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Thomas A. Buchholz, MD

Interview Session One: January 10, 2018

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Chapter 00A
Interview Identifier

Tacey Ann Rosolowski, PhD
[00:00:00]
All right, and we are recording. So it is 20 minutes after 9:00 on January 10th, 2018, and today I am in the Department of Radiation Oncology, in the office of Dr. Thomas Buchholz, and he has very kindly agreed to participate in our interview project. And for the record, I wanted to say I'm Tacey Ann Rosolowski, and I'm conducting this interview for the Making Cancer History Voices Oral History Project, run by the Research Medical Library at MD Anderson. And I just wanted to put a few details about your background, though we'll get to a lot more details, obviously, later on. You came to MD Anderson in 1997?
[00:00:42]

Thomas Buchholz, MD
[00:00:42]
Correct.
[00:00:42]

Tacey Ann Rosolowski, PhD
[00:00:42]
Is that correct? Okay, and you joined the faculty as an assistant professor in the Department of Radiation Oncology. And the division system was already set up at that point, so it was in the Division of Radiation Oncology.
[00:00:53]

Thomas Buchholz, MD
[00:00:53]
That is correct.
[00:00:54]

Tacey Ann Rosolowski, PhD
[00:00:54]
Okay. And you also at that time assumed the role of Director of the Medical School Radiation Oncology Program. Is that...?
[00:01:01]

Thomas Buchholz, MD
[00:01:02]
That is correct, yes.
[00:01:02]

Tacey Ann Rosolowski, PhD
[00:01:02]
All right. And since that time, Dr. Buchholz has served as Chair of the Department of Radiation Oncology, and as Division Head, that from 2011 to 2014, and then from 2014 to 2017 he served as Executive Vice President and Physician In Chief.
[00:01:20]

Thomas Buchholz, MD
[00:01:21]
Correct, and then I was Provost for a little while in between, too.
[00:01:24]

Tacey Ann Rosolowski, PhD

[00:01:24]
Oh, okay, all right, all right. I had neglected to write that down. Well, we'll talk about all those—
[00:01:28]

Thomas Buchholz, MD
[00:01:28]
Okay.
[00:01:29]

Tacey Ann Rosolowski, PhD
[00:01:29]
All those roles.

Interview Session: 01
Interview Date: January 10, 2018

Chapter 01
A Strong Family and Early Experiences with Leadership
A: Personal Background;

Codes
A: Personal Background;
A: Character, Values, Beliefs, Talents;
A: Influences from People and Life Experiences;

Tacey Ann Rosolowski, PhD
[00:01:30]
Well, we agreed we'd start kind of in the traditional place, so I wanted to ask you if you could tell me where you were born, and when, and tell me a little bit about your family background.
[00:01:40]

Thomas Buchholz, MD
[00:01:40]
Sure. So I was born in Louisville, Kentucky, although I didn't last very long in—as a Kentucky native. I think within six months I was moving on. I was born the second of three children to my parents, wonderful Midwesterners. Both my parents were from a small town in Wisconsin, and both went to the University of Wisconsin for their graduate and undergraduate degrees. My dad studied engineering. He went into the Army for a little while, then came back and completed a business degree, in addition to his undergraduate engineering degree.
[00:02:21]

Tacey Ann Rosolowski, PhD
[00:02:21]
And your dad's name?
[00:02:22]

Thomas Buchholz, MD
[00:02:23]
William Joseph Buchholz. And he and my mom went to high school together. She went to the University of Wisconsin in Milwaukee, and studied education, became a public school teacher.
[00:02:36]

Tacey Ann Rosolowski, PhD
[00:02:36]
And her name?

[00:02:37]

Thomas Buchholz, MD
[00:02:37]
Mary Ellen Buchholz.
[00:02:38]

Tacey Ann Rosolowski, PhD
[00:02:42]
And your siblings?
[00:02:43]

Thomas Buchholz, MD
[00:02:43]
I have Daniel Joseph Buchholz, who is my older brother, and John William Buchholz, who is my younger brother. So after my dad got out of the military and they got married, my dad started working in the food industry, as kind of an operational engineer type of person. Initially he was working for Pillsbury, and subsequently started working for General Foods, where he spent the majority of his career, in both operations and management, I would say.
[00:03:25]

Tacey Ann Rosolowski, PhD
[00:03:25]
So did you move around the country a lot, or...?
[00:03:27]

Thomas Buchholz, MD
[00:03:27]
We did, quite a bit. So from Louisville, Kentucky I moved to Grand Forks, North Dakota, where my younger brother was born. We knew—moved from there to Minneapolis. In Minneapolis, I think my dad still worked for Pillsbury. And then—I always respect this from two small-town Wisconsin people who had never really seen the world, except for my father was in Europe for the military for a little while: my dad took a job with General Foods in Brazil. So my mom and three little boys moved to Brazil when I was probably about five, four or five. So we moved to Sao Paolo, Brazil. We were in Brazil for three years. My father worked for General Foods, which had an affiliation with Kibon, K-I-B-O-N. Kibon's still an ice cream manufacturer today in South America. It was an interesting experience, living in Brazil.
[00:04:32]

Tacey Ann Rosolowski, PhD
[00:04:32]

So tell me about that. I mean, often living overseas has a huge impact on people's later lives.
[00:04:37]

Thomas Buchholz, MD
[00:04:37]
It did. It was great, in many respects. Growing up in a foreign country, we went—we became part of an American community there in Brazil. Sao Paolo, as you know, is one of the largest cities in the world, and so, not surprisingly, the American community kind of stuck together and socialized, and... But nonetheless, we really were engrained in the Brazilian culture. I got to enjoy the 1970 World Cup win with Pele, and the greatest football team of all time. And it—we learned Portuguese, and we learned the culture, and it was fantastic. In those days, in corporate America, there was something called "home leave" that places like General Foods would give international people, and that would be—they'd fly your family first class on very—on Pan Am back to the United States, to spend six to eight weeks during the summer months. Anyway, and so we'd sometimes come back to Wisconsin, but sometimes my parents would cash in these first-class tickets and by third-class tickets to tour around South America. So it was really interesting. We saw Iguazu Falls. We went to Machu Picchu, to Lake Titicaca, to Ecuador. We really—we went up the Amazon in a rickety old Peace Corps boat, and wandered through the Amazon jungle, and really kind of a fantastic... And this was right when my memories were first formed. My memories of Minneapolis are less well certain than in Brazil. So it was a—it was a fun experience, and we did that for three years, which was a meaningful time. I started, I guess, kindergarten, first grade, second grade in Brazil.
[00:06:36]

Tacey Ann Rosolowski, PhD
[00:06:36]
Now, did you go to an American school, or an international school? How did that all work?
[00:06:40]

Thomas Buchholz, MD
[00:06:40]
I guess it was called Escuala de la Americana, so I think it was an American school, yeah.
[00:06:44]

Tacey Ann Rosolowski, PhD
[00:06:46]
Now, looking back, how do you feel that experience had an influence on you? I mean, that's a time—around seven is also when kids are—their brains are really kind of taking in the complexity of the world, and...
[00:07:01]

Thomas Buchholz, MD
[00:07:01]
Yeah. I think it gave me appreciation for the world, and diversity, and different cultures. I mean, it was natural for me at that time to be exposed to something so different than America. We did have these blocks of time when we'd come back to America and there were some niceties. I remember I still kept a Hershey's chocolate wrapper under my pillow, and I could smell it before bed. And we missed, like, turning on the tap and drinking water, and other things. But, of course, Brazil was still kind of a chaotic third-world country, and so we had some niceties. Like, we had a maid, and we had a chauffeur, and we... It was just a fun... I think I also learned from my parents—I really to this day admire their courage for just going for something like this. Nowadays, when my kids were small and you're thinking about, oh, do we want to worry about a hotel room and all this and this. Boy, to just hop on and tour around what sometimes was—of course, memories sometimes get overdramatized, but just even some unsafe situations (laughs) where you're like, wow, that was kind of courageous to go for it.
[00:08:29]

Tacey Ann Rosolowski, PhD
[00:08:28]
Absolutely.
[00:08:29]

Thomas Buchholz, MD
[00:08:29]
And so I also grew to respect, from my parents, kind of this—"you've got to go out there and live your life and have the courage to go for things," and...
[00:08:39]

Tacey Ann Rosolowski, PhD
[00:08:39]
Yeah. I mean, I was thinking as you were saying—because, I mean, I did live overseas for a time, myself, and seeing parents who didn't really embrace the situation—I mean, they were quite fearful, and they communicated that in some ways to their kids, and limited the possibilities. So you had kind of the best of everything with that.
[00:08:57]

Thomas Buchholz, MD
[00:08:57]
We did, yeah. And we had a really close family, obviously. My brothers and I have been really close throughout our life, in part because of our travels. And our travels didn't end with Brazil. We moved to Wilton, Connecticut, where—which was close to White Plains, New York, which is kind of a hub for General Foods. We only lasted there for third grade, before we sat down

with Dad again and moved to Walla Walla, Washington, on the other end of the country. And I went to Walla Walla just for fourth grade, and then moved from Walla Walla to—back to the East Coast, to upstate New York.
[00:09:40]

Tacey Ann Rosolowski, PhD
[00:09:40]
Oh, where were you?
[00:09:42]

Thomas Buchholz, MD
[00:09:42]
There's a small town called Fulton, New York, which is north of Syracuse, between Syracuse and Oswego. It's geographically located in the absolute worst place for lake effect snow, (laughter) so the amount of snowfall that Fulton receives is just unbelievable.
[00:10:02]

Tacey Ann Rosolowski, PhD
[00:10:02]
I spent a good deal of time in Buffalo, New York, so... (laughter)
[00:10:04]

Thomas Buchholz, MD
[00:10:04]
Yeah. So we even got twice as much snow as Syracuse.
[00:10:08]

Tacey Ann Rosolowski, PhD
[00:10:08]
That's amazing.
[00:10:09]

Thomas Buchholz, MD
[00:10:09]
And it was... And it was an interesting town. My father eventually became plant manager of a Birds Eye there, and Fulton was a blue collar plant town. There were four plants. There—Miller Brewery came in, which was a big windfall for the city. There was kind of Armstrong Flooring, Birds Eye, and an ice cream plant. Oh, and a Nestle plant. So most of my peers—the industry of town was everybody worked in one of those plants. And so it was a pretty blue collar town. It was a town of 15-18,000 people. And I really grew up there. I feel like that's my home. I was there from fifth grade through eleventh grade, so I did a lot of those exciting times of being a kid,

from playing in the neighborhood to getting your driver's license to going out on your first date, playing high school athletics, etc. And it was a fun time to grow up, and I really enjoyed it. We had a good quality of life, too. I got a good education in the public school system, but at the same time I think only about 15-20% of the graduates from our high school went to college.
[00:11:34]

Tacey Ann Rosolowski, PhD
[00:11:35]
Now, tell me a little bit about your educational development at this point. What were you—what did you find you enjoyed? What were you gravitating toward? What thrilled you? If "thrill" is the word.
[00:11:48]

Thomas Buchholz, MD
[00:11:47]
Intellectually? (laughs)
[00:11:48]

Tacey Ann Rosolowski, PhD
[00:11:48]
Yeah, yeah. Or not. (laughter) Sort of the—
[00:11:52]

Thomas Buchholz, MD
[00:11:51]
Well, I think I grew up kind of as a normal kid. I was... I did well in school. Again, it wasn't similar to going to, like, St. John's, this... But I had more of an affinity to math and science, not surprisingly. I guess that's kind of the doctor thing. My dad was an engineer, so he was a very pragmatic, Midwestern math/science guy, and my brother was good in math/science. And then I was consumed with athletics, too. I was very interested in football, basketball, and baseball, kind of the all-American small town sports. And I played in those from fifth grade on, really, in various phases, and up into the public high school arena, and up to the varsity level at that time. So sports was really important. Ironically, leadership kind of always was a component of that. I moved, again, midway through my fifth grade year, and in sixth grade I was the class president of my sixth grade class. And then I became various leaders of various sports teams I was on. Became leader of Honor Society in high school.
[00:13:17]

Tacey Ann Rosolowski, PhD
[00:13:17]

So tell me about deciding to do that. Because you have to make the choice to step forward and run, and...
[00:13:22]

Thomas Buchholz, MD
[00:13:21]
Yeah. Oftentimes, it hasn't been such a conscious thing, or it hasn't been something that I really have been driven towards, but rather encouraged to do. Like, "Why don't you do this?" "Oh, okay." "Oh, you'd be great as our leader. Why don't you go ahead and do this?" And, "Oh, okay."
[00:13:47]

Tacey Ann Rosolowski, PhD
[00:13:47]
What do you think people saw at that point in you?
[00:13:49]

Thomas Buchholz, MD
[00:13:49]
Because the path just continued. The path continued in college, and in medical school, and after medical school, and then certainly here at MD Anderson the same. And this career path that I've had has given you time to stop and ponder and say, "How did I get these opportunities?" Because leadership—sometimes you could plan. You could have a five-year plan. And mine wasn't that story. It was just, like, life unfolding in front of you, and deciding to pursue opportunities.
[00:14:28]

Tacey Ann Rosolowski, PhD
[00:14:29]
When did you start becoming aware of your particular style, or the abilities that you had as a leader? Because every leader's different.
[00:14:40]

Thomas Buchholz, MD
[00:14:40]
Yeah. Well, as I reflected, why did I have these opportunities, I think it comes down to innate ability to connect with people and form relationships in an authentic and trusted fashion. And that wasn't anything that I'd necessarily learned from leadership training, per se. It was just part of who I was. And I think, again, I have to give credit to my parents, who instilled in all of us basic core values that really resonated during my youth, and I carry with me today, and that's my mom really stressed the importance of caring for people. As a public school educator in often

underprivileged areas, she really wanted all of us to give back to the world in some meaningful fashion. And my dad always, again, had the courage to, whenever given an opportunity, to say yes to. And I think I had that courage, too. I'd see my dad as a role model. And sometimes saying yes is hard, right? Because it puts different strains on your family. My dad, at the end of our tenure there in Upstate New York, kind of lost his job, so to speak, as plant manager. It was kind of going away. But he didn't lose his job with General Foods, but he said yes to some international work that displaced him from his family, and he worked in Colombia and Venezuela and Puerto Rico and Mexico. And that's a long way from Fulton, New York, and it wasn't clear that these were permanent jobs, so that we weren't moving to Colombia. And so it ended up being a two- or three-year thing, but it gave him new opportunities, and that. So I think both my parents gave me kind of a skillset to connect with people in a caring and thoughtful, empathetic type of way. And then my dad's courage to just go for it and feel comfortable in uncomfortable situations, or being comfortable trying something new, and not necessarily being obsessed with failure. Those are good traits, and so I've often kind of... Some of these things you think are self-evident to—like, that everybody in the world would see the world this way, because most of what I learned about leadership training came from after school sitting down with Mom, and talking about life, and the way you're supposed to live life, rather than get an MBA degree on leadership or so.

[00:17:50]
So... But yeah, I think leadership, like I said, had been kind of a consistent part of my life, dating back to elementary school. And then in high school, too, and in college. Seems like I always was first appointed social chairman, and then from social chairman moved to president or whatever. And it kind of followed, because that social connectivity of forming relationships with people, and then having the people themselves saying, "Hey, we want you to be the leader, because we trust you. You're efficient. You're..." I had enough native intelligence to handle situations. I was able to see the world through their eyes, and incorporate those thoughts into various decisions. I was president of my medical school class, for instance. That gets kind of caught up in minutial details of who gets to rotate in which service then, and how does that fit into getting married, or having a child, or other things, and still maintaining some objectivity and fairness to probably what are inconsequential decisions, (laughs) quite honestly, but...
[00:19:20]

Tacey Ann Rosolowski, PhD
[00:19:21]
Well, not inconsequential to the people who are making them, by any means. (laughter)
[00:19:24]

Thomas Buchholz, MD
[00:19:23]
That's right. That's right.

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[00:19:25]

Interview Session: 01
Interview Date: January 10, 2018

Chapter 02
The Decision to Enter Medicine
A: Educational Path;

Codes
A: Personal Background;
A: Inspirations to Practice Science/Medicine;
A: Influences from People and Life Experiences;
A: Character, Values, Beliefs, Talents;

Tacey Ann Rosolowski, PhD
[00:19:25]
Well, and the fact is institutions are made up of individuals, and... Yeah, very interesting. Now, you mentioned medical school. When did the thought occur to you that medicine might be, or medically-related fields might be something you'd be interested in?
[00:19:40]

Thomas Buchholz, MD
[00:19:42]
It came about the second year of college. Prior to that, though, I guess I had another what some would consider a life event, in that I had to move my senior year of high school, because my father eventually found his permanent position, and it was back in White Plains. And so after this six-year period where—longest we've ever lived in any place, we moved from Upstate New York down to Rye, New York. Rye is 180 degrees different than Fulton. It's a country club, Manhattan suburb community, where 95% of the graduates in my Rye high school went on to college, and it was a completely different socioeconomic rung. We were certainly one of the wealthiest families in Fulton and one of the poorest families in Rye, (laughter) I think, despite both my parents having a good income, etc. But that was—ended up being a great transition for me, too. That's where athletics really helped me, because I played football, and being introduced into a new school as part of a fall sport really gave me an immediate group of friends, and a conduit to meet everybody in the school quite easily. And subsequently, I think Rye's such a beautiful town, and those friends that I developed my senior year have been great. From there, I went to Bucknell University in Pennsylvania.
[00:21:18]

Tacey Ann Rosolowski, PhD
[00:21:19]
How did you make that choice?
[00:21:21]

Thomas Buchholz, MD
[00:21:22]
I liked Bucknell because it was a right size for me. It was relatively small, but standards—I think we had about 800 in our class, so about 3,500 people at Bucknell.
[00:21:36]

Tacey Ann Rosolowski, PhD
[00:21:36]
Why was that important to you?
[00:21:37]

Thomas Buchholz, MD
[00:21:38]
I like to get to know most of the class. It was quite bigger than either of my high schools, so it was a move up. I liked the academic rigor to Bucknell. It was a school that was competitive for me to get in.
[00:21:53]

Tacey Ann Rosolowski, PhD
[00:21:54]
Now, you were a philosophy major.
[00:21:56]

Thomas Buchholz, MD
[00:21:56]
I was a philosophy major, right.
[00:21:57]

Tacey Ann Rosolowski, PhD
[00:21:57]
So tell me about that choice?
[00:21:59]

Thomas Buchholz, MD
[00:21:59]
Well, that's kind of—you asked my strengths in academics, and they weren't in the realm of liberal arts or philosophy; they were in the math/sciences. So I started choosing courses, unknown what my career path would be. I thought maybe I might be interested in law, so I took some political science, and I had it in the back of my mind I might be a political science major. But then one of the first humanity courses I took was kind of a basic humanity/liberal arts freshman seminar type of thing, and I got introduced to philosophy, and I really was captivated

by that. I was very intellectually curious about meaning of life, religion. I was raised in the Christian tradition, and you get to that teenage period of your life where you really want to dig deeper. And philosophy I just thought was, wow, this is fantastic, and very interesting.
[00:23:01]

Tacey Ann Rosolowski, PhD
[00:23:02]
Were there particular strains of philosophy that you gravitated to more than others?
[00:23:06]

Thomas Buchholz, MD
[00:23:08]
Even—I liked—focused on, yeah, what's life all about. And I think that's a good match with being an oncologist, too. It's... So it was less about logic or some of those math/science type of things, and more about the true weird philosophy. What's the nature of man's soul? And what's the essence of being alive? And what is humanity? And so yeah, it was really—for me, it was refreshing. Again, Fulton, New York clearly didn't have any philosophy in its curriculum, (laughter) and nobody talked about it, so it was intellectually engaging and refreshing, and important. And it was a struggle for me, right? Because there were no multiple choice exams. It was all writing papers. And so I started out in—taking some math/science. I even took organic chemistry for some reason as a freshman, thinking that, well, science is good. I dabbled with the idea of being an engineer for a semester. But then my second year, my sophomore year, in between our first and second semester, we had a three- or four-week block in January that you could do something off the wall. I followed a family practitioner around for—in Mifflinburg, Pennsylvania. I think he was the only doctor in Mifflinburg, Pennsylvania. And it was great. And I knew at that moment, hey, I want to be a doctor. This is where the—my interest in humanities, my interest in science, my desire to give back, after my mom beat that... (laughter) All these things could come together in a really meaningful way, that my ability to connect—I could develop these types of relationships that I find so rewarding, that medicine was clearly the right path for me. So it wasn't so hard to change my curriculum. I actually ended up graduating in three and a half years.
[00:25:30]

Tacey Ann Rosolowski, PhD
[00:25:30]
And you graduated in 1984?
[00:25:32]

Thomas Buchholz, MD
[00:25:33]

Nineteen eighty-four, yeah. So I was, in part, doing that because I had to pay my own way through my senior year of college, and so that saved me a semester's worth of tuition. And, ironically, if you're a philosophy major, you're kind of a little different breed when you apply to medical school, and you could not just be in with all the other hardcore premeds, taking—you could create your own curriculum, and just do your—you could look up what sciences are required, find a course that meets those criteria. And you had to prove that you're good at taking science. Your scientific grade point average has to be competitive. But it's kind of an easier path to get into medical school than if you're in a traditional premed/biology major type of curriculum. So I had a great undergraduate, and I became—I was very social. I had joined a fraternity. I was president of the fraternity, and...
[00:26:35]

Tacey Ann Rosolowski, PhD
[00:26:35]
Which fraternity did you join?
[00:26:37]

Thomas Buchholz, MD
[00:26:38]
Phi Kappa Psi, which was a little bit—now, in retrospect, looking back, it was a little bit crazy, (laughter) I guess. Those are—I wish I had... I think I could've gotten even more out of college, looking at diversification and other things that the school was offering. But we had a great time. I met a lovely girl when I was a sophomore, and she was a freshman, and she's still my wife now, that—
[00:27:06]

Tacey Ann Rosolowski, PhD
[00:27:07]
And her name?
[00:27:07]

Thomas Buchholz, MD
[00:27:08]
Mara.
[00:27:08]

Tacey Ann Rosolowski, PhD
[00:27:09]
M-A-R-A?
[00:27:10]

Thomas Buchholz, MD
[00:27:10]
Yeah. And so we started dating. I think she was even eighteen years old. I think she'd probably skipped second grade or something like that, so...
[00:27:20]

Tacey Ann Rosolowski, PhD
[00:27:21]
And when did you get married?
[00:27:22]

Thomas Buchholz, MD
[00:27:23]
We got married third year of medical school. So after college, I was kind of—I think I was in medical school by the time I graduated in January. But I had, I guess, a nine-month period. I started to find a job, and I worked at Chemical Bank. And then I'd commute. I was living at home, in Rye, and would commute most weekends back to Bucknell, and hang out with my friends and my girlfriend. And then I went through graduation in the summer with all my class.
[00:27:55]

Interview Session: 01
Interview Date: January 10, 2018

Chapter 03
Specializing in Radiation Oncology
A: Professional Path;

Codes
A: Professional Path;
A: Military Experience;
A: Inspirations to Practice Science/Medicine;
A: Influences from People and Life Experiences;
A: Character, Values, Beliefs, Talents;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;
A: The Researcher;

Tacey Ann Rosolowski, PhD
[00:27:55]
So how did you choose your medical school?
[00:27:58]

Thomas Buchholz, MD
[00:27:59]
Again, I tend to choose the best, you know? So I think I got—I went to Tufts Medical School, and I think that was kind of the best medical school that I got into. I got into a couple state university schools. I got waitlisted at Cornell. I think I got waitlisted at Stanford, but I got rejected at a lot of medical schools, too. And Tufts had the appeal of being in Boston, which my wife was from Boston. My girlfriend, I guess, was from Boston, and would feel comfortable going back to Boston, although we weren't at that time certain we were going to get married or anything. Tufts was expensive, but that wasn't such a concern, because I got a scholarship with the Air Force to pay whatever costs were associated with the school.
[00:28:57]

Tacey Ann Rosolowski, PhD
[00:28:57]
Now, I didn't ask you if you had military service.
[00:29:00]

Thomas Buchholz, MD
[00:29:01]
Yeah, I did.

[00:29:02]

Tacey Ann Rosolowski, PhD
[00:29:02]
Okay, so tell me about that.
[00:29:03]

Thomas Buchholz, MD
[00:29:03]
So I competed, and got a scholarship for medical school, with the United States Air Force. And that affords you to get free tuition, and books, and most of your expenses. You do get commissioned as a second lieutenant as you start in school, and you serve 45 days of active duty a year during your medical training. As you get into third and fourth year, that's just doing a medical school rotation, just—so I did OB/GYN, for instance, in an Air Force hospital as a medical student. But the first couple years is more introduction into the Air Force. It was just camps with other scholarship medical students, and you learned what it is to be an Air Force officer, and some of... And then the second year you learned a little bit about aerospace medicine, and medicine of flight, and g-forces, and blacking out, (laughter) and other things. And we did some survival training, and got to fly airplanes, and learn how to parachute, and kind of fun things. So we had kind of two summer camps the first couple years, and then—but most of the time you didn't really have much connectivity, other—but they gave—I think I was making $16,000 a year, in addition to... So you come out of medical school pretty much debt free, or I did.
[00:30:34]

Tacey Ann Rosolowski, PhD
[00:30:34]
Yeah, yeah. That's huge.
[00:30:36]

Thomas Buchholz, MD
[00:30:36]
After medical school, I applied and was granted what's called a deferment, where they just essentially said, "You're free to do whatever you want for five years," or not whatever you want, but I applied to train to be a radiation oncologist, and they let me do that, completely on my own, with no obligations to the military. And so I was, just like any other resident in my program, I was paid by the University of Washington. I went to Seattle for my residency.
[00:31:11]

Tacey Ann Rosolowski, PhD
[00:31:11]

Now, tell me about the process of choosing radiation oncology.
[00:31:15]

Thomas Buchholz, MD
[00:31:16]
Well, my older brother, Dan, went to medical school, too, so he's three years older than I am. So when I was applying to medical school, he was in medical school. And when I started medical school, he was, I guess, graduating from—I guess we must have been in medical school one year together. And Dan told me during his fourth year of medical school he found out about radiation oncology, which was at that time a real small profession, and not one that's brought into the curriculum of your first- and second-year students. So it's not unusual to start finding out about it during your fourth year. So he said, "Wow, this is a great profession. Tom, you should look into it." He found out a little bit too late for himself, but... So I kind of checked it out, and I went down to the Radiation Oncology Department my second year, and hung out down there, and I ended up doing a little research with their faculty, and really learned about the profession. And indeed, it is a really neat profession in many respects. I think, for me, I was attracted to it because it gives this true human interactive connectivity with people, that most of your job as a radiation oncology doctor is helping people in their journey, and treating cancer. I liked it because you're really interacting with patients during a vulnerable and meaningful period in their lives. It's high stakes for them. And if you're effective at providing support and education, and helping them, you could have a really big impact on their lives in a way that's different than treating a rash or something. So I really liked oncology. And then, quite honestly, it's a very intellectual field, too. It's really governed by science. There's the discipline of how do you get the radiation to the target, and miss the normal tissues, which is physics, and computer science, and really neat technology. And then there's the biology, too, of how do you kill the tumor cell and not the normal cell. So it's a very strong scientific discipline, and it's a discipline that's very evidence-based, too, and rigorous. And it was a discipline that I kind of liked, because nobody else knew what went on, right? Very few doctors, even, truly understood radiation oncology, and you became kind of a real expert, then. You had a unique skillset, and various audiences that was differentiated. It was kind of special. So I thought, yeah, this is great.

[00:34:20]
Now, subsequently my brother, ironically, also had a military scholarship, and he, too, liked radiation oncology, and Dan decided to go and pay back his Navy obligation, which was three years he was in the Navy. And so he was a general-practice ship doctor. And so he came out of the Navy, after fulfilling his obligation, right when I was getting out of medical school and was granted this five-year deferment. And so we actually—he applied and got into radiation oncology, too. And we started our residency program the exact same year, then, because we got synchronized. I went to the University of Washington, and guess where he went.
[00:35:06]

Tacey Ann Rosolowski, PhD
[00:35:06]
University of Washington?
[00:35:07]

Thomas Buchholz, MD
[00:35:07]
No, MD Anderson.
[00:35:09]

Tacey Ann Rosolowski, PhD
[00:35:09]
Oh, he came to MD Anderson!
[00:35:10]

Thomas Buchholz, MD
[00:35:10]
He came to MD Anderson, yeah. So that's how I got first introduced to MD Anderson.
[00:35:15]

Tacey Ann Rosolowski, PhD
[00:35:15]
Oh, wow, that's amazing. Huh.
[00:35:17]

Thomas Buchholz, MD
[00:35:17]
So we went through the same residency period together, and it's been great. We've never worked side by side in the same building together, but we go to conferences together, of course, and we took our Board examinations, National Board examinations together. And University of Washington is kind of a small program relative to MD Anderson, and I would always hear about MD Anderson—they were so dogmatic, and University of Washington was unstructured and free-flowing and crazy. I'd come down for Thanksgiving or something, and I'd come into the department. You had to wear your white, pressed coat, and very formal, and we were eating pizza in the breakroom (laughter) and doing crazy things. So I never thought I'd like it. It was very... And my brother's kind of black-and-white. I'm kind of more of a grey person. So even when it got to our exam—national examinations, he would say, "Oh, you have to know this. You have to know this. Well, we have all the notes from 50 past examinations. You have to know this." I was like, "I've never heard of that." (laughter) So we were a little bit more on-your-own in Seattle. But it was fun. Of course, perspective changes as you mature in your own independent thought, so...

[00:36:45]

Tacey Ann Rosolowski, PhD
[00:36:45]
Of course, yeah. Tell me about that research project that you did when you were still in undergrad—or, I'm sorry, medical school.
[00:36:53]

Thomas Buchholz, MD
[00:36:54]
Well, yeah, in medical school I remember I thought it'd be helpful to have something on your résumé, and so I tried to find something within radiation oncology. And so I worked with a doctor in the VA, and we looked just at kind of the patient records, and an approach where they were using radiation before surgery for lung cancer, and then going on and doing surgery, and trying to describe kind of their outcome and their toxicity. And it was a relatively simple project that wasn't earth-shattering, or some major discoveries, but it was my first introduction into trying to collect data and analyze data and make a story that has some relevance to a field.
[00:37:47]

Tacey Ann Rosolowski, PhD
[00:37:47]
And it was cancer-related. I mean, was that—had you thought about oncology prior to that?
[00:37:53]

Thomas Buchholz, MD
[00:37:53]
Yeah, it was purposeful that that's—it was kind of during this period where I thought I'd be applying for a radiation oncology residency, and so I did that for—I took a research month, and focused that, in an effort to help gain me credibility of applying to radiation oncology programs. And it was—today, radiation oncology, I think, is the most competitive residency to get into.
[00:38:21]

Tacey Ann Rosolowski, PhD
[00:38:21]
Really?
[00:38:22]

Thomas Buchholz, MD
[00:38:22]
It was very competitive at that time, but not by today's standards. Today, we're fortunate to have, I think, the best graduating medical students in the country come here for our residency

program, so number of MD PhDs who've done fantastic laboratory research, and have published in the world's top journals, as—made major discoveries, and... So we have a lot of those people now in our residency programs from the best medical schools in the country. When I look back—and everybody has a very clearly defined career path and goals and objectives. Ironically, when I look back, it was a little different then. There was no residency match. So you'd write and get paper applications from all these programs throughout the country. We were in Boston. We were married at the time, and I'd say, "Oh, Mara, look, let's go to Pittsburgh. Look, they got a great downtown." (laughter) So this was before the internet, and so you'd just look at those brochures. And I kind of felt like, let's try something new, and my upbringing of moving around all the time, it gave me freedom to say... So I got in my head I wanted to go to Seattle, for some reason. And it was kind of a crazy game, because I ended up getting an offer from Tufts to stay in their residency program. And I had spent some time at Mass General, too, and they were in the process of wanting me to come for an interview, thinking that they were going to give me an offer. MD Anderson wanted me to come for an interview. But there was—it was more like applying for a job. There's some real advantages to the match currently, because you get to check everything out, and they get to check everybody, and make it fair. This was wheel and deal, because you didn't—someone would give you an offer, and they'd give you a short period of time to say yes or no, and if you said yes to this, you couldn't go on and interview any other places. But I was a competitive candidate. I graduated top of my medical school class, and I was... I had that little experience of doing a little bit of research. So I did my medical school rotation with the Air Force out in California, so that kind of brought me to the West Coast. And my wife would get calls from Tufts and say, "Have you given him the message?" (laughter) She says, "I think he's in survival training. No, we..."
[00:41:09]

Tacey Ann Rosolowski, PhD
[00:41:10]
So she was helping with the wheeling and dealing. (laughter)
[00:41:11]

Thomas Buchholz, MD
[00:41:11]
She was helping. And so I interviewed at Stanford, and then I went up to Seattle, and I said to Seattle, "Hey, I really like it here, but I got this offer from Tufts." And they said, "Oh. Well, okay, you can have an offer here." I said, "Okay, I'll take it," and that was the end of it. (laughter)
[00:41:25]

Tacey Ann Rosolowski, PhD
[00:41:25]
So what was it that you liked about Seattle so much?

[00:41:28]

Thomas Buchholz, MD
[00:41:28]
It was just gorgeous. I mean, the mountains. Again, I wish I could say that, oh, I thought it strategically would be best for my career path, but no, I think it was just, hey, this would be a fun adventure for a newlywed couple, getting away from all of our known friends, and getting out there in the world, and boy, we could go out in the North Cascades hiking this weekend, and the Olympic Peninsula. And so it was just a fun start for Mara and me as a young couple that... And it was. It was a great, great experience. We were there for four years, and...
[00:42:11]

Tacey Ann Rosolowski, PhD
[00:42:11]
Wow. And what does your wife do?
[00:42:12]

Thomas Buchholz, MD
[00:42:14]
She was an economics major, and worked for a bank in corporate lending in Boston, and then when we moved to Seattle she worked in insurance, and then in pension management, not necessarily finance but kind of managing pensions. And then right when we were about to leave Seattle we had our first child, and so then she became a stay-at-home mom for—
[00:42:45]

Tacey Ann Rosolowski, PhD
[00:42:45]
And your child's name?
[00:42:46]

Thomas Buchholz, MD
[00:42:47]
Alex is our oldest. We have two kids, Alex and Erin.
[00:42:50]

Tacey Ann Rosolowski, PhD
[00:42:52]
And that's Erin or Aaron?
[00:42:54]

Thomas Buchholz, MD

[00:42:55]
E-R-I-N.
[00:42:56]

Tacey Ann Rosolowski, PhD
[00:42:56]
Yeah, Erin, okay.
[00:42:57]

Thomas Buchholz, MD
[00:42:58]
So, and—yeah, in Seattle I finished my residency. I ended up spending the year in the lab. That's when I really got into doing some academics. I got --my first paper I wrote won a Young Oncology essay award that afforded Mara and I to go and present in this conference. I had a couple other successes toward the end of my residency that brought me into the national stage. And you'd say, wow, this is exciting, and it was a big deal. Not too many people from Seattle did it. And nowadays our residents do it all their first year, and they do about 40 of them before they graduate from residency, but for me it was a big deal. I remember writing my first paper. I remember going to the library and checking out a biostatistics book, and I remember trying to program Excel, which was a new software tool of how to do your own statistics, and I just kind of did it all on my own. And it was fun. And I kind of caught the bug of, hey, this is kind of fun, you know? So that became a component of my life. And again, I think just this natural tendency towards leadership also drew me in to wanting to work in an environment that was complementary to the patient care aspect, but gave something a little bit more, whether it was education with residencies, or academics with some discoveries, and ability to be part of a bigger group and a leadership focus. And so I was destined for that. So I thought I'd do a year in the laboratory, which was a great experience, but I'm not someone who just is enthralled with petri dishes and animals that bite and urinate on you, (laughter) and other things like that. And there was certainly a lot of frustrations over the course of that year, scientific frustrations, and convinced me that I don't want to be a hands-on PhD lab researcher. I'm much more inclined to be more clinically focused, although I loved the science. I really did love the science of oncology. So it was good to do that extra year.

[00:45:41]
Subsequent to that, I felt as if, well, my world is handicapped because now when I have all this momentum and I'm having such fun in Seattle, I could get an assistant professor job at the University of Washington, which is the best place in the world—of course, it's the only place I've been—and now, instead, I have to go into the Air Force. And I thought that would be, oh, what a bummer, what a setback. But it proved to be great. I went in to—I was stationed at San Antonio, which is the flagship, at that time the flagship medical center in the Air Force, Wilford Hall Medical Center. And I joined a group, and there was a great guy who had been there a

longer time, and he outlasted me, too. He had a commitment that probably included college and medical school or something. But he was a great guy, and he was fun to work with, and innovative. And so we were able to do fun things, like start the first prostate implant program in the Department of Defense, the first stereotactic radiation program in the Department of Defense. And it was fun, because I joined a group of really intelligent cancer doctors, and they were trained all over the country. So this person was trained at Stanford. I was trained at the University of Washington. We had someone trained at NIH, someone trained at MD Anderson. And it was a very enriching diversification of your own thought. And you're on your own. You're an autonomous doctor at that point. And so you come in with confidence, but then you're making decisions without any backup, and people's lives are at stake. And so it was great to have a variety of different approaches, and to learn—it's kind of like doing a clinical post-doc, almost, for four years of assuming that responsibility. The other—
[00:47:52]

Tacey Ann Rosolowski, PhD
[00:47:52]
I was just going to ask if there was a particular incident with a patient that you can tell me about that you went to somebody and they helped you see something differently. I mean, I know it's a while ago, and I'm just curious if you had one of those in your back pocket.
[00:48:08]

Thomas Buchholz, MD
[00:48:11]
Well, I think when you're trained in a residency program, at least, particularly, at MD Anderson, you do it the MD Anderson way. In Seattle, it was less structured like that. You could work with two different attendings, and they might have different opinions, and treat people differently. But clearly, when you went to the Air Force, the diversity of backgrounds, even within radiation oncology, every one of us over my four years trained at a different place. Was kind of opening that there are different ways of approaching this problem. And the nice thing, you have great plasticity in your brain, because you're just young, and you're starting out. You're not set in your ways. And the openness to, again, hear and appreciate—and I'm getting back to my relationship thing. It's really helped me be a better doctor. And the Air Force also loses 25% of its workforce and the cancer doctors every year, and get 25% in, because most people have a four-year commitment, like I did. And so it's always interesting in turning over, too. I tried to continue to do academics, too, in the Air Force, which is a little bit more challenging, because it's hard to assemble the data, etc. But I'd learned, too, about being autonomous, and writing papers on your own without having a mentor, and publishing, and picking good, doable projects.

Interview Session: 01
Interview Date: January 10, 2018

Chapter 04
Coming to MD Anderson
A: Professional Path;

Codes
A: Professional Path;
A: Joining MD Anderson/Coming to Texas;
B: Research;
B: MD Anderson Culture;

Thomas Buchholz, MD
[00:49:46]
And so I think it was really a truly fantastic four-year prep to come to MD Anderson, because I came to MD Anderson not just day one out of my residency training. I came four years as a seasoned clinical practitioner, someone who's done research completely on their own, created the story and followed it through all the way to publication. So I had a lot of self-confidence to come into this place. And I could see various opportunities within MD Anderson that were unparalleled. I had enough maturity that I wouldn't have been able to see coming here as a graduating resident. And so when I came here, I interviewed, and I was blown away with all the resources here, and all the patients here, and it's such a special place. My preconceived notion when my brother was here doing residency was, oh, those MD Anderson guys are so rigid. And then I came back with a greater appreciation for why that is, and the benefits of that, and how you could learn from that, and how you could treat one way and analyze your data and figure out if something needs to change. Let's change it, and do it in a methodical way, where you're actually learning.
[00:51:17]

Tacey Ann Rosolowski, PhD
[00:51:18]
So were you—was there a job opening? Did someone contact you? How did that opportunity come about?
[00:51:24]

Thomas Buchholz, MD
[00:51:26]
I knew a lot of the faculty here, because of my brother. And a lot of them paid attention to me. It was kind of fun. If I were in Chicago presenting, there'd be some MD Anderson faculty who'd come up to me and say, "Oh, yeah, you're Dan's brother." And Dan stayed on faculty

here at MD Anderson for a couple years when I was in the Air Force in San Antonio. And subsequently he went to MD Anderson Orlando, and that's where he still practices now, in Orlando. So we were never in Houston at the same time together as faculty members. So one day, I—MD Anderson had—has a lot of really famous people in our field, right? Some of the true thought leaders in the field, much more so than Seattle. And so one of those thought leaders was a professor named Kian Ang. And Kian really is a role model in many respects. Unfortunately—I don't know if you know Kian's story. He was a truly leading radiation oncologist who, unfortunately, died while on faculty here, just two, three years ago, of cancer, himself. So that was kind of a sad moment for our history.

[00:52:50]
But so I met Kian at a Marriott. I got upgraded somehow to one of those concierge floors, which --when you're in the military you never have such perks-- so that was a complete fluke. So I went in to breakfast, and there Kian Ang was sitting, having breakfast. And I sat down with him, and I asked if he knew of any academic job openings coming, thinking that I could call a chair and say, "Oh, I was having breakfast with Kian Ang and he mentioned you might be..." Networking, right? And he said, "Oh, you should come. You should come to MD Anderson." And I said, Oh, no, not MD Anderson, you know? (laughter) My wife and I had spent four years in Texas, and I was thinking of probably going back to Seattle, or... It was like getting out of college, getting—the whole world was open to us. I thought I knew MD Anderson, and I didn't really have a great appeal to even apply to MD Anderson, but now Kian was insisting that I come visit. And so I said, Well, let me make the best of it. I can't say no. Kian worked in Head and Neck Radiation Oncology, and he wanted me to apply for a job in Head and Neck Radiation Oncology. And I had done some research during that last year in the lab in an area known as apoptosis, which it's kind of a common word now. At that time it was just being described. And the leading researcher in that space with cancer was here at MD Anderson. (laughter) That's a little sad. I'm sorry. Because—
[00:54:33]

Tacey Ann Rosolowski, PhD
[00:54:34]
Yeah. Oh, no.
[00:54:34]

Thomas Buchholz, MD
[00:54:35]
Yeah. Sorry. (laughs)
[00:54:37]

Tacey Ann Rosolowski, PhD
[00:54:38]

No, that's all right. You want me to pause for a second?
[00:54:40]

Thomas Buchholz, MD
[00:54:40]
No, no, I'm good, but I have to give his eulogy on Saturday.
[00:54:43]

Tacey Ann Rosolowski, PhD
[00:54:43]
Oh, oh, yeah.
[00:54:45]

Thomas Buchholz, MD
[00:54:46]
He was a great guy. I hope I do better on Saturday. (laughs) Yeah, Ray Meyn. So he just died a couple weeks ago, and he was faculty here for four years, and a great guy. So when I came here, I asked to meet this Dr. Meyn, who I had never met before, and he was so welcoming, and said, "Oh, yeah, we could do all this great stuff together." And he was fantastic. So I got so jazzed during my interview, and I thought, wow, this is perfect. And I didn't want to work in head and neck cancer, though, and I said to Jim Cox [oral history interview], who was our chair at the time, "Hey, can you get me a job in the breast cancer section." And he said yeah. And so I joined the breast cancer section, which was in need of an academic boost, per se. Kian and the head/neck group, they were presenting papers at every conference. The breast cancer section was really outstanding clinically, but from the radiation side was not as robust as some of the other things.
[00:55:58]

Chapter 05
Creating Research Collaborations Focusing on Breast Cancer
A: The Researcher;

Codes
A: The Researcher;
B: MD Anderson Culture;
B: Research;
B: MD Anderson Impact; C: MD Anderson Impact;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
C: Collaborations;
C: Leadership; D: On Leadership;
D: Understanding Cancer, the History of Science, Cancer Research;
D: The History of Health Care, Patient Care;

Tacey Ann Rosolowski, PhD
[00:55:59]
Now, we hadn't—I hadn't asked you how your focus on breast cancer came about.
[00:56:04]

Thomas Buchholz, MD
[00:56:05]
It came about, in part, because of opportunity, I think. I had published a breast cancer paper in Seattle that had gained some national traction. And then when I came and looked at where professionally I could have the biggest impact at MD Anderson, I thought, wow, this is a group that sees a lot. Gabe Hortobagyi [oral history interview], who's the Chair of Medical Oncology—he's an internationally renowned person, and they're doing interesting clinical trials. So the multidisciplinary structure is there. It's just the radiation oncology piece hadn't been fully developed. And so I thought, this is perfect. It was a subsection, again, back to the relationship component of being a doctor that I really liked, that you tend to have very intelligent people who are going through a hard period in their lives. So I liked the patient care aspect. It was interesting, again, intellectually, biology, technical, treatment delivery, etc. So it just proved to be a good fit.
[00:57:18]

Tacey Ann Rosolowski, PhD
[00:57:18]

Now, I... When I was doing some of my background research online, I found an article, or an essay, that you wrote, "Preparing for the Future of Radiation Oncology," in the *Journal of the American College of Radiology*. And it was really interesting. I pulled out a couple of quotations. And you were talking about how it's only through translational research that radiation oncology can expand its role, and you were expressing the concern that radiation oncologists really need to develop those skills so that radiation oncology doesn't simply become a service that isn't contributing to the advancement of cancer science.
[00:58:02]

Thomas Buchholz, MD
[00:58:02]
Yeah.
[00:58:02]

Tacey Ann Rosolowski, PhD
[00:58:03]
And what I'm kind of hearing you say right now (laughs) is that when you took the job at MD Anderson, I mean, you weren't looking at the entire field in that way, but you kind of had, yeah, I want to make a contribution in that way.
[00:58:18]

Thomas Buchholz, MD
[00:58:18]
Yeah, yeah.
[00:58:19]

Tacey Ann Rosolowski, PhD
[00:58:19]
So that came real early for you.
[00:58:21]

Thomas Buchholz, MD
[00:58:20]
Yeah. It was... It was great. I mean, it was—one of the really appealing things was Dr. Meyn in experimental radiation oncology, and then I started hanging out with these lab people, and I didn't have to run the lab myself, right? Because they were PhDs, and they were very smart. And I didn't know they would be welcoming someone from the clinic, but there weren't too many doctors at that time who were going up into the labs, and they thought it was great. So I did form collaborative relationships, and I did start writing grants, and I'd start getting funding, as a principal investigator. And I tried to do things that would use human tissue, and bring it into the lab to build on science that they were doing on cells and animals, and give it a different

degree of relevancy. And so I based a lot of... So when I got to MD Anderson, I just kind of went for it. I didn't have any startup funds. I didn't... But I had the courage, like my dad. I just kind of went for it, and I got involved, and I said to—"Wow, you made this observation in mice? Has anybody looked at that in humans?" "No, how would we look at that in humans?" "Oh, there are all these patients getting that same chemotherapy that you were studying in mice. Maybe I'll just get some tissue from them." "You could do that?" "Oh, I guess so." And I'd write a protocol, and... Well, how you—nobody asked how you were going to pay for it, or so, okay. And then I'd write a grant, and I'd get a little money here, and a little money there, and it was kind of naïve courage, I guess, (laughs) because I started to do all sorts of translational studies. And by not owning the lab component of it, I could diversify, and I did a whole bunch of different avenues with three or four PhD collaborators.
[01:00:24]

Tacey Ann Rosolowski, PhD
[01:00:24]
What were some of the projects you worked on?
[01:00:26]

Thomas Buchholz, MD
[01:00:26]
The first was looking at a genetic predisposition to breast cancer, with a gene that had just been cloned called ATM. The second was looking whether chemotherapy-induced apoptosis was predictive for chemotherapy ultimate response and survival, and what are the biomarkers that influence that, and what are the chemotherapy agents that do. So I started to do biopsies of people—breast cancer patients getting chemotherapy before surgery, to show kind of early changes in tumor cells. That's a very frequent approach now. Even that's—Dr. DePinho [oral history interview] brought that out as an Apollo Moon Shot or so, but I was doing it in 1998, in 98004, my human subjects protocol. And it was fun, because it got me into collaborating with some of my medical oncology and eventual pathologies that started to look, then, at gene array expression, which, again, is very common now, everybody does it, but at that time nobody at MD Anderson was doing it at all. We had to collaborate with Millennium Pharmaceuticals, because they were very interested in these data. So we—I think we published the first gene set of serial biopsies during chemotherapy in breast cancer.
[01:01:56]

Tacey Ann Rosolowski, PhD
[01:01:57]
Now, I'm afraid I'm very ignorant about what piece you as a radiation oncologist would bring to a study of that kind.
[01:02:05]

Thomas Buchholz, MD
[01:02:05]
Well, that's a great question, (laughter) I guess, right? Because it was just... For that particular study, just nobody else was doing it, and so I said, "Let's do it." And I had some collaborators in medical oncology. They weren't doing biopsies, either. We didn't have the same infrastructure in 1998 that we do now, so nowadays if I was going to write a protocol like that, it'd be a little bit more awkward, because there would be a medical oncology patient, and the pathologist would be doing the biopsy, and this would be analyzed in here. "Well, what are you doing?" At that time, we were a smaller group. I would be going to every multidisciplinary clinic. I would be meeting with the patients. I would be convincing them. I didn't even have a research nurse. I'd be signing them up to the protocol. I went and learned how to do a biopsy from a pathologist. I bought my own biopsy guns. I bought my own lidocaine. I did this. I'd convinced the patients to stay for 72 hours in a hotel, and I'd personally do all these things, and then I'd take the specimens over to the pathology myself. And so I was kind of the one doing all the work with the study. This genetic predisposition to breast cancer, again, it's not a real radiation question, so... But I was the one identifying the patient populations. I drew their own blood, right? We didn't send any to a lab. I bought my own phlebotomy tubes (laughter) and bring them. That was kind of how you did it in the Air Force, right? And I thought, well, that's how you do it in MD Anderson, too. So—
[01:03:44]

Tacey Ann Rosolowski, PhD
[01:03:44]
So you were really facilitating this translational work.
[01:03:47]

Thomas Buchholz, MD
[01:03:47]
Yeah, exactly.
[01:03:48]

Tacey Ann Rosolowski, PhD
[01:03:48]
Yeah, yeah, you were the glue holding it together.
[01:03:50]

Thomas Buchholz, MD
[01:03:50]
I was the glue, right. And I'd often come up with the questions, and I'd write the grant, and I'd get the money, and...
[01:03:55]

Tacey Ann Rosolowski, PhD
[01:03:56]
Honestly, what a blast. (laughter)
[01:03:57]

Thomas Buchholz, MD
[01:03:57]
It was a blast. It was. Yeah, we started studying BRCA carriers, and whether they have BRCAs involved in double strand break repair, and I wanted to see if they had deficits in that in the laboratory, so you get a little tissue and you could grow it in culture and study the DNA repair process, and in the setting of a BRCA mutation. In the laboratory you could radiate their cultured cells, and... So we did a lot of projects, and everybody would tell me, "Oh, you gotta... Tom, you've got to focus," right? And it's true to some extent, and that's a good mentorship advice to an assistant professor, because if you have ten projects, and say you get ten preliminary datas, and they're all positive, to carry them forward gets to be a little bit challenging. So a lot of these things got to a point and I kind of dropped off. But I didn't really want a sustainable lab career, too. I was kind of... So, I don't know. (laughter)
[01:05:11]

Tacey Ann Rosolowski, PhD
[01:05:11]
You were sort of riding shotgun in between. (laughter)
[01:05:13]

Thomas Buchholz, MD
[01:05:13]
I was. I mean, I had a whole variety of collaborators within the scientific institution: people outside of our department, people inside of our division. So it was fun. It was really fun, and I was really caught up in this microarray gene expression. That was, I remember, so much fun, sitting with the bio informatician and trying to analyze these gene sets with—we didn't have the software that's available now. And at the same time, too, I did—if you look over my CV, it's mostly about clinical publications. And you mentioned I was interested in education from the onset, and so I ran our medical student program, and became then residency program director. And I really wanted to give younger people the opportunity to do clinical research. And so then you have success if people see, wow, you could get a good project with Tom, and you could—he'll let you publish it, and he'll be—you could be a first author on it, and... So, again, when I was an assistant professor, I kind of hit my stride, I think. I would be working with five or six residents on a variety of different projects that were more data based, and I had these lab collaborations going, and I was running the residency program. I was the busy—one of the busiest doctors, taking care of patients. And it was just fun, right? It was a really, really fun time, intellectually fun, and... And I was getting along. There was no politics. There was a little

politics, I guess, when I first got started about—inevitably, whatever you do in academics, you kind of get into potential turf battles, or, "Well, I was going to do that project," or... And there was a little—probably some of the more senior people on our service were kind of saying, "Wait," right?

[01:07:28]
But it all worked out. I think, in the end, again, that ability to connect with people and have relationships with people and be inclusive and have everybody win, and not be competitive, and listen to good advice, but still not let it inhibit you from moving forward. So it was a blast. I really had a great junior faculty time. And I had a great boss, Jim Cox. He thought the world of me. I was a high-performing faculty. I was publishing tons of papers. I was bringing in grants. At that time, nobody in our department, except for Kian, was really bringing in grants. I was very busy clinically. I was getting along great with all the medical oncology and surgeons, and they were saying to Jim, "Oh, Tom's been such a great..." I'd show up. They'd have protocol meetings. I'd just show up, and I'd participate. And they'd have a journal club, and I'd show up, and I'd say, "Hey, I got a great article. Let me present that." So I was an engaged member of their group in a way that they never had had before. And they loved it. And I, of course, then benefitted from those types of collaborations, too.
[01:08:47]

Tacey Ann Rosolowski, PhD
[01:08:47]
What do you think you were teaching them about what radiation oncology can do?
[01:08:52]

Thomas Buchholz, MD
[01:08:55]
Well, I think I taught them quite a bit, actually, right? Because just sharing—we are kind of in the basement, and nobody knows the technical aspects, and so people were concerned, oh, radiation causes heart disease, which it did for a long time, but now we could overcome that through technology, and as long as you don't treat the heart you're not going to cause heart disease. And we could... So I could help educate. Some of these historical things aren't the same as they are in modern days, and this is why we should think differently.

[01:09:35]
I think, more importantly, I also taught them that there are a lot of other important questions that are outside of their viewpoint. And so one of the best resources I had was the medical oncologist did a whole series of clinical trials here that had a very rich population of people treated with chemotherapy before surgery. And nobody else in the world—MD Anderson and Gabe [Hortobagyi] and Aman Buzdar [oral history interview], they were really thought leaders. Now everybody in the world does that, but at the back end of that there's all sorts of questions about

should you get radiation if you have a really good response, or does radiation work if you have a really bad response. And this was the most powerful collection of data to address real questions. And none of them were thinking about these questions, because that's not their profession, where they were so obvious questions to me. And so then we could look into the data and find not definitive answers but find the best answer that would be available. And I think that's what else I taught them was we started—I said, "Let's collaborate. We're going to ask these questions. Let's use your databases. Let's augment them with the necessary data." And there were literally a hundred papers or so we wrote over time on this topic. And it really opened their eyes as to, wow, these are really relevant and important questions that... And we're the leading institution now that has this, so... Eventually, I chaired the NCI Statement of Science about local, regional questions associated with that. And I started working in the cooperative groups with—to address prospective protocols on the basis of those. So, again, what a goldmine for me as an assistant professor to come in and have access to those types of important clinical questions that are nowhere else in the world.
[01:11:48]

Tacey Ann Rosolowski, PhD
[01:11:49]
Now, you mentioned some of your collaborators. Who were some of the other people you worked with that were really important?
[01:11:55]

Thomas Buchholz, MD
[01:11:58]
Kelly Hunt, I think, is probably one of my best collaborators through the years. We—she's a Chair of Breast Surgery. And so our local regional treatments kind of complement one another. Kelly, during her fellowship here, generated big databases that she so willingly would share with me. She was a wonderful collaborator in that she and I never had a political moment. (laughter) She was interested in the science and the team, and I was interested in her career, she was interested in my career. And so she's been a fun collaborator. Gabe, certainly from the medical oncology standpoint, but there's a number of other of his colleagues from Vicente Valero, and pathology. I worked with Aysegul Sahin and Fraser Symmans. There are a couple medical oncologists who have left, like Lajos Pusztai, who did this microarray work with me at the onset. He was a fellow. And Massimo Cristofanilli and I started the inflammatory breast cancer program here. And so there was just a number of great collaborators over 20 years. And then, of course, now in Radiation Oncology I have the greatest—I'm part of the greatest section ever. We went from three of us—and I've got to give credit to Eric Strom, as one of... Eric was—is the faculty member on our service in Breast Radiation who was—he had been faculty member five or six years before myself. And Eric taught me so much about clinical radiation oncology, and caring for patients, and he's still someone that I have a great relationship with, and have deep respect for. So he's still on our faculty, but our other nine faculty members are all people

that I mentored and hired, and boy, they're bringing our group to even new levels now. Now we have such a portfolio of radiation contributions coming from a whole variety of different avenues, and so it's been really fun to watch.
[01:14:42]

Tacey Ann Rosolowski, PhD
[01:14:42]
Because you're watching the institution, you're watching the careers, and you're watching the whole field grow.
[01:14:47]

Thomas Buchholz, MD
[01:14:47]
Yeah. And in ways—Wendy Woodward, who's now my section leader, Wendy and I must have published four papers together when she was a resident. And yeah, and she brought new dimensions. She's a real physician-scientist, and a really outstanding MD/PhD physician-scientist. And so while I helped her mentorship in some clinical things, she's also broadened kind of our contributions in biology in a way that I never can claim any mentorship to. (laughter) She really has got a skillset that's much more diverse than mine, and it's been awesome. Ben Smith I hired, too. He's truly an outstanding academic radiation oncologist, and he brought a whole expertise in health services research, again, and statistics, and in a way that, again, he's mentored me more than I mentored him in some of those academic aspects. And they've been great collaborators, just within our group now, and we have such a great group. And it's been fun to get back working with them again.
[01:16:04]

Interview Session: 01
Interview Date: January 10, 2018

Chapter 06
Chair of Radiation Oncology and Views on Leadership
B: Building the Institution;

Codes
C: Leadership; D: On Leadership;
A: Professional Path;
A: Professional Values, Ethics, Purpose;

Tacey Ann Rosolowski, PhD
[01:16:05]
Now, I wanted to kind of look at some of the moments when you were in positions of—where you were talking about people that you'd hired, and people that you'd mentored. And it was in 2007 that you became Department Chair. And I think you were interim before there, or no? No, no, I guess not.
[01:16:27]

Thomas Buchholz, MD
[01:16:27]
No, I wasn't.
[01:16:28]

Tacey Ann Rosolowski, PhD
[01:16:28]

I would've put it down if you had.
[01:16:29]

Thomas Buchholz, MD
[01:16:30]
Yeah, so it probably, I think, in... So I came in 1997, right? As an assistant professor, yeah. And in ten years I became Department Chair. That was amazing in some respects. I'm still mind-boggled. When I walked in here, there was four or five gold medalists, iconic figures, and I'm coming out of the Air Force with seven publications, looking at the thought leaders in the same clinic, and ten years later I'm their boss as their chair. Yeah, it's still kind of a remarkable story. And how did...? It didn't happen because I'd planned it that way. It just...
[01:17:18]

Tacey Ann Rosolowski, PhD
[01:17:17]
So tell me that story. (laughs)
[01:17:19]

Thomas Buchholz, MD
[01:17:20]
How do you even get promoted to professor in ten years? And so it was with, I don't know, a great degree of support. And as I started to get going—again, I hit the ground running here, because I was ready to go. I didn't have... I had the courage, I was going for it, and I formed these collaborations, and things just kind of fell into place. We were publishing a lot, and everybody in the nation noted, wow, what's going on at MD Anderson. We were at every meeting. Everything we're publishing is new. Everything's got to be unique. Everything's coming with very important, referenceable material, and tumor boards, etc. And so I was—my boss appreciated that, and put me up for promotions, etc. And I had great support. I was involved in so many things. I kept saying yes to everything. I was just—I got—and when you say yes and you do a good job, then it creates more opportunities.

[01:18:36]
So I was just involved in everything at MD Anderson, every committee they'd ask me to be on, and I joined the IRB, and had to sit through those three-and-a-half-hour meetings every Wednesday afternoon. (laughter) But then I became the Vice Chair of the IRB, and so I was just really involved in the institution. I remember distinctly going to one meeting and presenting, and feeling like, oh, look at all these important radiation oncologists around, and you could see them whispering and stuff, and then Jim said, "Oh, Tom, you might be getting a call to be a chairman." And I was still an associate professor, and I probably had been here five or six years. And it was like, what? And I did. I got a call from Wash U of all places, right? A really top-knot program. So I excitedly submitted my CV, and never really heard from them. And then eventually they called me, but that didn't really work out. But then I got started—then they started coming in waves, and mostly lesser programs. But for me, I was just like, wow. I could be chair of a department. (laughter) And...
[01:20:01]

Tacey Ann Rosolowski, PhD
[01:20:01]
Were you ever tempted?
[01:20:02]

Thomas Buchholz, MD
[01:20:03]

Well, I got to the point where one summer—I was talking to Jim—I decided to check out two of them, UCLA and Emory. And I went to UCLA, and I clearly thought they were a dysfunctional group, and it just was not my scene, and I knew it immediately, from the cab ride. (laughter) And I went to Emory, and I loved it, kind of. And they had such great resources within the department. They had a lot of money within the department, which—to build. They had a lot of laboratory space within the department. I thought, I could come here. I could recruit. We have all these brilliant people in residency training with the MD/PhDs who have got skillsets, like Wendy, that I don't have, that would be great. I could build a program. I'd be—it'd be really awesome. And, not surprisingly, it was a competitive job to get, and I became one of four finalists, two of whom were already department chairs at other academic programs. And then I became one of the two finalists, and then I became—they offered me the job. And that that time, I went out to coffee with my boss, Jim. And he said, "You're my friend. I'm happy for you. It's a great place. It's got great potential. But it's never going to be MD Anderson." And it's true: to this day, Emory Radiation Oncology, despite eventually finding a really great chair, has nowhere near the size and scope and impact of MD Anderson. So in the end, I just said no, which, by the way, if you ever want to negotiate, saying no (laughter) is the best way, because I think I could've negotiated any salary I wanted, because a lot of the resources in their system were just your own resources, right? So that was the one true time where I almost left MD Anderson. And I think it sent kind of a message to Jim that this might be a time, too, where we should see if there are opportunities for me just to do the division head—by our growth within the faculty, after I got here, was staggering, just staggering how fast MD Anderson grew.
[01:22:47]

Tacey Ann Rosolowski, PhD
[01:22:48]
Well, that was the early John Mendelsohn years, and it was really explosive.
[01:22:52]

Thomas Buchholz, MD
[01:22:52]
Yeah. And so Jim decided to do that. There, of course, was a national search. I was a candidate, and eventually I was selected, which was quite an honor. In some respects, it was a new position at MD Anderson, right? So if you were the chair at Stanford, you would kind of look at this position and say, well, this reports to another radiation oncologist. Jim Cox is kind of the face of radiation oncology at MD Anderson, and if I came as chair, hmm, I'm the face of radiation oncology at Stanford, so why would I give that up to...? It sounds almost like a lesser position. And so I think it was great for me in terms of being a competitively national candidate, because it fit—that was a non-issue for me, because Jim and I had a very synergistic working relationship, and I was confident that I could... I didn't have any remarkably different direction that I wanted to bring from the way our department was already heading. So it was a real natural fit for me, and I was thankful to have been given that opportunity.

[01:24:21]

Tacey Ann Rosolowski, PhD
[01:24:22]
What was the transition like from being a faculty foot soldier, even though a very active one, to being suddenly a leader, in a real major leadership role?
[01:24:32]

Thomas Buchholz, MD
[01:24:32]
Yeah. That's a great question, because there are some—even before that, for me to become the section leader of Breast Radiation Oncology over these more tenured people, that's not without its [low?]... But I think, again, it was much less awkward than you'd anticipate, because I had earned the respect of my colleagues, and I had—I think they saw that I had achieved these things without stepping on people along the way, and that I was—I couldn't help but my enthusiasm just kind of spread, even beyond my boundaries. So I convinced our GYN group to start doing serial biopsies in cervical cancer. I said, "Here's the platform; let's do this," and created other opportunities in that area. And I was involved with our Head and Neck group, and doing fibroblast normal tissue reactions, and getting them involved. And so I was a well-liked leader. And I think when there were candidates for the chairs, I think most of the people in our department really wanted me to become the chair, rather than saying, "Oh, how come Tom's becoming the chair?" And so I had had that relationship with our group that—again, and they were trusting that my agenda was consistent with their own personal agendas, and they were trusting that, hey, this could be a good fit. I don't dismiss that I'm sure that wasn't 100% universal, but it was a remarkably easy transition for that kind of awkwardness type of... Again, because I had some objectivity about—people could look at publications. People could look at who's getting grants. People could look at how many patients I was treating. People could look at your RVUs. People could look and say, oh, yeah, he's active. He's doing a good job. And I had really good relationships with most of my faculty colleagues. We hadn't been through some political drag-out war, so...

[01:27:06]
So then, yeah, Department Chair was really fun, too, because then I got the responsibility of taking that mentorship that I had done with our residency program—and I really had changed our residency program quite a bit to be very educationally focused. And, again, our—Jim was very supportive of residencies, so we wrote a mission statement. We said, "Why are we taking these people into our program? Is it to do these trivial tasks, or do we want them to become the next leaders of our profession? And if that's our goal, then we're going to focus on getting that goal. And it's going to put a burden on all of us to reach that goal." But everybody was onboard, and we had—and that made our program (makes whooshing sound), you know?
[01:28:01]

Tacey Ann Rosolowski, PhD
[01:28:01]
What were some of the—you used the word "burdens." What were some of the new responsibilities that were placed on people in stepping up to that goal?
[01:28:09]

Thomas Buchholz, MD
[01:28:10]
If there's a noon lecture, they're leaving and going to the noon lecture. If we have an opportunity, like we do today, that there's a visiting professor from Sloan Kettering, I'm sorry, you're going to be on your own in clinic, right? Because this is going to be a priority. We're going to teach them how to do biostatistics, and we're going to pull them out to educate. We're going to equip them with the tools that go beyond just having them at your side, making your life better. If you want to do research with them, you're accountable to actually mentoring them, and making sure this is completed, to giving them appropriate credit. We're going to make this the best residency program in the country, where everybody wants to come here, because they could see it. And it has now; it's the number one *US News & World Report* residency in radiation oncology, so... And it—there's that cultural change, but once the culture's established, once it's in the norm, then there's no longer any politics associated with it.
[01:29:17]

Tacey Ann Rosolowski, PhD
[01:29:17]
Yeah, I was going to note that, I mean, a lot of the things you're talking about sound about—sound like they're about changing culture, to cultural collaboration, mentoring... Yeah, very powerful. And sometimes hard to do.
[01:29:30]

Thomas Buchholz, MD
[01:29:31]
Sometimes hard to do, right. But I think that's... And we were able to do that when I became department chair. My goal was to do the same type of thing on the faculty. And I think Jim really paid a lot of time, attention to the residency program. But I could see that our assistant professors were saying, "Wait, I want to take that course," and "I want to get that training, I want to visit. Why don't you bring in the leading breast cancer radiation oncologist from Harvard and let me spend time with them? Because they're someone who's going to help my career more than a first-year resident." And so I could see those types of opportunities. And so I started to have that same sort of mentorship attitude focus now on our faculty in career development on faculty, and just like our residency program, that it became so easy to recruit. And I think I, over my—I don't know how many—I think I recruited 35 faculty members in my time as chair. And,

again, that helps to—that's a sure way of generating that culture, right? And you kind of lay down some principles. And most of these principles sometimes aren't radical changes, and they're hard to argue against. Like, "We're going to treat each other professionally," something like that. It's kind of hard to say no. "Do you think we'll do better if we're all collaborative or, like, arguing with one another?" (laughter) You could articulate these things in a way that this is where it seems, to me, why isn't everybody doing this as a leader? You don't have to go to take a leadership course to learn some of these things. They should just be in part of what we've learned as our human relationships building. But I kind of get—one of the—I'll tell you a little story that struck me. I think I was Department Chair at the time, and we were sitting down to interview residents, and I mentioned they're unbelievable. They're some of the most comical meetings you have, because they're so interesting people. You're graduating, "Oh, I see you're graduating first in your class at Harvard, and I see you're getting your PhD at Harvard, too, and I see you've published two papers in *Cell* and *Science*, and you took some time off to study English literature as a Rhodes Scholar in Oxford. How interesting. What are you going to do this weekend for fun?" "Oh, well, I'm donating my kidney to a homeless man." (laughter) It was just kind of over the top all the time. And so they are kind of funny, because these are really good people, right? They're not just brilliant. They're just unbelievable.

[01:32:30]
So we were meeting this person who's graduating number one from U Penn with an MD, and he's graduating number one from the Wharton Business School. He's got an MD MBA. I think if you graduate top from Wharton Business School, you could get a million-dollar Wall Street job like that. So we're listening to all this saga, and it gets to the end, and he says—and someone asked, "Well, what book are you reading? What's your favorite book?" Kind of lighthearted. And he says, "Oh, I just read this great leadership book, and it's by one of my professors. He's the youngest tenured professor at Wharton, and he's just a really dynamic guy." And I said... And he says, "It's a book called *Give and Take*. And, I don't know, it's just something that struck me," he says. "It was really neat." So I, of course, write it down, and I said, okay, I'm going to finally read a leadership book, right? I read this book, and it just kind of described my journey. It just articulated me perfectly, and it was just like, uh-huh, okay. Maybe everybody doesn't... It made it seem like maybe this just wasn't innately, like, everybody should be doing this, that there is, for whatever reason, some sort of science about how people view the world, and how we choose to make decisions. And so I think that's... That's the leadership book that I give my kids now, because... So you have to read that book.
[01:34:09]

Tacey Ann Rosolowski, PhD
[01:34:09]
I will.
[01:34:10]

Thomas Buchholz, MD
[01:34:10]
Yeah.
[01:34:10]

Tacey Ann Rosolowski, PhD
[01:34:10]
I will. Well, many years ago I learned that phrase from Carl Jung that you are your own instrument, which I really liked, and I thought for a long time, like, huh, what kind of instrument am I? And I think everyone is so different, because they not only have their—the nature, what are their particular gifts, but how those are formed. I mean, who knows if you would have been as comfortable taking on challenges if you hadn't had that amazing experience moving around and going overseas.
[01:34:42]

Thomas Buchholz, MD
[01:34:42]
Yeah, exactly.
[01:34:43]

Tacey Ann Rosolowski, PhD
[01:34:43]
You get forged in the fires of your own life, as it were, and...
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Thomas Buchholz, MD
[01:34:49]
But this relationship, too, it's so... I'll give you another example that was immensely helpful. So as MD Anderson's having success in breast cancer—I used to sit in the back row at our national meeting, and the breast cancer section would come up, and the leader of Harvard, U Penn, Michigan, Yale, they'd all congregate and kind of give these "Ha, ha, ha, how you doin'" kind of... And it was kind of off-putting to me. They kind of—they didn't seem to really be enjoying each other, and then they'd get up and criticize each other's work during the presentation, and there was a lot of jockeying and competitiveness of, "Hmm, you guys are saying that at Harvard, but at Michigan we want to say..." And I was kind of like, whoa, why do we have to compete? There's a breast cancer chair of Harvard program who is an iconic figure, breast radiation oncologist. He was iconic when I was at medical school.
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Tacey Ann Rosolowski, PhD
[01:35:53]

Who is this person?
[01:35:54]

Thomas Buchholz, MD
[01:35:54]
Jay Harris. And he was the figure in our profession. And he personally ran the residency program at Harvard, so we kind of got to know each other, because I was an assistant professor of publishing in breast cancer, and I ran the one residency program that competed for Harvard students, even. Sometimes Harvard students would leave Harvard and come. (laughter) And that was—Jay was a competitive guy at that time. Then there was a really noncompetitive, kind of really laid back, very productive breast cancer radiation oncologist at Yale, Bruce Haffty, and Bruce was the one guy that I could kind of connect with, even as a young person, and somewhat collaborate. So the three of us get invited to a surgical meeting, breast surgical meeting, so we're the three token radiation oncologists. So we each have our talk to give, and then there's multidisciplinary panels that we're on. And both of them are much more senior than I. So I called him up, and I said, "Hey, Jay, we're going to be here together. You've been such a great, iconic figure." I used a... "Let's go to dinner." And so I bought these two guys dinner. And then, afterwards, I was on a panel where it was me against four surgeons, and they were kind of watching, and I did fine and everything. But then I was invited to write an editorial from a surgical journal about this panel. They wanted to get the surgeon's perspective, because they thought it was such a great panel. So I reached out to Jay and Bruce. I said, "Hey, why don't we write this together? Eh? Why don't we do this together? I'm basing some of my data on your work." Well, nobody had written a paper that crossed Harvard, MD Anderson, and Yale. In the end, we formed this relationship. Jay became such an important friend and mentor. Bruce today is one of my best friends. We write papers together all the time. We started writing papers with—I started mentoring people at the University of Michigan. And we just kind of nationally put a kibosh to all this and formed a real collaborative group. So when ASCO started their first breast cancer multidisciplinary meeting—I was invited, Jay was invited, Bruce was invited, and Michigan was—all the kind of thought leaders in our little space. And I arranged a dinner, and my father-in-law taught me the art of toasting, of saying genuinely nice things about each of the people, and how this is a great community to be involved in, and these... And it's fun, right? And you form meaningful relationships in a way that just elevated the same type of thing that on a national level just... It was remarkable how close we all became. And in so doing, we support each other's junior faculties, give them opportunity. It's not just all about... Now if one of my residents wants to get a job at Michigan, I'm happy for them. I'm not disappointed. It's the way the world should work, right? (laughs) So it's been a great, fun run.

[01:39:33]
I got to, as a radiation oncologist, just serve for two elected terms as the NCI Steering Committee Co-Chair in breast cancer, which I'm the only radiation oncologist ever to have been elected. And that's because I crossed out of radiation and get along with the surgeons, and get along with

the national medical oncologists. They don't think that, oh, I'm rigid, and I have to defend my turf because it's my turf, right? Instead, you could disarm people, make them feel inclusive, be collaborative, add some intelligence to the conversation, but do it in a way that people are approaching it with open mind and open dialogue.
[01:40:19]

Tacey Ann Rosolowski, PhD
[01:40:20]
And that's a really important way of modeling that behavior so that it kind of gathers this momentum and eventually will change the culture. That's a wonderful story about your interaction with Jay Harris, and... Yeah, I mean, that's terrific.
[01:40:35]

Thomas Buchholz, MD
[01:40:35]
You know—
[01:40:36]

Tacey Ann Rosolowski, PhD
[01:40:36]
I mean, that's changing culture.
[01:40:37]

Thomas Buchholz, MD
[01:40:37]
Well, I remember one day Jay won the gold medal at ASTRO, a very appropriate... But sometimes in the old days you could say, like, "Oh, how come they're winning it and we're not winning it?" Instead, I wrote a handwritten congratulation note to him, and as he's walking from downstage and out the aisle in the ceremony where they gave the gold medal, I slipped him this thing. Things like that are really touching, you know? And, of course, he's nominated me to be, then, a fellow, or he's going that extra way to kind of... And I didn't give him that note in an effort to get that back from him, right? That's what give and take is. There are people who just genuinely want to do that. There are people who do it for the sake of, okay, I'll do it for you, you do it for me type of thing.
[01:41:34]

Tacey Ann Rosolowski, PhD
[01:41:35]
And people do know the difference.
[01:41:36]

Thomas Buchholz, MD
[01:41:36]
Yeah.
[01:41:36]

Tacey Ann Rosolowski, PhD
[01:41:36]
Yeah, that authenticity comes through.
[01:41:38]

Thomas Buchholz, MD
[01:41:39]
Yeah, so...
[01:41:40]

Tacey Ann Rosolowski, PhD
[01:41:40]
Well, thank you for telling those stories, and we're at 11:00, and I know you have something else you need to do next, so...
[01:41:44]

Thomas Buchholz, MD
[01:41:44]
Yeah, I've got to bring my daughter to the airport. (laughter) Really important.
[01:41:49]

Tacey Ann Rosolowski, PhD
[01:41:49]
Very important. All right, well, listen, thank you for this morning. Really interesting conversation, and I look forward to our next one next week.
[01:41:56]

Thomas Buchholz, MD
[01:41:56]
Okay. Okay, super.
[01:41:57]

Tacey Ann Rosolowski, PhD
[01:41:57]
Well, let me just say for the record I'm turning off the recorder at about two minutes after 11:00.
[01:42:04]

Interview Session: 02
Interview Date: January 31, 2018

Thomas Buchholz, MD

Interview Session Two: January 31, 2018

Chapter 00B
Interview Identifier

Tacey Ann Rosolowski, PhD
[00:00:00]
Okay, we are recording, and it's about 90:30 on the 31st of January, 2018, and I'm here in the Department of Radiation Oncology for my second session with Dr. Tom Buchholz. Thanks very much for making time.
[00:00:15]

Thomas Buchholz, MD
[00:00:15]
Thank you.
[00:00:16]

Tacey Ann Rosolowski, PhD
[00:00:16]
Beautiful day.
[00:00:17]

Thomas Buchholz, MD
[00:00:17]
It is.
[00:00:18]

Tacey Ann Rosolowski, PhD
[00:00:18]
You have a beautiful window behind you.
[00:00:19]

Thomas Buchholz, MD
[00:00:19]
Thank you.
[00:00:20]

Interview Session: 02
Interview Date: January 31, 2018

Interview Session: 02
Interview Date: January 31, 2018

Chapter 07
The Radiation Oncology Fellowship Program
B: Building the Institution;

Codes
B: Building/Transforming the Institution;
A: Professional Path;
B: Education; D: On Education;
B: Research;
C: Mentoring; D: On Mentoring;
C: Leadership; D: On Leadership;
A: Character, Values, Beliefs, Talents;
A: Personal Background;
A: Influences from People and Life Experiences;
C: Professional Practice; C: The Professional at Work;

Tacey Ann Rosolowski, PhD
[00:00:20]
And we were strategizing a little bit before the recorder went on, and I realized that you had not spoken about your role as Director of the Radiation Oncology Residency Program. That was from 1998 to 2001. So tell me how you were the person who came to step into that role, and what you were able to accomplish.
[00:00:45]

Thomas Buchholz, MD
[00:00:46]
Well, I've always been interested in education. My mom—I don't know if I said this last time—was a public school educator, and one of the enjoyments I had with academic medicine was residency training programs and medical students, etc., who are going to be the next generation of leaders in your given profession. They bring with them a lot of enthusiasm, a great degree of intelligence, and just really make—the educational environment is a really fun environment in which to work. So I came to MD Anderson 1997 with an interest in participating in education. Education, from a residency program, was one of the most important components of our department. It was, in part, because our division head at the time, Jim Cox [oral history interview], really prioritized development of outstanding residency training in our group. So it was a highly sought after role to play. Usually, in radiation oncology departments, the number of residents and attendings are somewhat equal, but in our department, because we're so big, not everybody could be as actively participated in the residency program. So Jim thought I'd be a contributor to the program. Again, I was one of the only junior faculty when I joined. We were

kind of more weighted to senior faculty. He thought I would be kind of a role model that was more in their generation, and he thought I'd be a good personal fit. So even my first day, I started as the Director of the Medical Student Rotation, and a component—then the Assistant Residency Program Director to a much more senior faculty member, a professor at that time, and I was an assistant professor.
[00:02:56]

Tacey Ann Rosolowski, PhD
[00:02:56]
Who was the professor you worked with?
[00:02:58]

Thomas Buchholz, MD
[00:02:58]
Alan Pollock. And so within a short—or within a year, anyway, then Alan became a chair at an outside institution, and Jim asked me to take over as the Residency Program Director. And it was a new opportunity for me, then, to be really in charge of something, again, with the support of the division head. Because it was such a priority placed by the division head and department chair, it was pretty easy for me to make some significant changes and establish kind of a new culture for education, because I knew I had the backing. And sometimes when... So one of the first things we did, based on my military training, was to really identify a mission statement. And so I worked collectively with our residency program leadership, and the residents themselves, to define why do we have a residency program? What do we really want to achieve? Residency program's a great thing in which to do that, because, not surprisingly, we focused our mission on training, because that's what residency programs are all about, but by articulating our residency program mission statement, which still exists today, it's really about training the next generation of leaders of radiation oncology. We were fortunate to have many, many more qualified applicants than we do training slots. And we wanted to decide, what is our program about? Is it about just training great practitioners, or is there something more? There's a uniqueness to MD Anderson in terms of the portfolio of resources we have for a young trainee to come in here. We have incredible opportunities for research, and incredible opportunities for leadership development. We have many of the leaders of our profession here. Obviously, we have incredible opportunities for great clinical training, as well. We have the whole gamut of—anything that you'd want to learn about radiation, we have at our disposal. So we focused on identifying this mission statement, and it really permeated then into how we ran the residency program, because we could turn back to that mission statement, and we could say to our faculty, "This isn't about the residents making your life easier by doing the scutwork, or doing this. There are going to be some concerted—if we're serious about this mission, we're going to have to take time for leadership training. We're going to have to take time for the ability to formulate an effective scientific presentation. We're going to go beyond just clinical training, because we're really here to train the next generation of leaders."

[00:06:05]

Tacey Ann Rosolowski, PhD
[00:06:06]
What was the level of participation of the department in creating that mission statement?
[00:06:11]

Thomas Buchholz, MD
[00:06:12]
We had a Residency Program Committee, that consisted of a variety of faculty representatives from various sections, whether they be disease site sections, but also then representatives from our biology group and our physics group. So I think that core element helped collectively define the mission statement, and then we brought it to the trainees for feedback, and then we'd bring it to the entire faculty during staff meetings. And so it was an iterative process, where we got a lot of give and take, but it started with kind of the core leadership community of the residency program.
[00:06:56]

Tacey Ann Rosolowski, PhD
[00:06:56]
Could you see kind of an impact of that process as it was going on? Were people enthusiastic? Were they skeptical? How did that all work?
[00:07:07]

Thomas Buchholz, MD
[00:07:08]
I think they were... I think... For me, I was a little bit skeptical about... I'm a very typical doctor, trained, who always kind of feels a little bit skeptical about soft sciences, and the social sciences aren't necessarily—I guess we're biased to proof and certainty, and oftentimes the social sciences aren't as rigorously conducted in terms of statistical certainty as some of the hard biological and physics sciences. So there's a degree of skepticism—and this is MD Anderson culture, too—
[00:08:01]

Tacey Ann Rosolowski, PhD
[00:08:01]
True.
[00:08:01]

Thomas Buchholz, MD
[00:08:02]

—about underplaying the importance of some of these leadership sciences, for instance. That would be kind of a social sciences that there's a degree of skepticism within the medical community about the importance of these types of things. And I, too, had such biases as I started my own leadership: Well, I get why would you write a mission statement, or where is the proof that something like that really benefits organizations, and when you read about it in Harvard Business Review there are all these so-called case reports, like, wow, here's an example of how a CEO turned a company around. In the medical literature, when you read a case report, it's kind of considered the lowest level of evidence, and most times now journals don't even accept a case report, because they're just a story without really credible science. And yet, I think for me this was an elucidating moment. I went from Air Force kind of rigorous, textbook, "Here's how you are a leader; let's all turn to binder three and paragraph six, section things; write a mission statement." Well, why do you write a mission statement? Well, because we have all these anecdotes that it might be. But then when you actually implemented it, for me, the first time in a leadership role during residency, I saw the power, that it was really transformative for our group. Because for the first year when I was on faculty you could see these tensions arise. The residents would sometimes go to the attending and say, "Oh, I have a noon lecture," and the attending would say, "We're not done with clinic yet. Your responsibility is to be here with me in clinic. Why should I have to be here in clinic if you're not here? You're a trainee. I'm an attending. Don't tell me you're going to go hear a lecture about leadership, because this is your priority." When I was at Harvard, during my training, I never left my attending. And so without an articulation of what we're doing as a group, and why we're doing it, there was always this kind of tension and our program couldn't really be elevated to the next level. And so for me it was a great learning opportunity about the power of these social sciences being truly transformative.

[00:10:40]
Now, again, I couldn't have done that without the engagement of the faculty. And sometimes just having this conversation of why is it that we have a residency program. Is it really so that you don't have to learn how to use Epic and order lab tests, because you could have someone else do it? Why don't we just hire a scribe for that, if that's what we really need? Or is it something more? Are we in a different generation of education than we were when you were a resident, right? And if not, why not? Why can't we do this? Are we serious about our commitment to train the next leaders? And if we are, then let's adhere to our mission statement, and let's make choices that are consistent with what we articulated as our reason. So I think it was a powerful elucidation in my own mind, and I think probably for many, too, that what is this all about. And then as I became a department chair, one of the—I think I may have mentioned this previously, but it struck me that during my period as Residency Program Director, we were able to really change the program quite significantly from one that a lot of our residents went into practice and not leadership, but after three or four years most everybody was graduating and pursuing real leadership journeys. And the quality of our program went up quite considerably, and, not surprisingly, the positive reinforcement among—do you choose to come to MD Anderson? Well, you come to MD Anderson, you talk to the other trainees, and they're saying,

"This is what we're all about." You actually—when I was running the interviews, we'd have a mission statement, say, "This is how we're going to guide you. And if you want to be a great practitioner of radiation oncology in your small town of Iowa, as a solo practitioner for your life, we applaud you for that, but you might not get a position, because we're aiming to... And I'm not passing judgment this position is better than that position, but we feel we have not only great clinical training to provide you, but we have a whole bunch of resources, and we do have a number of people in our profession who want to take advantage of those resources. So maybe a different residency program would be better for you."
[00:13:23]

Tacey Ann Rosolowski, PhD
[00:13:23]
Absolutely. I mean, it's very interesting, because that shift in perspective about let's take the time to talk about our basic values, professional values, and what we want to do with those. Those are often conversations that get put on the back burner because of all kinds of immediate fires that need to be put out, and so that this was really an interesting process. I mean, how long did it take, do you feel, before you began to see the impact of that mission statement on how people were actually behaving, specifically the faculty?
[00:13:58]

Thomas Buchholz, MD
[00:14:00]
Well, there's an acute phase and then a culture change. And so the acute phase happened pretty quickly, because to change the culture you're going to have to adhere to your mission statement. You're going to have to make choices that are consistent with your mission statement; otherwise, your mission statement doesn't have much value. So I think the first process isn't to write a mission statement and implement it. The first process is to work collectively as a group, and get everybody to buy in that this is a mission statement that they're happy or consistent with. And once you have people kind of signing off—and these things aren't so controversial. If you say, "Here we are at MD Anderson. You're all academic physicians. You're all proud to be here. You're a leader in your respective field, and this is why you're a faculty member in the best radiation oncology department in the world. And you realize that our trainees come here, and you're proud that they're coming here, and they're coming here because they have the opportunity to be the next generation of leaders, right? Is everybody onboard with that? Do we have a responsibility? Can we really do something different?" It doesn't sound so controversial. These are types of truths that are self-evident, almost. And in doing so, then, it's not that big a jump to gain a consensus. There are other situations, obviously, where you're going to find tensions, right? But this was something that there might be some people who would—but they would be a minority. So you have a vast majority who are saying, "Yeah, this is exciting." And then you start to put the resources in, and come up with, "What are we going to do?" And, again,

it sounds kind of exciting. But then the implementation phase, that's where [plainly?], well, what does that mean? Hmm, they snuck that one in.
[00:16:17]

Tacey Ann Rosolowski, PhD
[00:16:17]
It means behavior change.
[00:16:18]

Thomas Buchholz, MD
[00:16:18]
Behavior change.
[00:16:19]

Tacey Ann Rosolowski, PhD
[00:16:19]
I mean, I was thinking about that scenario you gave earlier of the attending and the resident, and suddenly the resident wants to leave, and that's when the rubber hits the road. (laughs)
[00:16:28]

Thomas Buchholz, MD
[00:16:28]
It does. But that's, again—I had the good fortune of being a hundred percent backed by the department chair and the division heads, right, who ultimately was... I'm a Midwesterner, where there's always a boss at the end of the day, right? And then, after a while, it's not that big of an issue. After a while, it's just the norm. And so I think to have that consensus and get everybody's buy-in, and then have the courage to say, "Okay, we're going to adhere by that, and there's going to be some ramifications about it, and not all of them are going to be fun," and then moving to that to... And what that enabled—I guess, what the insight from a lot of our faculty was like, wow, we could benefit from this, as well. And then it became an issue of how come our residents are treated so well, but I'm a new faculty, and I didn't train in this program, and I never got this type of opportunity as a resident? I need this type of training, and wouldn't it be more important for me as a junior faculty that you're really invested in, to...? How am I going to become a leader in the profession? And so that was a natural evolution, then, for me to start developing very similar focused programs in mentorship for junior faculty.
[00:18:03]

Interview Session: 02
Interview Date: January 31, 2018

Chapter 08
A Changed Perspective as a Chair of the Department of Radiation Oncology
A: Overview;

Codes
C: Leadership; D: On Leadership;
D: Ethics;
C: Professional Practice; C: The Professional at Work;
B: MD Anderson Culture;
B: Working Environment;

Tacey Ann Rosolowski, PhD
[00:18:04]
Let me—and I want to just let you know I forgot my watch today, which is why I'm taking time by looking at the counter [on the recorder]. I'm not... (laughs) My attention's not wandering from you. So I wanted to ask: obviously, for you, as a leader, there were some really big lessons that came out of this residency program. And you had mentioned last time that when you took over as department chair you began to use your experience with the residency program as a kind of model for what to do next. And we talked a little bit about that, but I wonder if you could go a little bit more deeply into some of—maybe some of the key moments that were really revelatory for you in your role as department chair. I mean, was there something that worked that you really learned from, or something that maybe was a struggle that you equally learned from? (laughs)
[00:18:55]

Thomas Buchholz, MD
[00:18:58]
So, yeah, I had a lot of bravado confidence, I guess, from some of my own MD Anderson experiences to date, that if you approached things, like I said, with self-evident truths, and follow this methodology, that in the end things should work. There might be some rough patches, but things should work. And I had had success in my multidisciplinary breast group of forming these types of relationships, and earning trust of developing great collaborative, that I remember as I was in that position of running the residency program, and running the breast cancer service, and participating in the multidisciplinary group, I remember attending some of these faculty development things where they say, "Navigating through the political nightmare of MD Anderson." And I'd sit there and I'd go, MD Anderson's not that political place. It doesn't seem like overtly challenging political environment in which to work. I'm having the time of my life. I'm not going home stressed about this or that. When I became department chair, you take

on a much broader context, and you find true pockets where things aren't working, and they're... I wanted... I think the hardest transition to being a department chair is your sincere desire to find the win-wins, you know? Come to a resolution that makes everybody happy. And I think I started to recognize that one type of solution doesn't always work, and you're not empowered to make everybody happy. There are some people who are just going to be unhappy no matter what, and that's their issue. That's not your issue. And you have to start to really focus on what's important beyond the individual, important for the group, and important for, again, doing the right thing, and doing the right thing by which, as prioritized for the group or the system, rather than the individual.
[00:21:27]

Tacey Ann Rosolowski, PhD
[00:21:27]
Did you find that some of your professional, personal relationships within the institution changed when you were department chair?
[00:21:35]

Thomas Buchholz, MD
[00:21:37]
Yeah. I mean, obviously they changed within our department quite a bit. I think whenever you—again, back to military training, there was kind of a strict fraternization rule about leadership, and that's done, again, for some good reasons. So the blurring of, "Oh, I'm Tom's friend," we'll go out to dinner with our wives together, and how come this faculty member's able to do that versus me, can lead to appearances, even if they're not of unfair treatment or so. So within our department, I think it took on a new level of responsibilities that said, well, I am the chairman, and we're going to treat everybody with the same equity, and we're not going to have, oh, this person likes to golf with Tom on Saturday mornings, or these types of things, unfairly. That service is better... So it's not just favoritism type of problems, but also perceptions that inevitably will happen in those types of situations. So you have to be mindful and careful of that. That, again, that could be a real problem in MD Anderson where you have so many spouses who work, and that was a problem (laughs) throughout our organization. Fortunately, I think most of my best MD Anderson social colleagues were outside of the department, and so it never became that big an issue, but I was mindful of that, and, I mean, I was still a member of the Breast Cancer section. And I remember the chairs before me saying, "Oh, Head and Neck always is treated the best because the former chair was a Head and Neck person," right? So there was always kind of that type of tension, but I always tried to mitigate that. I think what struck me, though, sometimes you'd have some really good ideas and elegant solutions, and they just wouldn't work, and they wouldn't work because of specific personalities that you just couldn't...

[00:24:18]

I remember once there was some obvious dysfunction in one of our sections, and it was a dysfunction in part because of personality, of some very senior faculty members. And they were in need of a change in their structure, to increase their efficiency, and they were in need of some sort of objective say of how to—the best path forward. And I thought, well, this is a way to use a consultant, right? Because it depersonalizes it. And sometimes consultants can bring new insights that you don't recognize, but sometimes they could just act as an arbitrator to... Because, again, some of the processes that I wanted to do, if you and I were to discuss them over coffee, you would find it in that self-evident, just equity of distributions. Like, do you think one attending should have three residents working with them when two attendings don't have any? Or should we maybe have an equal distribution, right? So that all faculty feel like they're treated fairly, and actually the residents get a better training experience. So some things like that. Well, no, I've always worked with three residents. I'm the senior member of the group. And so sometimes those types of things, you could be heavy-handed and say that, or you could try to find more elegant solutions to this. And so there were—we were having process problems, where people were seemingly doing what they felt was the best thing in radiation, for instance. We want to get patients started on treatment right away. And so you could say, "Oh, I saw a patient," throw him on the simulator, get him on the treatment unit, start him right away. That sounds like a good thing, but our attendings know that there's much more complexity to that, that there's a series of steps and measures that have to be done, and they have to be done very safely, and if we just throw someone on a machine we could have a major quality and safety error. And there's a lot of back work that involves physicists and phantom measurements, and all these things that intellectually we know, but why can't they just do that quicker? Doesn't always work. So that's where you try to explain processes, but then to have a consultant come and set up a system, and say, "Okay, are we all in agreement? Do we all understand? Do we need to educate, and...?" So some of those agreements I would ask a consultant to come in and say, "Okay, we're going to pilot this, right? We're not going to do it with the whole group, and we're going to pilot it with two groups: one, group A, which is completely dysfunctional; and group B, which is the group I came from, the Breast Cancer group," right? And not saying one's dysfunctional and one works well, just to say, "Well, we're all in this together." In fact, even the section I work in is going to go through the same arduous thing, and...
[00:27:35]

(Break in recording)

Tacey Ann Rosolowski, PhD
[00:00:00]
Okay, we are recording again after about a half-hour interlude for a technical issue, and, I'm sorry, the time is...? Just...
[00:00:10]

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Interview Date: January 31, 2018

Thomas Buchholz, MD
[00:00:10]
10:27.
[00:00:11]

Tacey Ann Rosolowski, PhD
[00:00:11]
10:27, okay, great.
[00:00:12]

Thomas Buchholz, MD
[00:00:13]
So I was mentioning that sometimes it's helpful to have a consultant tell you what already you know to be true, but it depersonalizes the... And going into consultantship with an open mind, certainly they might have some alternative strategies.
[00:00:31]

Tacey Ann Rosolowski, PhD
[00:00:31]
Well, and it helps to have an outsider come in and tell these truths and then leave. (laughter)
[00:00:35]

Thomas Buchholz, MD
[00:00:33]
Yeah, right. Then leave, right. (laughter) And, again, so one of the strategies I thought would work would be to depersonalize it, not say that your section of our entire group is the dysfunctional one, but say that we're going to do this as a departmental initiative, and look for two pilots, two groups that would pilot this, that then we could disseminate to the rest of the department. In a very altruistic fashion, I volunteered the section that I was in that was functionally doing quite well and bringing in the most dysfunctional section. And, not surprisingly, the consultant reinforced what I knew to be apparent going into this, and was able to articulate a best practice that was consistent for both groups. I thought that was a brilliant, non-personalized, non-heavy-handed strategy, where you would have buy-in from one component of the faculty organization, and it would just seem to be able to then be translated to the rest of the group. But, unfortunately, it didn't work, because of personalities that, in the end, weren't accepting of the outcome.
[00:01:57]

Tacey Ann Rosolowski, PhD
[00:01:57]

Can you sketch—and I realize that you want to kind of be sensitive about providing detail, but could you kind of sketch what the dysfunction was, so that—and why the individuals involved were so attached to sticking to that practice?
[00:02:15]

Thomas Buchholz, MD
[00:02:15]
Well, change is difficult. I think change, and your ability to change, is multifactorial. It's not just all emotional. People have— (loud background noise)
[00:02:28]

Tacey Ann Rosolowski, PhD
[00:02:28]
Do we have something happening here?
[00:02:30]

Thomas Buchholz, MD
[00:02:31]
That's my printer.
[00:02:31]

Tacey Ann Rosolowski, PhD
[00:02:32]
Oh, okay. Should we pause while it does its thing, or...? Because it's going to read on the...
[00:02:37]

Thomas Buchholz, MD
[00:02:37]
Okay.
[00:02:37]

[The recorder is paused.]

Tacey Ann Rosolowski, PhD
[00:02:38]
Yeah. All right, we're good to go again. So you were saying change is hard, and...
[00:02:45]

Thomas Buchholz, MD

[00:02:45]
Change is hard, and change isn't all just a psychological issue. It's an issue that sometimes people have different competencies with respect to skills needed for that change. A great example of that would be implementation of Epic. The ability of a younger generation to quickly adapt to a changing environment—I think in one of my Friday notes I wrote about the plasticity of one's brain, the ability to learn new work methods, and to implement them, are dependent on a variety of cognitive and physical factors, in addition to psychological factors. And so I think you have to be somewhat respectful of that. That, again, is somewhat of the art of leadership, in addition to holding principles. You can't be overly rigid. You have to allow for some flexibility for the human condition. And I was starting to mention it—I don't know if it was cut off or not—that comes then into the art of prioritizing decisions based on the cost benefits. The cost benefits are complex, because we live in a four-dimensional world, and you might say that we're making a decision about an individual circumstance that seems to be two-dimensional, without an appreciation that the decision that you make with this individual or this circumstance also has ramifications of what's going on next door, because they're going to be interpreting that in their own context. And it also has implications of how these things translate over time, because everybody's looking for consistency rather than inconsistency. Everybody's looking for fairness that is not about an individual.

Interview Session: 02
Interview Date: January 31, 2018

Chapter 09
A Decision-making Process Includes Lessons about Leadership
A: Overview;

Codes
C: Leadership; D: On Leadership;
D: Ethics;
C: Professional Practice; C: The Professional at Work;
B: MD Anderson Culture;
B: Working Environment;

Thomas Buchholz, MD
[00:05:12]
But so there's that art of human relationships that is important to make it all work. And this becomes, I think, very important in management of more senior faculty. And one of the strengths of MD Anderson, one of the things I enjoy most about MD Anderson, is the diversity of our culture, and the diversity of culture can bring in people who were raised in completely different traditions. For instance, in the Far East, the professor is idolized, and it's almost as if the junior people are there to care and serve the senior professor. We don't work in the Far East, and we have to have an appreciation for that. And if someone was in that tradition, we can't say that's fine to do in our context. But at the same time, we do have to appreciate that people bring value and wisdom and contributions in different ways. The experience of working in a field for 20, 30 years is highly valued, and that tradition is very important. That person might not be able to adapt to a new electronic health system immediately, compared to the first-year faculty member, but they might bring a certain element of depth that the first-year faculty member might not. And so to be hard and fast about requirements sometimes creates a little bit of a nuance.
[00:07:13]

Tacey Ann Rosolowski, PhD
[00:07:14]
So how did you work through the cost-benefit analysis in the example we were just talking about, with those pilot studies?
[00:07:22]

Thomas Buchholz, MD
[00:07:23]
I kept my end goal in mind, and I committed that we would get there, but sometimes you might have to take one step back before you move forward again, and you might have to alleviate a crisis, and sometimes you might have to compromise. One of the things I've appreciated in

leadership is the landscape of your viewpoint changes dramatically. And it's not as if you get brainwashed, or it's not as if you're smarter than anybody else. It's just you have opportunity to have different experiences than most people do. And it changes your vantage point. I'll never forget, as a department chair I ended up having a really great relationship with our faculty. I think they appreciated that I did have consistency, that I was focused on kind of the mission of our group, again, the greater good of our group. I didn't have a personal agenda. I don't think people were thinking of my leadership as, "Oh, Tom's trying to use us as a measure of getting to some greater place for himself," or that I wanted to divert all of our academic focus into the area that I was interested in. I think we had a good relationship within our department where I had the humility to not say that I had the answers, but I had the relationship ability to direct us as a group to find common answers that we wanted to pursue and move forward with that. Sometimes we even made the wrong decisions. There were a couple decisions that I look back upon now, and I say I wish I had made a firmer stance, because in the end it would've proven to be beneficial for the group. They didn't have the same landscape that I did. Of course, I didn't have the same landscape that they did.

[00:10:03]
A prime example is actually the Pickens Tower. So these aren't life-threatening type of major decisions (laughs) or anything, again, but I'll never forget when I had a great relationship with provost and Physician-in-Chief as a department chair, and we were trying to consolidate our faculty into the Pickens Tower, and I was able to secure for our departmental faculty two and a half floors of the Pickens Tower. And I thought this was a win, because we have faculty who have offices in the Mays Clinic, and we have faculty who have offices in Clark Clinic, or the Blue Zone. I'm not even sure what... Really remote areas of our institutions. And you lose out on being part of the faculty community, and we lose the cohesiveness of having a department where you see your faculty colleagues all the time. So we discussed this, and I thought one of my best negotiating with the Provost and Physician-in-Chief about the beauty of moving to the Pickens Tower, which would be a central location, readily accessible still to our treatment units back in either direction—it was kind of equal distance—a perfect path forward. We could utilize conference rooms together down here, and just have... That created almost an instinctive reaction from our faculty of negativity. Oftentimes we are called to see patients on our treatment machine, etc. Oftentimes we need to be near our clinic. But that change was just, oh. And the reaction within our leadership council was very emotional, and feeling as if, Tom, you've been such a good listener to us through the years, but why is this coming down heavy-handed? You clearly don't appreciate how important it is that we are here, and how devastating it would be to walk for five minutes to become... This is going to disrupt our whole clinic flow, etc., etc., etc. So after all this planning, I had to humbly go back. We reached a consensus that, no, we're going to have a small group here in the Pickens Tower, and we're going to continue to have a distributed faculty. And that was probably 80% consensus towards that.
[00:13:00]

Tacey Ann Rosolowski, PhD
[00:13:01]
So was it suddenly a conflict of values between the value of establishing departmental cohesiveness and community and the value of what do I need to know that I'm delivering good patient care?
[00:13:16]

Thomas Buchholz, MD
[00:13:17]
It was portrayed that way. I think there was the inconvenience value. This is my work environment. This is where I've traditional sat. The traditional value of being able to be called and run downstairs and see the patient. And everybody does have circumstances. Well, sometimes I work in the operating room over here, and this would be another burden of me. I'd have to drive in five minutes earlier, or whatever. And, of course, systems come into play, too. Now you can check things remotely in the computer that you used to do in a treatment planning room across the street. So I kind of saw the future, and I said, this is a good move for our group, and it was a win for our group, but that was flat-out rejected. And I remember being disappointed in some of the faculty who kind of even were using trump cards, like, "You've always been such a good leader, and you've always understood us, but, boy, you're really missing the point on this. Why are you not listening to us?" So in the end, I listened, and in the end we moved a very small contingent over to the Pickens Tower, and the vacuum of filling up the rest of the space was quickly done. And now, if you walk around to our faculty, our faculty say, oh, that was the worst move. Everybody wants to move into this little space. Everybody recognizes now that, wow, what I'd give to have one of our few offices over here. They're the premium. And ironically, then, of course, the new hires or the junior faculty, the ones who need to be most integrated into the institution, are relegated now to Nome, Alaska over there in the Mays Clinic parking lot building. (laughs)
[00:15:30]

Tacey Ann Rosolowski, PhD
[00:15:30]
But I can only imagine the negative impact if you had come down as a heavy and said "No, we're going to do this." Wow. Interesting. So what were the big lessons that you took away from that? I mean, that's a really interesting scenario.
[00:15:45]

Thomas Buchholz, MD
[00:15:48]
Well, I think the lessons are that it's always important in any type of relationship, whether you're a leader or being led, to try to understand the perspective, and really try to see and understand where people are coming from before trying to convince them that they're wrong. I think that's

true of any type of relationship. If you could have the person who doesn't want to move to the Pickens Tower stand up and argue for moving to the Pickens Tower, the one who doesn't want to move, and vice versa, and have kind of a reverse debate, you could begin to maybe appreciate the differences. I think those are some of the... It's in clinical medicine, too. I'm often asked to be on one of these debate panels of some new technology of some kind, and should we do it, yes or no, is it acceptable as standard of care. And it's almost great to have enough open-mindedness that you don't care which side of the equation that you're asked to debate, right? Because that gives you the ability to see both perspectives of why it should be done. And then it enables you, if you feel like there is a right answer, at least to be addressing and be acknowledging that you hear what they're saying. You're not negating what they're saying, but you do understand their perspective, and you appreciate their perspective. And sometimes we're going to have to make decisions, despite not everybody's perspective being realized, and that's because we're a group, and there's complexities, and it's more than just your dimension that enters into it. But at least we're not discounting that you have a perspective on this question. And I don't think leadership's always about majority rules. I think there has to be some appreciation, just because not everybody could have every piece of information. And I learned this even more when I became an executive vice president.

[00:18:18]
When you become an executive vice president, your day is filled with complex meetings about organizational structure, organizational finance. And it's really important to be transparent about why, and decision making. But it's frustrating sometimes that we have to appreciate that people have different skillsets, and it's not really important that every assistant professor here divert from their academic career path to do a two-year MBA to learn how to be an accountant, because we have accountants who know how to do that very well, and that's their job. And it's important for our accountants and our CFO to be very transparent, and help educate issues about our finances. But at the same time, we have to be trusting that they have the skillset that's not going to be replicated by everyone. When you're Physician-in-Chief and you're meeting on all these relevant, important issues, you can't substitute the word "transparency" for feeling like every single 20,000 member of our institution has to sit in every one of those meetings so that they could understand the same landscape that the leader has, because leaders inevitably are charged with the responsibility of making decisions on the basis of what's best for the mission and the group of the people. And there has to be an element that ultimately gets to trust, you know? Well, I trust that our accountants are really capable of this, and that they know accounting rules in a way that I don't. And I don't mind asking them, "Help me understand this." That's fine. But inevitably I'm not going to critique them that they're doing it the wrong way, or I'm not going to require that everybody has to be involved in every type of decision-making in an organization. That would paralyze things, right?
[00:20:54]

Interview Session: 02
Interview Date: January 31, 2018

Chapter 10
Looking Back on Years as Department Chair
B: Building the Institution;

Codes
C: Leadership; D: On Leadership;
C: Mentoring; D: On Mentoring;
C: Professional Practice; C: The Professional at Work;
B: MD Anderson Culture;
B: Working Environment;

Tacey Ann Rosolowski, PhD
[00:20:54]
Yeah, absolutely, absolutely, yeah. Now, obviously, I want to go on and talk about those other roles that you served. A couple of details, though. Who was serving as Provost at the time that this was going on?
[00:21:09]

Thomas Buchholz, MD
[00:21:09]
Ray Dubois.
[00:21:10]

Tacey Ann Rosolowski, PhD
[00:21:10]
Oh, okay. And the Physician-in-Chief?
[00:21:14]

Thomas Buchholz, MD
[00:21:15]
Tom Burke. I think when I started it was Margaret Kripke [oral history interview], offered me my Department Chair job. Ray offered me the Division Head job. So I served on Ray's search committee, actually.
[00:21:35]

Tacey Ann Rosolowski, PhD
[00:21:35]
Oh, did you?
[00:21:35]

Thomas Buchholz, MD
[00:21:35]
Yeah. Dr. Mendelsohn asked me to be on the search committee for the new Chief Academic Officer. It became Provost when Ray accepted the position.
[00:21:48]

Tacey Ann Rosolowski, PhD
[00:21:49]
Okay. Is there anything else that you'd like to say at this point about your work as Department Chair?
[00:21:57]

Thomas Buchholz, MD
[00:21:57]
It was fun. I think another thing that really helped to change the culture... First, I entered into the Department Chair position feeling like we had a great group and a great culture, and the previous chair was still the division head, and he was the one who hired me. And he and I were aligned on many things, and so it was a natural succession that worked well. And it gave an opportunity for the first appearance that there wasn't anything radically different going on. But then it did strike me about, at the end of the day, how much change really did happen, and how much really resulted from new directions, and new leadership. And it was a great way to transition. Part of the change that happens at MD Anderson that's really kind of a neat thing is growth. So I was able to hire 35 faculty members or so. And when you bring people in, you kind of have a different degree of ownership. You have a different degree of responsibility. These people have entrusted their professional career to come work under your leadership, and they have a great... They're looking to you to set expectations, to set mentorship, to help them realize what they articulated during their interview as why they want to come to MD Anderson. And I feel as if you're making a commitment to someone to be supportive of them, that you have to follow that commitment.

[00:24:00]
The other thing that was nice with new people, too, is you have a great opportunity to set expectations about some of those problems that end up happening. You can set expectations day one with people that say—about professionalism, for instance, about behavior in the workplace. You could set expectations about fairness, about communication and transparencies. And it's the most wonderful time in the world, when you have someone who their first week of faculty, and you call them in, and you have that Department Chair meeting with them about professionalism. Of course, they've done nothing wrong, and you hired them because you think they're a good fit in the department. But inevitably we work in stressful environments. You're going to be frustrated when your pager's going off constantly. You're going to hang up the phone harshly

sometime. You're going to inadvertently say, "Why are you calling me? Well, this isn't even my patient," or... And be [coarse?], and tell a faculty member their first week, "When that happens, I'm going to talk to you. It's going to be an awkward conversation for us, but this is of such importance in our safety culture that... And if you feel like you've been treated that way, I want you to come talk to me, because this is a priority for our group. And here are other things that sometimes faculty stumble in, and we're going to have a degree of responsibility and accountability. And, again, they're not getting to controversial issues. We're all going to participate fairly. We're all going to own these. And me, as a leader of this group, these are tenets that I hold to be very important. And if we recognize this is happening, we're going to have a conversation about that." They leave, of course, feeling like, oh my gosh, I just joined the best department in the world, right? Never have I had a department chair who would really address some of these things, and you'd just see them going on. And you'd also establish cultures. And then it also becomes much easier. It's like, "Well, last week in staff meeting I know you felt passionately about this issue, but the aggressiveness by which your communication style really was off-putting to a lot of people in the room." And they may, "Oh, wow," you know? But it would be a comfortable conversation, because you say, "Remember when I hired you I said we're going to have these types of conversations? Because I want you to be successful. I want you to grow."

[00:27:00]
I think that's kind of the art of leadership that, again, just takes some initiative. I was shocked. When I first became leader, I underappreciated how much time it takes to be a leader. You thought you just go about and a decision would crop up and you make the right decision. You didn't have to prospectively plan to avoid... But so I think those experiences were helpful to me, in really kind of learning how to do that. And then towards the end of my chairmanship, we really had a synergistic group. It wasn't perfect. There were still political things. I still had to deal—I had to let some people go, because they weren't working. I had to take people out of leadership positions, and I had to deal with conflict within our faculty. I'm not saying I dealt with these things perfectly. Sometimes we couldn't reach resolutions. But I think the culture of our group, looking now from the vantage point of serving in these executive groups, wow, we have great functionality. We had great camaraderie. We had a sense of community. We had positive things, too. So... And as Chair, too, I tried to promote that community. I'd always have a faculty-specific gathering at my house. I'd always welcome new faculty at that, and I'd kind of have fun interviews with them up on my stairs. And it was a nice event, and it'd bring people together. We'd have retreats that bring people together, and it'd be fun, and you could have that social connectivity opportunities that would get people together and recognize, hey, we're proud to be in this group.
[00:29:11]

Tacey Ann Rosolowski, PhD
[00:29:12]

You've used the word "fun" several times. Like, fun as department chair. What are the elements of that fun for you?
[00:29:20]

Thomas Buchholz, MD
[00:29:21]
Well, it's having an impact, I think, recognizing that... It's incredibly fun to lead a group where you're making a real human impact on a disease like cancer, or on your own profession. We're really making discoveries that are changing how things are done in the world. It's a tremendous sense of self-fulfillment. It's also fun to see people thrive, and see their enthusiasm. And a great thing about academics and leadership is you keep getting reinforced. There's a new wave. There's some new achievement and a new person that comes to you in your office, and is really excited, or writes this email to you to say, "Wow, I could never have done this without your support. Now look what we're doing." I mean, it is a rewarding type of thing. And it should be fun. We should all have fun at work. We should have relationships at work. We should wake up happy that we work at MD Anderson, excited to come in, and what the new day will bring.
[00:30:43]

Interview Session: 02
Interview Date: January 31, 2018

Chapter 11
On Changes Under Ronald DePinho, MD
B: Institutional Change;

Codes
C: Leadership; D: On Leadership;
B: Growth and/or Change;
B: Obstacles, Challenges;
B: Institutional Politics;
B: Controversy;
B: Building/Transforming the Institution;
B: Critical Perspectives on MD Anderson;
B: MD Anderson History; B: MD Anderson Snapshot;
C: Professional Practice; C: The Professional at Work;
C: Understanding the Institution;
C: Portraits;

Tacey Ann Rosolowski, PhD
[00:30:46]
How would you like to proceed with the story, the next role you had?
[00:30:50]

Thomas Buchholz, MD
[00:30:51]
Well, the next role came about, I think, as Dr. Dubois was, I think, a candidate for the president of MD Anderson. And after Dr. DePinho [oral history interview] was selected as President, I had great respect for Ray that he decided, well, I'm going to make a year commitment to help in the transition, to see how things play out. And, not surprisingly, I think when there is a presidential turnover, Ray reached the point where he thought, well, let me see what else is in the marketplace. And so during that transition, I think Dr. DePinho wanted to go—he was reaching the point where he had been here long enough that he wanted to be a man of action, right, in terms of recruitment, which is based largely on the provost's office, development of new academic programs, starting a new Institute of Applied Cancer Science, a whole new presidential initiatives that came with Dr. DePinho and his vision as the new President. Some of those created a bit of a culture clash, if you recall, here at MD Anderson.
[00:32:22]

Tacey Ann Rosolowski, PhD
[00:32:22]

Yeah, I do. Yeah.
[00:32:24]

Thomas Buchholz, MD
[00:32:25]
And I think the provost position was getting to be kind of at the epicenter of these changes. So Ray decided it was going to be time for him to move on. So at the time I was a Division Head, my division... So as a division head, I briefly met Dr. DePinho for 30 minutes before he was appointed president, for kind of a group interview. Subsequently, I was a member of various committees that the division heads participated on with Dr. DePinho, and I certainly knew him, and he knew me. He wanted to make a point to go around to each of the divisions and the departments, and come to the department meetings.
[00:33:19]

Tacey Ann Rosolowski, PhD
[00:33:20]
What was your impression, kind of first impressions of his style as a leader at that point?
[00:33:25]

Thomas Buchholz, MD
[00:33:27]
I was impressed. I was impressed with his boldness, that he came across, initially, to me of, wow, here's someone who's not going to come into MD Anderson and just keep doing it, right? He was going to bring something new or different. He was going to bring a different degree of opportunities for us, and he was going to... The other thing that struck me, I guess, during that first nine-month period was how intelligent he was. He is an incredibly intelligent person. And by intelligence, I mean—not too many people know anything about radiation. Ron has never practiced as an oncologist. So I was thinking he'd be completely naïve about what radiation oncology was. What's the difference between proton radiation and X-ray radiation, or something along the lines. But when I had these brief interactions—and they tend not to be one-on-one meetings with him, but—he would make comments about radiation oncology that were incredibly insightful. I even attended some donor events where someone would stand up and ask a question, and I'd go, oh my gosh, he's never going to be able to answer that. Maybe I should stand up and help him. And he'd be, like, wow, spot on, right?
[00:35:02]

Tacey Ann Rosolowski, PhD
[00:35:02]
Wow.
[00:35:03]

Thomas Buchholz, MD
[00:35:03]
He's a very incredibly intelligent person.
[00:35:09]

Tacey Ann Rosolowski, PhD
[00:35:09]
Very articulate, too.
[00:35:10]

Thomas Buchholz, MD
[00:35:10]
Very articulate. And so as he got started, I think, again, we had never had a one-on-one meeting. And he never made it to our group. I think there were high-priority groups, in some respects because our group was so functional. And he'd comment to me in group meetings. He would pull me aside and say, "Oh, Tom, your group is doing so great." And I would be like, "Well, how do you know? We're down there in the corner, I guess. How would you know?" But he would say it with such authority. "Oh, if only every division could be as functioning like yours." And our faculty didn't know him at all, right? And they started to feel this what's going on with this? Why are we in *The Cancer Letter*? What's going on with this development of all these scientists who aren't faculty, and drug discovery? And I would just say to our group, "Why are you worried about that? Is it affecting your career path? If there's a problem, if you're feeling like you're not getting sufficient resources, come talk to me. We can see what we can do about it. But you don't have to get in the drama that's happening next door. We have a good group. We're happy, right?"
[00:36:37]

Tacey Ann Rosolowski, PhD
[00:36:38]
When did you start to see the honeymoon period ending with Dr. DePinho? And what were the issues that you saw kind of coalescing? Because there was a lot of tension. And I think in retrospect it's useful to see, Huh, when did the systems start to have problems?
[00:36:57]

Thomas Buchholz, MD
[00:36:57]
Well, I remember his first talk to our faculty, and I thought it was brilliant. He came with his story, a very sincere, authentic, personal story of growing up as an immigrant with his father, and his passion for cancer, and how he dedicated his life to cancer research, and how he was here to listen, and he's proud to join such an outstanding community of cancer, and what an honor to be here, and he's got a lot to learn, all the right things. And it seemed, in the back of his mind, he

had a clear directive of what he wanted to do and how he wanted to do it. And I think the tension began after a while where he said, "Okay, Chuck, it's time to get going, right? And it's time to build our science," something that historically people have been saying for years, that our clinical care and our clinical delivery and our clinical research were great. How many National Academy members do we have? How many Nobel Laureates do we have, compared to Harvard or Stanford or...? Ron was our first National Academy member, and he traveled in those circles. He knew the people. He thought he could bring them with him. "I'm going to call X from California and bring him in." And if you're going to recruit someone like this, you can't give them the MD Anderson starter package. You had to really recruit something different, like these transformative. And MD Anderson's never done that before. If you want to have a pharmaceutical, real, innovative biotech, you're naïve if you think you're going to do it in academic labs. We proved that's not the case. "I've started six companies." I haven't. Ron DePinho was saying that. "I've started six or seven companies. I work with these people who are pharmaceutical-grade scientists rather than academic scientists, and there are different culture and different perspective and different thought processes, because they're not interested in publishing a paper or getting a grant; they're interested in developing a compound and bringing it to the market."

[00:39:33]
And so that's how he created... And he's kind of right, right? The vision is not a bad vision. We do need to diversify our revenue streams, and one way to do that is to patent and develop drugs that would be a source of huge amounts of revenue for MD Anderson, that would go back into our academic... But he lost everybody, right? That wasn't a community-based decision. And it kind of got to the point where he might be moving everybody to the Pickens Tower. He might say, "Well, this is what's best for our organization," and everybody was pushing back and saying, "This isn't the right time for us to do that. You don't understand our vantage point. We're getting a feeling like there's two sets of people: there's the people that are being brought in, and there's the rest of us. And some of the language is making us feel like we're underperforming." If you're a scientist here, and say, "Well, the level of science has to be raised," it's like, well, what do you mean? I'm doing the best I can, (laughs) right? If you're a clinician, you're feeling like, well, all these resources that we're giving a startup package tens of millions of dollars, where's that money coming from? Well, it's coming from my hard work taking care of patients. And is it fair to not have that...? I can't get $100,000 to support my research assistant, and I'm the one generating all the income.

[00:41:18]
So there was... Things just moved at a... And, again, the connectivity between those two, there's a lack of understanding of how the organization works. And that's where we got to the point where there, I think, was just fundamental "What's going on there?" There's distrust. And it got to the point where at my point I was, Okay … Because I wasn't one of those "What does the other guy have?" I was more, "What do *I* have? Oh, I have it pretty good." And so, yeah, if Dr.

DePinho says we're going to create an institute that's going to bring in new revenue streams from biopharma, I'm going to say, he knows a lot more about that than I do. I don't mind him transparently sharing that, but I can't really say I have content expertise to say that's a good idea or a bad idea. But I'm going to have to trust a leader to make that decision. That's kind of my dad's Midwestern heritage of, well, he's the boss, right? He's empowered. He was brought in to make that decision. I'm glad he's sharing the details with me. And if he shares all the details, I might say, "This doesn't really work with our culture. We have to be mindful of this. I don't disagree with the principles, but let's try to work together to find a solution."

[00:42:52]
So everything was going well, I thought, for our group. We were hitting some choppy waters with *The Cancer Letter* and other internal strifes. And then one day I finally arranged for Dr. DePinho to come talk to our group, and he ended up talking to our leadership group of about 15 or 20 people. And it was a Friday afternoon, and it was great. People had tremendous pride in what we were doing, and they wanted to talk about it, and they wanted to help educate him about what we're doing as a group and why this is important, and talk about some of our interests and things. There wasn't "What's going on with...? How come we're in the *Cancer Letter*?" Or "What...?" It was just a discussion about what we were proud of. And it was a free-flowing discussion. It wasn't just presentations, but it was a very... At the end of the day, I walked out with him and he's like, "Wow, you got a really great group." And I said, "Yeah, we do. I'm very proud of that." And he left happy.

Interview Session: 02
Interview Date: January 31, 2018

Chapter 12
An Offer to Serve as Provost and Executive Vice President
A: Overview;

Codes
C: Leadership; D: On Leadership;
B: Growth and/or Change;
B: Obstacles, Challenges;
B: Institutional Politics;
B: Controversy;
B: Building/Transforming the Institution;
B: Critical Perspectives on MD Anderson;
B: MD Anderson History; B: MD Anderson Snapshot;
C: Professional Practice; C: The Professional at Work;
C: Understanding the Institution;
C: Portraits;

Thomas Buchholz, MD
[00:42:52]+
And, then, I think the next Friday I got called, and they said, "Oh, Dr. DePinho is on the schedule to meet with you at 4:00." And I said, "Oh, no, that's a mistake. He met with us last week at 4:00. We've been trying to arrange a meeting with him at four o'clock on Friday forever." I said, "We just met last Friday." And they said, "Oh, no, no, he wants to meet with you in his office at four o'clock on Friday." And I said, "Okay." And I didn't feel threatened at all, because I knew my standing with him was fine. And I was pretty sure he was going to... I was doing a lot of initiatives in our group for transparency, managing faculty expectations, that everybody was clear on what their job description was. And I was trying to suggest in some of our clinical meetings that this should be a standard for every division, because faculty want to know what the expectations are. So I thought he was going to appoint me to a blue ribbon committee to do something like that. Dr. Mendelsohn had appointed me to various things.

[00:45:19]
So I walked in, and Tom Burke [oral history interview] came in, and Leon Leach [oral history interview] came in, and Ron came in, and he said, "Tom, I'd like you to be Provost of MD Anderson." And I said, "What?" (laughter) And he said, "Yeah, I'd like you to start Monday." And I said, "Wow." And he says, "So you want to do it?" (laughter) I was like, "Should I talk to my wife, maybe?" And he says, "Well, we kind of really have to make some decisions." And I said, "Sure." (laughter) I walked out, not knowing exactly what that meant. And I got together with Tom Burke over the weekend, and he kind of explained that Ray was moving on, and that it would be okay, and Tom was there to help me. And Tom was my boss, and Ray was my boss,

so I had a relationship with Tom, and I knew Leon very well, too, and they all assured that they'd help me. But it was challenging, and my skillset was a little bit stretched, because Ron was in full accelerator mode of recruiting National Academy of Science members, etc., many of whom's name after leaving his office I'd run back to the Provost Office, and Maureen Cagley and I would Google them, right? Because I had never even heard of them. (laughs) They would say, "Well, we have to recruit X," and I would go, "Oh, yeah. Yeah, he's going to be a gamechanger. He's..." I'd think, "Yeah, that would be... Yeah, okay." And, "Why don't you fly out to San Francisco and have breakfast with him, Tom?" And I was like, "Sure, yeah." (laughter) I think, I'm going to call this person, they're going to say, "Who are you?" Like, "I'm the Provost of MD Anderson." They were, of course, really welcoming. And so it was a really eye-opening experience. It was a hard job.
[00:47:36]

Tacey Ann Rosolowski, PhD
[00:47:37]
Why so?
[00:47:37]

Thomas Buchholz, MD
[00:47:38]
Because I didn't feel... I went from this apolitical thing into the heart of the politics, right? We were just launching the Moon Shot program. I was helping to define what should be the Moon Shot, how are we going to fund the Moon Shot program. I didn't have much in the way of experience with the whole institutional, financial arrangements of what can we use a Pickens fund for, what can we use this, how does all this work, where is all the... So there were a lot of other initiatives. The Simone Report was just coming out with trying to align administrative efforts, and I was kind of the new person that had relationship with the faculty, and the division, and everything was kind of saying, "Oh, here, Tom, do this." At the same time, I could perceive what wasn't going right on the leadership circle. I had the vantage point of the division heads. I had the vantage point of the faculty. I knew what the conversations, what they were in the hallway.
[00:48:54]

Tacey Ann Rosolowski, PhD
[00:48:55]
What wasn't going right? What were you observing?
[00:48:58]

Thomas Buchholz, MD
[00:48:58]

Oh, I don't think people feel connected, again. They felt kind of like there were two different cultures. They felt as if some of the institutional resources were frivolously being—that we were contributing, and we weren't part of where it was going. That "they didn't pick a Moon Shot for my group, and now we don't get any resources, and everybody else gets the resources" or so. And that wasn't necessarily true, again. I think that's where these rumor mills just took hold, and there was such sources of negativity at the time that, just kind of like in the modern press, in our national—you could take hold of a story and paint it in a very convincing fashion that things are really terrible, and it's easy to make people feel suspicious. It's harder to make people feel trusting. There are a lot of people that were threatened by this, or a lot of people, when they say "Raise the bar of science, we're going to hold tenure renewals to a different level of credibility." You're talking about, well, maybe you're going to lose your job. Maybe I don't have grant support that I should. And I know that. How am I going to survive in this? Well, one line of defense is to say, "Well, we're not going that direction," right? And "We're going to create pushback." And so it was challenging. And I thought, again, a little bit naïve, "Well, I could really help this, right? I could be kind of that bridge. I could be someone that people would say, "Well, Tom's not here to create his own Moon Shot, and we kind of trust him, and if he says that, 'Oh, I looked under the covers and everything's okay, that we're not diverting resources from you, and, in fact, Dr. DePinho's been so successful in fundraising that we have all the resources we need to do these initiatives without any compromise in our institutional budget...'" That was the reality of it, but there were forces that were pushing back hard against it. And I'm not saying that some of it wasn't legitimate. I didn't have an answer to every gripe. Some of the gripes were real, legitimate problems, and legitimate frustrations, and...
[00:51:52]

Tacey Ann Rosolowski, PhD
[00:51:54]
What were some of those legitimate frustrations, did you feel?
[00:51:56]

Thomas Buchholz, MD
[00:52:02]
Inconsistencies, I guess, was one, that kind of everybody wants to be treated fairly and consistently, or we should have policies that... We shouldn't just do arbitrariness. We shouldn't just take the make-it-happen type of deal. So some of those things were fair. I think people were feeling like they were frustrated with bureaucracy. They were feeling as if... The usual type of thing, I guess you could read about in the *Cancer Letter*.
[00:52:49]

Tacey Ann Rosolowski, PhD
[00:52:50]

Did you feel—I mean, so many people were mentioning to me—and I should say I began to interview folks in August of 2011, which was—or actually, maybe it was a little earlier, July—just before Dr. DePinho arrived. I interviewed people all through the honeymoon period, and then heard how the way people spoke about him really changed. And person after person began to say, "There's just been a real, perceivable change in MD Anderson culture," among many other things. And I'm just wondering if you felt that that was happening, as well.
[00:53:33]

Thomas Buchholz, MD
[00:53:35]
Yeah.
[00:53:36]

Tacey Ann Rosolowski, PhD
[00:53:36]
And what were the changes that you were seeing?
[00:53:39]

Thomas Buchholz, MD
[00:53:44]
Ron is a transformative figure, and he thinks that MD Anderson has a responsibility to be bold, and to be bold you have to be courageous of making it happen, right? The ends justify the means. And doing that, MD Anderson had been kind of more of an incremental advancing. That's hard to say with—look at what happened under Dr. Mendelsohn's leadership, how big we became, and etc. But—
[00:54:35]

Tacey Ann Rosolowski, PhD
[00:54:35]
But it wasn't such a fundamental, substantive change.
[00:54:38]

Thomas Buchholz, MD
[00:54:38]
Yeah. So Ron's recruitment style was off-putting to some, because it led to "Are you on the A team or the B team?" And this resource allocation issue became a real perceived issue. I'm not sure that really is a major issue, but this degree of fairness and inconsistency of, well, this is a special circumstance, we're not going to hold the same level of accountability as we do over here. And then this fear of, well, if we bring in a different caliber of science, is my science going to be good enough to be recognized as part of this community? And I used to be part of this community, and now is my job threatened? Is my livelihood threatened?

[00:55:40]

Tacey Ann Rosolowski, PhD
[00:55:40]
What about distinctions between clinical activity and research activity? A lot of individuals I've spoken to have said that there's just been a subtle shift in the way that patient care is valued, or... I mean, not that the patients aren't central, but that kind of how patient care factors into the status of a particular individual has changed, and you...
[00:56:14]

Thomas Buchholz, MD
[00:56:15]
I think that was a tenet. I'm not sure that that's actually true, again.
[00:56:22]

Tacey Ann Rosolowski, PhD
[00:56:23]
Well, what's your perspective on that?
[00:56:24]

Thomas Buchholz, MD
[00:56:24]
That leaders are defined by what they say. I think if you want to create safety, quality culture, the leader better be up there and saying that out of the first three words out of their mouth. If you want to... So Ron DePinho, I could honestly say, is incredibly impressed and thankful, and defines MD Anderson as the outstanding place for delivering clinical care of cancer patients. And I think his thought was that's a good piece; what they're missing is this other piece. And what this other piece is ended up being what was out of his mouth all the time, because that's where the transformation was going to be. It wasn't going to be in the clinical arena. But because of that, there was a perception that our whole institutional focus is not about the clinical thing. All we're talking about is these Moon Shots initiatives. Anything in the press, we're not celebrating the fact that I just did a 12-hour operation that nobody else in the world could do. We're talking about we need to bring in more discovery science, and get patents, and drug developments, and invest millions of dollars over here. We're going to spend $75 million on IACS, and nobody's going to buy another robot for the operating room. These are the types of things that lead people to have those percep... Like, well, we're undervalued in the clinical community. I could say with great sincerity I don't think that Ron ever undervalued it. I think, as a leader, he could have been more—he could've articulated that over and over again, and so that it didn't just become about... When you talked to Ron, it was Moon Shots, big data initiative, this... And there were legit—his wife was involved in all this stuff, too, and obviously you know some of the stories, too. (laughs)

[00:58:58]

Tacey Ann Rosolowski, PhD
[00:58:58]
Yeah, of course. Yeah.
[00:59:00]

Interview Session: 02
Interview Date: January 31, 2018

Chapter 13
From Provost to Physician in Chief
B: Building the Institution;

Codes
C: Leadership; D: On Leadership;
A: Character, Values, Beliefs, Talents;
A: Professional Path;
A: The Administrator;
B: Building/Transforming the Institution;
B: Institutional Politics;
B: Controversy;
C: Evolution of Career;
C: Professional Practice; C: The Professional at Work;
D: On the Nature of Institutions;
C: Understanding the Institution;

Thomas Buchholz, MD
[00:59:00]
So the provost, for me, was—again, talk about learning a new perspective on the institution. It was a great learning experience. It was stressful. It was fast-moving. I mean, when I walked in that first day with Maureen Cagley, we had decisions piled up to make. Should we transfer this grant to Dartmouth where the faculty member moved? Well, now we have this department chair in here screaming at me that, no, we can't release that grant. What do I know about this? (laughter) Oh, this person's being arrested, and here's the whole backstory, and it's like, whoa, this person has fabricated science, and how are we going to...? Wow. Well, this person needs lab space, but we don't have any lab space, and now Ron wants to recruit another Nobel Laureate, and now we're going to have to kick six people out of their lab space, and whoa, you know? So it was an amazing firehose of information, all of which needed to be done quickly, that had built up. And when Ron first offered me the job, I didn't know if he meant like a provost. That's how he said it. He didn't say, "I want you to do this for a couple months." He said, "Tom, I want you to be Provost of MD Anderson." It wasn't until I went over to Tom Burke's house that he said, "Oh, Tom, you're never going to be Provost of MD Anderson. He just wants you to do this. He's going to appoint a National Academy member, of course." And appropriately so. If you're going to have another National Academy member, provost is the position, and my expertise is not in laboratory sciences. And so then when we went around with this search process, there was like, well, who's going to be the next provost? And all sorts of names were flying. And as we had gone through that month, I think Ron decided initially there's not going to be an internal candidate for provost. And then after about six months or so, he

called me in his office and he said, “Tom, I’m really liking the job you’re doing. Would you be an internal candidate for the provost job?” And I said, “Sure.”

[01:01:46]
So then I interviewed, and there was a search committee, and I think Tom Burke was on the search committee. Leon Leach was on the search committee. Various department chairs were on the search committee. Almost universally everyone came and said, “Oh, we told Ron we want you to be provost. We told Ron we want you to be provost.” And so I ended up being a final candidate. Ethan [Dmitrovsky; oral history interview] and I were the two final candidates. And I was like, oh my gosh, this is kind of strange. And then Ron didn’t decide, and it just went on and on. And he invited me back, and we go out to dinner or something. He’d ask me all these probing questions of “What is the most important thing in science in seven years from now?” And I’d be like, “Oh, Ron, stop.” (laughter) I said, “I’m not even going to answer that question.” But it was fun. And I didn’t really care that much. I saw the huge negative consequences. I saw the fun, too. I was still the Division Head of Radiation Oncology. My division was screaming for me not to be the provost.
[01:03:13]

Tacey Ann Rosolowski, PhD
[01:03:13]
Why?
[01:03:13]

Thomas Buchholz, MD
[01:03:14]
They wanted me back as their leader. When I was gone, kind of the interim fill-in type of thing wasn’t working the same way it had been. People were kind of unhappy. People were really wanting me to be the division leader. People would come up to me and say, “Don’t do that.” And then I said, “Well, I have to explore this.” And then...
[01:03:39]

Tacey Ann Rosolowski, PhD
[01:03:39]
What was the reason you felt you had to explore the provost role?
[01:03:43]

Thomas Buchholz, MD
[01:03:43]
I don’t know. I think that’s how I led my career. I always say yes. Someone says, “Do you want to do this?” I say, “Yes.” I mean, it is a more impactful role. I thought, if Ron’s going to be the president, he needs someone like me to... He doesn’t need another National Academy

member. We don't need another person that's just going to create... They need someone that the rest of the institution... He's recruited 20 people. There's 19,080 people who are feeling disconnected, and they need that, right?
[01:04:24]

Tacey Ann Rosolowski, PhD
[01:04:24]
They need somebody familiar, somebody who represents their values, yeah.
[01:04:27]

Thomas Buchholz, MD
[01:04:26]
Yeah. So in the end, I was at an NCI meeting, and Ron called me and said, "Oh, I've decided to pick Ethan." And I was like, "Ah." [Again?], it was a devastating day in my life. I just kind of moved on. And I met Ethan, and I wanted to help Ethan, and I said, "Ethan, this is a very complex job." And so I worked with Ethan for about three or four weeks, and we had a really good relationship. And I said, "You're the Provost now. I'll help you get acclimated." And I think people saw that, too, and it's like, wow, this isn't... There wasn't any bitterness. I came back to Radiation Oncology. They were so happy. (laughter) They were just so happy that I'm not provost. Yay! Oh, it's going to be great. Coming back, though, it is different, you know?
[01:05:25]

Tacey Ann Rosolowski, PhD
[01:05:25]
How so?
[01:05:26]

Thomas Buchholz, MD
[01:05:26]
It's different because, again, you've seen the landscape over here, and you're involved in decisions like this, and it takes a little while to reacclimate, to say, well, now I'm just... I'm not worried about the IACS anymore. I'm not worried about the Moon Shots program. You had such a focus on these institutional things, and then they're kind of gone.
[01:05:52]

Tacey Ann Rosolowski, PhD
[01:05:52]
Was it sort of... Was that a negative? Was it kind of a sadness in letting it go?
[01:05:57]

Thomas Buchholz, MD
[01:05:57]
Well, it was just different. But so what happened pretty quickly was Ron, through a consultant, kind of approached me about being Physician-in-Chief. And that was—for me, I feel like that's a better fit in terms of the two faculty EVP roles, because I'm not a lab-based scientist. I'm a clinical scientist, and clinician, and clinical care giver. And so he kind of tried to woo me into being... He said, "You've just undergone a national search, right? You've been vetted by our community. I've only heard really positive things. I could just appoint you to be Physician-in-Chief." And I think that started in September, and probably I accepted it in November, and January 1st I became Physician-in-Chief. I didn't—
[01:06:55]

Tacey Ann Rosolowski, PhD
[01:06:55]
This is 2014, and you became Physician in Chief in 2015, January 2015. Yeah.
[01:07:01]

Thomas Buchholz, MD
[01:07:02]
If that's what my résumé says. (laughs)
[01:07:04]

Tacey Ann Rosolowski, PhD
[01:07:04]
Yeah, it's on your résumé. I'm just saying it for the record, so... (laughs)
[01:07:06]

Thomas Buchholz, MD
[01:07:08]
And so then it was a different type of transition. At first, I wasn't sure I wanted to do it.
[01:07:20]

Tacey Ann Rosolowski, PhD
[01:07:21]
Really?
[01:07:21]

Thomas Buchholz, MD
[01:07:21]
That one I didn't say yes to over the weekend. I...
[01:07:24]

Tacey Ann Rosolowski, PhD
[01:07:24]
So what was that about?
[01:07:25]

Thomas Buchholz, MD
[01:07:25]
Just because I knew that... I was in the midst of this institutional chaos, and suddenly I stepped out of it again, right? And I also recognized that this institutional chaos wasn't going to be something simply I could turn around by telling everybody, "Oh, hey, I'm here now, trust me. It's all okay. Your perceptions, you don't have to..." Even if I felt as if some of these things, they weren't validated, you don't have to worry about that, you don't have to worry about your research, it wasn't going to work that I could just make it all better. This was going to continue, and it was going to... And then do you want to be a part of that, or not?
[01:08:22]

Tacey Ann Rosolowski, PhD
[01:08:22]
Well, I was going to ask you that. I mean, did you feel that there were certain people who began to see you differently because you worked so closely with Dr. DePinho?
[01:08:31]

Thomas Buchholz, MD
[01:08:30]
Oh, sure. Oh, definitely. Look what happened to me. (laughs) This is a good story, for sure. And it did. I mean, and it continues to, right? For sure.
[01:08:42]

Tacey Ann Rosolowski, PhD
[01:08:41]
Well, tell me about that journey.
[01:08:43]

Thomas Buchholz, MD
[01:08:43]
And it was portrayed that way, just by... You didn't have to do anything. You just had to accept the job as provost, and within a day people said, "We've written you off. We don't trust you. You're no longer a faculty member." I was told, "You're not a faculty member anymore. You're an administrator, and we hate administrators, and you're an administrator, and we hate you." You crossed the line, right? You walked over the picket line or something, and...
[01:09:13]

Tacey Ann Rosolowski, PhD
[01:09:13]
You walked to the dark side, yeah.
[01:09:14]

Thomas Buchholz, MD
[01:09:14]
Yeah. And yeah, Tom used to be a good guy on Friday, but on Monday, he's not. Now we're going to have to view him as part of the problem, rather than part of the solution.
[01:09:28]

Tacey Ann Rosolowski, PhD
[01:09:29]
I mean, it's interesting that they didn't—because certainly another perspective would be, oh, here's a person who we know. We've known him for years. We've worked with him for years. We really do trust him. He would bring a positive influence to this scenario. Interesting they didn't say that.
[01:09:46]

Thomas Buchholz, MD
[01:09:45]
Oh, yeah. Well, they did, too, right.
[01:09:48]

Tacey Ann Rosolowski, PhD
[01:09:48]
They did that, too. Good. Good. (laughs)
[01:09:50]

Thomas Buchholz, MD
[01:09:49]
Yeah. So it wasn't all one or none. It's just probably the people who thought that are less apt to jump in in a very positive thing when there's chaos going around, right?
[01:10:09]

Tacey Ann Rosolowski, PhD
[01:10:10]
Yeah, and somehow naysayers are very vocal people.
[01:10:12]

Thomas Buchholz, MD
[01:10:12]
Naysayers are (laughs) very vocal people. And there was an agenda, even at that time, I think, to have Dr. DePinho removed. And they weren't looking for solutions that would make it okay. And so it was a challenging thing. And I wasn't naïve to that, right? I had lived that for a window of time, and I had my own credibility, and my reputation, and now I think it was recoverable, because it was a short period of time, and I did the best that I could, and they might think of me as, well, obviously, Tom, you'd never be the final provost because you're not that type, and, okay, we're going to let you back into our community. (laughter) So it was challenging. But then I jumped back in, and I jumped back in as Physician-in-Chief. And I thought I knew physician-in-chief, because a physician-in-chief and provost work very closely together, because we co-managed the faculty. That's a big job. I had been managing our clinical care enterprise here as division head. I kind of felt like I knew that, but the scope of our clinical enterprise at MD Anderson is daunting. So I underappreciate how big a scope the Physician-in-Chief job was, particularly under Ron's leadership. This wasn't where he had a lot of experience himself. So he wanted someone that he could really count on to do it. And we were implementing Epic, right? We were on our three-year journey. Are we still going to be *US News* number one? What's this whole healthcare reform issue? What's value-based reimbursement? How is healthcare going to change our clinical environment? I'm suddenly responsible for 80% of a $4 billion budget, in terms of revenues. It's like, wow, there's still a lot for me to learn. (laughter)

[01:12:33]
So I quickly realized, number one, I had to step down as Division Head of Radiation Oncology. I think that was a given. And that came with a lot of sadness, and challenging for our group here, which, again, I had a great degree of loyalty to. But it was fun. And I felt as if I was empowered as Physician-in-Chief to really tackle some of the things that we didn't do well in the clinical environment that everybody knew about. I'd worked here. If anybody ever had cancer, I would say, "We give the best cancer care. We have the best outcomes. We have surgeons who work closely with radiation and medical oncologists. We have our best pathologists. The talent of our people is par none, and the integration by which they are colleagues and work together, truly outstanding. But being a patient here can really suck, right? You could... It's impossible to get an appointment. So many people call and want to come to MD Anderson, and they can't get in. The systems are broken, the operational systems. You could sit in that waiting room, in chemotherapy, for eight hours before they give you a transfusion."
[01:14:01]

Tacey Ann Rosolowski, PhD
[01:14:01]
Really?
[01:14:01]

Thomas Buchholz, MD
[01:14:01]
The whole patient experience of being a patient here can be great, because everybody's passionate and caring. It can be a nightmare, too, right? People just wait and wait, and you're lucky you got in here. And even the whole focus was we were research-driven patient care. So sometimes people would say, "Oh, we don't want to see patients unless they're eligible for a protocol. We got too many patients." And then people would say, "Oh, thank God I got to see you. I've waited for four weeks. My tumor's growing, but I wanted to come to MD Anderson." "You're lucky you got in here, yeah, because we're..." It's not overly patient-centric. So I want to change that culture. I thought that was my calling. We're going to become patient-centered, value-driven care. And we did it right in the same time we were having a framework of our strategic plan. Remember that? And that gave me kind of an organizational structure by which to build a team. We lost—our Senior Vice President of Operations quit before I started.
[01:15:18]

Tacey Ann Rosolowski, PhD
[01:15:19]
And who was that? Remind me?
[01:15:20]

Thomas Buchholz, MD
[01:15:21]
Gerald Coleman. He worked with Tom Burke.
[01:15:24]

Tacey Ann Rosolowski, PhD
[01:15:24]
Yeah, I know—
[01:15:24]

Thomas Buchholz, MD
[01:15:24]
And I know Gerald quite well. He's a good guy. But it also gave me the opportunity to create my own team. I felt like there wasn't sufficient administrative faculty partnering in coming up with these clinical solutions, that it was kind of... Memos would come out on Friday that sometimes as Division Heads you weren't even aware of, and, like, hmm, what do you mean? And so I tried to create a system where we had more dyads of faculty, and so I created executive medical directors to work with executive administrative directors. We created an access program. We created a patient experience program. We highlighted quality and safety. We implemented... I'm really proud of what we've done. In the end, when you write it all down in a résumé or something, wow, we've made transformative changes at a time when our institution

really needed to do that. And it was fun. I think after a year's search, I brought in Bob Brigham. Bob literally, I think, is the best hospital administrative person in the country. His talent in that space is incredible, and his leadership ability, to... If you want to interview a good leader, go fly up to Duluth, Minnesota and interview Bob, because he really knows how to implement these leadership trainings in a real logistical way, and he knows how to run a hospital, and he knows how to run a clinic, and he knows how to build a team, and he knows how to get engagement. He could relate to faculty's perspective without alienating them, and he could relate... He was a really tough person. I was a philosophy major. I studied medicine for four years. I'd studied radiation oncology for five years. Then I learned how to practice cancer, and I learned how to do research, and I learned this, and... I had never once studied how do you run a 660-bed hospital. Right? How do you purchase drugs. How do you do... How do you run a blood bank, right? What does it take to be a high-quality inpatient care for a bone marrow transplant? I don't know, you know? (laughs) I mean, what kind of training did I have to be the person in charge of MD Anderson's massive clinical enterprise? It's kind of intimidating when you think about that. But, again, I felt completely competent in that, because of the people you surround yourself with. And then the leadership... MD Anderson is definitely a faculty leadership place, so they need to have that faculty leadership voice leading that. So that was actually fun for a while. It was, again, challenging: hard decisions, unpopular decisions. We tried to move towards a system-based approach to clinical care.
[01:18:39]

Tacey Ann Rosolowski, PhD
[01:18:39]
And what does that mean?
[01:18:41]

Thomas Buchholz, MD
[01:18:41]
It means if you are a patient in the GI Center and a patient in the Breast Center, you should have the same experience, and we should have some sort of equal consistency to—if you're called MD Anderson, that we should have courtesy, and patient-first type of... We should care about how long you wait in the clinic. We should develop systems that aren't always faculty-first, but are patient-first. But I think it also means if we're going to be successful we've got to take out the cost structure of our organization to become leaner. If we have each department have their own IT department, it's less efficient than if you have a central IT department. If you have each department have a scientific editor who's there to help you whenever you wanted to write something, it's probably less efficient than having a department of scientific publications. By centralizing things, even in the Breast Center, you say, "Do you really need the same...? Can somebody handle the Breast and the GYN Center in terms of some administrative function, that we could share some of these resources?" People like to build their own domain. As a department chair, I wanted to have all that stuff. "This is my stuff. I want to have my own IT

department, because then I could manage it." You don't want to give up. But lean healthcare organizations have to look at it from the systems standpoint, and manage... This is the most unique place where you could actually effectively manage as a system. If you go to Duke, you probably have a dean of medical school over here and then a hospital CEO over here, and the two are trying to marriage, and the faculty are caught in the middle. Here, we're all one entity. We have one budget. We don't have private practitioners who have a different agenda. Our academics and clinical are intertwined. It's an ideal system to be really effective at doing this, because we have a reporting structure that works to do it that way.
[01:21:04]

Tacey Ann Rosolowski, PhD
[01:21:07]
I know that we're almost at noon, and you have another commitment. Would you like to stop for today and make another appointment?
[01:21:15]

Thomas Buchholz, MD
[01:21:14]
Yeah, sure. (laughter)
[01:21:16]

Tacey Ann Rosolowski, PhD
[01:21:16]
I know.
[01:21:17]

Thomas Buchholz, MD
[01:21:17]
We're getting near the end, I guess.
[01:21:18]

Tacey Ann Rosolowski, PhD
[01:21:18]
We are, I guess, yeah. No, I really appreciate this conversation. It's just really interesting insights into the organization, and, yeah, it's going to be... I appreciate your time.
[01:21:29]

Thomas Buchholz, MD
[01:21:29]
Sure.
[01:21:29]

Tacey Ann Rosolowski, PhD
[01:21:30]
All right. Well, let me just say I'm turning off the recorder at—what time is it? Probably about five of, ten of noon, or...?
[01:21:38]

Thomas Buchholz, MD
[01:21:38]
Yeah, 12 of.
[01:21:39]

Tacey Ann Rosolowski, PhD
[01:21:39]
Twelve of, all right. Thanks very much.
[01:21:42]

Thomas Buchholz, MD
[01:21:42]
Okay.
[01:21:42]

Thomas Buchholz, MD

Interview Session Three: March 8, 2018

Chapter 00C
Interview Identifier

Tacey Ann Rosolowski, PhD
[00:00:00]
And we are recording, and it's about three minutes after 10:00, and I'm at the home of Dr. Thomas Buchholz for our third session together. Today is March 8th, 2018, and, for the record, I'm Tacey Ann Rosolowski. And thank you so much.
[00:00:17]

Thomas Buchholz, MD
[00:00:17]
You're welcome.
[00:00:17]

Tacey Ann Rosolowski, PhD
[00:00:17]
You retired on the 28th of February.
[00:00:20]

Thomas Buchholz, MD
[00:00:20]
I did, yeah, after a twenty-and-a-half-year career.
[00:00:22]

Tacey Ann Rosolowski, PhD
[00:00:22]
Yes, though it's not going to be true golfing and eating bonbons, right? (laughs)
[00:00:28]

Thomas Buchholz, MD
[00:00:28]
Well, that's true. Yeah, on April 16th I start my new job.
[00:00:32]

Tacey Ann Rosolowski, PhD
[00:00:32]
Oh, it is, okay. April 16th, yeah. So that's a little bit—like, five weeks?
[00:00:37]

Thomas Buchholz, MD
[00:00:37]
I know.
[00:00:37]

Tacey Ann Rosolowski, PhD
[00:00:37]
Six weeks? That's exciting.
[00:00:39]

Thomas Buchholz, MD
[00:00:39]
I know. Thank you. I'm excited.
[00:00:40]

Interview Session: 03
Interview Date: March 8, 2018

Chapter 14
A Physician in Chief's View on Strategic Planning: Successes and "Stumbles"
B: Building the Institution;

Codes
C: Leadership; D: On Leadership;
B: Building/Transforming the Institution;
B: MD Anderson Culture;
B: Institutional Mission and Values;
B: The Business of MD Anderson; C: The Institution and Finances;
B: Survivors, Survivorship; C: Patients, Treatment, Survivors;
C: Human Stories;
C: Offering Care, Compassion, Help;
C: Patients; C: Patients, Treatment, Survivors;
C: This is MD Anderson;
C: Understanding the Institution;
C: The Institution and Finances;
C: Professional Practice; C: The Professional at Work;
B: Critical Perspectives on MD Anderson;

Tacey Ann Rosolowski, PhD
[00:00:40]
Yeah. Well, we were going to talk a little bit today. We're going to talk a little bit more about your role as Physician-in-Chief, and I guess a question that—I mean, you may have a list of things in your mind that you'd like to address, and I guess a thing that occurs to me is that you were serving as Physician-in-Chief during a time of turbulence. And how did that manifest itself? Or did it? Maybe it didn't. Maybe the operating issues you had to deal with would have come up at any time. But at any rate, that just sort of occurred to me.
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Thomas Buchholz, MD
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There was—yeah, it was a period of significant turbulence, and significant institutional change, all at the same time. I may have mentioned when Dr. DePinho asked me to be Physician-in-Chief I had to think about it a long period of time—a couple months, in fact—because I had experienced some of that turbulence. And I didn't feel completely empowered to make the turbulence go away. Somehow, as a division head and department chair I felt as if I was ultimately responsible for the culture of our group, and it was a defined group of people that is academically defined and structurally defined. And I felt kind of as the leader of the group that you really are empowered to do that. With the Physician-in-Chief role, I became part of an

executive team, and ultimately didn't have that same level of empowerment to shape the entire culture of the organization, because it was the team responsibility, one that was ultimately the responsibility of the president. So clearly that was a change, and I think that was one of the struggles. Now, the Physician-in-Chief scope of MD Anderson is, at that time, very vast.
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Tacey Ann Rosolowski, PhD
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Yeah, you were mentioning that—I mean, I thought it was interesting; you said you had underestimated the job grossly. (laughter)
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Thomas Buchholz, MD
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Yeah. And part of the excitement for me was the ability to take on some very important issues for the institution's health, for the institution's wellbeing, for our patients, ultimately.
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Tacey Ann Rosolowski, PhD
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What were some of those issues?
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Thomas Buchholz, MD
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Well, again, I may have mentioned I came in at the time where we were undergoing a strategic plan, which was a fantastic opportunity for me to work with the collective institution, and define what are the most important issues surrounding patient care. I'd always been proud to be a member of the most outstanding multidisciplinary-focused team of oncologists and supporting care providers, and yet there were still some aspects that were particularly around the patient experience that can actually translate into worse outcomes, too.
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Tacey Ann Rosolowski, PhD
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What are some of those issues?
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Thomas Buchholz, MD
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Like the inability to get into the institution. Important one, right? Our degree of success cannot just be measured from the time that the patient gets in. It has to be measured from the time that access starts. So someone reaches out to us to receive care at MD Anderson, is a great candidate for care at MD Anderson, but never comes to MD Anderson, it's kind of a failure on MD Anderson's part. And I think that shifts the focus, and the doctors don't think of that because they never meet the patient, and that's really an organizational, administrative hurdle that had confronted MD Anderson for some time, and that's called patient access. And patient access was a real trying thing. Patient financial health: we don't want patients to become bankrupt because of performing procedures that weren't preauthorized. We don't want our institution to not have the resources to put back into our wonderful education and academic missions, because we don't get paid for the work that we do. So there's some nonmedical, social, economic issues that really affect outcomes that we could provide as a community. So patient access, and then patient experience, too. How can we enhance what it's like to be a patient? Patients love their providers. We have a tremendously caring environment. But it's not uncommon for patients to be sitting in waiting rooms for extended periods of time. It's not uncommon to see people with 12-hour days at MD Anderson, where if it was run more efficiently they could be in and out. It's not uncommon to have sometimes have seen the patient not be the first consideration, but other parameters, whether they're institution or physician-related, sometimes took hold. And so shifting our culture to become more patient-centric was a major goal of not just mine, but a recognition within our institution as a way that we need to move forward.
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Tacey Ann Rosolowski, PhD
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Now, let me ask you, because there are a lot of cynical people who see health organizations going in this direction, and they're saying, well, we're treating the patients more like customers and consumers, and it's really money-driven. I mean, what do you say to people like that, who have that mindset?
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Thomas Buchholz, MD
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I'd say listen in to the numerous calls that I have with people reaching out to MD Anderson for help. One of the greatest roles that I was able to play as Physician-in-Chief was to be an individual ambassador for our clinical care. And obviously, with the number of 140,000 patient visits, I should not be putting my efforts as Physician-in-Chief into helping each one of those visits go smoothly. But yet, countless times I called people trying to get into the institution that are kind of referred from a Board of Visitors, or referred... And the gratitude and the assurance that people have is one of the most rewarding things you could do. These are real human moments. There's such a power of being told you have cancer, or the feeling of helplessness, and even if the appointment's not for a week, to have an assurance that, okay, we got this, and

we have a plan, someone cares, someone tells me we're going in the right direction, someone has given me an opportunity to come, instead of being approached to say, "Oh, we might be able to get you appointment. We have to review your pathology first. Can you go find your pathology slides?" The patients don't even know what the term "pathology" means, and feel all of a sudden a lack of empowerment. They're trying. They go to their referring physician, who oftentimes doesn't want to lose the case to MD Anderson, and is going to put up barriers, and people feel trapped, and they feel helpless. And you only have to talk to one person to recognize the power—there's no cynicism in this. This is really helping people at a time of sometimes the most critical psychologically important need for them. And it's very much in keeping with our core value of caring. And it's tremendously rewarding. You really are forever remembered in these people's lives as a really important person who helped them at their hour of greatest need.

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So I think we have to be focused in this. Now, I kind of get customer service, right? We're not going to be a back of the yellow pages cosmetic dentist or cosmetic plastic surgeon who has most beautiful waiting room, and serves tea while you're waiting, because we're going to have it all focused on economic rewards for the institution. I think that where we want to be is to help people in their journey for cancer, and to do it in the way that provides the best outcome for them, outcome meaning medical outcome—that's the most important; outcome meaning survivorship; outcome meaning the patient experience; outcome meaning financial outcome. The whole package. And we have to look at that in totality, and prioritize it. If you don't prioritize it, there's going to be competing priorities. I'm on the MCI Breast Cancer Steering Committee. We have conference calls. Sometimes those conference calls are right in the middle of my clinic. I'm not going to choose an equally important thing to just say, "Oh, don't worry about it. The patient can wait." Or am I going to choose to figure out a system that really affords us to do both? Am I going to say, "I want all my patients to come and be scheduled at 8:00 in the morning," because one time a patient didn't show and I was there doing nothing from 8:15 to 8:30, and it was a real downtime, so that can never happen again? So all my patients come at 8:00, and there's never an interruption in my schedule, but unfortunately that means someone else is being seen at 11:00, because there's a whole bunch of patients waiting until their time comes up, and they've had to wait three hours. So it's choices like that that our providers probably don't recognize, because you're just working your tail off, going room to room. And we have to have that administrative expertise, that system operational expertise, to really facilitate that care for the patients, but we also have to have an agreement that this is an important tenet that we're trying to achieve. And I think we are able to make headways in that. We are able to come up with—strategic plan really helped that. We had a plan about access. We had a plan about patient flow. We had a plan about enhancing the efficiency by which we work, through prefilling out a lot of data, through not being duplicative, and that leads to the Epic implementation of getting an electronic system that works for both the patient and the provider to deliver more efficient care. So we did a lot of transformative things. Sometimes in the long run

they're good; in the short term there's a lot of pain, and there's a lot of stumbles, and there are things that—mistakes are made. And it's quick to say, "Let's go back to the old way."
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Tacey Ann Rosolowski, PhD
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What were some of the learning moments? I mean, I think it's always interesting to look at those moments, that, ooh, there was a stumble here, but look what we learned, and hanging in there was worth it.
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Thomas Buchholz, MD
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I think one of the biggest feelings of stumbling—we wanted to move to centralization and sharing of services, and one of the first ones we did was with financial authorization, which used to be controlled at a local level.
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Tacey Ann Rosolowski, PhD
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What does that—meaning?
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Thomas Buchholz, MD
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Meaning that we have 37 disease site centers, and they were run by 37 center administrative directors. And oftentimes, some of these were run even within departments, if they weren't multidisciplinary. So some of the hematology ones, where there's just medical oncology, a lot of the medical oncology department administrators would be involved. And they would have to get authorization. There were kind of governing sets of rules. But the reporting structure was fragmented within the context of authorization. Each reported to their own CAT or department administrators. They weren't brought together in one way of doing things. And healthcare authorization's get—it's just dynamic. It changes monthly. It's complex. Across the institution, we might be calling Blue Cross Blue Shield of Texas for 15 authorizations. If you have 15 people calling across the institution at the same time to get these 15 authorizations, it's much less efficient than if one person calls and gets—Blue Cross Blue Shield gets 15 authorizations. So just that structure was recognized that it needed to change, but we moved this from the clinical arena into the finance arena, and we were partnering with the people who really knew healthcare authorization. These are the people who interact, who negotiate our contracts with the healthcare authorization, whose job and responsibility is to know this space, and as the space becomes increasingly complex it's hard for any individual distributed person to have the same expertise.

So I think there was an agreement that that was kind of broken, and it's not just a self-recognition at MD Anderson. The people from Epic were saying this. The people from Ernst & Young, who were consulting about best healthcare practices, everybody's reaching the same conclusion, for us to be more efficient, to eliminate revenue loss through bad debt, or procedures done that weren't authorized and not paid for, or financial hardship for patients that were getting stuck with bills for unauthorized procedures. There had to be a different system. And I think it's done remarkably well now in the long term, but as it got started we were pulling people who had this expertise from the distributed system into a centralized person. And when you had someone with content expertise now supervising someone, they found a whole variety of skillsets, some of whom were fantastic, some of whom they were saying, "Whoa, I can't believe this has been happening for five years." So there was a variety of education that needed to get started.

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It soon became clear that we didn't build up the center with the—over-resource the center so that everything would go smoothly. There was still a feeling as if how come my person's not right here next to me. This isn't working. It's much less efficient. They would used to say, "This isn't authorized." I'd say, "Well, it's medically necessary, (snaps) and we'll take care of it down the road sometime." Now we're getting a sense that the physicians sometimes were feeling, well, who runs this? I'm the doctor, and we can't have administrative roadblocks to giving care. And that's, I think, the importance of change management, and having physician leaders, like a physician-in-chief, who really gets the medical aspect, to have department chairs and physician leaders and executive medical directors distributed to be peers with this, and can understand and say, "Well, I get what you're saying, but I'm sorry, we work in the United States healthcare system. We do. It's crazy sometimes, but these are the steps that we have to take. And if we just shortcut them every time, we're going to be worse off. The patient's going to be worse off. And we're just going to have to deal with the frustrations of our modern healthcare system." So there were a lot of—I think the lesson learned from that was we really stumbled a little bit, and I think we didn't fully anticipate what we would find when we brought everybody together, and in doing so didn't have—we didn't adequately resource it. They suddenly kind of uncovered, like, wow, look at the backlog of things that we have to do, and look at the people we have to be doing it. And it took, not surprisingly, some time to really make headway in there. And it got to be, unfortunately—it stumbled enough that there was kind of this archival memory that wouldn't go away. There was always the antidote from, well, three months ago we had this case where we had to cancel the surgery because it wasn't authorized. Those stories, once they're out there, are hard to change, and we should've been more anticipatory to help, and probably resourced it in a different fashion, and really be... I think what happened wasn't really shocking, right? It could've been anticipated, and it could've been better prepared for. And we could've been through mock scenarios, like disaster planning, to help say what are we going to do when this happens. Let's do an exercise, a mock planning. We go live with this financial clearance center, and here's the responses we're getting. How are we going to react to that? Are we sure? Because this could be a real setback. In Epic, we did that.

Interview Session: 03
Interview Date: March 8, 2018

Chapter 15
Shifting to Epic: Taking Stock of a Major Change
B: Institutional Change;

Codes
C: Leadership; D: On Leadership;
B: Building/Transforming the Institution;
B: Multi-disciplinary Approaches;
B: Growth and/or Change;
B: Obstacles, Challenges;
B: Institutional Politics;
B: Controversy;
B: Institutional Processes;
B: Devices, Drugs, Procedures;
B: MD Anderson Culture;
B: Working Environment;
B: The Business of MD Anderson; C: The Institution and Finances;
B: Critical Perspectives on MD Anderson;
C: Understanding the Institution;
C: The Institution and Finances;
D: The History of Health Care, Patient Care;
D: Politics and Cancer/Science/Care;
B: MD Anderson and Government;

Thomas Buchholz, MD
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Again, the Epic implementation was the most significant, transformative issue for our institution in its 75-year history.
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Tacey Ann Rosolowski, PhD
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Really? Really? Nobody's said that before. Why?
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Thomas Buchholz, MD

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(laughs) Well, we took away the basic informational backbone of so much of what we do, and completely redeveloped it. And it's not just it changes your workflow. It changes how you practice medicine. It led to—it required changes on everybody, right? Every 20,000 individuals who worked there were affected by Epic in some form or fashion. So it wasn't just an isolated thing. We could go back and look at the publication about how many electronic systems we sunsetted and replaced with Epic. Its cost was staggering, as human capital, the amount of investment, of time and effort and money that we put into this system, yeah.
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Tacey Ann Rosolowski, PhD
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What were some of the statistics with that, or the figures with that?
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Thomas Buchholz, MD
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Oh. (laughs) I forget. We could go back and look, but...
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Tacey Ann Rosolowski, PhD
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You've repressed it. (laughter)
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Thomas Buchholz, MD
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Repressed it. I just got a text from someone here on March 4th, which was a couple days ago, that said, "Oh, congratulations on our two-year anniversary of being"—I think it was from our IT people—
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Tacey Ann Rosolowski, PhD
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Oh, wow.
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Thomas Buchholz, MD
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—of being... And really now I think we're over the pain of Epic, and really start to appreciate its benefits. It's a financially—it's a much stronger system for financial transactions. It's a vehicle

that we could use moving forward to get access to reports that help us manage our operations. I think one of the things pre-Epic that would've been frustrating when you try to make change for the better was the lack of data, in that everybody perceives that, well, this isn't really a problem, or this is a problem, and Epic provides you with a significant amount of data, and the reports that allow you to make data-driven decisions about how to maximize your operations, both from, again, the patient experience standpoint and from the financial operational standpoint of the institution. One of the things that was great about Epic, too, is their project management skills. They were very hands-on through our three-year pre-implementation journey about meeting milestones. We got monthly report cards about the status of whether they'll allow us to move forward or not, whether we were making sufficient progress, and doing all that we needed to do to make this a successful launch, where we could do it safely and effectively. And so they were right in line with us for three years. We had Accenture, who, again, it's common to have a change of management organization consultant watching how you're getting engagements, and this roadmap, again, taught us as an institution of how to work together in a true multidisciplinary project management system. We had people who were in pharmacy. We had people in the financial sector. We had people in operations. We had physicians. We had operating room perioperative services. The whole breadth of MD Anderson was affected by this, and...
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Tacey Ann Rosolowski, PhD
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So these were workgroups from these individual areas that would come together to plan and...
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Thomas Buchholz, MD
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Yeah.
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Tacey Ann Rosolowski, PhD
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I mean, people must've come into contact with individuals in the institution they'd never encountered before.
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Thomas Buchholz, MD
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Yeah, to a large extent, and we had an executive committee that I chaired and was responsible for that brought it all together, and we met—I can't even begin to fathom how many hours we

met over this three-year... It was a major component of my job description at that time. And it's—
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Tacey Ann Rosolowski, PhD
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Do you feel like it created additional...? Well, I don't want to say that, put words in your mouth. How did going through that multidisciplinary project planning process, how did it have an impact on the culture, do you think?
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Thomas Buchholz, MD
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Well, I think there was kind of broad recognition and acceptance that we have to move forward in this space. There wasn't... Ultimately, there was pushback about it from some individuals. It, again, moves one more to a system structured and less of an autonomous, "I used to practice this way; part of my identity is the pride of my particular patterns of care, of how I do things. I'm recognized for that in my own self-worth. And this is taking the beauty of what I'm doing, and making me do a paint-by-number. And that you're getting to kind of where my core is, too, and I'm feeling uncomfortable with that." So there's some of that. Other people say, "Well, my identity isn't wrapped up in this thing. I care deeply about my patient/doctor interaction and care thing, but documentation and other things, this is just an administrative process anyway, so just tell me how to do it, and I'll do it that way, and I'm going to continue to be the physician that I want to be, and I'm not going to get—you could tell me to do this way or that way; it doesn't matter to me."
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Tacey Ann Rosolowski, PhD
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Has Epic increased—I mean, once people learn how to use Epic, do they spend more time on administrative—
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Thomas Buchholz, MD
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Mm-hmm.
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Tacey Ann Rosolowski, PhD
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—duties? They do.
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Thomas Buchholz, MD
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They do. They do. And they... Yeah. There are... You have choices, again. The clinical documentation... I remember when I first got to MD Anderson, you meet some of our legacy, old-school surgeons, and the beauty of an operative note that can describe in poetic terms what I just did for the past six hours in removing this person's pancreas, with very artistic flair, again, appropriately, can be a true source of pride, you know? To come out of it now and look at an Epic note where it's just kind of—they all look the same, they're all kind of structured, they all blah-blah-blah-blah-blah-blah-blah-blah-blah-blah, takes away the fun of doing it. And there's ultimately more and more responsibilities placed on the end provider, the highest-paid attending physician, who used to have the nurse fill out all the orders, and suddenly there was something in your—as you walk by, she'd say, "Oh, here, Dr. Buchholz, sign this," and they'd quickly sign it. And now the rights and responsibilities, etc., of who's really accountable for this, is Medicare going to bill this if the nurse requests it, all these complexities gives this—formalizes a process that makes it much more onerous for the physician. And it puts a lot of onus on mid-level providers, too, and you start to work below your skillset, some people feel. And that's true. That's true. There are efficiencies, no doubt. If you want to learn Epic, and really understand Epic as a software tool that could increase your efficiency, you could be extremely efficient. And if we had the discipline to, again, go into this as a shared group, where you and I are working together, and if I see the patient, I agree to fill out this body of work that directly benefits you, and you don't have to repeat it, and everything's there and handled, you could be exceedingly efficient. And if you template things, and you don't... More importantly, we're able to generate data. Then if we take a poetic, operative note, there's no structure to it, and we can't glean, well, what are the important elements in these 15 operations. We'd have to manually go try to interpret this and pull data and make them all match, because they're not in the same format, whereas if you get into structured clinical documentation, you really have data then to show what your outcomes are, and you have data that eliminates the redundancy, the waste of doing clinical research. We're going to get to a system with electronic interfaces that really provide useful, efficient way of practicing medicine. That's why the government's mandating this, right? That's why this is a strategic thing on the government's part to say we're going to get there. And we should be the leaders in that space, I think, right?

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One of the frustrations in leaving was Epic has a lot to learn about oncology. They're building this healthcare thing to cover primary care. That's the most common type of medical care. And so we were the biggest oncology go-live they had, and we could serve as a resource to standardize United States oncology workflows with Epic. And it was a great opportunity that I

had hoped to pursue. Because of the size of our institution, I'd developed a professional relationship with the founder and CEO and sole owner of Epic, who—
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Tacey Ann Rosolowski, PhD
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Who is...?
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Thomas Buchholz, MD
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Judy Faulkner. She's very interesting, *Forbes* billionaire who signed the Buffett pledge to give it all away at the end. And she's sincerely interested in that, but... So there's still a great opportunity for MD Anderson to have that influence on Epic and United States healthcare. And you couldn't do that without this type of electronic medium to their... But I'm proud of how Epic did. Again, we stumbled a little bit on this. Unlike the Financial Clearance Center, we had anticipated that. We had gone through those mock scenarios. We had people at the elbow, ready to support. We had come a long way. Again, when we went live, I think from Epic's standpoint people would say, wow, this is one of our most successful go-live, that we could've done things better. I think one of the things that became a source of frustration was still lost revenue, that we didn't have those checks and balances in place to be matching things up pre and post, and assuring we identified discrepancies. And that took us a little bit of time to do that.
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Tacey Ann Rosolowski, PhD
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Yeah, I was thinking that the discussion during the financial crisis, of some of the, quote, "leaks" as they were called in the Epic system, how... I mean, I'd like for you at some point to talk about the finances of Epic, and how much Epic contributed to the institution's financial crisis, but we can get to that later, if you...
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Thomas Buchholz, MD
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Well, no, I think it contributed in some ways. One, the contribution was decreased productivity. We kind of slowed the engine down to do this major change in workflow. I think one of the things, in respect to that element, that we didn't do very well, was because of this turmoil with our physicians, because of this lack of trust with the leadership, there was a sense, like, wow, we're really working hard. We have been working really hard. You've been telling us that we have to do more every year, and I'm working hard, and now you're throwing this new change management thing... And so we're going to slow everything down. And there was a period of

time where it was like, ah, okay. But that was coupled with this change in electronic system. We didn't have the discipline to say, "Okay, we're going to do that, and we're going to bounce right back." We didn't have the recognition across our providers of saying, "We could only do this for two months." And so we kind of got into—
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Tacey Ann Rosolowski, PhD
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You mean the slowdown?
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Thomas Buchholz, MD
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Yeah, we kind of got into a new normal. That's not just the physicians. It's the schedulers. It's what do the templates look like. So we kind of got a little bit, "Oh, yeah, we're not back to 100% yet. Let's take our time." In the private community, if everybody's income depended on it, people would learn and recognize the urgency of learning this and getting on, because we have to move. So that bounce back in productivity I think took longer than... And in part that was because, again, people weren't clear on, wow, is this going to result in 800 people being laid off, or is this just going to result in that we don't do the IACS or something like that? The second avenue of revenue leaks—it gets... If you talk to the revenue people, they would say, "Wow, this is the best system ever. We're getting our bills out so much quicker. We're getting paid so much quicker. We have a greater degree of clarity. It's working fantastically." One of their frustrations was they weren't in charge of the revenue. Again, it was a distributed thing. And so each individual department might have different expertise, and this central person, this Brad Gibson, the treasurer who was one of the co-leaders at the executive level on Epic, he didn't have a reporting structure that got into all aspects of billing, that the billings, again, were done locally, and it was their responsibility, and they couldn't control everything. Maybe some of their billings was ending up in a different department, and they had no control over that. And then, again, different skillset within the department. So eventually, I think, we developed kind of standard operating procedures that says, okay, every department has to do this, and prove that you're doing okay. This gets back to two—well, there's a local distribution of things. There wasn't that huge degree of local accountability when it comes to financial performance at MD Anderson, that nobody... There weren't a lot at risk at the local level, so if something went wrong at Epic locally, they would just say, "Well." Life would move on. If there was a deficit at the end, it didn't necessarily affect anybody's pay at the local level. You know, it would just be part of the bigger picture. So we had kind of a systemic accountability for local responsibilities. But I think we got through that, too. We identified things that we were doing wrong as an institution, not surprisingly, and we identified things that, oh, previously we hadn't been capturing this revenue that we now can capture. So there were some of those types of tradeoffs, too.

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Tacey Ann Rosolowski, PhD
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Yeah, interesting.
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Thomas Buchholz, MD
[00:38:20]
But I think on the whole, it becomes, again, once you—you have to learn the system. You're dependent on the user to do it right. Once it becomes kind of part of your workflow and part of your standards, I think the way we used to do financial, the revenue cycle, you look back and go, wow, that was archaic. Wow. (laughs) So I think we're poised now to be in a much better place moving forward, and there have been some disasters in Epic implementations in the country that really have caused healthcare systems to crumble. And I think, in total, while we think about things, MD Anderson did relatively well. What we didn't do well, I think, again, we were really sensitive about the pain aspect. So during this period of time, we really increased our hiring. We're going through Epic. Everybody's feeling the stress. Our clinical providers were feeling the stress. There was a perception that they were providing all this clinical work. They're working harder. Their revenue's not coming back to them. It's going for the Moon Shot program. It's going for some presidential initiatives that they may or may not felt connected to. And why can we spend $75 million over here, but then if I need an additional mid-level provider to help me where all the revenue is generated, why can't I get approval for that? And it's a very commonsensical question, and it's one that I used to ask myself when I was an assistant professor. Organizationally, you have to think about things differently, that, sure, if we get a $200 gift for the Moon Shots we're not going to hire a nurse to see patients with you. We have to have an agreed-upon budget that, within radiation oncology, we're responsible for giving this back, and we have to have a positive operating margin in our unit, independent of whether we're doing the Moon Shot programs or not. And so there was a little bit of confusion on people's minds, but it's easy to see that, hey, there's a real need. And this actually came up leading to the Faculty Senate white paper, with their concern about a whole variety of physician-provided—not physicians, but faculty-provided grievances against how the institution was performing.
[00:41:28]

Interview Session: 03
Interview Date: March 8, 2018

Chapter 16
MD Anderson in Transition after Ronald DePinho's Resignation: Context
B: Institutional Change;

Codes
C: Leadership; D: On Leadership;
B: Building/Transforming the Institution;
B: Growth and/or Change;
B: Obstacles, Challenges;
B: Institutional Politics;
B: Controversy;
B: Institutional Processes;
B: Working Environment;
B: Critical Perspectives on MD Anderson;
C: Understanding the Institution;

Tacey Ann Rosolowski, PhD
[00:41:30]
And remind me when that was published, the White Paper.
[00:41:33]

Thomas Buchholz, MD
[00:41:35]
It was—
[00:41:35]

Tacey Ann Rosolowski, PhD
[00:41:35]
Late 2016, or was that into '17?
[00:41:38]

Thomas Buchholz, MD
[00:41:37]
No, I remember it was in February of... It must've been February of '15. Oh, wow. Ultimately, Chancellor Cigarroa had come down and met with the Faculty Senate. Chancellor McRaven took over, really wanted to address some of the issues. The faculty morale survey had been out there. There was a great degree of dissatisfaction at that time. They were striking chords across not just a small group of Faculty Senators, across the entire institution, and people were feeling stress about the clinical situation, or feeling stress about some of these implementations that were

changing the way that they practice. They were feeling stress about the upcoming Epic go-live. They were feeling a lot was changing at one time, and it was pretty tumultuous. And I think the chancellor wanted people to say, "Okay, write down what are your needs." And one of the needs was we need more people to help us do our work. That's not probably the best way to decide expenditures. You need a CFO to start to help make such decisions. So one of the key things that we did in that white paper was we authorized over $10 million personnel expenditures to help with the situation. That has a direct consequence on your operating margin, right? And we eventually got to a point, then, where we weren't making sufficient revenue to handle the expense structure that we had in place. We had too many employees and not enough revenue generated per employee to make this a sustainable path moving forward. And in part that was contributed because of the inability to have an engaged, meaningful dialogue so that people—I don't know that people all have to understand it, but they have to trust that we have a well-run organization, with appropriate expertise, that are making intelligent decisions on behalf of the health of the organization. And without that trust, then you think something crazy is going on: "This isn't really working the way I think it should be working." And then you can't have 20,000 CFOs run the institution. You need a CFO who really understands institutional performance metrics, and can give us the institutional discipline, to sometimes not make everybody happy but to do what's best in the long run for the organization.
[00:45:07]

Tacey Ann Rosolowski, PhD
[00:45:07]
What was your feeling, working on the executive committee at this time, through this turbulence? And, I mean, did you have trust that decisions were being made well, that there were effective conversations?
[00:45:21]

Thomas Buchholz, MD
[00:45:24]
I felt like I had engagement, right or wrong, the way—for the scope of my responsibility, that we tried to create dialogue with the division head community, to a great extent. All of them sat on some organizational structure that ran clinical operations. We had physician administrative partnering down every aspect that would report up into this executive clinical operations team that consisted of the entire division head community. That should be able to represent each of the—each provider in the institution, as long as they're communicating down to their people, and representing their people. You have to have some sort of hierarchy in a system this size to have efficiency and leadership. You have to have some leadership structure. I think where I felt there was failure is we didn't have a real cohesive executive leadership team. I... One of my frustrations was we didn't have the CFO and the provost and the physician-in-chief. For instance, Bob Brigham was our Senior Vice President of Hospital Operations. Bob remains, still, one of the most talented healthcare administrators that I've ever met, and it was a true pleasure to

work with him. He was kind of my side... He had expertise that I don't have, and I had the physician component that he didn't have. And he respected that MD Anderson is a physician-led organization, and he didn't want to change that for any reason. He thought MD Anderson was fantastic. But I also had deep respect that, wow, he really has administrative training and background and 30 years of experience in doing this that does shape how I'm going to go into this. It's a complementary skillset. So we tried to formulate that on the clinical side, but Dr. DePinho didn't like to really have that type of... That wasn't his style. He was much more comfortable meeting with me one-on-one, and saying, "How's Epic going? How's...? How are this? Oh, here's what I'm hearing from some people." He was a tremendous boss because I felt like he supported me, he was confident in me, he had my back. If someone... I always felt as he represent—he'd give me credit. I wasn't seeking credit, but he would speak highly of me. And I could—I felt comfortable talking to him about hard things. And he was very supportive of me. If I called him and I said, "I need you to be here," he would be there. And he didn't micromanage me at all, and he wasn't someone who I wanted to do something, and someone would run around me to the president, and he'd come and say, "Tom, you can't do it that way." He respected that, gave me the authority to do this, and stood by me with that.

[00:49:23]
So that was great. I really thought he couldn't have been a better boss for me as Physician-In-Chief in terms of my responsibilities for my job scope. But secondarily, my responsibility as a member of the executive organization to make this whole culture piece work, to really set kind of... One of my responsibilities is to go downward and do everything that reports up in to me. Another is to be a leader of the organization, a member of the executive team. How are we going to shape this? How are we going to get...? What type of...? Let's sit around. How are we going to get the division heads onboard and make them really feel connected? How are we going to get the faculty—what are we going to do about this Faculty Senate, right? They're clearly trying to impeach you, Ron. Who's going to own this white paper? Is this really the best method that we want? Do we really want this? How come we're not—how come I'm not contributing to such a conversation as an executive vice president? Because they're going to say things about clinical. Are you having a dialogue with the chancellor? Why don't you bring the chancellor down and meet with your executive team? Why don't we have kind of just an honest, engaged dialogue? Should we really be doing this IBM Watson? Boy, there's all sorts of things. Do we want to evaluate? Now, you could say, "Well, that's not really your job description, Tom. You're the Physician-in-Chief. You've got enough going on. You don't have to..." But ultimately, we are accountable as an executive leadership team, and ultimately I was accountable for those very reasons. I don't think I lost my position so much because we were working on patient access, or the Epic didn't go well, or... It was because you're a member of an executive team that wasn't really functioning as an executive team.
[00:51:24]

Tacey Ann Rosolowski, PhD
[00:51:24]
Interesting, yeah.
[00:51:25]

Thomas Buchholz, MD
[00:51:26]
And so then we'd get surprises sometimes, and... But I think...
[00:51:35]

Tacey Ann Rosolowski, PhD
[00:51:36]
Can I ask you: did you... Were there other members of the executive team who kind of had that feeling that there could've been a more effective culture of executive leadership?
[00:51:51]

Thomas Buchholz, MD
[00:51:51]
I think so, yeah. Yeah. I think I saw through this there would be a tendency for someone to say, "Well, all that choppy water, that's over here. That's not me. I'm over in this space. I'm going to just focus on what my work is. And maybe it's best that I not push for an executive function that brings me into those... I'm just going to sit down and come in every week and do my work," right? That's not the best, healthiest of attitude for someone, when you only have three executive vice presidents, to do that. So I think we all got along well. I don't think there was rivalry between the provost and the physician-in-chief, or competing resources from business to... So I think we got along well. We just... I don't know. Obviously it didn't work, right? I think the endgame proves that there was—for whatever reason, it didn't work. Now, maybe it was unfair, or other things, but there was sufficient that it ended up with a bad outcome, or...
[00:53:22]

Interview Session: 03
Interview Date: March 8, 2018

Chapter 17
MD Anderson in Turmoil Under Ronald DePinho: A Critical View of the UT System Response
B: Institutional Change;

Codes
C: Leadership; D: On Leadership;
B: Building/Transforming the Institution;
B: Growth and/or Change;
B: Obstacles, Challenges;
B: Institutional Politics;
B: Controversy;
B: Institutional Processes;
B: Critical Perspectives on MD Anderson;
C: Understanding the Institution;

Tacey Ann Rosolowski, PhD
[00:53:22]
When did you see the handwriting on the wall, that this is really not going to work?
[00:53:30]

Thomas Buchholz, MD
[00:53:31]
Well, I was... I was getting to the point myself where I was feeling like, wow. I felt frustrated, in part, with UT System, too, that UT System was concerned, and welcoming input, and getting a lot of phone calls and welcoming emails from disgruntled faculty members. And they had some concerns, but they never came and met with me one-on-one and say, "Hey, you're probably the closest one in the midst of this organization. You could see it from the leadership perspective. You could understand. What are your thoughts on it?" They were... And I'm not the type of person that's going to hop in my car and drive up to Austin and talk about shortcomings of the executive functions of the institution. I would be someone that would welcome a dialogue if asked, but if they're not interested in hearing that, so...
[00:54:49]

Tacey Ann Rosolowski, PhD
[00:54:50]
Why do you think they didn't? I mean, it's kind of interesting. They were in a weird position, obviously. I mean, they had so backed the selection of...
[00:55:00]

Thomas Buchholz, MD
[00:55:00]
Well, I think if they came down... If you want an honest opinion of how Dr. DePinho's functioning, and how can they be more supportive to enable him to function better, it makes sense to talk to the people who were working with him every day, right?
[00:55:17]

Tacey Ann Rosolowski, PhD
[00:55:17]

Absolutely, yeah.
[00:55:17]

Thomas Buchholz, MD
[00:55:17]
And to do a 360-degree kind of assessment of the climate, and what are suggestions for improving the climate. There wasn't a true assessment of Dr. DePinho's performance by UT system. They were just kind of letter-to-the-editors assessment, right? There wasn't a true effort on their... They could've hired someone to do that, right? We had all these leadership consultants coming in every week it seemed like, that would try to help with this, and we'd have honest conversations. We'd say, "Well, where did this go?" And so there was enough people offering suggestions. It's just they chose not to do that. And back to where you felt what I felt, like things really have changed, they came up within a solution to the problem that didn't really address the problem. And I think that was when the solution just organizationally didn't make any sense.
[00:56:28]

Tacey Ann Rosolowski, PhD
[00:56:28]
What was the incident?
[00:56:29]

Thomas Buchholz, MD
[00:56:30]
Well, I think, in the end—this is Tom interpretation. Now, I wasn't in the room, so this is... In the end, they felt as if Ron had tremendous strengths in a lot of areas: fundraising, connectivity. He was even getting more—Ron himself was getting more interested in becoming a national voice of healthcare, and he was involved with the transition to the Trump administration, and having a real influence of who are going to be the leaders of healthcare moving forward. And he was connected with the Pope, and he was hanging out with Mark Zuckerberg. And he had become such a face of not just oncology but really healthcare, and electronic healthcare, and the

interface of how we could deliver healthcare, and he was into that. He really enjoyed that. And he was good at that. So I think UT System saw that, and saw the benefits of what that could bring to UT, and then they said, "But what's his shortcoming? It's the downward, inward facing connectivity." So their solution was, well, let's just create out of the blue a different organizational structure. Let's have a chief operating officer who is just kind of randomly put in place almost overnight.
[00:58:10]

Tacey Ann Rosolowski, PhD
[00:58:11]
And this is Steve Hahn.
[00:58:12]

Thomas Buchholz, MD
[00:58:12]
It was Steve Hahn, without any sort of dialogue, without, again—no sitting down with the executive team and say, "Is this the best solution? How would this work? How should we go about recruitment?" They were just going through this whole Rooney rule at UT System about how we couldn't offer a department chair a position unless we had interviewed a female or minority candidate, and how equity... And all of a sudden the deputy president is whimsically appointed within a 24-hour period, it seemed, as if there is this crisis without... I never gave any input in the organizational structure. And you think, again, as—I don't know if Ron was given an option about this.
[00:59:10]

Tacey Ann Rosolowski, PhD
[00:59:10]
Yeah. Yeah, I was wondering about that myself.
[00:59:12]

Thomas Buchholz, MD
[00:59:12]
I don't know. It wasn't as if we have an executive committee meeting to talk about this. It was, "Oh, Tom, this is going to be okay. Your job's not going to change. You're—"
[00:59:26]

Tacey Ann Rosolowski, PhD
[00:59:26]
And who was the one who gave you that message?
[00:59:27]

Thomas Buchholz, MD
[00:59:27]
Ron, yeah. We'd have one more... I was like, "Well, I think... Why don't we pull us all together? Of course it's going to change. Let's welcome Steve. Let's kind of identify what's going to be your roles and responsibilities." And Steve was put in a really awkward position. I think he was hearing one message from UT System, and hearing another message from Ron. And from there, it just started to look like, hmm, things are going to unravel. And, again, this is Tom's speculation, not with any insight. I don't think the Chancellor brought in Dr. Hahn to then give a pathway for having Ron step down. I think he really brought him in as a solution to allow Ron to be successful. But the irony was within six weeks or so, then...
[01:00:35]

Tacey Ann Rosolowski, PhD
[01:00:35]
It was over.
[01:00:36]

Thomas Buchholz, MD
[01:00:36]
It was over. And...
[01:00:38]

Interview Session: 03
Interview Date: March 8, 2018

Chapter 18
MD Anderson in Transition after Ronald DePinho
B: Institutional Change;

Codes
C: Leadership; D: On Leadership;
B: Building/Transforming the Institution;
B: Growth and/or Change;
B: Obstacles, Challenges;
B: Institutional Politics;
B: Controversy;
B: Institutional Processes;
B: Critical Perspectives on MD Anderson;
C: Understanding the Institution;

Tacey Ann Rosolowski, PhD
[01:00:37]
Yeah. And he resigned. It was March—was it March 8th?
[01:00:42]

Thomas Buchholz, MD
[01:00:42]
I'm not sure.
[01:00:43]

Tacey Ann Rosolowski, PhD
[01:00:44]
Yeah, I think I have it someplace in here.
[01:00:45]

Thomas Buchholz, MD
[01:00:45]
So that kind of—
[01:00:47]

Tacey Ann Rosolowski, PhD
[01:00:48]
March 8th, 2017. We're doing this on the anniversary, (laughs) to one year.
[01:00:53]

Thomas Buchholz, MD
[01:00:53]
Holy smokes, yeah. So I think... Yeah, that was... So now we have in place a new structure, and nobody knows what the structure is. Nobody knows what the roles and responsibility—what's the role of Chief Operating Officer? What's operation? Well, is that clinical operations? Well, isn't that the role that the Physician-in-Chief has? Who's going to...? It was clear that I wasn't reporting to Steve Hahn; I was reporting to Ron. We weren't having an executive team meeting, saying, "How do we all work together? We're introducing a new member. Who's going to do what? Who's going to...? If someone has an issue, who do they come to?" It was just complete (overlapping dialogue; inaudible)—
[01:01:45]

Tacey Ann Rosolowski, PhD
[01:01:45]
I mean, I have to say, I'm sitting here exerting great self-control in not dropping my jaw, because really, it's nuts. It just seems nuts when you lay it out like that.
[01:01:55]

Thomas Buchholz, MD
[01:01:55]
(laughs) It is. And it just became... It became crazier and crazier.
[01:02:01]

Tacey Ann Rosolowski, PhD
[01:02:01]
Yeah. And it's just... Philosophically, it's so completely at odds with how you think leadership expands as you move up in an organization, because the logic is the higher you are in the organization, the more holistic a view of that organization you have. So of course you would sit down with your people at your similar level and have a conversation about what they do, so everyone can have a more sophisticated understanding of the whole organization. That's, yeah, crazy.
[01:02:33]

Thomas Buchholz, MD
[01:02:33]
So there are a lot of... Yeah. And I think we have to—in some respects, Ron without having this team type of engagement was set up for this. The UT System, without reaching down and getting engagement from other people, I think eventually the dissatisfaction from the Faculty Senate was echoed by the division head community. And I think the division head communities were really feeling, wait, there's so much of this going on. How much we're having an institutional financial problem, and now I'm hearing that we're going to spend money to build

new roads at Bastrop Primate Center? I've never even been up there. What are we doing up there? Wait, how come I can't be a part of the conversation? And they were thinking that there's this executive member team that's having this, and they're not involved. I wasn't in any meetings to talk about this. There was no type of... And that's what UT System had to come to understand before they started to make arbitrary decisions. Even the selection of anybody for this chief operating—what would be the first thing you do? Is this the right person for the job? Well, we better talk to their boss. Nobody talked to Ethan [Dmitrovsky, oral history interview]. Nobody talked to me about anybody's qualifications, or lack of qualifications. So it was just so random and arbitrary, it seemed like. And it was a solution that I didn't feel really fit, and it led to, then, confusion. It led to discomfort. Steve and I were friends, right? So I personally recruited Steve to take my job as Head of the Division of Radiation Oncology. I personally put him in charge of the Finance Committee of the Executive Clinical Operation team. And he had a good connectivity with the faculty. I think he became someone that the Faculty Senate really respected, and I think that was kind of their person for the job, at least the endorsements coming out of the cancer letter. It really [felt?] awkward, then at the point in time reading about all of these things, and just having it propagated in the press about... And you're scratching your head and going, wow, this is strange, right? This is really strange. And then to have Ron resign so shortly thereafter really kind of threw this place into chaos. So yeah, I didn't know what was going to happen. I really—I didn't know what was happening. Everybody in the Physician-in-Chief Office, everybody in the Provost's Office, nobody knew what was going to happen.
[01:06:06]

Tacey Ann Rosolowski, PhD
[01:06:06]
Oh, I was wondering about that, too.
[01:06:07]

Thomas Buchholz, MD
[01:06:07]
And there wasn't any type of engagement. And then, in the end, I got—this was after Ron resigned—Dr. Greenberg was tasked to appoint a committee to find the next interim leadership. And so he reached out to me for the first time, then, to say, "What are your thoughts, Tom? I'm going to get thoughts from a lot of people, but I want to start with you. What are your thoughts?" And it was an interesting conversation. I didn't know... I'd had a call that—Dr. Greenberg had scheduled a call with me, and I was like, hmm, that's going to be interesting. (laughs) I didn't know if he was going to say, "I'm sorry, Tom. We're moving on. Everybody's transitioning out, and we've got to start fresh and new, so good luck. We're having you step down," or... In contrast, I mean, we had a really positive conversation where he spoke very highly of me and the job I was doing, and the role that I played in the organization, and how I was someone who had trust with a lot of people, and etc. And, I mean, I got off the phone and I was like, I had no idea that he felt that way about it, and it was very positive, very... And

Greenberg's a very authentic person. He'll tell it like it is, right, with very little filters, kind of like I'm doing right now. (laughs) And so I think he wasn't trying to make me feel good. I've had conversations with him in the past where I know that that's not him, he's not going to have that same conversation with everybody in that way. But then I didn't hear again from him until they... And he was saying, "You'd be a good interim president." (laughter) And I said, "Oh, thanks." He says, "I don't know anybody else in the organization that has your experience." And I said, "Well, thanks." It was very positive. And so though—
[01:08:59]

Tacey Ann Rosolowski, PhD
[01:08:59]
Was he seriously assessing your interest in that role?
[01:09:02]

Thomas Buchholz, MD
[01:09:02]
Yeah. Yeah, I think he was. And he wanted my advice on other options, too. He wanted my advice. It was the first time I felt like, wow, I feel a degree of connectivity to the UT System. And then it was two weeks later or so, a week later or so, they scheduled a conference call, and I was pretty confident I wasn't going to be the interim president, because no one had talked to me about it, right? And they said, "Oh, Dr. Hicks is going to be the interim president." And the Chancellor says, "Tom, I really need you to be onboard." And I was like, "Why wouldn't I be onboard? Sure, whatever." And so I think they had listened to a lot of voices in the dialogue, and they decided to go that route.
[01:09:56]

Tacey Ann Rosolowski, PhD
[01:09:56]
Why do you think Marshall Hicks was selected?
[01:10:00]

Thomas Buchholz, MD
[01:10:00]
Well, Marshall had been—when I joined the division head community, he was a division head who... His calm demeanor. He had the respect of the other division heads. A long institutional track record. He hadn't had blatant controversies about himself. So I think he was—
[01:10:29]

Tacey Ann Rosolowski, PhD
[01:10:29]
What were the controversies around him?

[01:10:31]

Thomas Buchholz, MD
[01:10:31]
No, I don't think he had—
[01:10:32]

Tacey Ann Rosolowski, PhD
[01:10:32]
Oh, there weren't any.
[01:10:33]

Thomas Buchholz, MD
[01:10:33]
There weren't any. I think he was—
[01:10:34]

Tacey Ann Rosolowski, PhD
[01:10:33]
Yeah, okay. So a very safe choice in a lot of ways.
[01:10:35]

Thomas Buchholz, MD
[01:10:35]
He was—yeah. He was quite different than Ron. Exceedingly different than Ron, right?
[01:10:42]

Tacey Ann Rosolowski, PhD
[01:10:42]
Yeah, like, (laughs) 180 completely.
[01:10:44]

Thomas Buchholz, MD
[01:10:44]
One-eighty. And so I think... I mean, and I think he had the support. I think there was... Some speculate that this was a great orchestration, and I don't know yes or no, that there was this planned type of thing, and... But anyway, he came in, and then this transition started. And the transition did get uncomfortable, because it was kind of clear to me at the onset that this isn't going to let the dust settle down, and this wasn't a... We need a new president. Ron wasn't the right president, wasn't the right organizational fit. We need a new president to come in, and one who's going to be connected with us, and could appreciate us, who'd get us more engaged. This

was more of we need to restructure our organization. We need to give greater empowerment to the voices of the faculty. We need to give greater empowerment at the local division level, because we hadn't been feeling that empowerment. So we're going to eliminate the EVP positions. We're going to distribute—we're going to move away from the centralization of access, get it back like it used to be. We're going to move—we're going to give more... We were just going through a painful period, right? We laid off a lot of people, and when someone wanted to hire more people—not me—the shared governance committee of all the division heads voted that we have to have a hiring committee, a bureaucratic step. And when you implement that, even though these same people are the ones who approved it, it becomes painful, right? "Oh, well, I just need this person. How many forms...?" "Well, they're not going to meet until next Tuesday." And they wanted to just do away with that. Like, tell me what I need to do and I can take care of that. So the pendulum swung, right? And it swung back hard. And so the organizational changes that happened in the interim period where you not just eliminated the executive vice presidents but you eliminated their entire offices in some respects...
[01:13:29]

Tacey Ann Rosolowski, PhD
[01:13:29]
Yeah, I went over to 1MC [the administration building] a few times, and I was like, wow. (laughs)
[01:13:34]

Thomas Buchholz, MD
[01:13:35]
So just profound organizational change, and done in a way that whomever the new president's going to be, the cement is hardened, right? And there's a proclamation that this is good. People are happier. There's less complaints. So good—
[01:13:55]

Tacey Ann Rosolowski, PhD
[01:13:55]
Was that true?
[01:13:56]

Thomas Buchholz, MD
[01:13:56]
Yeah, absolutely. Because I think the answers were, yes. Sometimes the answer isn't yes, it's going to make the institution better. Culture is one thing, but organizational performance, you're going to get back... Are our Press Ganey scores about patient access going to be continuing to improve? Are they going to drop? Is that going to be good in the long run or the short term? Are our operational performance going to spiral back down? What's going to actually happen

when the local thing underperforms? Are we going to cut their pay? Are we going to get rid of that chair? That wasn't our culture, right? So it's all excitement about local autonomy and accountability. It's very popular, but, believe me, I met with hundreds of department chairs, and said, "How come you have a $10 million deficit here?" "Well, that was—I don't know—that was an administrator that we had to get rid of because... That was left because this faculty member left, and I didn't know how that was happening, and they're not here anymore, so it's not my responsibility," right? Those are the types of things that if you really had a... Well, it *is* your responsibility, right? And I'm sorry, maybe your segment, none of your faculty are going to get a raise because of that. And over here, this group's doing well. We're going to give them a 10% raise. That's not MD Anderson culture, to have these inequities, and start to have competition within the group. So you have to have lived that moment to see this. A chair leaves, and you uncover, wow, there's this cesspool of stuff left behind. And it's not really the new chair's problem, right? They didn't do it, but who owns that now?
[01:16:06]

Tacey Ann Rosolowski, PhD
[01:16:06]
It's part of what they inherit, yeah.
[01:16:08]

Thomas Buchholz, MD
[01:16:07]
Does the division own that? Well, no. I didn't know that, you know? That wasn't kind of the... So it's going to be interesting. I feel a frustration that we were—I got an opportunity to mingle with lots of CEOs in healthcare summits and stuff. We, in many respects, were the envy of the world with our system of having the healthcare system and the physician system all integrated into one thing, that the economic incentives of being salaried was controlled. You didn't have economic competition between services. You could truly work as a group. You could support your research effort with clinical revenue. It's the perfect system. You could share services, decrease expenses. You can focus on institutional initiatives. You just need the right... Everybody wants to operate as a system, rather than a series of fiefdoms. Our structure was designed to allow that to happen in a way that most academic healthcare systems don't have. They have an academic dean and a hospital CEO, and the two are kind of competing. So it's perfect, but we lost that opportunity, maybe. I don't know that we lost it, though. I think Peter [Pisters, MD], our new president, he's a system thinker in his heart.
[01:17:50]

Tacey Ann Rosolowski, PhD
[01:17:50]
And so you're referring to Peter Pisters—
[01:17:53]

Thomas Buchholz, MD
[01:17:53]
Yeah.
[01:17:53]

Tacey Ann Rosolowski, PhD
[01:17:54]
—the new president, who started—when was that?
[01:17:57]

Thomas Buchholz, MD
[01:17:57]
Yeah, he started.
[01:17:57]

Tacey Ann Rosolowski, PhD
[01:17:57]
Was—I'm trying to remember, two months ago he's been here?
[01:18:00]

Thomas Buchholz, MD
[01:18:00]
Yeah. So...
[01:18:04]

Tacey Ann Rosolowski, PhD
[01:18:04]
Yeah. And he was an interesting choice, too, because, coming back to MD Anderson, recruited by Raph Pollock [oral history interview].
[01:18:12]

Thomas Buchholz, MD
[01:18:12]
Yep. I mean, Peter... I think Peter met a lot of the... You could look retrospectively and say, I kind of get why they selected him. He's a true clinician. Ron wasn't a clinician. So he really could connect with the clinical faculty, and appreciate what they were saying in a way that Ron didn't have that connectivity. So he's a truly outstanding oncologist, truly outstanding surgeon who came from MD Anderson. He had administrative skills at MD Anderson. He got formalized training at Harvard. And then, most importantly, I think, he has this experience of being a true healthcare executive leader. That's the experience that changes your perception of

things, you know? It shouldn't change mine. I can see the world differently in each of the various leadership levels that I have, and not because you're drinking Kool-Aid or something. You have a different organizational landscape that you're a part of, and you start interacting with other people who do this. You start interacting with healthcare administrators. You start reading literature that I wasn't reading as a radiation oncologist. You meet other CEOs of healthcare systems, and academic healthcare, and you start to see that some of the things you're confronting, everybody in the world's confronting, and we have to be prepared for that. So I think Peter has that experience, and will bring that to our organization, so... And for me, I guess my final chapter, then, as I was asked to step down as EVP, I went back to being a professor of radiation oncology. And it was great to go back, of course, because I was a division leader for a long time, and I was loved by the community, and welcomed back with open arms, and I loved being a doctor, and so it was fun to get back to patient care. But it was shocking how you went from being busy in meetings from 12 hours a day to not having a single meeting scheduled, and for the first time not having an institutional leadership in any form or capacity, even when I was a second-year faculty member. So I started to run a residency program, and do other things. Here, I was just, oh, you're free. (laughs) And in many respects, the institution treated me fairly, from I didn't feel as if... I get that when you raise up the organizational ladder you're very vulnerable. I had seen that for the people I replaced, right? So I'm not naïve to that. And it's okay to make organizational changes, too, particularly, I thought, if a new president came in and wanted a different physician-in-chief. I get that. I'd be supportive and help that. I didn't like the way that the whole thing came about with lack of clarity, or lack of the way I would want it to be done, but that happens, and...
[01:21:49]

Tacey Ann Rosolowski, PhD
[01:21:50]
How was it done?
[01:21:51]

Thomas Buchholz, MD
[01:21:52]
I just didn't... Again, that whole—I'm not sure having this whole interim period changed the—tried to change some really important institutional structure, and to change it within a six-month period, and having it all in place without input from your new leader, not sure that's the best way to go about it. I think to let the organization catch its breath... We lost so many good people, right? Think of all the people who've left in this period. And you could say it was time for them to leave, but there's just such a widespread swath. We don't have a provost department. We don't have a physician-in-chief. The reporting structure of the division and faculty has changed. We have all new people in all new positions here, with no continuity of care. So I kind of disagree that that should be the way to handle it, but, again, I wasn't given the... I wasn't in a position then to be responsible for that.

[01:23:12]

Tacey Ann Rosolowski, PhD
[01:23:12]
Right. I want to just check in with you about time, because it's 11:25, and I—
[01:23:18]

Thomas Buchholz, MD
[01:23:17]
Okay, let's wrap up. (laughs)
[01:23:18]

Interview Session: 03
Interview Date: March 8, 2018

Chapter 19
A New Opportunity in California
A: Post-Retirement Activities;

Codes
A: Personal Background;
A: Character, Values, Beliefs, Talents;
A: Professional Path;
C: Evolution of Career;
C: Professional Practice; C: The Professional at Work;
A: Activities Outside Institution;
A: Career and Accomplishments;
A: Post Retirement Activities;
A: Professional Values, Ethics, Purpose;
C: Leadership; D: On Leadership;

Tacey Ann Rosolowski, PhD
[01:23:18]
Okay, because you want to stop around 11:30. Okay, yeah. So, well, you're going to a new opportunity, so tell me about that.
[01:23:28]

Thomas Buchholz, MD
[01:23:28]
Yeah. It was... I had to decide if I wanted to stay at MD Anderson and ride out my career here. And there was a little bit of hurt in the beginning. I'm a pretty optimistic, positive person, and I could get over that, and heal, and forgive, and move on, and... So I have reached a really good place, and... But I felt as if I wasn't contributing enough, that this leadership component has been part of my job for... Well, you saw it here. (laughter) And there were some—
[01:24:22]

Tacey Ann Rosolowski, PhD
[01:24:22]
Actually, from when you were in football. (laughs)
[01:24:23]

Thomas Buchholz, MD
[01:24:23]

Yeah, so many people in the organization, too, are saying, "Tom, you're more than just going back and being a doctor, and you're more than..." And I've done enough academic research-wise that... I'm not a Jim Allison in the laboratory, about to make the next discovery or so. My research is being carried on by those who came after me in a similar type of fashion, so it's not a huge void. So I was thinking, well, what should be my next step, and I was offered a position of leadership in a major cancer center, like MD Anderson. Obviously smaller, but... That just wasn't a good fit for my wife and I, in terms of its location. People started to call us to run healthcare systems. I interviewed for a CEO of a major healthcare system in the Northeast. That, too, I don't think I have the right skillset for that, or the right interest as... So in the end, going to Scripps, it was appealing to me because it allows me to keep my MD Anderson identity, even though I used to be responsible at the end in my Physician-in-Chief role for the entirety of the national network, in addition to from the medical standpoint. And so I was there at the Scripps signing ceremony, and I met with the recruiter when they first posted this position as what are the characteristics that I think should be in this thing. So some could consider this, I think, ah, well, you're not moving up, per se. You're kind of taking a... But I'm looking at it as I'm less worried about a legacy. I don't really care. I want to contribute in a meaningful way, and I want to do it in something that's meaningful to me. And I found I really love the cancer space, and I love being... I think I have the right skillset to do it here. They certainly feel—
[01:26:46]

Tacey Ann Rosolowski, PhD
[01:26:46]
What's the position, exactly, that you will be serving?
[01:26:49]

Thomas Buchholz, MD
[01:26:49]
I'm going to be the medical director of their Scripps MD Anderson Cancer program. So I'm going to be a member of the Scripps Healthcare Executive Team, and then I'm going to have a 10% effort of being an oncology doctor. So the physicians there, they respect me as an oncology doctor. They respect me as an academician. They don't have the same opportunity to publish like I have had in my career. They don't get invited around the world to speak on oncology. And so I think they respect me as being a national, international figure in oncology, who really gets the practice of oncology, and gets academics, and can help give some authenticity to the MD Anderson Scripps program that they're excited about. And in the healthcare administrative side, too, they love the fact that, wow, look at your expertise and how you could help complement that from an organizational... So I think it's a great fit, and I'm excited about it. I'm excited to get in there, and I'm excited about the outward-facing things, too. I kind of got to the point where I really enjoy that. One of the most rewarding things about being Physician-in-Chief was I had the credibility to be a national spokesperson about cancer, and the mission of MD Anderson. I love the fact when people say, "Oh, can you help me with MD Anderson?" I would say, "Yeah, I can

help you. Yeah, do you need help seeing someone, or...?" I love being the face. I was probably the best at being the face of clinical care at MD Anderson, not from an ego standpoint but from a pride of being able to represent that. And I think Scripps is going to afford me that opportunity to start anew, and they have a lot of building to do, but I feel like I got that. This is a... I've been there. I've been through... They have a lot of organizational change to do, and... But it is amazing. Experience does help, right? And I'm confident that I'm going to bring and be a positive thing. And it's fun. The last two months have been tremendously personally rewarding and fulfilling, to the number of people in the organization who are sad to see me leave, who give testimony of the impact that I've had on their careers. It's awesome. (laughs) Really awesome. So it's fun.
[01:29:42]

Tacey Ann Rosolowski, PhD
[01:29:42]
Well, I remember when I asked you to define—because you had said being chair was fun, and I said, "Well, what do you mean by fun?" And you had said it was having an impact. And so you've had an impact on people, a patient, colleagues, patients, and institutions. So that's really great.
[01:30:00]

Thomas Buchholz, MD
[01:30:00]
Yeah. I mean, it's awesome. Yeah, so the advocates are having a party for me Tuesday, or a week from Tuesday. My colleagues are having a party for me on Saturday. Peter Pister's taking me out on Sunday. One by one, all these faculty members want to take me out for dinner one last time, and I'm going to get fat. (laughter) No, but so it gives me a great sense of pride. And I was in the military, as you know, and after 20 years in the military you're supposed to retire. And so I've been at MD Anderson. It feels kind of natural, like, well, that's a good way to close it, and I could have a sense of pride that what I've been able to do far surpassed what I ever thought I'd be able to have the opportunity to do. And then, at the same time, it's, okay, now I've got a new chapter, and I could do this for a period of time and see how it goes. So it's great. And MD Anderson does take care of you. I mean, it's fun to have the freedom now to take care of from the experience, from, yeah, we've been able to afford this beautiful house, and move on. And so it's good.
[01:31:22]

Tacey Ann Rosolowski, PhD
[01:31:24]
Well, I'm delighted. I've really enjoyed our conversation.
[01:31:26]

Thomas Buchholz, MD
[01:31:26]
Thank you.
[01:31:27]

Tacey Ann Rosolowski, PhD
[01:31:27]

And I want to ask you if there's anything else you would like to add at this point.
[01:31:30]

Thomas Buchholz, MD
[01:31:31]
No. I've enjoyed it, too.
[01:31:33]

Tacey Ann Rosolowski, PhD
[01:31:33]
Good.
[01:31:33]

Thomas Buchholz, MD
[01:31:33]
Thanks for hearing my story.
[01:31:36]

Tacey Ann Rosolowski, PhD
[01:31:36]
Oh, yeah. No, it was really interesting. I've really enjoyed it. (laughter) I can see why people say "You have to talk to Tom Buchholz."
[01:31:42]

Thomas Buchholz, MD
[01:31:44]
Well, I'm glad to be part of the archived history now, so... So, good, thank you.
[01:31:49]

Tacey Ann Rosolowski, PhD
[01:31:49]
All right, certainly. It's been a pleasure. And I will just say for the record that I am turning off the recorder at 11:35.

Interview Session: 03
Interview Date: March 8, 2018

[01:31:57]