But it's interesting because patients get wise to that. And we knew this even way—I mean, it's well-known in the pain literature, for example, so there are people who have true pain, and then there are people who are drug seeking. And how do you distinguish? I mean, it's really very difficult, because pain is a purely verbalized—

Interview Session: 03
Interview Date: May 1, 2015

there's no objective measure of pain. Although I have to say people who are truly in pain also have vital sign changes that go along with that. But then there's also the so-called adaptation to pain, so over time, the body becomes adapted to pain. And then the vital sign signals are not there.

Tacey Ann Rosolowski, PhD

[00:28:21]

Yeah, that's the normal.

Alma Rodriguez, MD

[00:28:24]

So how do you know when people are really in pain? You have to go by what they say. And so again, in the noise of the saying, the pain seekers or the drug seekers versus the truly ill patients—you know, the signals are very difficult to interpret. So we know from that discipline that it is very, very difficult to separate signals of true distress from just demanding people. It's going to be difficult. So that's one of the challenges we face, quite frankly. That is still the number one complaint. And true complaints about the quality of care are relatively small, compared to the volume of just the "You didn't answer my phone call," "You didn't tell me about this," "The timing on my card for the appointment was wrong," I da da da da, da da da da da."

Tacey Ann Rosolowski, PhD

[00:29:23]

Yeah.

Alma Rodriguez, MD

[00:29:23]

It's continuous, continuous—

Tacey Ann Rosolowski, PhD

[00:29:25]

All the little things that seem overwhelming to people when they're going through the cancer process. But not really, in the grand scheme, essential—

Alma Rodriguez, MD

[00:29:31]

Correct.

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[00:29:36]

—situations.

Alma Rodriguez, MD

[00:29:36]

Correct. And that, unfortunately, can derail a relationship.

Tacey Ann Rosolowski, PhD

[00:29:39]

Yeah.

Alma Rodriguez, MD

[00:29:40]

It can derail, if you will, the harmony of relationship between the patients and the providers.

Tacey Ann Rosolowski, PhD

[00:29:49]

Yeah. Yeah.

Alma Rodriguez, MD

[00:29:49]

And that's unfortunate.

Tacey Ann Rosolowski, PhD

[00:29:52]

What about on the issue for advocacy for Physicians?

Alma Rodriguez, MD

[00:29:58]

Very interesting question. Are you asking do we have a body of people who advocate for the physicians? Or—

Tacey Ann Rosolowski, PhD

[00:30:05]

Yeah. You said that there was a Physician Advocacy Group.

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[00:30:09]

No. It's a Patient Advocacy Group.

Tacey Ann Rosolowski, PhD

[00:30:10]

Oh, a Patient Advocacy Group. I'm sorry.

Alma Rodriguez, MD

[00:30:13]

Yes.

Tacey Ann Rosolowski, PhD

[00:30:15]

So that's why—but maybe we could talk about the two halves of that coin.

Alma Rodriguez, MD

[00:30:22]

Well, you know, they are an incredibly important group of people. And they put up with a lot of stress. I mean, they face a lot of stress.

Tacey Ann Rosolowski, PhD

[00:30:29]

I mean, are you talking about the physicians?

Alma Rodriguez, MD

[00:30:32]

The advocates.

Tacey Ann Rosolowski, PhD

[00:30:33]

The advocates. OK.

Alma Rodriguez, MD

[00:30:34]

And the advocates have to balance between what is a legitimate issue that the patient is facing, that we, you know, that requires immediate attention, versus what might be unrealistic expectations, what might be, in fact, what make—and it does happen—what might be in essence,

Interview Session: 03

Interview Date: May 1, 2015

unfortunately, an abusive patient that is making unrealistic demands of their provider, in which case, then, we have to take a stance for advocating for the Physician rather than the patient. And that's incredibly—that's an incredibly tough job, and requires a number of processes of discourse within the advocacy group. Some of them float up to my office personally, some of them—most of them, actually, they resolve themselves. There are some really interesting issues in oncology. I mean, it's true in healthcare in general in our country. But oncology, in particular, and for our organization, because we get referrals of patients who have been treated already by their community oncologists, and they're failing treatment. Well, I'm going to rephrase that, because the patients, obviously, would never want to fail the treatment. But their cancer is not responding to the treatment.

[00:32:22] So the patients get sent to us, and the patients expect, or hope, that we're going to tell them differently, that there is something else that can be done, and that it will work. But unfortunately, that is not the case for many, many, many patients that are referred to us. I mean, that's just a reality. And often, these individuals have invested a great deal of resources, both emotional psychological and economic to get here, and to hear the same narrative from us as they heard from their oncologist at home sometimes makes them very unhappy. Sometimes, frankly, abusive. And it makes, then, the dialog difficult. It makes the experience very difficult. If you ask any of the physicians here what is their biggest stressor, it is that. How to have the difficult conversations with patients who are not ready to hear that their disease is not going to have a favorable outcome. And although, there's a lot of literature about how we should and must be having these poor prognosis conversations with our patients. In fact, one of the quality indicators is, have you discussed with your patient within the first three office visits about advanced directives?

Tacey Ann Rosolowski, PhD

[00:33:56]

Right.

Alma Rodriguez, MD

[00:33:58]

Which the patients immediately interpret as, "You're telling me that I'm dying, right?"

Tacey Ann Rosolowski, PhD

[00:34:02]

Right.

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[00:34:04]

Which is not the case. For newly-diagnosed cancer patients, that's not the case. You know, more than two thirds of newly-diagnosed cancer patients are going to be well. It's the patients who come with recurrence of disease and/or multiply treated—multiple treatment events, those are the patients who really are not likely going to do well.

Tacey Ann Rosolowski, PhD

[00:34:22]

Well, with any, you know, with any topic that has a really big emotional charge to it, you have to plan very carefully how you situate that conversation in the midst of many other conversations.

Alma Rodriguez, MD

[00:34:39]

And that's the interesting thing. And so it is why it's so interesting to me that there is now almost a mandate that we must do this. And the mandate is being placed upon the physicians. I don't know if the public knows that, but it's one of the national quality indicators for oncologic care. And so, as you said, you know, how do you do that in the midst of time pressure, volume pressures? You must—you know, patients have to be seen within a certain timeframe because there's only so many rooms, right? So many hours in the day. And there are twenty patients who expected to be seen today by you, so how do you carefully orchestrate, and time, and so on? That's the biggest stressor for Physicians today in our practice. How to have the time to have the meaningful conversations when they are appropriate, how to deal with the patients who are not ready to hear them. And how and where are those conversations best done when we do have certain external pressures.

Tacey Ann Rosolowski, PhD

[00:35:57]

And I'm even thinking, you know, backing up a few years and saying, well, how do you get the skills to have them? I mean, those are special conversations. And you know, you have to be able to bring those issues up and read people's body language cues and all those non-verbal cues in a conversation that can help you help a person process that information. And—

Alma Rodriguez, MD

[00:36:24]

Well, and that's even a larger and more complex issue, which goes back to how do we select individuals for healthcare professions. And up until now it has been, or even now in most medical schools, the overriding criteria are about academic performance, they're not about communication skills or personal skills.

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[00:36:43]

Right.

Alma Rodriguez, MD

[00:36:45]

Personal interaction skills. And yet, progressively, or most critically, that's going to be an essential element.

Tacey Ann Rosolowski, PhD

[00:36:59]

Interesting.

Alma Rodriguez, MD

[00:37:02]

So very challenging.

Tacey Ann Rosolowski, PhD

[00:36:59]

Yeah, very challenging, but a fascinating area that's emerging. And this role, these advocacy groups, they were formed when?

Alma Rodriguez, MD

[00:37:13]

Patient advocacy has been around for a long time. They precede me. When I joined MD Anderson, we already had Patient Advocates in this organization. I don't know exactly the history as to how far back it goes. But I know it was well—you know, I came in here in the late 1980s, they were already here.

Tacey Ann Rosolowski, PhD

[00:37:35]

Yeah. I see.

Alma Rodriguez, MD

[00:37:37]

So—and over time, we have expanded the numbers, obviously, as the organization has grown. And we are focusing more and more, as you said, on the issues of how do we select, you know, personal communication skills, if you will, certain philosophical perspectives. I mean, these are

Interview Session: 03
Interview Date: May 1, 2015

individuals who have to be well—for lack of a better word—well-balanced. They have to have some skills for self-care, so that they are not overwhelmed by the task at hand, and so on.

Interview Session: 03
Interview Date: May 1, 2015

Chapter 18

Creating MD Anderson's Practice Algorithms; On Blending Art and Science in Medical Practice: Practice Algorithms and Targeted Therapy

B: Building the Institution;

Story Codes

B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
C: Understanding the Institution;
C: Professional Practice;
C: The Professional at Work;

Tacey Ann Rosolowski, PhD

[00:38:29]

Yeah. Interesting. Other areas of function within Medical Affairs—

Alma Rodriguez, MD

[00:38:34]

Well, you mentioned the issue of the algorithm. So of course, you know, I said it's really important that we have the individuals with the right credentials and the appropriate competence to perform the job. We also want to provide them with the right tools to perform their job.

Tacey Ann Rosolowski, PhD

[00:38:53]

Hmm, OK.

Alma Rodriguez, MD

[00:38:58]

And so it became apparent, even predating my coming into this role, somewhere in the 1990s, there was a movement nationally as well to establish what were called "pathways of care," and this was particularly true in surgery where, again, organizations, just HMOs [Health Maintenance Organizations], and so on, were pushing for the delivery of care within X-number of days, within X-number of hours, and you know, the whole trend to efficiency in how patients were moved through, if you will, moved through the system of the hospital or the clinics.

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[00:39:46]

And I guess standard it too—

Alma Rodriguez, MD

[00:39:47]

Standardizing it—

Tacey Ann Rosolowski, PhD

[00:39:51]

So you realize what you're paying for.

Alma Rodriguez, MD

[00:39:55]

Exactly. Exactly.

Tacey Ann Rosolowski, PhD

[00:39:52]

Yeah, OK.

Alma Rodriguez, MD

[00:39:55]

So even back then, there was some movement to start to begin to look at the processes of delivery within the organization. Nothing much happened out of that, other than some groups did map out what their care processes were. But eventually, when I was assigned to this role, I realized that on a national scale, we also were beginning to talk about algorithms of care, actually they were called “guidelines,” guidelines of care. And there's a whole debate around the terminology, what is a true guideline, what is a pathway? We chose to call our maps of care “algorithms,” because essentially, it was, like, if this, then that. If that, then this. You know, so it gave essentially a map. Essentially we mapped out processes of care. And within those maps of care, there were unique focus areas that we felt needed a deep dive in, particularly all the domains that had to do with the delivery of chemotherapy.

Tacey Ann Rosolowski, PhD

[00:41:11]

Can you give me an example of what one of these algorithms might look like?

Alma Rodriguez, MD

[00:41:14]

Interview Session: 03
Interview Date: May 1, 2015

Oh, I can show you on our Website—

Tacey Ann Rosolowski, PhD

[00:41:17]

Oh, sure.

Alma Rodriguez, MD

[00:41:18]

If you want to see them.

Tacey Ann Rosolowski, PhD

[00:41:19]

And then actually, if you could, then maybe I could ask—I'll remind you to maybe send me a shot of it so that we could—

Alma Rodriguez, MD

[00:41:26]

So when will—

Tacey Ann Rosolowski, PhD

[00:41:26]

And ooh, so we're worried about our recorder, here—

Alma Rodriguez, MD

[00:41:30]

Well, I think this one has a—or some of these [inaudible]. So let me show you here in this book, textbook that we published on cancer survivorship— We developed algorithms for survivorship care, of course. So today, we have algorithms of care for several domains of care; for cancer treatment, for survivorship, for prevention and for what we call “supportive care,” or, “medical supportive care,” I forget what the subheading is. But it's about managing other associated problems, such as preventing thrombosis, prophylaxis for deep vein thrombosis, management of pneumonias, whether they are related to community infections or hospital-acquiring infections. Management of chest pain and myocardial infarction, and so on, so that we are taking into account the more common complications we see, as well as the actual treatment of the cancer itself. So this is what they look like. I mean, essentially, they're a map. And the map says, “If this, then you must do that.”

Tacey Ann Rosolowski, PhD

[00:42:46]

Interview Session: 03
Interview Date: May 1, 2015

OK, so myeloma post-treatment and NED, which means--?

Alma Rodriguez, MD

[00:42:52]

No evidence of disease.

Tacey Ann Rosolowski, PhD

[00:42:53]

Oh, OK. Yeah. So then you go through surveillance, oh I see. And then it's, like, selecting from a flowchart.

Alma Rodriguez, MD

[00:42:56]

Exactly. Exactly. And so every map--

Tacey Ann Rosolowski, PhD

[00:43:01]

Wow, one year of age and up, four years of age and up—

Alma Rodriguez, MD

[00:43:03]

But this is [inaudible].

Tacey Ann Rosolowski, PhD

[00:43:04]

[inaudible] diagnosis. OK. Got you. OK. Interesting.

Alma Rodriguez, MD

[00:43:05]

So many—so—

Tacey Ann Rosolowski, PhD

[00:43:11]

I can't even imagine the database that you would require to put together something like that.

Alma Rodriguez, MD

[00:43:17]

So we have that. (laughs)

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[00:43:19]

Yeah. Yeah.

Alma Rodriguez, MD

[00:43:22]

And we established some ground rules, so we say, for example, in survivorship, all your algorithms must contain four domains. One domain is the surveillance one, but the other one is also monitoring for late effects, early detection and risk reduction and psychosocial functioning.

Tacey Ann Rosolowski, PhD

[00:43:35]

OK.

Alma Rodriguez, MD

[00:43:38]

You must address these four domains; tell us what you would do for your patients in these four domains.

Tacey Ann Rosolowski, PhD

[00:43:43]

Right. OK. Did you work with Lewis Foxhall on this? I think he mentioned to me something about he uses different domains—

Alma Rodriguez, MD

[00:43:52]

Well, he was a co-editor of this book.

Tacey Ann Rosolowski, PhD

[00:43:52]

Oh, yeah, there's his name. Yeah.

Alma Rodriguez, MD

[00:43:53]

But the domains of survivorship, we worked with all specialties. Each specialty really designs its own survivorship domains. We took those four domains from the Institute of Medicine report on what constitutes good survivor care. So we said, OK, there are national estab—or national recommendations and what should be the domains of care that survivors receive, so let's be sure we built our care—models built on those domains.

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[00:44:26]

So I can see the advantage here. Now, I guess I was making the assumption that these practice algorithms were created diving into MD Anderson databases on treating thousands of patients with all sorts of different cancers. Is that the case?

Alma Rodriguez, MD

[00:44:42]

No. You're talking about, then, outcomes analysis.

Tacey Ann Rosolowski, PhD

[00:44:50]

OK. OK.

Alma Rodriguez, MD

[00:44:50]

You're talking about analysis. This is about simply creating an informational work tool for physicians.

Tacey Ann Rosolowski, PhD

[00:44:57]

OK.

Alma Rodriguez, MD

[00:44:57]

Within those informational work tools, then, there will be areas where you have to do a specific tool for that performance. So again, so if you say for breast cancer, we just updated one, for example, for invasive breast cancer, limited stage. So the recommendation is you must do either doxorubicin or Taxol-based chemotherapy if the patients are hormone receptor negative and they don't have Herceptin. OK. So for that subset of patients, then you do Taxol and doxorubicin chemotherapy, which regimens, so we create order sets for those regimens that map—then, along with that algorithm.

Tacey Ann Rosolowski, PhD

[00:45:42]

OK, interesting.

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[00:45:42]

So anyhow, so this is a theory—this is part of how one then develops also quality controls and quality measures, because we can then say one of our quality measures can be, do you provide—in fact, this is one national quality measure for patients who have estrogen receptor, progesterone receptor positive breast cancer, do you give them hormonal therapy, which our algorithms say you should. So do you walk the talk of your [inaudible]?

Tacey Ann Rosolowski, PhD

[00:46:11]

Interesting!

Alma Rodriguez, MD

[00:46:13]

So, no, I think you're talking about measuring outcomes.

Tacey Ann Rosolowski, PhD

[00:46:19]

OK.

Alma Rodriguez, MD

[00:46:19]

Looking at outcomes. That's the Tumor Registry. And we have a Tumor Registry, the Tumor Registry follows patients for periods, you know, for their lives to find out how they are doing, and have they relapsed, and are they still alive? So, for example, these are the survivors for cervical cancer, early stage, across many decades. You know, you can see that. And what is interesting is that for some cancers, the outcome has always been good, even before—even in the 1940s. And we haven't made much difference, and for some, we've made a huge difference, and for others we have made absolutely no difference, and the outcome is really still horrible, despite seventy years.

Tacey Ann Rosolowski, PhD

[00:47:07]

Wow, amazing! Amazing.

Alma Rodriguez, MD

[00:47:07]

Yeah.

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[00:47:09]

Now, in putting together these practice algorithms, how did that happen?

Alma Rodriguez, MD

[00:47:16]

So that, by the way, is run by the Department of Clinical Effectiveness.

Tacey Ann Rosolowski, PhD

[00:47:18]

OK.

Alma Rodriguez, MD

[00:47:21]

They report to me also.

Tacey Ann Rosolowski, PhD

[00:47:25]

And when was that department established? Is that, did that—

Alma Rodriguez, MD

[00:47:33]

Again, it sort of preceded my coming on board.

Tacey Ann Rosolowski, PhD

[00:47:33]

OK. OK.

Alma Rodriguez, MD

[00:47:36]

Because they—once upon a time, they were supposed to be working and developing those pathways. When I took over the office, we tightened up the process. We said we will have institution-wide clinical algorithms, we will have for all the major disease categories, all the major cancers that we see, we are going—you can't have an algorithm for everything; there are some malignancies that are so rare that you can't, you know, really—there is no standard, if you will, or no known best strategy for treating them. But for all the more common and more widely-seen malignancies, we have developed algorithms for cancer care. We have over 100 now, 147 algorithms. And—

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[00:48:22]

What's been the effect of the algorithms?

Alma Rodriguez, MD

[00:48:27]

Well, what has been the effect of the algorithms is in—number one, it brings to awareness, to people's awareness, that there are indeed best practice processes. In a way, it's an intellectual discipline process, it's a process of doing a very rational and thoughtful analysis of where should we be? Then it usually piques the interest of people in saying, well, where are we? So some departments have, I would say, the most—the best outcomes have been that some departments have become interested in looking at themselves again, a self-inquiry, looking at ourselves and saying, "Gee, are we really doing this?" And, "Is this what we want to keep doing?" Some of them have questioned, well, you know, just because we have done X, Y or Z forever, it doesn't mean that it's the best strategy. What does the data say? And this is where Stephanie Fulton and her group come in, because they support us in doing fairly—very professional intensive literature searches. And they then can give us the objective information that says, well, you know, that's changed. Other people think that this is better, or they might say, you know, the needle hasn't moved, it's still the same, in which case, it might also initiate a different conversation, which is, "Gee, should we start to try something different?" (laughter)

Tacey Ann Rosolowski, PhD

[00:50:04]

Yeah.

Alma Rodriguez, MD

[00:50:04]

So, you know, so that's been, again, in the best case scenario, it is, and for some departments, this has been a process of self-inquiry, of self-assessment, of updating, renewing, refreshing information on what's appropriate and relevant to their practice. In others, in many of the supportive care algorithms, for example, the management of deep vein thrombosis, it has initiated major conversations about who are the appropriate patients who should be placed on these prophylaxis modalities of treatment, are we doing it? It generated a whole deep analysis into practices by various groups. And we sort of surfaced, who are the people who really do it, the people who don't do it, and we fed that data back to them. And they're like, "Ooh, that's us, we can't believe it!" So it again has brought—one department that said, you know, our patients are really high-risk, we understand. And yet we're seeing this as a complication often. Why is that? So they initiated a research protocol for that. So it can have very positive consequences, depending on the attitude of the individuals who are participating in the process. And again, we

Interview Session: 03

Interview Date: May 1, 2015

don't expect humans to be uniform. So it's a good thing. I mean, it has generated a lot of very good things out of the process.

Tacey Ann Rosolowski, PhD

[00:51:40]

Was there anything in particular you learned from going through this process of working with all of these individuals, and taking this perspective?

Alma Rodriguez, MD

[00:51:51]

Well, so I've learned that there's some—well, first of all, I've learned that the overwhelming majority of the physicians who practice here care deeply about doing the right thing, and taking the best care of their patients. I mean, that's been incredibly rewarding for me, to say as a profession, I think we are an outstanding group of people. I'm very proud to work with them and for them, actually, because I work for them. And so that's been one thing that I've learned. The other thing that I've learned is that there is always a potential risk in medicine. I mean, this has been true for centuries; we are a profession that is very, for lack of a better word, dogmatic, and that you have to be vigilant to the risk of being purely dogmatic versus quality and safety-motivated, when you say, no, look, this is the best way to do this. It's not OK to do X, Y or Z, just because you like to do things that way, right? I mean, there is always the—the physician is the artist. I mean, everyone says that medicine is both an art and a science. Well, one has to guard a bit against the over-artistic aspects, as well as the over-scientific aspects, because being at both extremes may not be the most optimal medium for the patient. I think that there is a certain—there's a harmony to both the art and the science. I think that while the—and patients are very conscious of this, they truly do want the treatment that, according to the scientific evidence is the best, or would be the best. But at the same time, they want the treatment that would be most suited to them as individuals. So there is a—that's the—I think that's the most valuable professional skill to have, to have the appropriate judgment to determine the harmony of the science versus the humanity of the decision. If this is the right treatment, is it the best treatment for this individual?

Tacey Ann Rosolowski, PhD

[00:55:16]

Just the way you phrase that kind of brought to mind the whole issue of targeted therapy. And I'm wondering how targeted therapy fits into the practice algorithms at this point.

Alma Rodriguez, MD

[00:55:29]

Well, there are some scientifically-proven targeted therapy strategies. And, in fact, the most

Interview Session: 03

Interview Date: May 1, 2015

general of the targeted therapy principles is that you decide the treatment according to the tumor type; you know, a breast cancer may not necessarily be the same as a colon cancer, as an ovarian cancer, as a brain cancer, and so on. Even within breast cancer now, we know that there are different types of breast cancer. So the algorithms are supposed to align to each of the sub-categories of malignancies. Now, having said that, there is now an expectation that we do the [inaudible], even to the molecular level of the individual. The problem is that only a handful of the specific tumor markers today can be meaningfully addressed, OK? And so to do a whole genome analysis of every single individual is, in fact, meaningless, unless you know that there are useful therapeutics for certain targets.

Tacey Ann Rosolowski, PhD

[00:56:53]

Right.

Alma Rodriguez, MD

[00:56:57]

And at this point in time, we do have some scientifically-confirmed useful treatments for targets. But, I recently heard a talk from a world-renowned scientist, talk about this issue. He said, you know, even within a single tumor, we are finding that there is huge heterogeneity in the complexity of the gene. You know, so some cells will have this pattern, but other cells will have this pattern, and yet other cells will have this pattern. So which one of the malignant cells are you going to aim your tumor at?

Tacey Ann Rosolowski, PhD

[00:57:37]

Right.

Alma Rodriguez, MD

So in fact, we're shifting now our thinking, well, we haven't abandoned the concept of targeted therapy. And, in fact, it's a valid concept for many tumor types, for some tumor types. So for example in breast, we know that the presence of the HER2-neu receptor calls for treatment with the antibody Herceptin, because that helps many of the patients with that marker. It doesn't help everyone who has that marker, OK, but it is proven to be of benefit to a large proportion of those patients. So therefore, we would use that treatment for that particular tracer marker. But at the same time, you know, what about all those people that didn't respond to the targeted therapy? So we're shifting now to a concept of thinking, how does the body fail to recognize that these cells are not normal, or they're not healthy? Because our body has self-regulatory mechanisms by which, you know, cells that are damaged do autolyze; they kill themselves. So why is it that this control of self-regulation failed? Why did the immune surveillance fail to recognize the

Interview Session: 03

Interview Date: May 1, 2015

cells as essentially rogue individual cells that are doing their own thing, outside of the, if you will, the overarching domain of health control that the body has. So the concepts now are shifting towards, let's look at the regulations for—let's look at the mechanisms that have failed in the so-called immune surveillance of tumors, and that's where all of the novel immune therapies that you probably have been hearing about are now coming to the fore, because that model of care is very attractive, in that it's generalizable. You don't have to have a specific gene marker; you simply have to have a recognition that that cell is not normal. And the recognition mechanisms are very generic, they're broad. They're not to a specific gene, or more specific DNA marker, or a specific—they simply are to recognizing this cell is not acting normal. And so that's really the shift in paradigm that we probably are going to be seeing prominently evolve. It's already becoming prominently recognized. So I think there's a lot going on right now.

Tacey Ann Rosolowski, PhD

[01:01:04]

Yeah.

Alma Rodriguez, MD

[01:01:05]

Yes, indeed, for some tumors, targeting a gene or genetic marker is appropriate. But those tumors are rare, the ones that are really sensitive to the one targeted therapy are rare. So more to come.

Tacey Ann Rosolowski, PhD

[01:01:24]

Absolutely. Absolutely. Is there more that you wanted to say about the practice algorithms, kind of next steps, or—?

Alma Rodriguez, MD

[01:01:36]

Well, in the next iteration of the algorithms, we hope to be able to have more robust capabilities to self-monitor the practices; in other words, to say if you said that this is the best strategy, are you, you know, are you following what you said was the best strategy?

Tacey Ann Rosolowski, PhD

[01:02:02]

Is there any oversight right now of that?

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[01:02:08]

We have the Medical Practice Quality Committee.

Tacey Ann Rosolowski, PhD

[01:02:10]

OK.

Alma Rodriguez, MD

[01:02:10]

That was just named in November—

Tacey Ann Rosolowski, PhD

[01:02:14]

Oh, wow!

Alma Rodriguez, MD

[01:02:15]

(laughs) —of 2014 by the Executive Committee of the Medical Staff. And these are the focus areas that we launched as critical for oversight of this committee are, number one, the access of patients to the Institution, the diagnosis, are we doing the right diagnosis in a timely and efficient fashion, and appropriate fashion? Treatments, treatment decisions based on best evidence and eliminating adverse outcomes for the treatments. So, safety guidelines as well as effectiveness guidelines. And then at end-of-life care, are we having the discussions in a timely fashion, and are we referring patients to appropriate support services? So essentially, you know, it starts from the beginning to the end of our cancer care domains. And we're looking at the two very—you know, the start and the end, of course, are critical for the patient for their experience perspective. But these, the diagnosis and the treatment are very driven by expertise and appropriateness of care. So these two are huge, huge domains that we're going to focus on from a medical practice perspective.

Interview Session: 03
Interview Date: May 1, 2015

Chapter 19

Integrating Advance Practice Providers into Care Teams; Training Program for Physician Assistants

B: Building the Institution;

Story Codes

A: The Administrator;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Institutional Processes;
B: MD Anderson Culture;
C: Professional Practice;
C: The Professional at Work;

[01:03:35]

Tacey Ann Rosolowski, PhD

I have, I mean, I'm about ready to shift topics right now, if that's OK.

Alma Rodriguez, MD

[01:03:44]

Sure.

Tacey Ann Rosolowski, PhD

[01:03:44]

OK. Because I had on my list a couple of other things I wanted to ask you about; one was the survey, it was the 2014 BIG survey, but I didn't want to jump to that if there were other initiatives within Medical Affairs that you wanted to make sure you got on record.

Alma Rodriguez, MD

[01:04:06]

Well, the other domain within Medical Affairs that I think needs to—it's also a major—has been evolving again slowly and organically, over the last twenty years, really, but has taken off really dramatically over the last ten years is the expansion of the physician practice to include Advanced Practice Providers, to include Physician Assistants and Advanced Practice Nurses. And initially, when this work model was introduced, it was mostly the surgical services that embraced it because the model of Physician Assistants in surgery was established in the military during the major wars in the twentieth century, and so it is was not so alien to the surgical

Interview Session: 03
Interview Date: May 1, 2015

specialties. But what has been very, if you will, culture-changing has been their integration widely, now, into the medical oncology practices. There are still—and amazing to me, there are still a few holdouts within the organization; not in medical oncology, but in internal medicine where the Physicians feel very threatened by the medical providers.

Tacey Ann Rosolowski, PhD

[01:05:42]

Why is that?

Alma Rodriguez, MD

[01:05:43]

By the Advanced Practice Providers. I have no idea. I'm trying to wrap my head around that one. I really don't understand. I just got an email from one of the chairs, one of the departments, saying, "We have no comprehension of why at MD Anderson you think that the mid-level providers can give care of equal competence to the Physicians," or something to that effect. I was stunned, because everybody works with mid-level providers here, except, like I said, very few focus groups.

Tacey Ann Rosolowski, PhD

[01:06:08]

Now, tell me how a mid-level provider would be integrated into a care team.

Alma Rodriguez, MD

[01:06:15]

They are. (laughs) They are part of the team—

Tacey Ann Rosolowski, PhD

[01:06:18]

No, meaning just—no, I mean—

Alma Rodriguez, MD

[01:06:18]

They just are.

Tacey Ann Rosolowski, PhD

[01:06:18]

—not to convince me, but what do they do? How do they operate?

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[01:06:21]

They do everything the physician does.

Tacey Ann Rosolowski, PhD

[01:06:24]

OK.

Alma Rodriguez, MD

[01:06:24]

Under the physician's direction, with some exceptions, of course. They cannot initiate the decisions for surgery or chemotherapy, but they assist us in the delivery of that care. They do physical examinations, they do procedures, they call patients, they interface with external providers. They interface with each other. They help us to facilitate—they help the patient and us to facilitate getting certain things done on time. They essentially are an extension of our brains and our hands. I mean, two hands are not enough to get the work done in a day, bottom line.

Tacey Ann Rosolowski, PhD

[01:07:00]

So what's the difference between an Advanced Practice Provider and an oncologist, or--?

Alma Rodriguez, MD

[01:07:09]

Well, they are not physicians, first of all. They're not physicians, they don't have the training we do. So their privileges are granted only under the approval of the Physician, number one, and secondly, they are limited to what we call the more basic performance of responsibilities, being doing the physical exams, eliciting symptoms from the patients, and driving certain therapeutic interventions. I mean, they can order hydration. They can order electrolyte replacements, they can order transfusions, they can order—I mean, they can order tests. But they cannot generate the oncological care plan for the patient. They cannot write chemotherapy orders. They can help us write the orders, because the orders are already preformatted in our order sets. I mean, essentially, once I make the decision, you are going to get Protocol A—in the clinic, my mid-level provider helps me. He pulls up Protocol A, and he says, oh, this, do you want to give all the drugs? Do you want to delete some of the drugs? I go, "OK, we're going to do full dose everything today, for starters." OK, he can help me calculate doses, because our current system doesn't have the dose calculation capability. But in the future, the future an Electronic Health Record is even going to calculate that. So, will I necessarily have to have assistance from them? Probably not. But anyway, we have two-person check requirements in the calculations. So my mid-level provider has to help me—he does his calculations, I do my calculations, we compare.

Interview Session: 03

Interview Date: May 1, 2015

Did we get the right dose? So that's how we work together. On the in-patient service, we make rounds. We go over the problems for the day, I say, OK, it looks like the patient needs electrolytes. They need this, they need this, they need this, let's start to plan for the discharge. Please call the case manager, please call the social worker. Please blah blah blah—they take care of all that.

Tacey Ann Rosolowski, PhD

[01:09:13]

So tell me about the growth of how this office has worked with developing APPs within the Institution.

Alma Rodriguez, MD

[01:09:23]

So we—they report, the Physician Assistants program reports to my office because they're licensed through the same mechanisms as Physicians, through the Texas Medical Board. So if you go to the Texas Medical Board Website, you will see Physician Licensing, Physician Assistant Licensing, and Acupuncture Licensing. So acupuncturists also report to the Texas Medical Board. Pharmacists have their own board, and nurses have their own board. But the Physician Assistants reside within the domain of the governance of Physicians. So there is a bit of—so the Nursing Advanced Practice Providers do not report to me. They report to Nursing, which is confusing to the Advanced Practice Providers who are nurses, because actually, their practice, as Advanced Practice Providers, their practice really resides under the oversight of Physicians. There's a huge—and it's been—in Texas, this is a big political issue. In other states, the Advanced Practice Nurses can set up their own practice. In the State of Texas, they have to have oversight by a Physician.

Tacey Ann Rosolowski, PhD

[01:10:39]

Interesting. Huh.

Alma Rodriguez, MD

[01:10:48]

Yeah. So in any event, I sort of have a co-oversight with the Division of Nursing, but the Physician Assistants report to me directly; their Directors report to me directly.

Tacey Ann Rosolowski, PhD

[01:11:06]

Now, am I correct, in 2008, this office started an oncology fellowship program for Physicians Assistants?

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[01:11:12]

Yes, it did. Yes.

Tacey Ann Rosolowski, PhD

[01:11:15]

Tell me about doing that.

Alma Rodriguez, MD

[01:11:16]

Well, again, so Physician Assistant programs, our Physician Assistant's education parallels that of Physicians in that the first year of the Physician Assistant's education is exactly as first-year students, have the same curricula, you know, you have to have anatomy, physiology, pharmacology, etc., etc. Where it deviates is that Physician Assistants immediately move into clinical rotations their second year, whereas physicians don't until about their third or fourth year, actually fourth year. So physicians have a much longer didactic training period than the Physician Assistants. And furthermore, we are required to do residency programs, training, you know, and some of us even do fellowship programs which are beyond—so for us, our training lifespan is about ten years, if you count starting medical school and residency education and fellowship education. It's very long, and for some surgical specialties, even longer. Whereas the Physician Assistants, immediately after one year of didactics and one year of what is called clinical rotations, they're sent off to the job. And so they basically are more in the apprenticeship model. They learn on the job to do what they do.

So many of the Physician Assistants who are going into oncologic practices really felt a bit lost. And we've done our own analysis. When we take in Physician Assistants that we hire either fresh out of school or from other primary care practices, it takes them six months to a year to really get up to speed on what they're doing here. They require very, very close oversight and supervision. So we thought, why would we not prepare Physician Assistants to be more competent in the job force as oncology trained. There is a precedent in that there are, for example, emergency room fellowships for Physician Assistants, where they spend a year in the emergency room as part of their training, and therefore they are competent at, very competent at working in emergency rooms. There are some that are surgical, so once they've done their year of surgery fellowship, they're very competent in the surgical environment. So we felt, let's do—why do we not train oncology—why do we not train PAs [Physician Assistants] out of school in the oncology environment for a year? So at the end of that year, because it's how long it takes us anyway, if we hire them.

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[01:14:17]

Right.

Alma Rodriguez, MD

[01:14:17]

And we consider that a fellowship; they're not obligated to work for any one physician. We will expose them to various rotations throughout the hospital. They will do some surgery, they will go to radiation, they will also do medical oncology, hematology practices and see what they like best. So there is an American Academy of Physician Assistant education; they do have criteria for credentialing programs. We were the—and most of their experience had to do, like I said, with emergency medicine, and surgical programs, we kind of an outlier group for them. So it took a while for us to get through that entire process of accreditation as a program. We had to develop curriculum, we had to identify instructors within the organization, or preceptors, rather, within the organization. So Maura Polanski is the lead Director of Education in that program, and I'm the designated Medical Director of the program. Because again, because it's—because their training is under the guidance of a physician, they have to have a Medical Director for their program.

Tacey Ann Rosolowski, PhD

[01:15:46]

So that was formed in about, well, about eight years ago. So what are the effects that you've seen? Are there many of these fellows who decide to stay at MD Anderson? What's been the impact of the program?

Alma Rodriguez, MD

[01:16:04]

Yes. The impact has been that, you know, some of the best fellows we've had have, fortunately, stayed with us, and some of them have gone to really—most of the ones that have not stayed with us have gone to excellent programs in the nation. Dana Farber Memorial and other programs, simply because, you know, family or interest of the individuals leads them to those locations.

Tacey Ann Rosolowski, PhD

[01:16:27]

Right. Right.

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[01:16:30]

We wish that more programs would do this. We've had lots of—we've been asked by the American Society of Clinical Oncology, our Director, Todd Pickard, has been a member of a committee at the national level for the American Society of Clinical Oncology, because many of the community oncologic practices are beginning to realize we need to have help. And how are we going to do this, and who is capable of doing—who is competent to do it, how do we get people trained to do it? So we've developed, actually, an online course for—precisely for those people who cannot physically be here. Because we can't—of course, we don't have the funds to have, you know, 100 fellows at MD Anderson. Let me see if I—I used to have a little flyer here for that program. Let me see if it's still here. Oh, yeah, here it is.

Tacey Ann Rosolowski, PhD

[01:17:33]

Oh, neat!

Alma Rodriguez, MD

[01:17:33]

We have an e-Learning course.

Tacey Ann Rosolowski, PhD

[01:17:34]

Oh, how neat! Could I take this?

Alma Rodriguez, MD

[01:17:37]

Sure.

Tacey Ann Rosolowski, PhD

[01:17:37]

That would be great.

Alma Rodriguez, MD

[01:17:40]

Let's see if—yeah, Maura Polanski and I.

Tacey Ann Rosolowski, PhD

[01:17:40]

Neat!

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[01:17:43]

And we've updated it a couple of times. It requires, you know, when you have online learning courses, you have to—they expire, they have a life span, because knowledge, of course, keeps accumulating, so you have to update them periodically in order to be certified.

Tacey Ann Rosolowski, PhD

[01:17:59]

And is that the same kind of—I mean, does the person come out with the same kind of status of approval, as if they were coming here?

Alma Rodriguez, MD

[01:18:08]

No.

Tacey Ann Rosolowski, PhD

[01:18:10]

No.

Alma Rodriguez, MD

Not really. I mean, this is didactic information—

Tacey Ann Rosolowski, PhD

[01:18:12]

Right.

Alma Rodriguez, MD

[01:18:13]

It's not the same as the—

Tacey Ann Rosolowski, PhD

[01:18:14]

Not the apprenticeship.

Alma Rodriguez, MD

[01:18:14]

Yes. It's not the same as having your roots on the ground and face-to-face with the patients' situations, and learning from, again, face-to-face from experts who can explain why this is

Interview Session: 03

Interview Date: May 1, 2015

different than that, and so on. So no, of course a live person-to-person experience always is richer than— But nonetheless, I think, we think that this provides an incredibly rich—this is an incredibly rich source of knowledge that can inform people on how to get themselves prepared, or at least have a basic and working knowledge of why there is a difference between this category of disease and that category of disease; what kind of side effects might you expect from this kind of chemotherapy drug, versus this other drug, and so on. What might be some of the more common complications of surgery, you know, in patients who have had a mastectomy versus a renal removal, or versus a cystectomy, a bladder resection, and so on. So just some very basic understanding, so they are not going into their jobs completely unprepared. Right.

Interview Session: 03
Interview Date: May 1, 2015

Chapter 20

The Office of Medical Affairs: Job Satisfaction Survey of Mid-level Providers **B: Institutional Processes;**

Story Codes

C: Understanding the Institution;
C: The Institution and Finances;
C: Mentoring;
B: MD Anderson History;
B: MD Anderson Culture;

Tacey Ann Rosolowski, PhD

[01:19:41]

Can you tell me, I mean, I'm sort of wondering if there—since the Office of Medical Affairs has been in existence for a decade now, were there some important landmarks in its evolution? I mean, that's—

Alma Rodriguez, MD

[01:19:55]

Well, let me say that the Office of Medical Affairs has been here forever, I mean this is saying why are—

Tacey Ann Rosolowski, PhD

[01:20:04]

But I mean you being here—

Alma Rodriguez, MD

[01:20:05]

Me as the person here? Yes.

Tacey Ann Rosolowski, PhD

[01:20:06]

Yeah.

Alma Rodriguez, MD

[01:20:07]

Oh gosh, everything. We, you know, when I stepped, again, into the role, we didn't have a Physician Assistant Program's office with the Director. I mean, Maura was sort of a volunteer

Interview Session: 03
Interview Date: May 1, 2015

Director, if you will, and she was sort of the volunteer Education Director. We established those as formal titles for individuals. We established roles and responsibilities, job descriptions for them. I can say with confidence today that, you know, Todd Pickard is the Director of this office, serves as an invaluable resource to all the departments and processes of evaluate—for starters, you know, how do you do an evaluation that's meaningful for your mid-level providers, what do you expect of them? We're right now—we just completed a really important survey looking at job satisfaction of the mid-level providers, and what do they see as [inaudible] their roles are meaningful to them or not, or what kind of disparities do they observe, what kind of dissatisfiers are there that we need to address? It's very interesting, because they're all very committed to their job. What we found is they're all very committed to their roles, but they do observe major inequities in terms of work distribution and in terms of in a significant proportion, and slightly more than a third, they think that they're not being—their jobs are not fully up to the optimum level of performance they could perform. If you will, they're being underutilized—

Tacey Ann Rosolowski, PhD

[01:21:55]

Yeah, interesting.

Alma Rodriguez, MD

[01:21:55]

—in their jobs. So, you know, they're an incredibly valuable resource to the organization, and very—of all the complaints that we get, the group that gets the least complaints and the most appreciative notes is the mid-level providers group.

Tacey Ann Rosolowski, PhD

[01:22:22]

Wow. That's amazing. What was the name of that survey?

Alma Rodriguez, MD

[01:22:26]

I—it was just a mid-level provider's survey.

Tacey Ann Rosolowski, PhD

[01:22:29]

OK.

Alma Rodriguez, MD

[01:22:29]

We made it up ourselves. We asked them, what do you want? What do you think? HR [Human

Interview Session: 03
Interview Date: May 1, 2015

Resources] helped us to develop it; it was just a survey of work environment assessment.

Tacey Ann Rosolowski, PhD

[01:22:40]

Wow. That's amazing. And how will you use the information that's come out of the assessment?

Alma Rodriguez, MD

[01:22:44]

Well, that's what's in discussion right now.

Tacey Ann Rosolowski, PhD

[01:22:47]

OK. (laughs)

Alma Rodriguez, MD

[01:22:47]

What are we going to do about this?

Tacey Ann Rosolowski, PhD

[01:22:48]

Yeah.

Alma Rodriguez, MD

[01:22:49]

Yeah.

Tacey Ann Rosolowski, PhD

[01:22:50]

Yeah. Well, and it's always a pleasure to discover a situation when people want to be doing more.

Alma Rodriguez, MD

[01:22:56]

Uh-huh.

Tacey Ann Rosolowski, PhD

[01:22:58]

You know, to feel good themselves, and [inaudible].

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[01:22:59]

Yeah. Very few of them said that they wanted to do less.

Tacey Ann Rosolowski, PhD

[01:23:01]

OK.

Alma Rodriguez, MD

[01:23:02]

Many of them did say that—well, let me put it this way. They were not dissatisfied with the challenge, the intellectual challenge and emotional challenge their job was offering them. They were dissatisfied with the physical stress of hours. Some of them work very long hours, and that probably is not appropriate. And they feel that there is inequity in distribution. Some of them have physicians who—but what ends up happening is that their job responsibilities are going to more or less mirror the physician's. Some physicians have huge workloads, others don't. But—so here's the thing. If the mid-level providers have inequity, so do the physicians, right? I mean, I have to draw the parallel.

Tacey Ann Rosolowski, PhD

[01:23:45]

Right.

Alma Rodriguez, MD

[01:23:46]

And it's likely that that's the case. So the next question is, what are we going to do about the physicians?

Tacey Ann Rosolowski, PhD

[01:23:49]

Yeah. Right. Right. Right. Now, just to ask the obvious question, I mean, are the mid-level providers paid equally regardless of that workload? I mean, is that part of the stress that they're talking about?

Alma Rodriguez, MD

[01:24:09]

Yeah, they're paid differently, depending on the number of years or level of competence and experience, and so on. But they're not paid more if they see more patients, or work harder.

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[01:24:23]

Right. Right.

Alma Rodriguez, MD

[01:24:23]

So that's what—at the core, it's really an issue.

Tacey Ann Rosolowski, PhD

[01:24:27]

Money, yeah. Yeah. Now, there was another survey that you did; this is the 2014 BIG survey of employees.

Alma Rodriguez, MD

[01:24:35]

Oh, the BIG survey?

Tacey Ann Rosolowski, PhD

[01:24:36]

Yeah.

Alma Rodriguez, MD

[01:24:36]

Mm-hmm?

Tacey Ann Rosolowski, PhD

[01:24:37]

So tell me about that. Because I was reading a lot about that. What was the motive for doing that? And what was the outcome?

Alma Rodriguez, MD

[01:24:47]

Well, I think—so the institution has had this survey for quite a long time, it's every other year, every third year—

Tacey Ann Rosolowski, PhD

[01:24:53]

OK. All right.

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[01:24:55]

—I forget the time frequency. But it's been going on for quite a long time. And the intent was simply to look at satisfiers in the workforce; you know, what makes the workforce, in general. And I think overall, we have an incredibly stable workforce. Our turnover rate, as I understand it, is relatively low compared to other organizations. Nonetheless, there are certain pockets of the organization that do have high turnover rate.

[01:25:26]

So the questions were, you know, where are these pockets? Why is there dissatisfaction? Culturally, what are issues that we face? What I can say overall is that—or, what I've learned, and what has been consistent in the survey over time is, number one, everybody knows what our mission and vision are. They're highly committed to it. Most find their jobs rewarding personally, on a personal level. Many want opportunities for improvement, or promotion that they think we failed to provide them, and that may be the case. I mean, it's unfortunate, but not everybody can be a Manager or a Director. And sometimes you have to move either laterally to another department to be able to have that opportunity, or you need to go to another organization and move up the ladder there. You know, it's just a reality. And we can't have as many chiefs as Indians, you know, for lack of a better metaphor. So there is going to be only X-number of opportunities for promotion up the ladder in any one organization. And so the people who are very highly-driven motivated, ambitious and so on, unfortunately, we may not have an opportunity for all of them.

[01:26:52]

So we find that consistently in our survey, every time that we've done it. The other issue that we find, which is very unfortunate, is that there is a fear of retaliation. If people complain, or at least that's the perception, that if they bring up issues of things that are not going right that there's going to be a negative retaliation against them. We've tried to do in-depth analysis of that; that seems to be across the board. Oh, and of course the other thing that people consistently complain about is that they're not paid enough. That, as I understand it, our measurements are exactly the same as the national measurements in all health organizations. Fifty percent, or some of the people, think that they're not paid enough.

And that's apparently the national norm. We're not different than the national norm.

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[01:27:58]

What's the value of doing a survey of this kind, every two or three years?

Alma Rodriguez, MD

[01:28:01]

I have no idea. (laughter)

Tacey Ann Rosolowski, PhD

[01:28:05]

OK.

Alma Rodriguez, MD

[01:28:05]

I truly don't know.

Tacey Ann Rosolowski, PhD

[01:28:06]

No big truth from the mount on that one.

Alma Rodriguez, MD

[01:28:09]

Well, I mean, there has been some, there have been some things that we've done as a result of the survey. So let me say the biggest one is, we're not paid enough. Well, there's no way that we can changed salaries. They're fixed by the state, OK? We paid whatever it is that the other state organizations pay. And then we also usually measure ourselves against—we do what is called a market analysis, and we look at what is it that our competitors are paying, and we try to match those benchmarks. So it's whatever the marketplace decides and whatever government regulations decide, that's what we pay. I mean, I don't know what else we can do about that. So I don't even know why we ask that question. Because to me, that's kind of like a silly question. I mean, we should process that continually and proactively assess, are we doing the fair thing? Are we paid the fair salary? And if we are, we are. I mean, what else is there to—why are you asking that? You know?

So the one thing that we did do, that we have done that I think is positive is that some people wanted to have an opportunity for mentorship. So they said you should establish this mentorship program to onboard new employees, or employees who wanted to transition to something else, or who could learn—who wanted to learn about something else. So, for examples, in the survivorship—in the patient—the Physician Assistant programs, we established a mentorship

Interview Session: 03
Interview Date: May 1, 2015

program for employees who wanted to learn about what the PAs do. You'd be amazed how many of the technical staff, like, laboratory technicians and so on, say, "Oh, I could go to medical school," or, "I could go to PA school." What they don't know is that getting into PA school is just as hard as getting into medical school. It's getting even harder, because there are fewer positions.

So in any event, but so we said, OK, there are probably a lot of very capable people who could possibly be accepted to PA school. Why don't we just have a program where we talk to them about what is it that we do, how do we do it? And the reason that we wanted to have a formal program is, we didn't want—what was happening was, you know, a friend of a friend of a friend recommended that so-and-so shadow PA Smith in Orthopedic Surgery. And PA-X in Orthopedic Surgery then felt obligated because their friend, so-and-so so-and-so said that they wanted to have—so they would take this person around. And I said—when I started to discover this, I said, "Wait, time out. Has this person had all the appropriate training? I mean, you are exposing patients to individuals whose job descriptions do not permit that these patients be exposed to them." I mean, you have individuals in vulnerable situations, maybe half clothed, or you don't know. And there's private information that's being revealed or disclosed to these individuals who have nothing to do with this particular job function, they just want to do it out of curiosity or self-knowledge, or whatever.

[01:31:54]

[01:31:57]

Fine. Let's have a formal vetting process. They have to go through HIPAA [Health Insurance Portability and Accountability Act] training, they have to have ethics training, they have to have—

Tacey Ann Rosolowski, PhD

[01:32:04]

Right.

Alma Rodriguez, MD

[01:32:05]

You know, do you know what I'm saying? I mean, you can't just—

Tacey Ann Rosolowski, PhD

[01:32:07]

Absolutely.

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[01:32:07]

—have people walk in.

Tacey Ann Rosolowski, PhD

[01:32:10]

Yeah.

Alma Rodriguez, MD

[01:32:11]

Or walk into the OR just because I want to observe what it's like to do a hysterectomy. I mean, sorry, no!

Tacey Ann Rosolowski, PhD

[01:32:17]

(laughs) I can see people in the compliance office having coronaries!

Alma Rodriguez, MD

[01:32:22]

Yeah, well, I was having coronaries.

Tacey Ann Rosolowski, PhD

[01:32:22]

And you too, of course!

Alma Rodriguez, MD

[01:32:24]

Because that's inappropriate. That's—

Tacey Ann Rosolowski, PhD

[01:32:25]

I'm sitting here thinking, wow, I'm really glad that Dr. Rodriguez stepped in!

Alma Rodriguez, MD

[01:32:29]

It's a violation of patients' rights.

Interview Session: 03
Interview Date: May 1, 2015

Tacey Ann Rosolowski, PhD

[01:32:29]

Absolutely.

Alma Rodriguez, MD

[01:32:31]

You know, so, no. So anyway, that's why we established that. And there's many other mentorship programs in the Institution. That's the one positive thing that I've seen come out of the survey. Outside of that, honestly, I don't think that much has happened.

Tacey Ann Rosolowski, PhD

[01:32:49]

Dr. Rodriguez, I just checked my watch, and we're almost at noon.

Alma Rodriguez, MD

[01:32:54]

Yes.

Tacey Ann Rosolowski, PhD

[01:32:54]

And I want to make sure—I know you've got a meeting. So do you want to close off for today?

Alma Rodriguez, MD

[01:33:00]

I—I think we've talked about a lot.

Tacey Ann Rosolowski, PhD

[01:33:01]

We have. And well, what I thought was that, you know, we could probably do one short session for the final things that I have to ask you.

Alma Rodriguez, MD

[01:33:06]

Uh-huh. OK.

Tacey Ann Rosolowski, PhD

[01:33:09]

For follow-up, would that be all right?

Interview Session: 03
Interview Date: May 1, 2015

Alma Rodriguez, MD

[01:33:10]

Yeah. Sure.

Tacey Ann Rosolowski, PhD

[01:33:11]

OK. Because I don't want to make you late for your meeting.

Alma Rodriguez, MD

[01:33:11]

No, that's all right. Thank you so much.

Tacey Ann Rosolowski, PhD

[01:33:13]

So I am turning off the recorder at 11:56, and I want to thank you for your time this morning.

Alma Rodriguez, MD

[01:33:21]

(laughs) I'm just curious, have other people said that something important has come out of the BIG surveys? (laughs)

Tacey Ann Rosolowski, PhD

[01:33:25]

I've never asked anybody about it. Actually, it was—you were the only person where it was, you know, in your background research. All right, I'll be turning off the recorder now.

Alma Rodriguez, MD

Interview # 61

Interview Session Four: 5 June 2015

Chapter 00D

Interview Identifier

Tacey Ann Rosolowski, PhD

[00:00:00]

All right, today is June 5th, 2015, and the time is about eight minutes after two. And I'm on the eighteenth floor of Pickens Tower in the office of the Physician in Chief, talking my fourth session with Dr. Alma Rodriguez. So thank you very much for making the time. I know this has been a lot of sessions.

Alma Rodriguez, MD

[00:00:21]

Not a problem.

Tacey Ann Rosolowski, PhD

[00:00:21]

And I really appreciate the gift of time that you have given to the project.

Alma Rodriguez, MD

[00:00:28]

You're welcome. Thank you.

Interview Session: 04
Interview Date: June 1, 2015

Chapter 21

Patient-Centered Care: Formalizing the Practice at MD Anderson

B: Building the Institution;

Story Codes

A: The Administrator;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: The MD Anderson Brand, Reputation;
B: Building/Transforming the Institution;
D: The History of Health Care, Patient Care;
C: Patients;
C: This is MD Anderson;
C: The Life and Dedication of Clinicians and Researchers;
C: Volunteers and Volunteering;

Tacey Ann Rosolowski, PhD

[00:00:29]

So, we were strategizing a little bit before we turned on the recorder. And I first wanted to ask you about an area within the scope of Medical Affairs that we've touched on, but not really addressed, you know, forthrightly, which is the institution's very explicit move to patient-centered care. So I was wondering if you could address that, and also talk a bit about the Psychosocial Council which is under the scope of your role, as I understand it.

Alma Rodriguez, MD

[00:01:02]

Right. Well, I think that certainly the concept of patient-center care is not unique to our organization, it is part of a national movement that acknowledges that, obviously, that's the reason that healthcare happens, is that we are taking care of individuals. And furthermore, that we are not—again, there's a shifting in consciousness, if you will, that we're not really treating a disease, or a series of disease processes, but we were actually treating a person. And so, which then, if you will again, shifts the elements of the experience that are being paid attention to. So for example, it would never have—when I did my training in medical school, it would never have occurred to us to ask a patient how satisfied were they with their experience of being in the hospital, because our assumption was, they were not happy, and it was a terrible experience.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[00:02:24]

Oh, wow.

Alma Rodriguez, MD

[00:02:26]

Why would we ask people that, right?

Tacey Ann Rosolowski, PhD

[00:02:27]

Yeah, that's the first time anybody's ever said that. (laughs)

Alma Rodriguez, MD

[00:02:33]

Why would you ask people that? The assumption would be that it is terrible, that is not—is something outside of your experience. So the novel thing today is that we are, if you will, customer-centered. And we wanted to know if the patient had a good experience in terms of how the lobby looked, how the meal was, how courteous people were. And frankly, I think that's a valid question, because although on the surface, it might appear to be, how shall I say, a set of trivial events, the truth is that when you are ill, when one is ill, all of these other things can, of course, soften the blow, if you will. And so to a good degree, having just a pleasant environment and a pleasant interpersonal exchange with the individuals taking care of one can, in fact, make the experience of the illness bearable, if you will. So the realization that it isn't just the therapeutic intervention that matters, that, in fact, all the other interventions are part of the success of that story of that narrative for the patient during illness is relatively new in the consciousness of healthcare. And so, we—imagine how much more dramatic all of that is when the patients have a diagnosis of really serious and potentially life-threatening illnesses, which many cancers can be, right? So we are sort of, if you will, we're attempting to move in that direction. I don't think that we're there yet, I don't think, that we have, if you will, for lack of a better word, mastered all the elements of improving the patient experience.

But in general, I think that patients have consistently, across time, experienced that MD Anderson is the kindness and the devotion of the people who work here, particularly in the clinical care setting; the nurses, the Physicians, the technicians, the Therapists. The people who are sitting face-to-face with patients have to be special to work here. And that's my subjective observation, if you will. I don't have the scientific evidence to say across the board we all have this particular psychological profile, and we all behave in this way. I mean, we don't have that kind of profile, but I can tell you just from observing and interacting with the individuals who work there that in general, across the board, they're kind, thoughtful, dedicated persons. And

Interview Session: 04
Interview Date: June 1, 2015

patients sense that. They know that. So many of the comments that we get in feedback pertain to that.

And in particular, one of the biggest treasures of our Institution, actually, are the volunteers that come to our Institution. Many of them are cancer survivors. They either have had cancer themselves, or they have been caregivers for someone who had cancer, so they understand what the experience is like, and they can relate to the patients. And if you will convey that empathic message of, you know, we understand, we care how you feel. So that's one of our great advantages. We also moved sometime back to the concept of room service, that is that people could request their meals at their own time, when they were ready to eat. I mean, certainly people who are undergoing cancer treatments can have challenges in feeling hungry or being able to enjoy food, but it turns out that if you allow people to have control over the times at which they eat, and choose the kinds of foods they want to eat, that, you know, they can be better-nourished. So we've done that. And the food service usually is one of the things that gets better ratings in our—as opposed to many hospitals, where the food service gets terrible ratings! (laughs)

Tacey Ann Rosolowski, PhD

[00:07:27]

I was just going to say that. It's like a joke about hospitals—

Alma Rodriguez, MD

[00:07:27]

Yes.

Tacey Ann Rosolowski, PhD

[00:07:28]

—the food is so terrible. Wow.

Alma Rodriguez, MD

[00:07:35]

So we do some things very well. You know, we still have to improve on other things; you know, the efficiencies of our workflows, decreasing wait times, improving our information and communication systems with patients so that they get information in a more timely fashion, all of those process changes we're still working on.

Interview Session: 04
Interview Date: June 1, 2015

Chapter 22

Patient-Centered Care: the Psychosocial Council, Advanced Care Planning **B: Building the Institution;**

Story Codes

B: MD Anderson Culture;
C: Patients;
C: Patients, Treatment, Survivors;
B: MD Anderson Culture;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Institutional Processes;
B: Devices, Drugs, Procedures;
B: Institutional Mission and Values;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;
[00:08:02]

Alma Rodriguez, MD

Excuse me. In addition, there's also a very—one of the reasons that we formed the Psychosocial Council was that we wanted to have more interaction between the various disciplines that provide what in today's terminology is called psycho oncology, that is, the whole realm of services, supportive services, that improve or address people's emotional and spiritual well-being. We wanted to bring all of those disciplines together to have conversations about what might be programs or processes that are of critical importance that we should improve? You know, where do we need to move the needle, in what domains, or what specific care delivery issues do we have today that we should be addressing? So again, I see that you have written down in your notes Advanced Care Planning. The whole conversation, again, on the national scene around end-of-life decisions is part of this conversation of Advanced Care Planning. But I'm going to give you a different personal spin on Advanced Care Planning. And here's my thought. Advanced Care Planning should be about thinking ahead of how your healthcare will be, how you will manage it, or who and when and why, and who will pay for it, and so on. That's part of what should go into this; it's like planning your child's college education, right? So this is about planning your own health in the future, and how you will be cared for in the future, through wellness, through aging and through dying, OK? For some reason, the conversation has been made entirely about dying. And for that reason, I think that it frightens many people, and it decreases willingness of families or patients to talk about it.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[00:10:27]

Yeah.

Alma Rodriguez, MD

[00:10:28]

But the reality is that today, almost seventy percent are going to be alive. And we touched upon that when we talked about the survivorship program. You know, today having a cancer diagnosis is not a death sentence. And so people need to anticipate that they're going—many of them, most of them, are going to be alive after the diagnosis of cancer, and that their lives need to reintegrate into wellness. They need to anticipate that. How am I going to be—you know, who should be best—who should I address myself to, who would be best for me to go to to handle X, Y and Z? And so that's what the whole survivorship program is about. But we have not really integrated that concept well into the topic of Advanced Care Planning. So my goal is to hopefully integrate well into every single patient's discussion with their Physician, when their treatment plan is being made, that this conversation about what will the future likely be for you? Will it be wellness? May it be period relapses of this illness, because there are some cancers that can be put into remission for some periods of time, but they can re-occur. Is that likely going to be the future for you, or is it, unfortunately likely that your life will not be too long, but we can help you best, or we can help you deal best with the situation by alleviating pain, by relieving discomfort, etc. There is some form of care that is available and possible to deal with each of those scenarios, and it's a matter of having the conversation about that, when the treatment plan is made. I think it's totally appropriate to have at least a glimpse of the future so that people aren't entirely left in the dark, or unprepared for what can come later. To me, that's what Advanced Care Planning means. And I'm hoping that that's going to be part of the MD Anderson culture in the future.

Tacey Ann Rosolowski, PhD

[00:12:52]

So—

Alma Rodriguez, MD

[00:12:53]

So that was one of the initiatives that became embraced by the Psychosocial Council.

Tacey Ann Rosolowski, PhD

[00:12:57]

I see.

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[00:12:59]

I finally have got around to where I started.

Tacey Ann Rosolowski, PhD

[00:12:59]

Yeah, no no, I had no doubt you would. (laughs)

Alma Rodriguez, MD

[00:13:02]

We decided that that was going to be one of our key initiatives. It's not the only one. But it is one that is going—if it does get embedded in the culture, I think it would have a very significant impact in how patients experience cancer and cancer treatment.

Tacey Ann Rosolowski, PhD

[00:13:19]

So what are the steps that you're taking to shift the culture so that these discussions are kind of part of the way a treatment plan evolves?

Alma Rodriguez, MD

[00:13:31]

Well, it's a multi—of course, it's a very—it's a multi-layered process, and it will still take us a long time to get there. We always start, of course, first, with a conversation of why is this an important topic. That was part of the exploration of the Council. This is a topic that's not just important from the perspective of, if you will, treatment planning, but it's also important from the perspective of appropriate resource utilization, if you will. And let me explain. I'm not talking about saving money, cutting here, cutting there. But it is about ensuring that the resources, the categories of services that are going to be needed to provide this domain of care versus this other domain of care versus that domain of care are aligned with the expectations of the outcome for that patient. And that if, for example, again, I might consider that this patient is going to be well, I'm going to start to prepare that patient psychologically, as well as clinically, for their eventual transition to a survivorship care model.

[00:14:59]

Versus if a patient is unfortunately going to need to have supports, palliative care, symptom management, that I've appropriately, then, referred the patient to the providers that are going to assist the patient dealing with their symptoms. It's about anticipating what resources might be most beneficial for the patient at the appropriate time. And that conversation, again, is not unique to us. I mean, I think it's a conversation on the national agenda, as well. What categories

Interview Session: 04

Interview Date: June 1, 2015

of services, or what types of healthcare needs does America as a society need? Do we have the right kinds of people that are trained to deliver those categories of care? Do we need to devote more resources, to train more Physicians or more physical Therapists, or more—you name it, in a way. Do we really have—are we going to meet the need of the growing, aging population? How are we going to do that? So we anticipate, for example, severe shortages of geriatricians, of home health care providers. We don't have enough nurses and Therapists to provide home health care services to people with decreased mobility, you know, and that's one of the conditions of aging, that people have less mobility, less, if you will, geographic translation capacity. And so people need to come to them, rather than the patient going everywhere. So this is just setting, you know, in perspective, why it is that it's important to think about this.

Tacey Ann Rosolowski, PhD

[00:16:48]

Right. Right.

Alma Rodriguez, MD

[00:16:49]

How are we going to have to adjust to that new reality? So the Psychosocial Council, again, is all of these specialists that deliver social, psychological and spiritual support services. And this is yet—you asked about the patient experience. People experience, of course, illness in an emotional way. Although there may be physical symptoms associated with it, the more, again, from the patient's experience, the emotional effect of those symptoms is what they react to, or respond to. So chronic pain can lead to depression, can lead to anxiety, it can lead to a sense of debility, of uselessness, of worthlessness, and so on, which in itself, then, of course has a huge myriad of effects of the capacity of that individual to function as a member of their family, their workforce, the society, etc.

[00:18:09]

So going to the root of the symptom of the pain is important, but dealing then also with the emotional response to the pain is equally important, if you will. So the integration of psychosocial care into the clinical care framework is, or was, the initial drive for the formation of the Council.

Tacey Ann Rosolowski, PhD

[00:18:42]

Was there push-back against that?

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[00:18:47]

So there is a very—so conceptually, everyone agrees, right, it's like motherhood and apple pie. It's wonderful that we should take care of the emotional well-being of patients. The downside of that is that to really deal with the psyche versus the soma, dealing with psyche takes time. It takes a lot more time than dealing with physical—with a physical side of illness, or at least that's—I can tell you that's my experience in the clinical setting.

[00:19:28]

It's—and perhaps it just comes with experience, but I can formulate a treatment plan for the lymphoma much more easily than I can formulate a treatment plan or a conversation or a therapeutic plan for the whole range of negative emotions that the patient is dealing with. That takes time. It takes time to—it takes very—the skillset for being good at that are totally different than the skillset for being good at clinical care, or at the expertise of dealing with clinical illness, OK, or physical illness, I should say, more correctly. So it takes time. If one is not trained well, and one has not developed appropriate, if you will, defenses or boundaries, it can also be very intrusive and in some ways, destructive of one's inner emotional well-being. Certainly from a pragmatic perspective, the way that our healthcare system is set up, it does not value psychosocial health, and it does not, then, reimburse for it. It does not compensate for it. And time is very valuable. So having the right—or most of the barriers in, if you will, obstructive viewpoints about psychosocial health and psycho oncology is that we don't have the resources, we don't have the time, we can't hire any more people. You know, it's not that—and so the solution is to say it's not that important or critical, right?

[00:21:31]

I think we've made a lot of progress. I think we've, over time, solidified, to a greater degree, the importance of psycho oncology. For example, we now have an independent and freestanding department of psychiatry. It used to be a small section embedded in neurology. It's now its own freestanding department. We have more psychologists who are now practicing clinical psychology, whereas when the Council started, the vast majority were basically on the research side of the house, and there were only maybe two or three that were clinicians. That's—

Tacey Ann Rosolowski, PhD

[00:22:18]

Well, just for the record, when was the Psychosocial Council started?

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[00:22:22]

Well, we were charged to begin, to form, in 2007.

Tacey Ann Rosolowski, PhD

[00:22:25]

OK.

Alma Rodriguez, MD

[00:22:26]

Although we really didn't get much traction probably until 2008, 2009.

Tacey Ann Rosolowski, PhD

[00:22:34]

OK.

Alma Rodriguez, MD

[00:22:37]

We've also increased significantly the number of social workers that we have. And I think that we've made—we were just looking at all of the accomplishments that we'd arrived at over the years, we've created policies that embed, now, you know, evaluation of distress, is one of the intake questions that we are—it's embedded into the nursing intake forms for all patients. We've established policies on how to deal with symptoms, or how to assess for symptoms of depression and suicidal ideation. We've established, as well, a whole algorithm that is a care plan for addressing distress. We've, of course, established a policy about implementing in the future Advanced Care Planning. We've developed forms for documenting the discussions with Advanced Care Planning; they're going to be embedded into our new Electronic Health Record. They're going to be part of the intake of every person, every patient, and so on. So we're slowly starting to, if you will, integrate this, interdigitate this process into the day-to-day workflow. And that's the only way that you can get sustainable change.

Tacey Ann Rosolowski, PhD

[00:24:00]

Right.

Alma Rodriguez, MD

[00:24:00]

Most transformational gurus will say that. Unless you embed these changes into the routine day-to-day work of people, virtually all of these grandiose ideas come and go. It has to be in your

Interview Session: 04
Interview Date: June 1, 2015

daily routine before it really becomes engrained.

Tacey Ann Rosolowski, PhD

[00:24:17]

Sure. Sure.

Alma Rodriguez, MD

[00:24:21]

In the culture.

Interview Session: 04
Interview Date: June 1, 2015

Chapter 23

Patient-Centered Care: the Department of Chaplaincy and Pastoral Education and the Future of Psychosocial Approaches at MD Anderson

B: Building the Institution;

Story Codes

B: MD Anderson Culture;
C: Patients;
C: Patients, Treatment, Survivors;
B: MD Anderson Culture;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Institutional Processes;
B: Devices, Drugs, Procedures;
B: Institutional Mission and Values;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;
B: MD Anderson History
C: Research, Care, and Education;

Tacey Ann Rosolowski, PhD

[00:24:22]

Yeah, makes perfect sense. You mentioned spiritual support. What does that look like?
Because we talked about some social, some psychological, what about spiritual?

Alma Rodriguez, MD

[00:24:35]

Well, we have a whole department of Chaplains.

Tacey Ann Rosolowski, PhD

[00:24:39]

OK.

Alma Rodriguez, MD

[00:24:40]

And I think compared to most hospitals, it is quite robust, in that we have full-time Chaplains of several denominations, but they all have to be certified in healthcare Chaplaincy. And there is actually a whole discipline for that, and certification process for that. And the difference

Interview Session: 04
Interview Date: June 1, 2015

between healthcare Chaplaincy and, of course, a position of clergy in the religious communities is that a healthcare Chaplain, if you will, needs to focus more on the spiritual concerns around illness; the questions or relationship, if you will, to a higher spiritual being. Questions of, or issues of existential anxiety, for lack of a better word. Why am I here? Why did I get this illness? Why did I survive, versus my friend, my child, my neighbor? So Chaplaincies that are linked to healthcare are aligned with those—along those lines, that is, how illness then brings to the surface, the existential questions of why I exist, and what is my relationship to a—or do I have a relationship? Or am I worthy of a relationship to a higher entity, or higher spiritual being?

Tacey Ann Rosolowski, PhD

[00:26:21]

Is it unusual that a cancer center has a department devoted—you said that “The department is robust.” I mean, is that—

Alma Rodriguez, MD

[00:26:32]

Robust in numbers. Also in—

Tacey Ann Rosolowski, PhD

[00:26:35]

Yeah, I’m just wondering if it reflects sort of a different level of investment in this particular issue for patients.

Alma Rodriguez, MD

[00:26:41]

Mm-hmm. I’m sure, very likely. Again, when the hospital was established, remember that it was in the 1940s. Cancer, hardly anybody survived.

Tacey Ann Rosolowski, PhD

[00:26:51]

Survived, yeah.

Alma Rodriguez, MD

And so in those days, I think it was seen very much—if you asked people what was important, psychology or spirituality, they would have said spirituality over and above everything else, right? So I think it just has to do with the roots of how the organization was built.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[00:27:11]

Interesting.

Alma Rodriguez, MD

[00:27:12]

Or when it was built. But also, in addition, that I think although it may not seem this way, but I think that Houston as a community has very deep religious roots and deep spiritual roots. We have an established Jewish community, we have, of course, a Catholic community. We have Baptists, Methodists. The interesting thing is that one of our most supportive organizations comes from the Lutheran church. So it wasn't necessarily—so there's, across the board, a very broad, if you will, support for the Chaplaincy service here. It had the benefit of several lines, if you will, of spiritual practice and viewpoints to be built. So in addition to our full-time staff, we also have volunteer staff from the community, and we also have students who come to train here.

Tacey Ann Rosolowski, PhD

[00:28:35]

This is in the Chaplaincy department?

Alma Rodriguez, MD

[00:28:39]

Correct.

Tacey Ann Rosolowski, PhD

[00:28:38]

Wow!

Alma Rodriguez, MD

[00:28:39]

Correct.

Tacey Ann Rosolowski, PhD

[00:28:41]

Well, you know, I often ask interview subjects about their own spiritual beliefs; I mean, if I kind get a sense, you know, that that's an issue. And I've been really surprised at how people have said, yeah, you know, everything in my medical practice is very deeply embedded in my spiritual life.

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[00:29:05]

Mm-hmm.

Tacey Ann Rosolowski, PhD

[00:29:06]

I mean, and so at the level of individ—on the provider's side, you know, you find that as well, that it's a very important, maybe not very often talked about—

Alma Rodriguez, MD

[00:29:11]

Right.

Tacey Ann Rosolowski, PhD

[00:29:12]

—but certainly a very important part of the ethos, if you will, of the institution.

Alma Rodriguez, MD

[00:29:20]

Mm-hmm.

Tacey Ann Rosolowski, PhD

[00:29:21]

Yeah, very interesting. So what's the future, do you think, of the Psychosocial Council and this whole movement? Kind of what's the next big thing to work on, and what's the prognosis for—

Alma Rodriguez, MD

[00:29:35]

Well, it's really interesting. We're asking ourselves that.

Tacey Ann Rosolowski, PhD

[00:29:38]

Uh-huh?

Alma Rodriguez, MD

[00:29:40]

You know, since we've been in existence now almost—it's been, I mean, not quite there, but almost ten years since we were given the charge. And the institution has changed. You were going to bring up the issue of change. The question that we are asking ourselves, is it time to

Interview Session: 04

Interview Date: June 1, 2015

really shift in a different direction? And I don't know the answer, actually. We're still—we are exploring that. I think that as the, if you will, academic infrastructure for psychiatry, psychology—clinical psychology and other disciplines, as the academic infrastructure strengthens, where there are no longer just the rare and small services that embedded into other larger departments, as they come into their own being, perhaps they will take the banner on. And we may not need to have the Council as the support structure—

Tacey Ann Rosolowski, PhD

[00:30:39]

Right.

Alma Rodriguez, MD

[00:30:41]

—for those efforts. So we'll see. Only the future will tell. In fact, I'm rooting for the stronger formation of all of these professional groups to no longer be isolated in small, freestanding services, but that actually, hopefully, someday, there would be a division of what I would call, you know, psycho oncology medicine, or behavioral medicine, or behavioral and spiritual medicine—I don't know what the office term would be, but that it would be its own entity, standing side-by-side with surgery and medical oncology and all the other disciplines of medicine.

Tacey Ann Rosolowski, PhD

[00:31:24]

Now, are academics in these various fields at MD Anderson also conducting research?

Alma Rodriguez, MD

[00:31:29]

Yes. Yes.

Tacey Ann Rosolowski, PhD

[00:31:31]

And, I mean, what—because you know, I've been in so many conversations, I mean, this is an evidence-based institution. And so, you know, if something is going to have an impact, then you want to document that it does, indeed have the impact—

Alma Rodriguez, MD

[00:31:42]

Right.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[00:31:44]

—I mean, for a whole variety of purposes; not only intellectual legitimacy, but also for, you know, the valued care movement.

Alma Rodriguez, MD

[00:31:52]

Mm-hmm.

Tacey Ann Rosolowski, PhD

[00:31:54]

So what kind of research are individuals—you know, for example, what kinds of research projects are people doing in these fields?

Alma Rodriguez, MD

[00:32:03]

Well, there's one person who's doing a project that we actually have supported through survivorship, through the survivorship grants mechanism, who has a very interesting field of study, which has to do with body image. How do we perceive—how does our physical—our perception of ourselves as a physical entity influence how we feel about ourselves, if you will, as a psychological entity as well. And her research has been predominantly with head and neck patients, although she also has done some work with breast cancer patients. But you know, when you have your face changed, you know, our face is actually the one physical entity of our bodies—if we lose our hand, we still consider ourselves to be the person we are. If we lose our legs, we still are the person we are. But if our face gets changed, how we feel about ourselves changes dramatically as well. And the degree to which—which is, of course that explains plastic surgery, right?

Alma Rodriguez, MD

[00:33:14]

Right. Sure.

Alma Rodriguez, MD

[00:33:17]

People want to improve their faces because they want to be more beautiful, for example. But imagine that your face is changed to the degree where you are less perfect, not more perfect, but less so. And in some cases, terribly disfigured.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[00:33:35]

Maybe unrecognizable.

Alma Rodriguez, MD

[00:33:35]

Correct.

Tacey Ann Rosolowski, PhD

[00:33:36]

Yeah. Yeah.

Alma Rodriguez, MD

[00:33:38]

That can have an enormous impact to psychological health, to the individual.

Tacey Ann Rosolowski, PhD

[00:33:45]

And I suppose there is even a complexity of people that have multiple surgeries, they have to kind re-go through that trauma—

Alma Rodriguez, MD

[00:33:51]

Yes.

Tacey Ann Rosolowski, PhD

[00:33:52]

—with each transformation.

Alma Rodriguez, MD

[00:33:54]

Right.

Tacey Ann Rosolowski, PhD

[00:33:55]

Wow, that's—

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[00:33:56]

Right.

Tacey Ann Rosolowski, PhD

[00:33:56]

OK.

Alma Rodriguez, MD

[00:33:58]

So that's her field of interest. And it's interesting, we were talking about spirituality, but one of her observations is that people who have a stronger spiritual connection, in fact, deal with whatever change happens on the surface of their bodies much better.

Tacey Ann Rosolowski, PhD

[00:34:20]

Interesting.

Alma Rodriguez, MD

[00:34:22]

And so that, in itself, is a very important observation, I think.

Tacey Ann Rosolowski, PhD

[00:34:26]

Yeah. Interesting.

Alma Rodriguez, MD

[00:34:30]

So that's one of the studies. Other people are doing studies on cognitive, the recovery of cognitive functions after people have brain surgery and after certain exposure to certain chemicals that can cause the so-called chemo brain. So the studies on the whole phenomenon of what is called "chemo brain," what is it, to what degree is it reversible, versus not. Who might be at more risk for it than others.

Tacey Ann Rosolowski, PhD

[00:35:06]

Wow.

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[00:35:07]

So those are just some examples of the, if you will, the psychological and the psychiatric aspects of cancer that are still being—that are just now, in many ways, still being—just being looked at.

Tacey Ann Rosolowski, PhD

[00:35:21]

So it's kind of like entirely new fields—

Alma Rodriguez, MD

[00:35:21]

Correct.

Tacey Ann Rosolowski, PhD

—are evolving just as we're watching.

Alma Rodriguez, MD

[00:35:27]

Correct.

Tacey Ann Rosolowski, PhD

[00:35:28]

It's pretty—in which, you know, there are any number of fields that have evolved at MD Anderson and other cancer centers since the 1940s.

Alma Rodriguez, MD

[00:35:36]

Correct.

Tacey Ann Rosolowski, PhD

[00:35:36]

Pretty amazing.

Alma Rodriguez, MD

[00:35:38]

New knowledge.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[00:35:40]

New knowledge being created, yeah.

Alma Rodriguez, MD

[00:35:40]

And new ways of systematizing it.

Tacey Ann Rosolowski, PhD

[00:35:44]

From different perspectives.

Alma Rodriguez, MD

[00:35:44]

Exactly. And even old knowledge now being reframed.

Tacey Ann Rosolowski, PhD

[00:35:49]

Yeah. Cool. Can we turn to the issue of Institutional change at this point?

Alma Rodriguez, MD

[00:35:56]

Sure. Certainly.

Interview Session: 04
Interview Date: June 1, 2015

Chapter 24

Transitional Moments in MD Anderson History

B: Institutional Change;

Story Codes

B: Critical Perspectives on MD Anderson;
B: MD Anderson History;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: Growth and/or Change;
B: Industry Partnerships;
B: The Business of MD Anderson;
C: The Institution and Finances;
C: Research, Care, and Education;
C: The Life and Dedication of Clinicians and Researchers;

Tacey Ann Rosolowski, PhD

[00:35:58]

Yeah, I mean, you know, you've been at the institution for a long time, I mean, you've seen it go through a whole variety of arcs and peaks and valleys. And you know, I kind of, I guess I'd like to throw the question to you. You know, what are some of the kind of big moments you think of as the key moments of change? And then I did want to ask you about, you know, the most recent period since 2011 when Dr. [Ronald A.] DePinho took over at the Institution. But you know, what have you observed in terms of big, key moments of change at MD Anderson?

Alma Rodriguez, MD

[00:36:36]

Well, I think coming to the Institution in the late '80s or so, the very first thing that I experienced as a real change in the Institution was the growing consciousness that we were an economic entity. When I first arrived at this Institution, believe it or not, we didn't even talk about submitting bills for our services. There were no such thing as billing forms. You just saw the patients, somebody somewhere submitted a bill, but we never knew who did it, or what. You know, we were completely free of any link or any consciousness of the economics of what we did and the actual delivery of care. It was completely focused on taking care of the patient. Somewhere in the early '90s, I don't know exactly the date; it was kind of a subtle thing. We began to have forms that we needed to fill, check boxes. You know? You simply checked boxes. And there wasn't very much, if you will, complexity to the billing forms. And then suddenly, there were all of these rules. We had to learn about how you fill the boxes, and how

Interview Session: 04

Interview Date: June 1, 2015

many checks of this or that, and the complexity of the level of the care. You had to learn all the rules about that, to eventually people even looking at how much of this or that have you done? What is the downstream revenue that you have generated as an individual to the current situation, which is, you have to state what your commitment is to what percent of your time are you dedicating to the clinical service, and what does that translate to in measurable quantities of care delivery units? And there are all these formulas for calculating the care delivery units, and so on, per unit of service, and so on. So it's become now its own, if you will, almost accounting discipline, keeping track of what is your productivity quotient—that, from a care delivery perspective, that's been a radical change. It's been—it has escalated over time, but it has been, in my experience, speaking of the day-to-day and routine work, that was a very dramatic shift in the way we did our care delivery. The second, of course, was the introduction, progressive introduction of more structured forms of documentation.

And one of those that I actually was instrumental in implementing was the development of structured forms for chemotherapy; structured forms for the orders, so that we were able to track several—embed into the orders several safety elements to ensure that we were consistently doing X, Y or Z. So consistently, we were, for example, ensuring people had anti-nausea medicines that were appropriate to the level of complexity of the chemotherapy; ensuring that we had specified, in a very specific way, that we had prescribed in a very specific way the types of medications that a challenge with handwritten chemotherapy orders, where sometimes the pharmacist couldn't read the name of the drug. So these, of course, when you have typewritten, structure forms, everything is legible.

[00:40:58]

So legibility, safety measures, standards of best practice embedded into each of those. That has been a change, in my opinion—not in my opinion, actually—evidence-based across the nation, when you have certain standards embedded into structured forms for orders, it improves—it decreases the risk of errors, of grave errors. There are still minor errors; people misread this, or whatever. It still happens. But much less serious than when you couldn't even read the names of the medicines. Structurally, I think one of the key changes that happened was the buildings across that way, on 1515 Holcombe [Boulevard], from the Lutheran Pavilion. Suddenly there is the Love Clinic, the [R.] Lee Clark Clinic, the such-and-such clinic. It was just expanding, exploding clinics. And then of course, now, across the way. So the expansion of buildings. It just has become, honestly, unmanageable. I don't know MD Anderson anymore. I used to know MD Anderson, I don't anymore. It's just too spread, too far, too much. I know the clinical aspects of MD Anderson, I no longer know the research domains of MD Anderson, the breadth of them. Certainly the laboratory-based research, it's totally alien to me now. I used to know most of the basic researchers when I started in the organization, I don't anymore.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[00:42:47]

Yeah.

[00:42:49]

Alma Rodriguez, MD

[00:39:46]

So just the physical expansion of it has made it very difficult to, if you will, truly have a comprehensive, well, for lack of a better word, embrace of what MD Anderson is.

Tacey Ann Rosolowski, PhD

[00:43:14]

Intellectually, emotionally?

Alma Rodriguez, MD

[00:43:20]

All of that.

Interview Session: 04
Interview Date: June 1, 2015

Chapter 25

Change Under Ronald DePinho: The Balance Between Research and Clinical Care

B: Institutional Change;

Story Codes

B: Critical Perspectives on MD Anderson;
B: MD Anderson History;
B: Institutional Mission and Values;
B: MD Anderson Culture;
B: Growth and/or Change;
B: Industry Partnerships;
B: The Business of MD Anderson;
C: The Institution and Finances;
C: Research, Care, and Education;
D: Business of Research;

Tacey Ann Rosolowski, PhD

[00:43:24]

What's—is there—what's been preserved? I mean, you're alluding to things that have been lost, are there things that have been preserved throughout that growth?

Alma Rodriguez, MD

[00:43:38]

Well, I would like to say—I would like to believe, and I think from being in the role that I currently perform, I can see, or I can speak to this, I think the one thing that has been preserved is that the physicians are truly dedicated to doing their best for the patients. I mean, people are very proud of being good doctors. And that's—and they want to be good doctors, and they want to do their best for the patients. That I don't think has changed. I think the nursing staff continues to be excellent and compassionate and dedicated to doing this very difficult task as well. That, I think, has been preserved. I think something that is changing very radically, or that has changed very radically as I said, has been this shifting away from—well, to some degree, shifting away from the mission of the organization as a cancer care facility. To some degree, shifting from that to a research-generating facility. And it's not that research hasn't been part of our DNA before, but that it had always been superseded by the clinical mission. I really don't think that's true today, at least I don't—that's not the messaging that we receive, and it's not what is rewarded or recognized.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[00:46:00]

Is that part of the change that's occurred since 2011? Or did that begin under Dr. [John] Mendelsohn?

Alma Rodriguez, MD

[00:46:05]

Well, it began to some degree under Dr. Mendelsohn, although I have to say that Dr. Mendelsohn repeatedly made his message, that the research mission was to personalize cancer care. For him, that was truly the research mission; to personalize cancer care, to make the treatment meaningful to every patient, or to make it relevant to every patient for their own particular disease. The degree to which industry-sponsored research was promoted did accelerate under Dr. Mendelsohn. That definitely was one of the changes.

Tacey Ann Rosolowski, PhD

[00:47:07]

And why was that important?

Alma Rodriguez, MD

[00:47:09]

Well, the importance of pharmaceutically-sponsored research was that we, ourselves, were not—we, ourselves, did not have, if you will, a pharmaceutically-produced, or a pipeline that was producing new drugs. We were not creating the new drugs. But we had the patient populations in which we could test and formulate the most appropriate—or investigate the most appropriate application for these new drugs. And so it was, in a sense, a symbiotic relationship. We have the patients, they have the drugs, why not work together? In addition, of course, the pharmaceutical industry had the resources, the financial resources, to support the research infrastructure that would be required to do those kinds of tests, in the scope that would be necessary. And, for example, one of the departments that became very prominent, very large, as a result of the drug, the pharmaceutical research interaction was a Leukemia Department.

Tacey Ann Rosolowski, PhD

[00:48:26]

Right. Now, the way you shaped that statement, I'm assuming that there's been a change in that with indus—there is a different field to industry-sponsored research now?

Alma Rodriguez, MD

[00:48:41]

Well, not really, I mean, it's still there, and it's still very present. What has shifted is that we

Interview Session: 04

Interview Date: June 1, 2015

now have said, or Dr. DePinho's vision is that we will be the new pharmaceutical drug pipeline producer, or that from the research that is conducted at MD Anderson, from the basic laboratory research conducted at MD Anderson, there will be new drug products that will be placed in the market. So we no longer are simply the testers of the drugs, but we will be the producers of the drugs, or the initiators of the drugs that would then be put into production. So do you see that—

Tacey Ann Rosolowski, PhD

[00:49:26]

I do.

Alma Rodriguez, MD

[00:49:26]

—shift in the—

Tacey Ann Rosolowski, PhD

[00:49:29]

And what do you feel are the implications of that shift?

Alma Rodriguez, MD

[00:49:34]

Well, the implications of that shift are that that's really—to be the pipeline producers of drugs requires enormous financial resources, number one. It also requires top-tier intellectual resources, which again is a financial resource requirement. I mean, great minds don't come cheaply.

Tacey Ann Rosolowski, PhD

[00:49:57]

Yeah.

Alma Rodriguez, MD

[00:49:58]

And so that degree of financial infrastructure really requires big money investment. You have to have a pipeline of investors, of entrepreneurs who want to do that. They've never had, if you will, the know-how. We don't have the skillsets to do that. And also being a state-funded organization, there probably are even legal ramifications to doing that. That's outside of my scope of knowledge, I really don't understand the complexities of all of that. But I'm certain that there likely are complexities to that, and barriers to that. So I see it as a challenge; clearly not an impossible one since we've embarked on it, and hopefully we will succeed at it. But there are enormous problems with taking that on as a new initiative. There are, of course,

Interview Session: 04

Interview Date: June 1, 2015

potential benefits, huge benefits in the future. Like all investment enterprises, if the investment pays off, the payoff could be huge for us, as well. It could, perhaps, lead to self-sustaining, a self-sustaining research infrastructure. I can tell you that at the present time, we do not have a self-sustaining research infrastructure that, you know, there is a significant proportion of the funds that are generated from the clinical side of the house that do go to support the research infrastructure.

Tacey Ann Rosolowski, PhD

[00:51:43]

Right. There's also a lot of philanthropic support for it.

Alma Rodriguez, MD

[00:51:46]

And there's a lot of philanthropic support for it. So whether we will—as one of the threats that we see to that is that, of course, we know for sure, given the national imperative to cut down on healthcare costs, we know for sure that the degree to which we will be able to support research in the future from the clinical side of the enterprise is going to diminish very significantly.

[00:52:21]

Sooner rather than later. I mean, everyone is anticipating very late, but we know that by 2019, we already have very significant likely reduction in the reimbursement for healthcare in general, but for cancer care specifically. We are one of the biggest cost items on the Medicare bill, and so we will be a target. And by “we,” I don't mean just MD Anderson. I mean cancer care in general.

Tacey Ann Rosolowski, PhD

[00:52:57]

Cancer care in general, yeah.

Interview Session: 04
Interview Date: June 1, 2015

Chapter 26

Turbulence During Dr. DePinho's Early Presidency; MD Anderson's Future

B: Institutional Change;

Story Codes

B: Critical Perspectives on MD Anderson;
B: MD Anderson History;
B: MD Anderson Culture;
B: Growth and/or Change;
C: Leadership
D: On Leadership
B: The MD Anderson Brand, Reputation;
C: Professional Practice;

Tacey Ann Rosolowski, PhD

[00:52:57]

How are—how has this change in focus reverberated in MD Anderson culture, and kind of where you see, you know, sort of day-to-day priorities? You know, what's your read on that? I mean, obviously, there's been a lot on tension amongst the faculty, kind of questions on how the culture is changing. What's your perspective on that?

Alma Rodriguez, MD

[00:53:31]

Well, my perspective on how or why things have not gone so well is that the magnitude of the change, the magnitude of the infrastructural change, philosophical change and operational change of this new way of identifying MD Anderson, it's a transformational change of such magnitude that it would require—from what all transformation literature says, it requires a really major imperative in urgency message to begin with. And I don't think that the imperative of the message for change was verbalized. It was more—how can—I think that the imperative for change was seen as a change driven by the vision of a single individual, rather than a change being required by a certain dramatic threat, or a dramatic desire in the organization for the change. And it also was not seen as risking, if you will, from a groundswell, up. It was seen as an imposed vision. And so most transformation literature says that under such situations, if there isn't an overwhelming threat to the survival of an organization, when the change is being driven by a single individual vision, it is not going to succeed, or it will have a really difficult time in begin implemented. Because the rest of the group will see it as a threat to their own identity; to their own personal vision, and so on. So—

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[00:55:58]

At the very least, people like to be asked. (laughs)

Alma Rodriguez, MD

[00:55:59]

Exactly. Exactly. And it's a matter of, you know, it's a matter of identity, it's a matter of integrity, it's a matter of preserving, if you will, the wholeness of a group's identity. I think that's what happened. I mean, that's how I interpret it, just from what I know of change, and how—you know, change in itself is difficult to begin with, even when it's being mandated under a crisis. It is so much more difficult when there is no perceived immediate crisis and when it is not an integrated vision. And at the time, you know, we really did not have a perceived crisis. Dr. Mendelsohn had left us on a fairly good ground; we were productive, we were doing a lot of good work. We were expecting change, but I think we had hoped to all participate in the creation of the change. I think that the change process was imposed on very rapidly, with very little integration, if you will, grassroots.

Tacey Ann Rosolowski, PhD

[00:57:36]

Do you feel that the executive leadership has its certain moments, you know, recognized certain missteps and tried to take corrective action, and if so, how effective has that been?

Alma Rodriguez, MD

[00:57:52]

Well, I think so. I—or at least there have been several town hall meetings, things have been explained. We've had the Chancellor come. I mean, let me say that I don't think that Dr. DePinho would have imposed his vision on our organization without the explicit support, and possibly even a mandate, by the Board of Regents of the University of Texas system. That would never have happened. So the people who really had to see how misguided that approach was had to be the Board of Regents.

Tacey Ann Rosolowski, PhD

[00:58:38]

Right.

Alma Rodriguez, MD

[00:58:40]

And it took a long time for them to pay attention. (laughs) So let me say that I am not impressed with the governance of the University of Texas system. And no matter how well-meaning the

Interview Session: 04
Interview Date: June 1, 2015

Chancellor is, we also know the Chancellor has only certain limited powers; because in the long run, the Chancellor reports to the Board of Rents, and they, in turn, report to the Governor. So I think in the longer picture, I think this is a symptom of the dysfunction of governmental bureaucracies and how authoritarian systems can be destructive to creative enterprises. The same thing happened with CPRIT [Cancer Prevention Research Institute of Texas], it almost went down the tubes because of meddling from bureaucratic, or at least governmentally-associated individuals, and so on. So it's—

Tacey Ann Rosolowski, PhD

[01:00:04]

Or, pretty removed from the processes—

Alma Rodriguez, MD

[01:00:06]

Exactly.

Tacey Ann Rosolowski, PhD

[01:00:06]

—on the ground, yeah.

Alma Rodriguez, MD

[01:00:09]

Exactly.

Interview Session: 04
Interview Date: June 1, 2015

Chapter 27

Creating a Future Under the Affordable Care Act

B: MDACC in the Future;

Story Codes

B: Critical Perspectives on MD Anderson;
B: MD Anderson History;
B: MD Anderson Culture;
B: Growth and/or Change;
B: The Business of MD Anderson;
B: MD Anderson in the Future;
B: Institutional Processes;

Tacey Ann Rosolowski, PhD

[01:00:10]

What's your prognosis? We're in year four, coming up on the Moon Shot's anniversary soon. You know, what—what's the temperature now, and what do you think is going to happen, what needs to happen to get the Institution onto a track? It'll be different, obviously, but how to get it on track into a place of where the creativity is recognized, where the culture is--

Alma Rodriguez, MD

[01:00:46]

Yeah—

Tacey Ann Rosolowski, PhD

[01:00:51]

—evolving in a productive way?

Alma Rodriguez, MD

[01:00:51]

Well, I'm not trying—I hope this doesn't sound like I'm evading the question—

Tacey Ann Rosolowski, PhD

[01:00:57]

No.

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[01:00:57]

—but the answer is I truly don't know in that regard. Because I'm actually much more focused on the real threat, the very real threat, very imminent threat of the changes, speaking of another authoritarian system, of the healthcare system governed by the federal new loss around reimbursement for healthcare, specifically for Medicare, which is a significant portion of our patient population, but that will be across the board, the overwhelming likely population in healthcare another ten years from now. And for us in cancer, the threat is really very imminent because, like I said, probably by 2019, given the number of changes that are coming, we likely will be seeing anywhere from five to ten percent reduction in reimbursement, or at least that's what the pundits say, or predict. That degree of loss of revenue is certainly going to make certain enterprises in this organization unsustainable.

Tacey Ann Rosolowski, PhD

[01:02:09]

Which kinds of—what are the categories of activity?

Alma Rodriguez, MD

[01:02:10]

Well, I can't predict entirely, but I can tell you that we would not—I already mentioned that we provide a very substantial support to infrastructure for research. We would not be able to afford that. We will not be able to afford that in the future. Now, so seeing that perspective of the future, I have to say I sincerely hope that Dr. DePinho's vision comes to pass, that we will be able to generate revenue from the research enterprise of the house, because the clinical side of the house cannot support it.

Tacey Ann Rosolowski, PhD

[01:02:45]

Can't do it. Yeah. Yeah. And as I understand it, the burden on clinical providers has a systematic—

Alma Rodriguez, MD

[01:02:53]

Is only progressive.

Tacey Ann Rosolowski, PhD

[01:02:54]

Yeah, it's been increasing.

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[01:02:56]

It's progressive, and the progressive increase is unsustainable. I mean, there's a threshold above which really sanity, creativity, productivity, declines.

Tacey Ann Rosolowski, PhD

[01:03:14]

Yeah.

Alma Rodriguez, MD

[01:03:15]

And so for some Physicians, I can tell you that the burnout is imminent, if not already active.

Tacey Ann Rosolowski, PhD

[01:03:24]

And that's even—and I'm thinking, too, of, you know—I mean, clinicians come in, obviously, with a presumption that they'll also be doing research, and that it's pretty impossible to keep that professional balance.

Alma Rodriguez, MD

[01:03:38]

Correct. That's correct.

Tacey Ann Rosolowski, PhD

[01:03:42]

Yeah. Yeah. I mean, you know, I'm not sure what question to ask you about, you know, this specter that's looming. You know, is your office looking ahead towards this moment, 2019? Or at least these other changes—

Alma Rodriguez, MD

[01:04:00]

Yes.

Tacey Ann Rosolowski, PhD

[01:04:02]

What kinds of questions are you entertaining? What kinds of actions are you starting to take?

Alma Rodriguez, MD

[01:04:09]

Interview Session: 04
Interview Date: June 1, 2015

Right. So first of all, we need to educate people, and the message is slowly making its way down the ramps. In fact, this week, there was a symposium in which economic issues of healthcare were discussed. There are some very specific changes that we will need to make; number one, we will need to be much more conscientious about the documentation of what we do and how we do it, because those, in the end, you know, the attorneys say, if it's not written, it didn't happen. That's a lawyerism. But that is a fact. If it's not somewhere where it can be—that information can be retrieved, then that information cannot be conveyed; it cannot be reported, it cannot be seen. So managing information is going to be one of—it has to be an imperative that we take very seriously. And to that end, I'm hoping that our new Electronic Health Record will be one of the tools to facilitate that for us. But in the end, you know, any system is purely that; it's just a system, it's just a method, it's just tool. It has to—everything hinges on human behavior; so how we do what we do and how we document what we do is going to be imperative. Secondly is that we have to feel comfortable with looking at this information, that we don't get defensive, that we don't get angry and that we simply see it as opportunities for change, or opportunities for self-reflection and self-improvement. And that's a major psychological and cultural shift in medicine, simply because we tend to see everything as—anything that doesn't align with what we hope or expect of ourselves, we see that as embarrassing, humiliating, deprecating, etc.

Tacey Ann Rosolowski, PhD

[01:06:24]

And get defensive.

Alma Rodriguez, MD

[01:06:26]

Then a defensive attitude is generated. We have to get over that, and we simply have to see it as just information. Information that might require some change, or might not. It may be fabulous. We may surprise and shock ourselves and do extremely well. That's what I hope for. We happen to be a culture that is very, like I said, performance-driven. I'm hoping that that culture will show in its best light as one that will see this information towards better performance, rather than towards self-flagellation, if you will.

Tacey Ann Rosolowski, PhD

[01:07:10]

Right. Yeah. Absolutely.

Alma Rodriguez, MD

[01:07:13]

So those are very—so information, information, information—

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[01:07:18]

Mm-hmm?

Alma Rodriguez, MD

[01:07:18]

—is an important one. The second one is acquiring a totally different set of skills that have to do with—I'm trying to think of the appropriate terms—but it has to do with shifting from the expert-centered mentality that we have lived with, which has been—and that many of us were trained with, as a matter of fact, which is, Dr. So-and-So is the most knowledgeable person, and whatever he or she says, goes, because they are the best. Going from that to saying, what do we know, what has been demonstrated, what is the best data? And it doesn't have to be our own data; what is the best data from all our peers? And what is the most appropriate, taking all of these factors into consideration? Never mind that I am the Big Kahuna, what do my friends and peers think about this particular situation? So although we talk about evidence-based care, the truth is that culturally, we still have a great deal of the expert mentality. I think we'll have to overcome that to a greater degree. Most of the young Physicians, actually, are very attuned to the knowledge-based decision-making process versus the expert. It's also a generational thing.

Tacey Ann Rosolowski, PhD

[01:09:12]

Yeah.

Alma Rodriguez, MD

[01:09:15]

And I think as we move towards a younger workforce, we will, hopefully, also overcome the expert base mentality. That's another cultural change that we will have to overcome.

Tacey Ann Rosolowski, PhD

[01:09:26]

Interesting. Yeah.

Alma Rodriguez, MD

[01:09:29]

And lastly, that we will have to also think very consciously about the value of all the resources we have; how fortunate we are to have as much as we have, and how at some point, we can't keep demanding more, that we will have to make do the best with what we've got. How can we most optimally utilize resources? That's the other skillset; resource utilization and consciousness and awareness about resource utilization. So managing information, managing knowledge and

Interview Session: 04
Interview Date: June 1, 2015

managing resources.

Tacey Ann Rosolowski, PhD

[01:10:23]

And resources, yeah. Yeah. Very interesting. A lot of change demanded. You know, it is a different Institution, in different times.

Alma Rodriguez, MD

[01:10:37]

Mm-hmm [affirmative].

Interview Session: 04
Interview Date: June 1, 2015

Chapter 28

Women and Leadership at MD Anderson

B: Diversity Issues;

Story Codes

A: The Leader;
A: The Mentor;
C: Leadership
C: Mentoring
B: Critical Perspectives on MD Anderson;
B: Gender, Race, Ethnicity, Religion;
A: Experiences Related to Gender, Race, Ethnicity;
C: Women and Minorities at Work;
B: MD Anderson History;
C: MD Anderson Culture;

Tacey Ann Rosolowski, PhD

[01:10:39]

Yeah. You want to shift gears right now?

Alma Rodriguez, MD

[01:10:41]

Yes, I'm—(laughter) I think I've said all I can about—

Tacey Ann Rosolowski, PhD

[01:10:49]

You've said—

Alma Rodriguez, MD

[01:10:48]

—the future of medicine!

Tacey Ann Rosolowski, PhD

[01:10:50]

Yeah, you've said a lot. No, I mean, it's very interesting, because I appreciate your style of responding to questions, because you like to set things in a broader context, and that's very useful. That will be incredibly useful for people who are listening to this. And it provides another layer of understanding of the Institution and how it's responding not merely to an

Interview Session: 04

Interview Date: June 1, 2015

internal set of pressures, but you know is also in a much broader field of change. Yeah. I wanted to ask you about track for women at the institution. You've seen a lot of change in that area too, that's something we really haven't discussed.

Alma Rodriguez, MD

[01:11:40]

Well, I think that we are in a positive direction. And again, frankly, I don't think that the institution can go in any other direction than in a positive one in this regard, simply because the workforce of medicine in the future is about women, even today. Today, at least there's parity in the number of newcomers to the medical school classes, in fact, in some medical schools there's even a predominance of female students over male students. I predict that that will be sustained, simply because as more medical schools are also integrating behavioral characteristics, not just intellectual or rational intellect as their selection criteria for classes, but also, they're now doing the interviewing for interpersonal skills, I think that it'll be a natural selection process, I think, that women will continue to be a major presence in medical education.

So the pipeline for new people coming into medicine is female. We will be seeing more female physicians come to the organization as well, I hope. And that, in turn, will also give us a bigger pool of potential candidates for leadership. The truth is that beside—you know, there's the old ongoing conversation or arguments, are leaders born or made? The truth is, it's both. I think you have to have certain interpersonal skills; it's certain personality traits that direct people towards—or incline people towards leadership roles, but at the same time you also need to learn certain skills. You're not just a leader because you feel like you're one. You have to have—you have to learn certain things. And I think in the brave new world of medicine in the future, all of those skills that I mentioned, you know, knowing about information systems and infrastructure, knowing about best evidence, knowing about what others are doing, what the best practices are across various levels of the organizations in healthcare, and also understanding resource management—all of those are going to be really critical for leadership. You cannot just make good speeches. You have to know systems in order to manage well, to lead well.

Tacey Ann Rosolowski, PhD

[01:14:34]

I was really, you know, interested that—as you were describing the sequence and roles that you took on, you know, you spontaneously talked about the leadership training that each one of those roles gave you.

Alma Rodriguez, MD

[01:14:50]

Right.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[01:14:52]

So it was an interesting, you know, kind of second theme, you know, running through those parts of our conversation. And I was curious, you know, really how you felt your own leadership track has evolved. You know, what is smooth? I mean, did you encounter obstacles? Did you see other—your peers among women encountering obstacles at the Institution? In other words, what was the environment as you were coming up for kind of free growth into leadership, as a woman?

Alma Rodriguez, MD

[01:15:32]

Oh gosh, well, I don't think it existed. I—well, first of all, there weren't very many of us in the organization. So I have to say there's both good and bad aspects of that. You know, if there aren't enough of us, then the opportunities might be fewer. On the other hand, because there are fewer of us, we stand out more. And I think that depending on how much one is willing to put a foot forward, one can create opportunities in that kind of environment, where one is visible to some degree. I think that happened to me. I just simply—I was willing to do some of the tasks that other people were not willing to take on. And thankfully, I happened to have some aptitude for carrying them out well.

And so I think that that's—I mean, to some degree, I think that that was how things happened for me. I don't think anyone consciously was thinking, let's create a career path for person X, Y or Z. Truly, I don't think that ever has been in the consciousness of the organization, even today. I think that although we have a lot of leadership training courses and so on, we're still struggling with, how do we select people appropriately for leadership roles? How do we encourage succession planning? How do we strategically think of that? I mean, you asked me previously about the organizational leadership on the larger scale. So, for example, it was no secret that Dr. Mendelsohn had on-boarded Dr. [Raymond] DuBois, because he wanted to have a succession plan in place when he stepped down. And he had envisioned all along Dr. DuBois, I think, was going to be his successor, or at least that's what we understood. But that did not happen. And so even in the best-laid plans, the succession planning, we have not been successful at carrying that out. I can tell you that I don't think that Dr. [Thomas] Buchholz was in any one succession plan to be our Executive Vice President for Operations. But he sort of was appointed to that. So the rules of how leadership is designed, if you will, or preemptively planned at this organization are not clear.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[01:18:35]

And then there's the question of how women fit into it when there's an absence of women here at the highest levels of leadership.

[01:18:46]

Alma Rodriguez, MD

[01:16:44]

Correct. Correct. My own personal strategy for this is to encourage as many of the women who I see express an interest, or a potential, for leadership. I encourage them to take on tasks that may be a little bit of a stretch for them. As much as possible I champion them or sponsor them, recommend them. But in the end, really it is an individual choice. People have to be willing to take things on and carry them forward. And then supplement their own innate skills of leadership with additional knowledge.

Tacey Ann Rosolowski, PhD

[01:19:41]

Were you involved in [Office of] Women Faculty Programs at all? Or in the original committee of women that began to review salaries, for example, in recruitment strategies?

Alma Rodriguez, MD

[01:19:54]

I'm not sure when—I mean, I've always had some link or connection to the Women's Academic Affairs office. I've participated on and off in various committees, but did I consciously want to do the salary review initiative? No. It was not my initiative. I mean, that came from Liz [Elizabeth Travis, PhD]—

Tacey Ann Rosolowski, PhD

[01:20:16]

Liz Travis? Yeah. OK, I was just curious, because, I mean I don't have perfect memory of the names of everyone who was—

Alma Rodriguez, MD

[01:20:23]

Yes. But actually, the whole initiative stemmed from the faculty senate, they wanted to know if their salaries were fair. It turns out women's salaries were not fair, and so I was the beneficiary of that. (laughter) And I'm deeply grateful to the faculty senate for their interest in that topic way back when.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[01:20:41]

Yeah, absolutely. Absolutely. Is there anything else that you wanted to say about this issue of women at the institution? Or, anything else at this point?

Alma Rodriguez, MD

[01:20:57]

Well, I think that the women at this Institution are amazing, simply because I see them juggling so many roles. Most of them are mothers, wives, Physicians, researchers, leaders. They have so many hats. I just, I'm in awe of them, really. I don't wear half as many as they do. And I think that they're admirable in how well they perform at so many tasks. I, you know, from the perspective of—if you ask me do I think that MD Anderson has the talent to embrace the future? Yes, I do. I'm hopeful, however, that that talent will be appropriately harnessed.

Interview Session: 04
Interview Date: June 1, 2015

Chapter 29

Accomplishments, Retirement, and a Love of Cosmology

A: View on Career and Accomplishments;

Story Codes

A: Character, Values, Beliefs, Talents;
A: Personal Background;
A: Influences from People and Life Experiences;
A: Career and Accomplishments;
A: Post Retirement Activities;
A: Professional Values, Ethics, Purpose;
A: Faith;

Tacey Ann Rosolowski, PhD

[01:22:02]

I had—we're at 3:30, but I had just a few more questions I wanted to ask you, if we could go over a tiny bit, is that OK?

Alma Rodriguez, MD

[01:22:10]

OK—

Tacey Ann Rosolowski, PhD

[01:22:11]

Or do you—

Alma Rodriguez, MD

[01:22:11]

Sure. There was one other—I know there was a meeting I'm supposed to go to.

Tacey Ann Rosolowski, PhD

[01:22:14]

OK. Do you want to check on the time?

Alma Rodriguez, MD

[01:22:15]

Let me check on the time.

Interview Session: 04

Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[01:22:17]

OK. I'll just pause this for a moment. [The recorder is paused] All right, we paused just for a couple of seconds. Well, I wanted to ask you, kind of, you know, retrospective look. What do you feel most contented to have set in place or accomplished during your time as VP [Vice President] of Medical Affairs? Or, in general here at the Institution?

Alma Rodriguez, MD

[01:22:45]

Well, I'm very happy to have been charged and to have successfully launched the whole concept of survivorship care. I'm also very happy to have initiated, and hopefully by this time sufficiently embedded into the organizational structure the concept and roles of quality officers within the departments, because I think that that is going to be a really integral role and process for the future of how we conduct medicine. I'm also hopeful that I will be able to, before I retire, to change the culture enough to embed into our day-to-day processes the whole Advanced Care Planning conversation, and to also embed into the consciousness that this is not just about talking about dying, for God's sake, that's not it! It's about considering all aspects of one's future, and how healthcare will be, how one will plan for healthcare in whatever faces of life come in the future; whether it's wellness or protracted illness or end-of-life. Any of those are in the future of any one of us, really.

I'm also very happy to have been, and to continue to be, I hope, a champion for the Physician Assistants program, which was a relatively small group when I took on this job, and now has grown to really a major workforce in the organization. I deeply respect them as professionals; I think they're very important and critical in helping us carry out our mission. And they're going to be here to stay, as well. And I'm very happy to have helped everyone who, in some way, has reached out to me. I hope I've been an appropriate role model for them, and that I've stimulated them to extend their potential.

Tacey Ann Rosolowski, PhD

[01:25:40]

Exciting role.

Alma Rodriguez, MD

[01:25:42]

Yes, thank you.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[01:25:43]

Do you have retirement plans?

Alma Rodriguez, MD

[01:25:52]

Well, yes and no. I know that I do wish to retire. I don't envision myself being here forever. I don't have a defined date, but I do want—I don't see myself lingering here forever, like some people have in the past.

Tacey Ann Rosolowski, PhD

[01:26:20]

What are you looking forward to doing?

Alma Rodriguez, MD

[01:26:21]

I actually am looking forward to learning totally different disciplines than medicine.

Tacey Ann Rosolowski, PhD

[01:26:29]

Such as?

Alma Rodriguez, MD

[01:26:33]

I'm very interested in psychology, I'm very interested in cosmology. I'm very—

Tacey Ann Rosolowski, PhD

[01:26:36]

Oh, really? How neat!

Alma Rodriguez, MD

[01:26:36]

—interested in art.

Tacey Ann Rosolowski, PhD

[01:26:40]

Uh-huh? Do you practice any kind of art form? Do you paint, or—

Alma Rodriguez, MD

Interview Session: 04
Interview Date: June 1, 2015

[01:26:43]
I used to paint.

Tacey Ann Rosolowski, PhD
[01:26:48]
Really?

Alma Rodriguez, MD
[01:26:48]
I have not painted for probably twenty years.

Tacey Ann Rosolowski, PhD
[01:26:49]
Wow. That's wonderful!

Alma Rodriguez, MD
[01:26:49]
I hope I'll pick it up again.

Tacey Ann Rosolowski, PhD
[01:26:54]
Yeah. Anything else? Other kinds of areas that you're planning on exploring during retirement?

Alma Rodriguez, MD
[01:26:59]
I think that's enough.

Tacey Ann Rosolowski, PhD
[01:27:01]
Yeah, that is enough. And when you cosmology, do you mean astronomy, or do you mean, you know, reading the cards?

Alma Rodriguez, MD
[01:27:10]
Oh no no, I mean astronomy.

Tacey Ann Rosolowski, PhD
[01:27:11]
Astronomy.

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[01:27:11]

And understanding the birth of the universe.

Tacey Ann Rosolowski, PhD

[01:27:14]

Oh, cool. Very cool! (laughter)

Alma Rodriguez, MD

[01:27:16]

I'm looking forward to people finding out exactly what dark matter is. I hope that happens in my lifetime.

Tacey Ann Rosolowski, PhD

[01:27:25]

Yeah, I'm a big fan of dark matter myself. This sort of idea that emptiness holds us together is pretty cool. (laughter)

Alma Rodriguez, MD

[01:27:33]

But that's the thing, it's not empty.

Tacey Ann Rosolowski, PhD

[01:27:33]

It's not totally empty, I always think that. What are they called, WIMPs? Weekly Interactive Massive Particles, or something like that? Yes. Very cool stuff. Very cool stuff. And is there anything that you would like to share about who you are as a person behind the role, you know, a special hobby, or fascination, or talent?

Alma Rodriguez, MD

[01:28:00]

Oh, gosh.

Tacey Ann Rosolowski, PhD

[01:28:07]

A book you read that changed your life?

Alma Rodriguez, MD

Interview Session: 04

Interview Date: June 1, 2015

[01:28:07]

Oh, the book I read that changed my life, well, I think that book was one that I read many, many—it wasn't a book, it was a whole discipline of books. I have a minor in philosophy from my college, and I was most influenced at the time by the process philosophers, which—maybe that's why I like cosmology as well, because their point of view is that unlike the platonic classic view that everything is fixed, and there is an underlying structure to reality, the process philosopher's point of view is that philosophy is a constantly evolving and self-creating reality. Or reality self-creates. Which, if one believes in the underlying force of reality being a god or a mind, or the universal mind, it's exciting to think that the universal mind is self-creating as well, along with its creation. So it gives me a sense of being part of the creative process of the universal mind, and that, I think, is exciting.

Tacey Ann Rosolowski, PhD

[01:29:36]

Does that have a spiritual dimension to it for you?

Alma Rodriguez, MD

[01:29:38]

Oh, sure. Of course.

Tacey Ann Rosolowski, PhD

[01:29:42]

OK. Yeah. How does that—

Alma Rodriguez, MD

[01:29:43]

I think it explains everything.

Tacey Ann Rosolowski, PhD

[01:29:44]

It explains everything. (laughter) Does it play out in your professional life and your personal life? That fundamental belief?

Alma Rodriguez, MD

[01:29:53]

Well, I think in my professional life, it helps me to deal with change. I mean, there is no such thing as stability. I mean, nothing is static. Everything is in motion. The planet is in motion. I mean, here we are hurling through space, I don't know how many thousand miles per second. We don't perceive it, we're not conscious of it, but it's happening even as we stand here, so the

Interview Session: 04
Interview Date: June 1, 2015

next moment, maybe we'll be coursing through a worm hole that will throw us into a totally different universe, how do we know, right?

Tacey Ann Rosolowski, PhD

[01:30:19]

And wouldn't that be a cool event?

Alma Rodriguez, MD

[01:30:23]

Yeah! (laughter)

Tacey Ann Rosolowski, PhD

[01:30:24]

And in your personal life? Does that play out there too?

Alma Rodriguez, MD

[01:30:30]

I have to say my personal life, paradoxically, I like routine and stability. (laughter)

Tacey Ann Rosolowski, PhD

[01:30:39]

It helps you get [inaudible] change here.

Alma Rodriguez, MD

[01:30:40]

Some things have to be steady and stable, otherwise you could be hurled off into space, you know?

Tacey Ann Rosolowski, PhD

[01:30:49]

Absolutely true.

Alma Rodriguez, MD

[01:30:52]

There's value to gravity, OK?

Tacey Ann Rosolowski, PhD

[01:30:53]

There is. Well, is there anything else you'd like to add at this point, Dr. Rodriguez?

Interview Session: 04
Interview Date: June 1, 2015

Alma Rodriguez, MD

[01:31:02]

No. I thank you for the opportunity to have this conversation. It's been very interesting, actually.

Tacey Ann Rosolowski, PhD

[01:31:10]

It has been. Well, I thank you for your time. I really do.

Alma Rodriguez, MD

[01:31:12]

You're most welcome.

Tacey Ann Rosolowski, PhD

[01:31:12]

And it was a really interesting conversation.

Alma Rodriguez, MD

[01:31:14]

So I'm looking forward to seeing the transcript.

Tacey Ann Rosolowski, PhD

[01:31:14]

Yes.

Alma Rodriguez, MD

[01:31:17]

See how many "oops" moments I have.

Tacey Ann Rosolowski, PhD

[01:31:21]

Oh, there'll probably be a few, everybody has those. But, well, I want to thank you for time.

Alma Rodriguez, MD

[01:31:26]

You're welcome.

Interview Session: 04
Interview Date: June 1, 2015

Tacey Ann Rosolowski, PhD

[01:31:26]

And I want to just for the record say that I am turning off the recorder at twenty minutes of four.
Thank you.